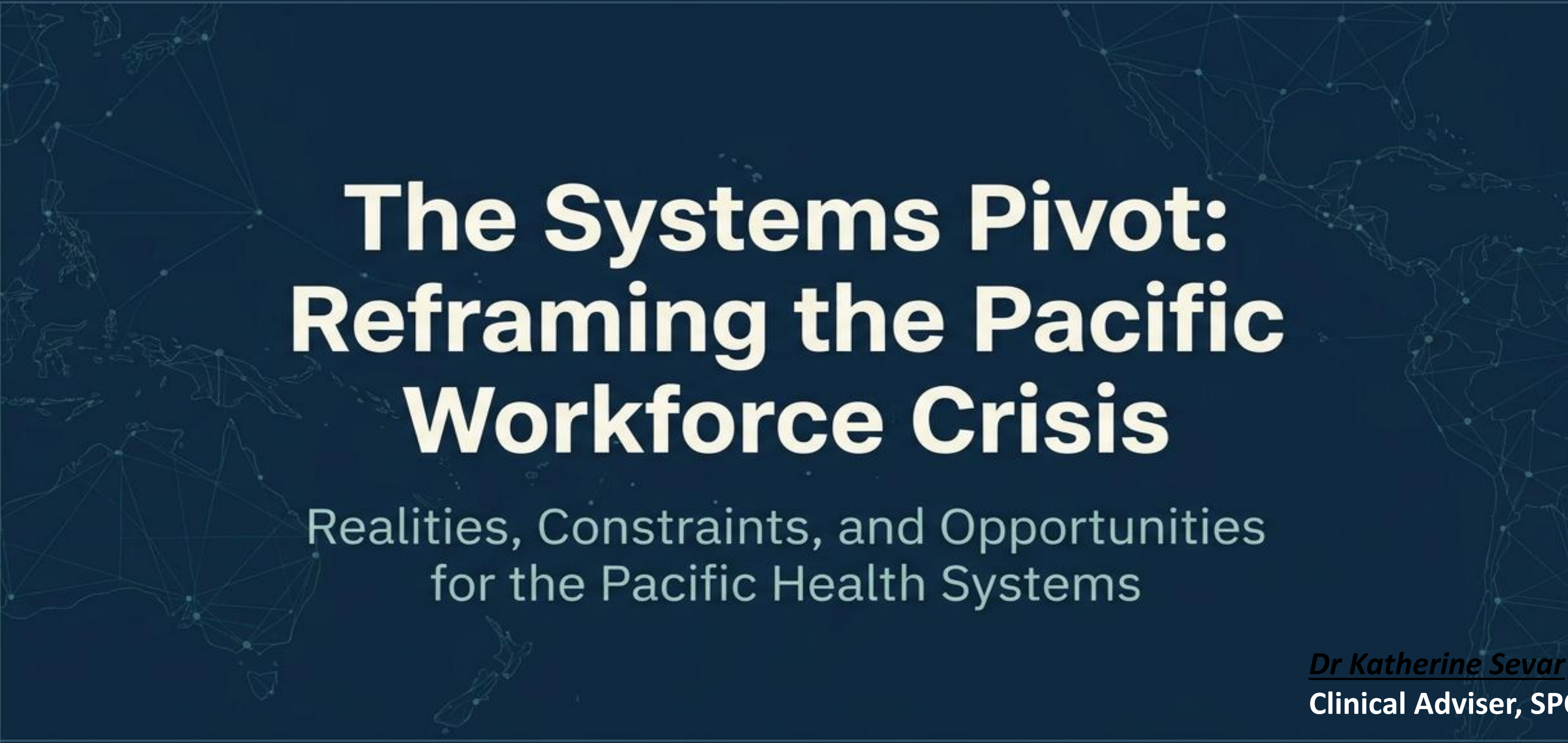
