MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

Maximising workforce participation for older New Zealanders – Opportunities, Challenges and Prospects

Case Study 2: Employer Needs and Practices

by

Sally Keeling, Judith Davey and Fiona Alpass

November 2020

Contents

INTRODUCTION

Purpose of research

As the New Zealand population ages, the need for older people to remain in the workforce for longer is highlighted. Current policy focuses on raising awareness of the value of older people's contributions and reducing discrimination (Office for Seniors, 2019). However, many businesses are already aware of these needs and require more information and practical guidance to attract and support an ageing workforce (CFFC, 2018). At present, there is little advice for employers who are facing these challenges and very little is known about the actual needs of different groups of older workers. Accordingly, the current project focuses on understanding the needs and practices of employers whilst also considering the needs and desires of a diverse range of older workers.

The current organisational case study research project is part of a larger programme of research undertaken by the Health and Ageing Research Team (HART) based at Massey University entitled "Maximising workforce participation for older New Zealanders: Opportunities, Challenges and Prospects (MAUX1705)". This research programme, funded by the Ministry of Business, Employment and Innovation Endeavour Fund, seeks to answer a crucial question for an ageing population: How can government, employers and workers maximise older New Zealanders' participation in the workforce?

Businesses were identified as possible candidates for case study analysis through discussions with the programme's stakeholders, contacts with experts, and by approaching companies and organisations which are known for innovative human resource management. A regional district health board (DHB) was approached to participate in the research through a senior manager. An initial research development meeting was held in March 2019, following a written expression of interest between the DHB and Massey University. Ethics approval for the case studies was granted by Massey University in December 2018.

Methods

***Case study development*:** A week-long programme of interviews was conducted by two Massey researchers (Davey and Keeling) June 17- 21, 2019. A total of 14 individual interviews were held, and three group interviews involved a further twelve staff members of the DHB[1]. See Appendix A for a summary of the characteristics of people who took part in the group interviews.

Data analysis and reporting: All interviews were audiotaped, and then transcribed. Analysis of these transcripts was then undertaken, to compile this report. A feedback process was planned for March-May 2020, at which agreement would have been sought about the content of this report. Due to COVID-19 related issues and the national lockdown in March-April, the feedback and discussion process was conducted electronically. At the same time, this feedback process provided quality assurance of the research process for both the University and the organisation.

[1] Interviewees are noted and numbered throughout this report where appropriate as "Int" and Focus Groups as "FG".

Case Study 2: Workforce

In mid-2019, there were approximately 2700 staff at the regional DHB, referred to as Case Study 2, in 2300 FTE positions. About 70% of staff were in professional categories, covered by the Health Practitioners Competency Assurance (HPCA) legislation of 2003. The gender balance of the staff was 70% female, and the average age of staff was 46.5 years. There were 130 staff members aged over 65 years, and a further 277 in the 60-65 range.

Based on data provided by the DHB, relating to December 2018, the average age distribution varied by classification: clerical staff average age was 52 years, nurses and allied health workers around 45 years, the senior medical officers' average age was 51, and resident medical officers' was 29. The largest professional groups employed were nurses and midwives at 1258 staff, followed by allied health workers at 510, with 403 clerical staff. The average staff turnover rate for Case Study 2, at around 10% per annum, is slightly lower than the average across all DHBs.

Union participation across the DHB workforce is high, averaging 90%. Staff are distributed across several major clinical clusters (including health professionals and clerical support staff), and several clusters described as 'enablers' such as Corporate Services, People and Culture, Digital, Strategy and Performance, and Māori.

Defining older workers

Most of the respondents found it difficult to define older workers in terms of specific ages and they accepted that different people would have different definitions. Where figures were mentioned this could be 55 or 65. There was some suggestion that 65 could be a marker of when physical capacity could begin to decline but there was reluctance to "put anybody into a box" (Int.13). Several examples were given of older workers who were still functioning well (a mental health nurse who is 70 plus) and where older workers were doing better than their younger counterparts.

> *"We have some people here that are 72, and they are as sprightly as you can imagine. And we have some other people in their 40s who are not as sprightly and maybe have a different way of thinking"* (Int.8).

Definitions often cited experience and competency as characteristics of older workers. The main criterion suggested was ability - *"(if they) do their job, and do it efficiently and effectively, I don't think age matters"* (Int.10).

There was acknowledgement that the physical demands of different jobs will have an effect. A nurse, for example –

> *"who is on the ward, on their feet a lot, maybe having to move and support patients … their ability to keep doing that might be compromised earlier than, say, an administrative staff member who's working predominantly with computing, or booking systems "* (Int.4).

A senior DHB manager saw particular positives in age –

> *"I would basically see someone with significant experience and competency, being classified as an older worker"* (Int.1).

"I think we have to take care of our older workforce - their healthcare, their wellbeing, emotional, spiritual and how we support them. Because they are the ones who will continue to develop the next generation to come through" (FG2).

Respondents were also asked if they considered themselves older workers. Quite a few, who were only in their fifties, did so, suggesting that at this age they may be beginning to think about retirement or were at least in mid-career. But again, the viewpoints were diverse and individual, and reflected the variety of settings and demands of a complex workplace.

"I'll be 59 in a couple of weeks. I don't think it's a bad thing, but obviously there might be people that would prefer to have some younger people in (the workplace). At a certain age, they, at a management level, they're probably are looking for younger people".

"I'm 54. I consider myself an older worker lately, because I feel so tired. It's just me talking personally, feeling like an older worker".

"I think some would consider me an older worker. I don't consider myself an older worker. I think that at some point that you would just think you may not have the appetite to come to work and keep doing what you're doing every day. But I don't necessarily think it's about age".

Challenges in managing and supporting an ageing workforce

While few respondents could readily identify initiatives being taken by the DHB in response to workforce ageing, and some said they had not heard of any, all recognised that an ageing workforce did bring with it issues which required notice. Most could see that these were likely to increase in significance in future. Some of the issues identified related to individual workers, but some were more global in their effect.

Physical effects

There was mention that the effects of muscle pain may increase with age –

"…with an ageing workforce, we have had the hip operations and knees and things like that".

Eyesight and hearing may deteriorate, the former affecting workers using screens for long periods. Hearing issues may emerge and needed to be addressed.

"I wouldn't have any hesitation in having a discussion openly about that, with that colleague" (Int.10).

Physical stress may affect older workers who carry out on-call duties. One interviewee noted that a 65 year old may be less able to tolerate two or three calls overnight, or that long working hours may have a greater impact on functioning the next day. In many DHB services, rostering for 24/7 cover, and on-call roles are central to the organisation, so most interviewees recognised that it was necessary to be proactive and think about how the DHB

can manage this in an ageing workforce. This may lead to re-assessment of roles, potential redeployment and possibly "winding-down", which is discussed below.

Declining competence

The possibility or even probability of declining competence and effectiveness on the part of older workers was commented on, along with suggestions of what could be done when 'fall-off' was identified, either by the workers themselves, by their co-workers, or by their managers. At the informal level, one interviewee suggested that older workers may be unwilling to take on extra duties or may take longer to accomplish certain tasks. In this case, teams often work around the situation or -

> *"…start to pick up things to help them"* (FG1).

One respondent in her mid-fifties admitted to feeling tired but put this down to "crazy" demands and an enormous workload.

> *"I think as you get older, you just do get more tired."*

> *"In the case of memory failure or competency issues then you've got to say, "Is this the best choice of work for you now? … Would you like to have some reduced hours?" It may not be the nicest thing to do but we've also got a duty of care to the patients, if someone is not performing at their usual capacity. Most likely, the worker initiates it"* (Int.11).

Some of the issues in this area can be addressed by the DHB's Occupational Safety and Health (OSH) section. People can go straight to OSH and get attention. This can include assessment of cognitive faculties which may not be visible to the person themselves but are having an effect on their colleagues. A comment from FG1, made up of members of the OSH team:

> *"We've had people come through to us for assessments due to major errors that have been made, that have had a cognitive component to them [when] the person's felt that they were fine. Their staff have covered up or made allowances. Because they're part of a team, they're part of their friendship, you know. Other staff have actually provided support to them; sometimes maybe not so helpful in that. And they end up making serious errors. So, we look at their health requirements and their health status. And HR looks at the competency components. They get very blurred, at times, but we try and keep them separate. What's health, what's competency?"* (FG1).

These issues are not of course, confined to older workers. However, in a health sector organisation, it is not surprising that there is widespread awareness of these potential issues in the workforce at any age. Cognitive decline is certainly something which needs to be considered in an ageing workforce and where people are encouraged to work longer.

> *"How do we monitor cognitive skills? Dr X was maybe forgetting to do certain things: would they feel confident enough to report that? And that whole process, then if somebody does raise an issue, and how you handle that? It is worth thinking about that and planning for it now, rather than*

waiting for it to occur. Having a very clear process that we can follow to guide us - dealing with the possibility of cognitive decline in a senior professional. But I've not been faced with it personally, up until this stage" (Int.12).

"Competence has been a recurring theme for me as a medical manager in the last 17 years. There has been the occasional senior doctor, who we have had to stop working - an incredibly painful and difficult process that is for everybody including them. The immense sadness I feel in those circumstances, it's awful" (Int.6).

One respondent makes the link with Advance Care Planning for older workers, as part of encouraging staff to consider their own wishes regarding future health care.

"One of the things we encourage a lot at the moment, and have done for several years, is Advance Care Planning, particularly as (workers) are getting older, to be able to plan how (they) would like to be cared for" (Int.4).

Professional groups in health services have their own competency criteria and processes. As long as workers meet the competency and registration criteria of their professional groups or colleges, and undertake the regular competency assessments required, age alone is not sufficient grounds for an employer or colleague to question their ability to do their job. In addition, the DHB has an annual performance review framework which includes the possibility of personal development plans. These allow the role and performance of individuals to be assessed year by year, for the development of personal goals and plans, and for help to be put in place where needed.

Finding another role

As well as showing concern for their staff, DHB management are motivated by efforts to "get value" out of staff as they age, using their experience and knowledge in other ways; to upskill those that might pick up their duties once they retire (see later sections) rather than losing their services in an abrupt manner. Given the large size of the DHB workforce at approximately 2,700 people, there is often the possibility to absorb a worker into another employment area if they find it hard to function in a particular area because of age. However, we were not given particular examples of instances where that had happened.

Other interviewees commented that there are, however, constraints to these approaches based on the availability of substitute staff and, especially of covering rosters, often on a 24/7 basis. Rosters and on-call work are especially important for medical staff, where substitution is often not possible.

"You can't put an orthopedic surgeon into a mental health unit".

Flexibility for junior doctors can also be difficult as they must meet their training requirements.

One respondent suggested that there is potential for use of older health professionals in research, clinical governance work, oversight of clinical processes, audit, and development and quality improvement, but these functions are not well resourced. A hypothetical example was given of a doctor nearing retirement who could have a significant role in incident review.

> *"But the biggest barrier, to my mind would be resource"* (Int.8).

There is more scope for redeployment in nursing, where the workforce is larger and less specialized, allowing, for example, movement from night to daytime nursing duties. Within administrative, clerical or allied health roles there is also some scope for flexible and supportive adjustments.

Reducing hours

The option of reducing working hours to part-time is an appealing option for older workers and frequently requests in this area have been met and are seen as advantageous.