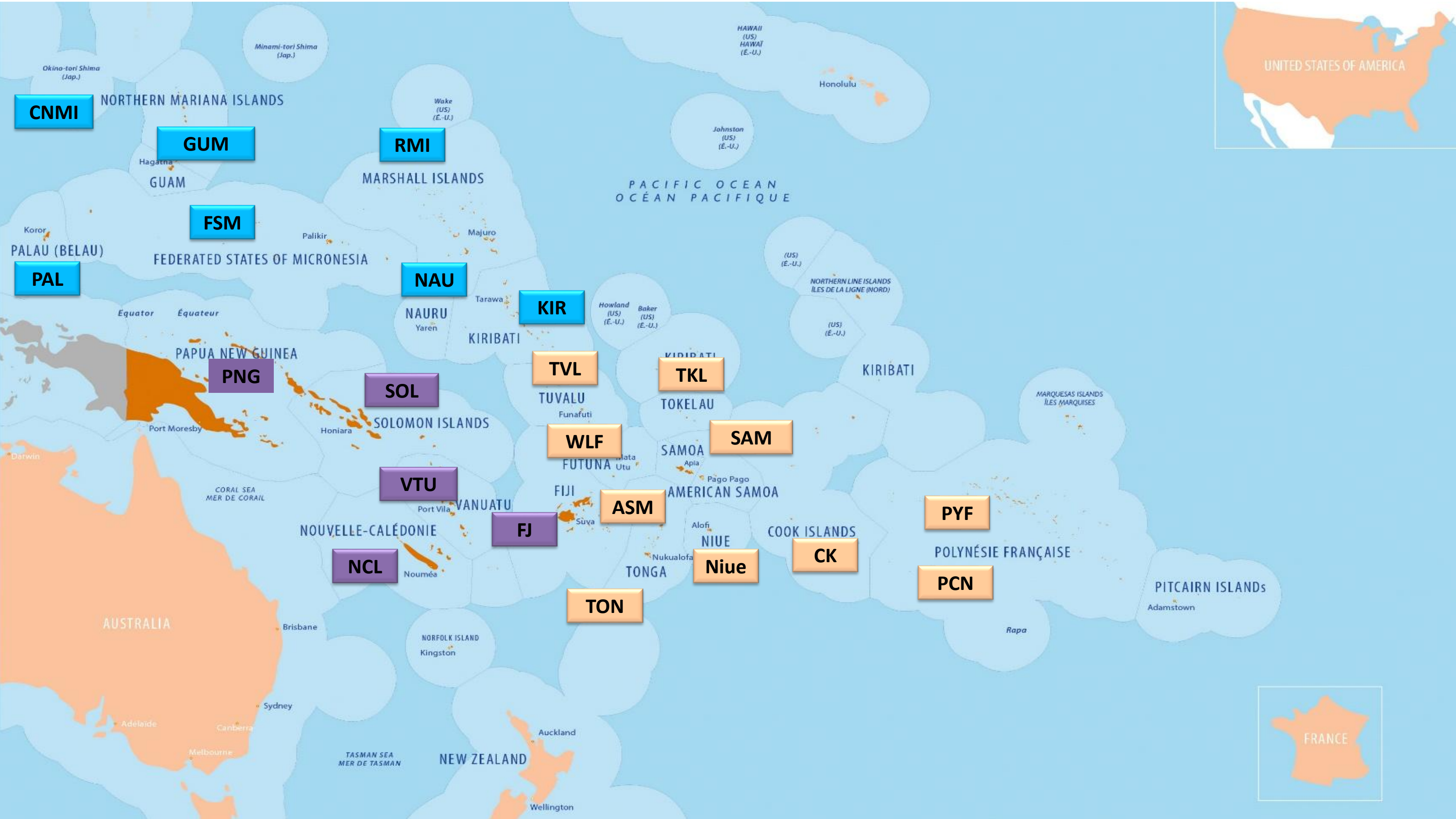