> *"We've already had some people obviously wanting to retire, and the conversation has started by reducing their working week to four days. I think it's a win-win situation, we still have her knowledge, so she will be around to train a new person. She'll be around to be able to go back to, if we have a query around that service. So, if people are still able to work, and they do a good job, then why not? I like to think that we can be as flexible as possible"* (Int.10).

But several respondents remarked that this may be easier said than done in many areas of the health service.

> *"If you've got three people in a department, and one wants to go half time - - Well, you just can't get a half-time person, it's just not like that. If we have an orthopaedic surgeon who works seven tenths with us, and three tenths in private - Well, that doctor has some more flexibility because they will say, 'well actually, I'll drop my private, and I'm just doing my public', or round the other way. It's easier for bigger departments to do that. But it does create some challenges and issues"* (Int.6).

If it were a specialist who wants to reduce to three or four days, this will put a burden on others who have to pick up the work.

> *"If someone wants to reduce one tenth, it is impossible to recruit an SMO at one tenth. But there might be a tenth here and a tenth there, that you can add up to make a point 7 role"* (Int.14).

If a senior doctor reduces their hours, then some salary would be available to pay a locum. However, locum cover is more expensive than a simple salary cost and can be very hard to find in some specialities. This may result in increased waiting lists and reductions in service.

Working from home

Accepting the fact that the DHB workforce is going to age significantly over the next 10 years or so, senior HR staff see a requirement for lateral thinking. Working from home is one possible response. One "classic example" for this is radiology, where staff -

> *"…can sit at home and read an X-ray. Bringing in a fair bit of artificial intelligence, more reliance on technology where people will continue to do quality work and let the mundane work be done by machines"* (Int.1).

This is seen as part of an adjustment to change, through adopting and -

> *"…advancing technology solutions, so that people can work from home or work more flexibly and contribute in different ways to the delivery of healthcare. We are already advancing telemedicine and those types of initiatives, which might provide some opportunities for people to do things differently"* (Int.1).

Taken to the extreme, new technology may have profound effects on the workforce. Given that radiologists, for example, are an ageing group and hard to recruit, how long before artificial intelligence (AI) will take over and replace this branch of the workforce?

However, when the business is delivering a personal service to patients -

> *"…there's not the opportunity that you might have for flexibility for ageing workers that you might have if you were in a law firm, for instance. And working from home can be a bit of an issue. We are looking at people being able to do (medical) transcriptions from home. But I mean a registered nurse on the ward cannot be working from home"* (Int.1).

The third focus group involving medical transcriptionists explored several issues emerging as proposals for them to work remotely, using password protected access to recordings. One disadvantage mentioned was the potential loss of collegiality for them as a group, and the capacity for them to support each other in workload management, and covering for leave, for example.

Coping with change

Many of the suggestions for adjusting to workforce ageing in the DHB come down to coping with change, both at the individual and institutional levels. Difficulties in adapting to change could precipitate early retirement/departure, which would put strain on staffing adequacy and involve loss of experience.

Intergenerational and interprofessional strains may also be emerging. This was epitomised by industrial action in 2018-19 and calls for shorter working hours and lower workloads.

> *"Younger clinicians have a different approach and different lifestyles. Our older workforce is quite challenged by having to work with a generation who they would see don't have the same commitment as they did - 72 hours on call. I think that's it is a real challenge for the older workforce to work nicely alongside the younger workforce"* (FG2).

Approaches which the older workforce would -

> *"…see that's what you expect to do as a clinician and that's what we were expected to do, the younger workforce sees as bullying. So I think there are some challenges over the next few years, how the two work together"* (FG2).

Managing succession

The related issues of recruitment, retention and retirement come together as DHB managers consider the question of succession and ensuring that key posts in their ageing workforce are filled with appropriate and well-qualified staff.

Gaps can arise between resignation or retirement and having a replacement on the job, which are likely to affect the delivery of health services as well as increasing the burden on existing staff and potentially causing burn-out. Key areas of difficulty have already been identified. Policy responses may be difficult to manage. For example, where senior staff indicate their wish to retire well in advance, a condition has been imposed by the DHB - there is a time period after which they cannot rescind their decision, because a process of replacement would have commenced. Another response would be to "grow" a potential successor from within the staff wherever possible.

Respondents suggested that succession planning could be done better within the DHB with a more proactive approach, although this may risk assuming a specific 'retirement age'.

> *"If we had information about our workforce, - proportions of old vs. young - and if we had information about staff members who were approaching their last five years of work. If that was kind of made available to us, on a regular basis, as a matter of routine, it puts it on the radar, so you can have conversations early"* (Int.12).

Ageism

In an ageing workforce there is the potential for ageism on the part of workers and employers, whether overt or covert. There were mixed views among the interviewees on this topic. Several had not experienced any discrimination and felt that older workers were valued for their experience. But others felt that ageism could be subtle or disguised.

> *"Staff have come to me and said that they don't like certain remarks that are made by young people about them being old. But I haven't seen it as a big enough issue to really go and talk with that person about it, it's all done in the guise of banter, but then a lot of things are in the guise of banter, aren't they?"* (Int.10).

> *"I think of instances where age has come into a conversation because somebody is not fitting in to what we need to do. There's an implication they will be potentially moving on, so it will cease to be a problem, which is obviously coming from an ageist perspective"* (Int.9).

Recruitment

The DHB managers generally exhibited a willingness to recruit older people, largely based on their experience. But ideally often they are looking for a range of ages so that younger people can be trained up and especially when the current workforce is obviously ageing. For some positions, there may be a limited number of applicants, so restricting by age could be counter-productive.

> *"I'd hate to have the general surgery department full of brand-new surgeons. I think some of our older workforce bring a bit of maturity. They've got that experience; they bring a bit of grounding to what we can or can't do"* (FG2).

> *"I just employed two guys who are 52 in the last little while. I started here when I was 58"* (Int.9).

> *"We have recruited older people - middle-to-late 50s. There's a couple that we've recruited that were in their early 60s"* (Int.9).

This openness is clearly reflected from the HR perspective -

> *"…there are no distinctions or discrimination within our recruitment processes... we do recruit a lot of people who are over the age of 55"* (Int.1).

> *"We're constantly recruiting nurses, we're constantly recruiting allied health, we're constantly out marketing for doctors. Because we're anticipating the turnover that may come, or people indicating that they're choosing to retire or take a year's break in another six months or a year. So, we start recruitment pretty early"* (Int.4).

These problems are clearly concentrated in the specialist nursing and medical areas. Immigration is a factor here, but probably not age.

> *"A number of SMOs who we recruit are well into their late 50s and 60s. They come to New Zealand probably for a lifestyle reason. But they come with huge experience and skill sets"* (FG2).

One senior interviewee mentioned that it has been difficult at times to secure a foreign consultant, with uncertainty about age-based immigration criteria, and procurement of real estate by foreign citizens. In the past, the DHB has sought an immigration dispensation for a specialist who was above the immigration age threshold. One interviewee questioned whether their area could measure up in attractiveness when compared to Auckland and other larger centres, either for the quality of available real estate, or potential employment opportunities for an accompanying partner.

Given the scarcity of experienced registered nurses, "picking and choosing" in the area of recruitment is not feasible.

> *"Very much anyone that applies that has got the skills will be employed - snapped up. This has led to an emphasis on employing as many graduate*

> *nurses as possible to keep NZ trained nurses in the DHB workforce, and move them through, trying to look at our succession planning for the next 5-10 years"* (Int.7).

Another area of specialised recruitment is the Māori section, where for cultural reasons elders are especially valued. In the communications area older people would be willingly recruited for their experience. But -

> *"…journalism tends to be a younger person's game"* (Int.2).

So, applicants tend to be new graduates, as older journalists move into PR and other areas where pay rates are better.

Foreseeing future challenges for the ageing health workforce, a certain amount of horizon scanning is carried out in the area of recruitment. But this is limited in its effect by the length of notice given by health professionals.

> *"Some will give long notice, both informal and formal, of their retirement. And others stick entirely to the book, or decide very late, and only give three months' notice. Now, replacing a senior doctor at three months - it's impossible"* (Int.6).

Another example shows where length of notice has been less of an issue.

> *"We had one secretary, who'd worked in one of our departments for 30 years, and when she told us she was leaving, she gave us six months' notice. It was brilliant, but we couldn't find someone that was anywhere near to cover her. The whole department said: "Oh, we're never going to replace her, what are we going to do? Everything's going to fall apart". We said, "look, can you stay on a bit longer, give us a bit more time". She said, "yeah, that's fine". I'm really hot on succession planning and thinking in the future"* (Int.8).

Discussion about the recruitment issues, some of which are associated with workforce ageing, is linked to national health policy. On interviewee suggested that -

> *"…modernization of the recruitment process could incorporate greater use of digital communication: shifting our recruitment process into a more digital form, so that it's slicker and leaner and more responsive"* (Int.4).

Another innovation in recruitment would be for DHBs to work together. The Ministry of Health is taking a lead role in developing *A Framework for Workforce Planning in New Zealand*.[2] Several of those we interviewed were actively engaged in a national process of consultation on this framework, during the first half of 2019, concurrent with this case study.

[2] https://www.health.govt.nz/our-work/health-workforce/health-and-disability-workforce-strategic-priorities-and-action-plan/background-information-development-strategic-priorities Accessed 21/02/20

Retention

Many of the points raised in the previous section apply also to staff retention. The ageing of the workforce could presage a wave of retirements which would be hard to counter.

> *"We've got many, many very experienced clinicians, nurses, allied health, senior clinicians. So, in a way, what we're really worried about is what we're going to do when everybody wants to retire"* (Int.13).

In several areas DHB managers feel that they have been successful in retaining staff. The effect of a "good culture" was mentioned more than once.

> *"If people feel that this is a culture where workforce is valued, that they're recognised and appreciated (they will stay)"* (Int.12).

> *"We do have a really good culture in the public health service – sort of a whanau culture, we're very supportive of each other"* (Int.5).

Examples were given in FG 1, of instances when leaving or retiring in areas where there are staff shortages is seen as 'letting the team down'. In one case a member of staff sought permission from a superior to retire, and another showed their loyalty by ensuring that a successor was in place before they left.

Good wages and flexible hours were thought to contribute to retention of staff, and to generate loyalty. Another strategy which can be adopted is that of career breaks.

> *"One staff member is going back to Europe for a year to be with his family. And we hope he returns"* (Int.4).

This approach is related to entitlements under employment agreements. Most of the DHB's professional and clinical staff can request leave without pay, or a career break for a period. Doctors are able to take advantage of this provision, given difficulties of recruitment, and to avoid the risk of losing the staff member.

The senior doctors' Multi Employer Collective Agreement (MECA) allows for them to apply for a paid sabbatical, intended for training, education and personal development purposes. These breaks could be used by anybody of any age -

> *"…we're fairly generous and open about those things, particularly if we want to retain that person and their skillset"* (Int.1).

Another factor is that most of the DHB collective employment contracts have long service provisions, which are quite attractive for people who want to stay on. When staff do leave or retire, exit interviews are helpful for HR to understand motivations and possible issues in retention.

Training

Access to training is a means of maintaining and developing the skills of staff. This is especially important for older workers, but also assists in retention and showing staff that they are valued. Training therefore relates to several issues which have already been mentioned. The general opinion at the DHB is that age is not a factor in access to training,

but rather need – on the individual's behalf or the employer's. From the HR perspective the value of training is recognised. Some collective agreements have provisions for professional development, which is seen as a significant contribution to public sector education.

Several respondents expressed a positive view on access to training.