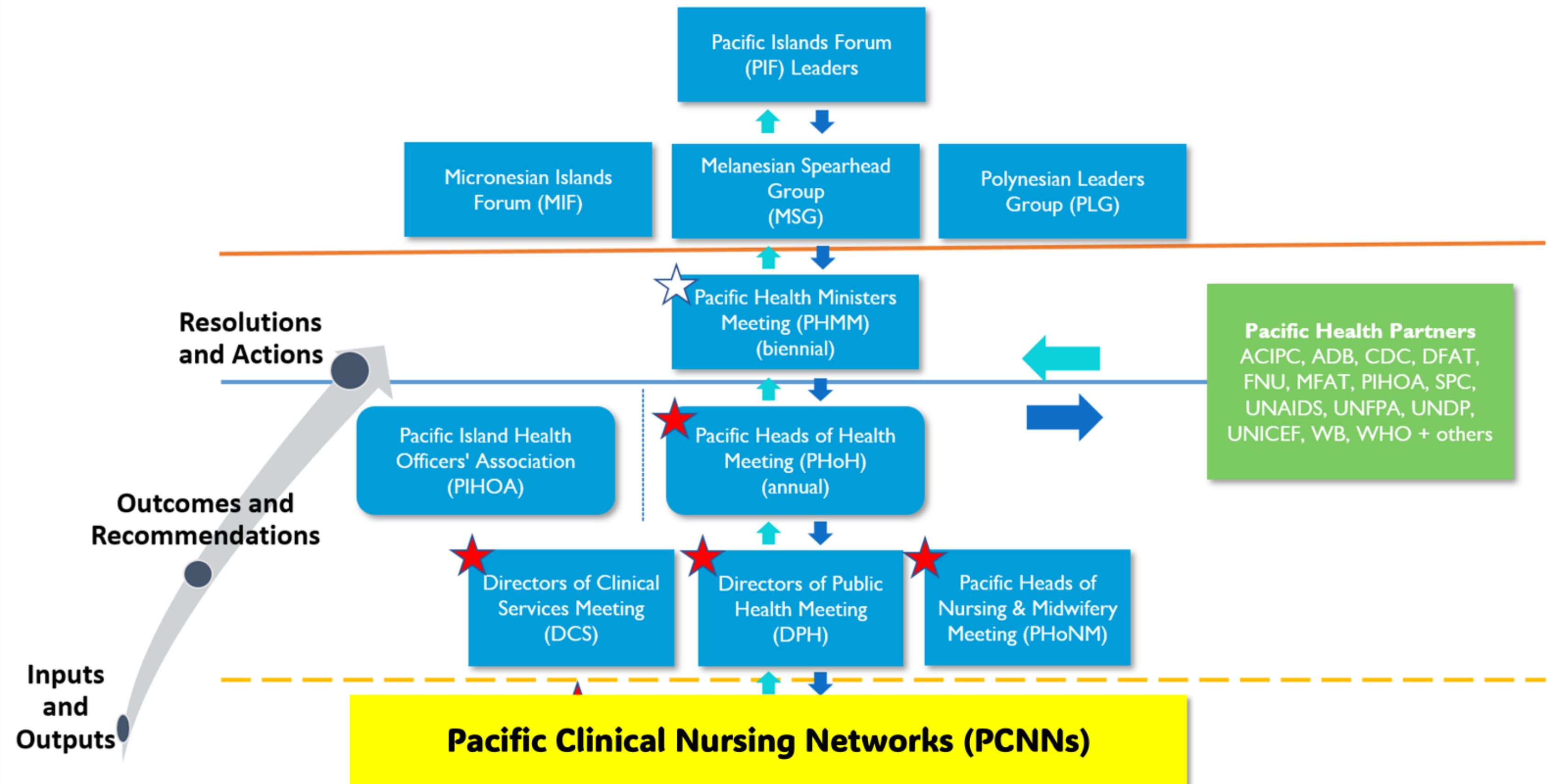
A stylized map of the Pacific region, including Australia, New Zealand, and the Pacific Islands, is shown in a light blue color. Overlaid on the map is a network of white lines and dots, representing a global or regional network. The background is a dark blue gradient.