> *"We support individuals to work out what their training needs are, and we allocate a budget every year for every individual. We're very flexible around what inspires them, and what they want to learn"* (Int.13).

However, while the study budget is considered "very generous", when it comes to staff having to find their own cover, "if they want to attend a professional conference, that can be quite a bit harder" (Int.13).

Although managers are tasked to ensure all staff are a hundred percent trained, this does not guarantee an equitable outcome in a workplace as complex as a DHB (Int.2). The main barrier to training identified in the interviews was funding, and the way in which this impacts differently between groups of staff. The impression is that medical staff do well, but nurses, physios and others struggle to get approval to attend seminars or workshops because of lack of funding, or of provision for cover (Int.1). This can occur even when the need for training to do their jobs better has been identified in annual performance reviews.

> *"I think that (access to training) adds to the culture of being supportive to the development of the workforce and that would help retain people. But within this DHB education and training has not got the priority that it needs"* (Int.1).

Among several complaints brought up by those who work in medical transcription (FG3) was the lack of career progression and training opportunities for them, in comparison with how they saw the ability of other groups of staff to continue with their ongoing professional development.

A reservation relating to age and training, which has been found in other studies of older workers, was expressed by the OSH group involved in FG1.

> *"I think it's very dependent, though, on their age, and how much longer they're planning on staying. Because the simple fact of cost and time to train someone into a role - if you spend the first six to twelve months getting them into that role and you've only got a further 12 months, and then they want to leave: I think that would be off-putting to a lot of people, because of the simple investment, cost wise"* (FG1).

This attitude was not however widespread at the DHB. A speaker in the same group also supported access to training for all age groups, saying -

> *"I would expect that if you're in a role that requires you to continue to keep abreast of what's changing, then training wouldn't be an issue"* (FG1).

Retirement

The interviews stimulated a great deal of discussion about retirement – how, by whom and when it was broached and the procedures around it. It seems to be frequently preceded by working reduced hours, whether for financial, personal or operational reasons. As previously mentioned, staff did not want to let down a team of colleagues, or commonly they opted to give time for a replacement to be found and trained. The balance of opinion was that the initial move towards retirement appropriately came from the worker themselves, but the question of retirement could also be raised in regular performance reviews.

Phased retirement

Phased Retirement was a favoured option, achieved by cutting down hours. This may arise through a belief that the worker involved was no longer able to manage a full load, or because of changes in the work structure or procedures. We heard several reports of this occurring because the worker wanted to do other things (which in some cases could mean a new job), but usually was accompanied by a move into 'retirement activities' such as spending more time with family, or sometimes caring. The request for phased retirement could be initiated by the worker involved, or by the relevant manager or team leader. In either case the new arrangement would have to be accommodated within the work unit.

Notice of retirement was another common topic. Managers preferred this to be signalled well in advance so that steps could be taken to replace either the whole or part of the leaving worker's input.

Initiated by manager or worker

Several respondents suggested that broaching the topic of retirement with an employee could involve "tricky conversations" and would require caution on part of the manager. We heard several versions in interviews of how well staff understood the need for care and sensitivity in broaching this topic, and Box 1 in Appendix B, offers five illustrative comments.

It may be a question of HOW, and BY WHOM, the question is asked.

> *"I guess it's how you phrase the question. You don't want to make it appear that you're looking for them to move on so you can find a younger replacement. But I would have no problems raising it, you know, in the context of the department and the direction we're going. Asking 'where do you see your role? You are senior, do you think you'll have an ongoing role? What are your plans?' I think it shows that if you're having that sort of discussion, that you actually care about your workforce. On the other hand, you know, there's some people who feel obliged to keep working. They might feel or they might know that to replace them will be a challenge, and so they almost feel obliged to continue. If that's what you're thinking you want to do for personal reasons, family, whatever, you should be thinking about it. We should be supporting you"* (Int.12).

More frequently, it seems, it is the worker who raises the topic of their retirement.

> *"Generally, people decide when they're going to finish work. That could be whether they're 65 or 72, or whatever, and then they send in a letter saying*

that they wish to retire, and here's their notice – [whatever] they are obliged to give us as per the contract. Some will give us a lot more than that, when they know they're definitely retiring, not just leaving, so we've got time to train up somebody else, which is nice. Others don't do it that way, they just give us the notice we require" (Int.8).

"I have just had a team member retire at 72. She signalled her retirement about 4 months ago, letting us know with plenty of time that she was going to retire at the end of May, before her annual practice certificate was due" (Int.11).

The topic of retirement emerged in FG1 in connection with performance management.

"When you're doing yearly performance management discussion, then you would be having discussions with people around what the future looks like for them. And often they will say, 'I'm looking at only a couple more years in this role, and then I'm looking to retire'. The people that I've had dealings with have been very open around how long they're looking to continue in their roles, to be fair. The discussion sometimes starts with the manager or the team leader asking 'what do you see your future looking like for the next five years?' And people start talking about, 'well, I'm actually wanting to retire. I'm looking to reduce hours'. And then you would talk to them around how they might look to facilitate that, and whether or not that could be accomplished" (FG1).

"If you're asking someone, 'where do you see yourself in five years' time?' They're either going to say, 'actually, I would like to have moved into a new area', or, 'actually, I'm not planning on being here in five years'. So, I mean, by default you're going to get your answer, rather than, 'when do you expect to retire?' No, I wouldn't ask. I think they probably did in the past - you'd be discriminating against someone. I mean, you'd be more tactful than that, I would hope. I mean all the people that I've known, since I've been here, that have retired, have been incredibly vocal about it. There is not one person in the hospital that hasn't known that they were retiring - because they've been counting down" (Int.1).

A manager may have to consider several implications of planning for the retirement of team members: resources to cover replacement of key skills, the role of unions and HR, and fairness and consistency across different departments, while considering the needs of individual staff members as well as the needs of the wider organisation. Some stressed the importance of making sure that the DHB also creates opportunities for new graduates, and younger health professionals, as well as benefitting from the accumulated experience of older staff. A series of interview extracts illustrating some points of commentary on such factors is included in Box 2, in Appendix B.

The topic of the right to request flexible work arrangements was also discussed, not solely in association with the process of planning for retirement. Some interviewees questioned whether there might be potential for some dissonance between Occupational Health (the

safety or wellbeing of an individual worker), and the Human Resources perspective of fair and equitable treatment of staff under a range of employment contracts.

> *"Requests for flexible working come to a manager and if a manager is unable to accept it then it gets escalated to the union on behalf of the employee. So, the unions get on board. I think it's a really important point. But we haven't actually addressed it as a more global or DHB wide matter"* (Int.1).

Some were unclear if there had been any discussion or documentation of such a thing as 'an ageing workforce strategy', although it was recognised as a significant and emerging issue.

> *"We have very regular team meetings, and staff members bring issues. They also have internal communication processes where they can email their managers and outline any service changes that they want to discuss. A large union density within an organisation is helpful in a way, because you'll always have advocacy and support, so managers will not be able to make irrational decisions without being challenged. We have some good platforms to interact with unions. Unions are our partners. If you develop a relationship with the unions and try and involve them in the pre-decision making, it makes a huge difference. It makes them feel included in all decision making"* (Int.1).

Retirement seminars

The DHB have been trialling retirement seminars for staff members including their partners. All staff are invited, so -

> *"…you could have a senior doctor and a ward clerk and their partners sitting together, because retirement applies equally to everybody. And it is notable that not only senior or older people want to take part in these seminars. Sometimes it's the 28-year-old as well"* (Int.1).

The seminars are run by an external consultant,

> *"to make sure that the perception does not arise that the employer could influence decisions in future"* (Int.1).

In arranging and trialling these seminars, the HR team are aware that staff may be anxious, but that over time, it is hoped that staff will see these seminars as supportive. There is no intention to follow up the participants, with a message that because they expressed an interest, it assumes they are considering retirement. It is hoped that those who attend will serve as 'ambassadors' for future seminars. While the DHB might offer three or four such seminars in a year, it will take time for the organisational culture to move to that level of acceptance.

Other managers support this initiative, saying that they recognised that it involved considerable investment on the part of the DHB as employer. It showed that the DHB is serious about retirement planning as part of staff welfare, and also was a good way to gauge staff interest.

Attitudes and expectations surrounding retirement

Interviewees were invited to consider their own professional futures and movement towards retirement. These comments are similar to those already expressed, when they considered the retirement plans of their staff and colleagues. In Appendix 3 (Box 3), there is a selection of these comments, in which interviewees respond to questions about their own personal retirement plans.

Several talked about reducing their working hours and improving their work-life balance. Others said that they would continue working for financial motives. Some had already changed their roles and looked back as well as forward; others wished to feel they had made, or could still make, a significant contribution, in the final phases of their working lives.

As a final question, interviewees were asked what changes they would like to see in their work environment before they finally left. Given the previous discussion, many of these related to workforce ageing, and these are presented here. There was support from the Māori viewpoint.

> *"A purposeful strategy that looks at older workers and supports more flexible working options. Making the most of all that experience and knowledge and supporting people to keep working too. I think that we could do a whole lot more. That's what we're doing in our own team. We've got a kaumātua role that we value. It's probably really different to the rest of the organisation. It's a Māori worldview, that that elder perspective is really important for the balance of our whole team, providing tikanga support and advice. One of our staff is probably a year away from 65 and could retire, but we're saying: 'we really value your knowledge', and 'how can we be flexible? Do you want to reduce your days? We could, even if we keep you for three days, that's worth it for us, if you want to do something else' "* (Int.13).

> *"I'd like a better work-life balance, respecting (staff) working hours rather than having an expectation that they will continue to work well beyond a 40-hour week. And maybe if we could digitally enable some of the more mature workers to make things easier - it would be good if there was voice-activated software to help that"* (Int.6).

This senior medical officer continued and effectively summed up the overall situation with respect to workforce ageing.

> *"If a health board or any other public sector agency aren't flexible in terms of working opportunities, you'd probably look elsewhere (for a post). But if they are, they might find that they can retain some of those skills and use them effectively. I think, as the population ages, there won't be a choice; (there won't be) the number of people to sustain the work we need. I mean unless automation- and automation will happen – means that some jobs will become less or disappear. But I don't think in healthcare automation is going to take over everything, because so much of it is about the person. You'll still need somebody to ultimately look at all those things. I don't think*

you'd ever trust a computer to diagnose things, to treat you and to do your operations, and so on. So, I think (these jobs) are more likely to increase, actually, than deteriorate, I can't see it with the population demographic, I can't see the work being done, unless people are open to the older workforce finding a way to help them do it" (Int.6).

Summary and Conclusions

Given the size, age composition and complexity of the DHB workforce, the issues raised and explored in our interviews are likely to have both medium and longer term implications. They will also need to be considered in a national context, in relation to the ways in which this DHB might differ from the other 19 across the country. Taking a case study approach to workforce ageing also raises many questions about the transferability of these provisional findings to other employment situations, in sectors beyond health, and in other regional or occupational labour markets.

Nevertheless, these questions do not detract from the need to offer some core messages for discussion, which arise from this study. They may offer a qualitative evidential basis to any policy or strategic development work undertaken by the DHB in future. They can also be carried forward into our own comparative work, as further case studies are undertaken.

Key messages

- No clear definition of older workers is evident, but 65 years of age can be a marker. Experience, competence and ability were seen as more important than age. Self-definition as an older worker can begin in the fifties. There was clear acknowledgement of age-related physical demands in several work areas, including shift and on-call work, and of the critical need to maintain and assure professional competency, in relation to the demands of public health protection, and a comprehensive 24/7 health service.