The Systems Pivot: Reframing the Pacific Workforce Crisis

Realities, Constraints, and Opportunities
for the Pacific Health Systems

Dr Katherine Sevar
Clinical Adviser, SPC





16th Pacific Directors of Clinical Services Meeting: 22-24th July 2026



MEETING RECOMMENDATIONS

1. **Health workforce**
2. **Health Education and Research**
3. **Clinical Governance**
4. **Health Emergencies**
5. **Pacific Clinical and Nursing Networks (PCNNs)**



PACIFIC CLINICAL AND NURSING NETWORKS (PCNNs)



PISA
Surgery

iMOP
Int Medicine

PSA
(Anaes)

PPA
(Paeds)

PacEYES
(Ophth)

OPIA
(Dental)

MHOSP
(Mental Health)

PBEN
(Biomed)

PRS
(Radiology)

PRATA
(Rehab)

PicNET
(IPC)

PIORNA
(OT)

PIOA
Ortho

PENTAG
ENT

PISEC
ED

PRSH
O&G

TOR



This is not an HR problem. It is a clinical safety emergency.

< 49 / 10k

Health workforce density per 10,000 population

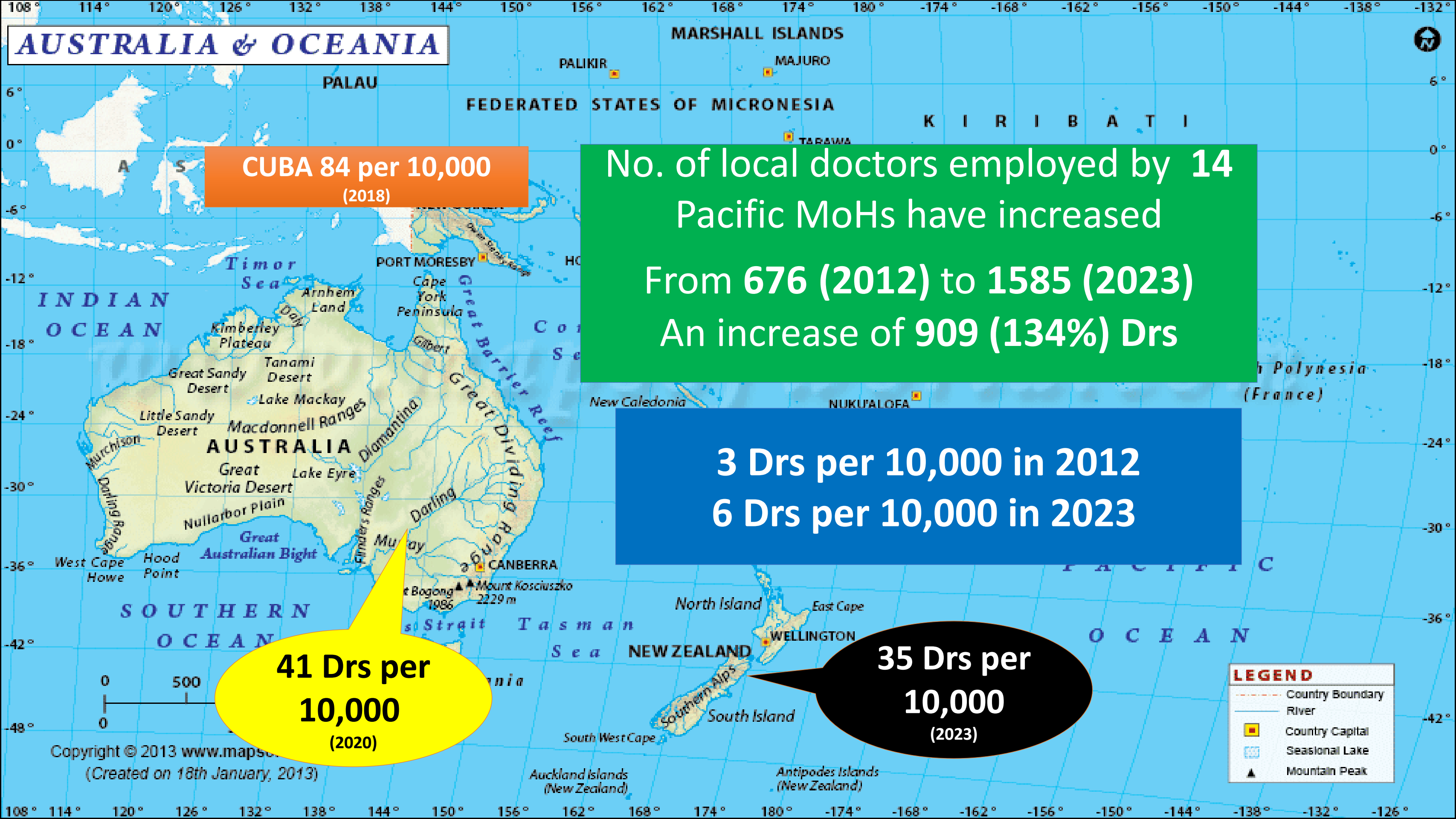
+

< 55 / 100

UHC Service Coverage Index



When numbers drop below these thresholds, we are no longer just losing headcount.
We are losing the structural capacity to deliver essential reproductive and maternal health services.



CUBA 84 per 10,000
(2018)

No. of local doctors employed by 14 Pacific MoHs have increased
From 676 (2012) to 1585 (2023)
An increase of 909 (134%) Drs

3 Drs per 10,000 in 2012
6 Drs per 10,000 in 2023

41 Drs per
10,000
(2020)

35 Drs per
10,000
(2023)

Latest Clinician Profiles - 2025

17

Countries With Data

308

No. of Clinicians

10

Clinicians per 100K

191 (62%)

Male

117 (38%)

Female

Age Group

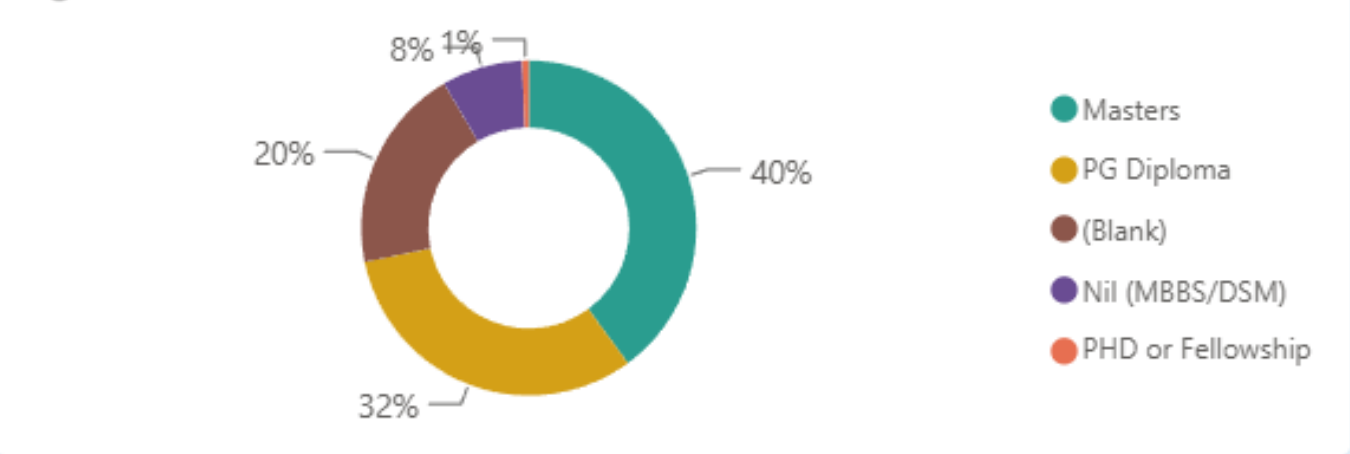
31-40 years	46%
41-50 years	23%
51-60 years	13%
> 60 yrs	10%
< 30 yrs	8%