- We found clear recognition that workforce ageing raises issues for health services. Few of those interviewed could identify what the DHB was doing about workforce ageing.

- Moving workers into other less demanding roles is a way of retaining the experience and knowledge of older workers. However, specialisation may limit the ability to substitute staff in organising rosters and on-call work. Similarly, resource constraints can also limit redeployment of staff. There could be alternative forms of work for older medical staff, such as research, governance, audit and quality improvement; redeployment of older workers in nursing, administrative and clerical areas could also be extended with innovative thinking.

- Allowing older staff reduced working hours is often appealing and can be advantageous – experience is retained, and new staff can be trained up. It may however be difficult to find staff to fill in for workers who have reduced their hours. More mobile working, including from home, is being considered and may be appropriate for some staff, given changes in technology, although others noted some disadvantages in loss of collegiality and effective team functioning.

- Coping with change arising from workforce ageing presents challenges for workers and for management. Managing succession is a challenge as health services have to be maintained and gaps in coverage may occur between resignation and re-appointments. Growing potential successors from existing staff may be a preferable option. There is a feeling among management staff that succession planning in the DHB should be improved and become more pro-active.

- The interviewees had mixed views on ageism, but many felt that discrimination against older workers at the DHB did not occur, or, if it did it was not overt. There was a general willingness to recruit older workers, based on their experience, but advantages were also seen in a mixed age workforce.

- In some areas, recruitment is difficult (e.g. senior medical and nursing staff). Improvement in this area will involve national health and immigration policies and cooperation between DHBs. Retention of staff is an urgent issue as a "wave" of retirement can be seen in the future. A supportive culture for older workers, showing that they are valued, can help with retention, as can good wages and access to flexible hours. Offering career breaks and leave without pay can also help retention and these may be part of employment contracts.

- The value of training is generally recognised at the DHB and age is not a factor in access to training, which is rather based on need. Professional development and training is part of some employment contracts. The main barrier to training is identified as funding, which may not be seen as equitably allocated.

- Phased retirement is available at the DHB through reduced work hours and sometimes reallocation of roles. Movement into phased retirement can be initiated by the worker or by their manager. Broaching the topic of retirement by a manager requires care and tact, to avoid implications of age discrimination, or inequity. More often the worker involved raises the topic of retirement and this is the preferred approach. This can arise during performance assessment, when the manager asks about future plans. Knowledge of retirement intentions can help managers in succession planning and giving adequate notice will help in recruiting replacement workers.

- Both HR and Occupational Safety and Health need to be involved in setting the terms for flexible work and retirement and there is also a role for unions. Policy development and clarification in this area is required as the workforce ages.

- The DHB is trialling retirement seminars for staff, managed by an external consultant. These are seen as helping to improve the understanding and management of retirement. Interviewees were experiencing similar issues to their staff and colleagues when considering their own retirements. These included "winding-down", continuing to contribute, exploring alternative options and financial considerations.

- There is a view that the DHB could do more to build on the experience and knowledge of older workers through innovative and creative action. This would benefit the workers themselves through opportunities for extending working lives in flexible ways. It would

also benefit the DHB through easier recruitment and retention and encouraging person-centred services.

References cited:

CFFC. (2018). Ageing workforce: Business survey results. https://www.cffc.org.nz/reviews-and-reports/2016-review-of-retirement-income-policies/ageing-workforce/. Commission for Financial Capability.

Office for Seniors. (2019). Better Later Life - He Oranga Kaumātua 2019 to 2034. Wellington, New Zealand. http://www.superseniors.msd.govt.nz/about-superseniors/ageing-population/better-later-life-report/index.html Ministry of Social Development.

Appendix A:

Individual interviews

The fourteen individual interviews conducted were all assigned numbers. The roles these interviewees held included several in management (in Human Resources, Communications, Finance and Corporate Services), and leadership roles from a range of clinical areas.

Focus Groups

1. Occupational Safety & Health (OSH) department, with work covering wellness and safety of staff. The four women participants in the first focus group had an average age of 47 years, across an age range of 40 – 52 years. Three of the four had a university degree, and all were working in an occupational health and safety roles, several of which were relatively recent (range of time in this role was from 3 months to five and a half years). While one had worked within this DHB for thirty years, the others had built up their experience in a range of health sector organisations. All lived in a shared household situation, usually with a partner and children of various ages.

2. Operations Executives Group had two women participants, from different clinical departments. One was in her mid-40s and had worked for the DHB for about a year, while the other was aged about 60, and had worked for the DHB for over 18 years. Both had advanced or postgraduate clinical qualifications, and had full time workloads, with scope extending across the region served by the DHB.

3. Medical transcriptionists. The six women who took part in the third focus group all worked within the medical transcription service. They ranged in age from 30 to 69 years of age, although five were in their fifties and sixties, with the group average age being 57 years. Although one had worked for the DHB for 12 years, the others had worked there for two to four years. Each was assigned to one of five different departments, with the sixth saying she worked across several departments. Two had completed post-secondary qualifications, with the others reporting secondary education only. Four lived with a partner, one lived alone, and one with others in a shared housing situation.

Appendix B

Box 1: Handling the retirement question

"I could not say to a staff member 'are you thinking of retiring soon?' Well, because people might feel I'm trying to get rid of them, which is a no-no, and I wouldn't want that to happen anyway, even though actually there is a couple that I probably would like to get rid of. I have regular meetings with all staff. And people tell me all sorts of things, I get lots of people telling me more than I actually need to know, sometimes."

"They're tricky conversations, I think. Because you want to maintain and support someone to work as long as possible, and as long as they want to. I think that's part of the organisation's responsibility to support people to keep working if they want to. And that should be individual choice, not organisation choice. But if there is impact on service delivery and/or capability in the role, that's when the conversations might need to be had."

"Have I ever turned around, and said to somebody, 'well, you're getting along. When are you planning to retire?' No. It's more the case of, staff having the comfort to say, 'I'm thinking that I will want to work until this point and then I want to have a transition', or, 'I've actually started to, to groom somebody for my job'. Just whenever it suited them, really."

"The only time I would probably initiate discussion around retirement is if there was a performance problem, and we were going down that performance management path. If I'm going to ask somebody, 'you must be close to 65, when are you going to retire?', they know they don't have to tell me that. So, I would wait for them to do that."

"I don't know who should initiate, because that's a potentially awkward situation, you get to someone who's 64, or 63, and you say, oh, Gooday John, you know, you're 63 now, nearly at retirement age, do you wanna have a chat about it? I suppose that's the way you broach it, but potentially someone might get a little bit offended by that or think that you're trying to push them out. So, I think it probably needs to be an appropriately worded and optional discussion."

Box 2: Management implications of retirement planning

"The worker was asked to cut back on work time for clinical reasons and changed the way they worked so that they could do everything in four days, instead of five. Nobody ended up picking up extra work. This released a little bit of money, which can go into a pot and contribute to other things. And so, as long we can use that for other service development, I think that's okay. But if somebody wants to start working half a week, then you have half a job to cover. It's going to be quite difficult to find half a geriatrician. I think will be a challenge."

"Another worker asked to reduce her days, and we said yes, because someone else wanted to pick the work up. Then the next person who retired said, 'well I'm retiring soon, so you did it for her, so you can do it for me'. And I said no, I've spoken to HR, everything has to be on a case by case basis, depending on our resourcing at the time. And just because we've said yes to one, that doesn't set a precedent, because each case is individual. I don't promise anything, and I always go to HR to get them to look at things as well, and discuss it with my manager, too. So that we're not seen to be making favourable decisions for someone. That's actually quite hard to try and maintain that everyone's equal. They might not see the reasoning behind some decisions and then think that we haven't applied the rules properly, when actually, we have."

"I think it's a decision between the management of public health and HR. It's a bit of a tension. Are HR there to advise the company? Or are they there to assist staff? I suppose it's both, but that's where the tension comes in I think."

Box 3: Personal retirement plans

"I find it difficult to see myself working at this pace right up to 65. I think I'd find it really difficult. That's a big loss, someone like me walking out the door completely. You know, it might be worthwhile the organisation thinking about succession planning, transition, flexibility around retention of knowledge and experience, even transition to the next thing."

"I suppose [I think about retirement] any time that I think, "I just want a change." You just get mentally tired. If it's "I'm tired now. I'm not at the top of my game," then it's time to make changes."

"I wouldn't call myself old, but I have a plan that by about 65 I would consider being at least able to scale down my work, if not retire completely. Here, as you become more senior, you have more power over what the organisation does, and actually the new people which are new nurses and doctors and newly qualified staff coming in in their 20's may have greater insights or thoughts about innovation and change. I'd like to think that I could still contribute, in my 60s and 70s in some way, but in a more flexible way that isn't as demanding. The job I've got now, I couldn't sustain it as I become older- I wouldn't want to sustain it, because the type of work I do now is not the intensity I'd want to enjoy in my late 60s and 70s by any matter of means. But, you'd like to think you could contribute in terms of insight and thought, and on a less demanding basis."

"I would be prepared to do on call, just four or five days. We (older workers) can be very efficient, we have got that expertise of how to deal with situations. But don't expose us to everything, because then we get side-tracked, and we're not so efficient anymore and we feel a bit put upon, you know, a bit exposed, in our work."

"At the moment I need to work. I still have a mortgage and I love my job. But there's still a few years left of me. I think if you get to an age where you get stuck in your ways, and you can't cope with change, or think of other innovative ways of doing things, then I think it's time to move on."

"[It depends on] ability to maintain my lifestyle, so what retirement funds I can build and generate, and some of that is in the unknown. That will probably determine when I make those choices. Together with whether the intensity of work, expectations in the workplace continue to go up, because the demands have definitely risen in the last 20 years in health. If that continues to rise, I suspect any person, as they get older, will question whether that's what they want in their life."

Box 3: Personal retirement plans continued…

"Even though it dumbfounds me, I do see some health professionals who reach the late stages of their career and are still not financially secure. I guess there's always going to be a few, but that is a reality – [depends on] financial skills, and financial planning, and all of that."

"I'm not spending so much time on the wards, and I miss that. I miss the contact with juniors, having acquired experience and knowledge and seeing different ways of doing things. I've got a lot of things that I think I can share. But I have been thinking ahead, even, about how long I want to be doing this executive role: it's an important job, it carries quite a lot of pressure and stress. It has impacts on family life. So, what am I going to do? Become a whole-time clinician? If I'm in my 60s, that might not be the right thing to do or, [maybe] do something different."

"There are family circumstances that will probably determine my ability (to stay on). I won't say retire but definitely explore different ways of working, if I can, because over this last so many years, being in [health], I feel I have picked up some sufficient skills to be able to contribute to the workforce in a more flexible way."

"(I have) a huge level of satisfaction with my contribution, and the many things I've hopefully achieved, or helped the organisation achieve. Most of all to empower others, and to provide oil in rusty situations. And then there are other opportunities that I'm looking at, that are new opportunities – growing potential for many health professionals to engage in later careers. I purposely made decisions around further training and upskilling in management and administration and clinical governance, while still maintaining a full clinical specialty profile. That was a purposeful choice. It would be good if others are able to think through... diversifying skills, and so on, so that they have more options. Organisations need to, where possible, be engaging and caring and facilitating, in these aspects of professional development."