Nationality

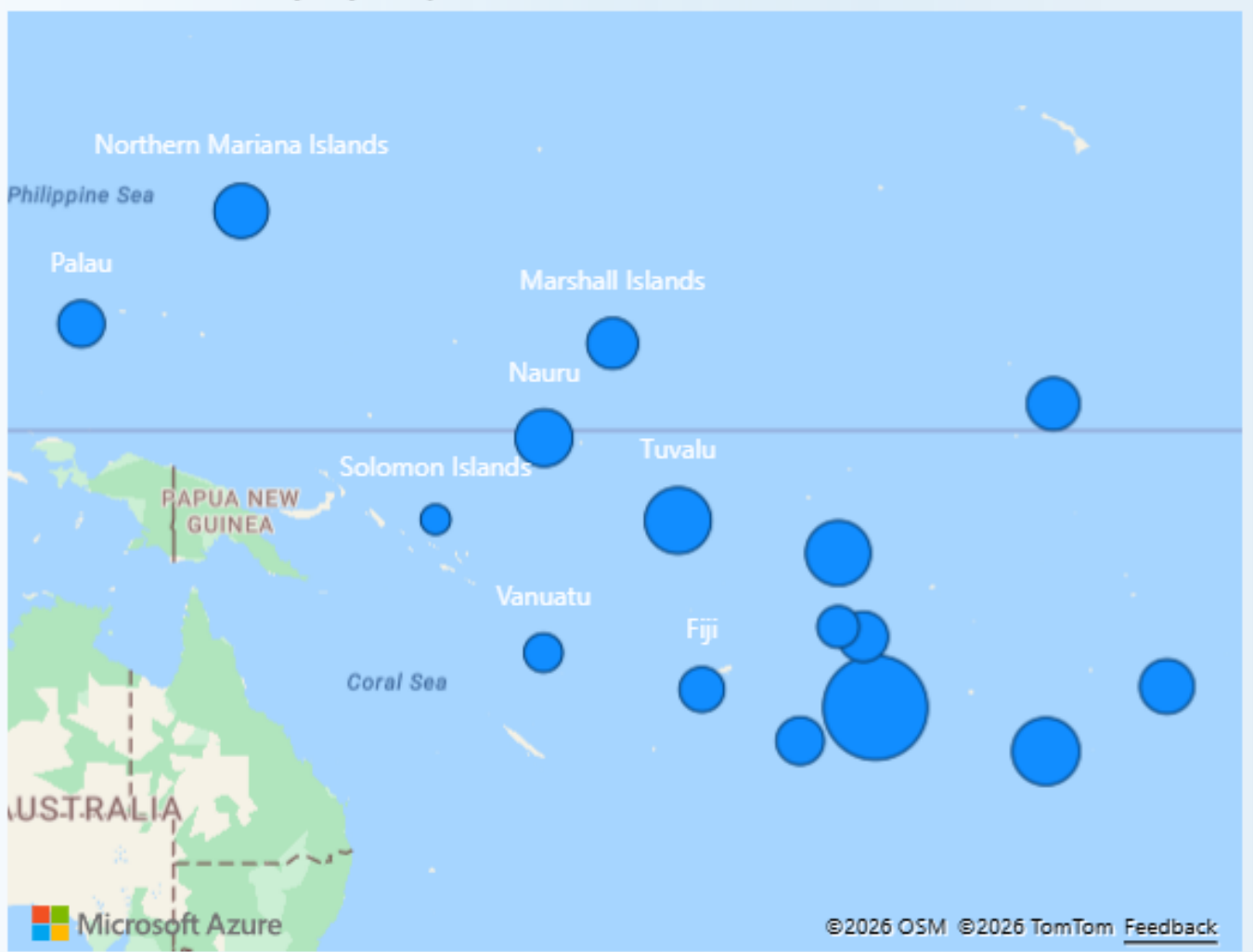
Local Blank Expats

Local	66%
Blank	26%
Expats	8%

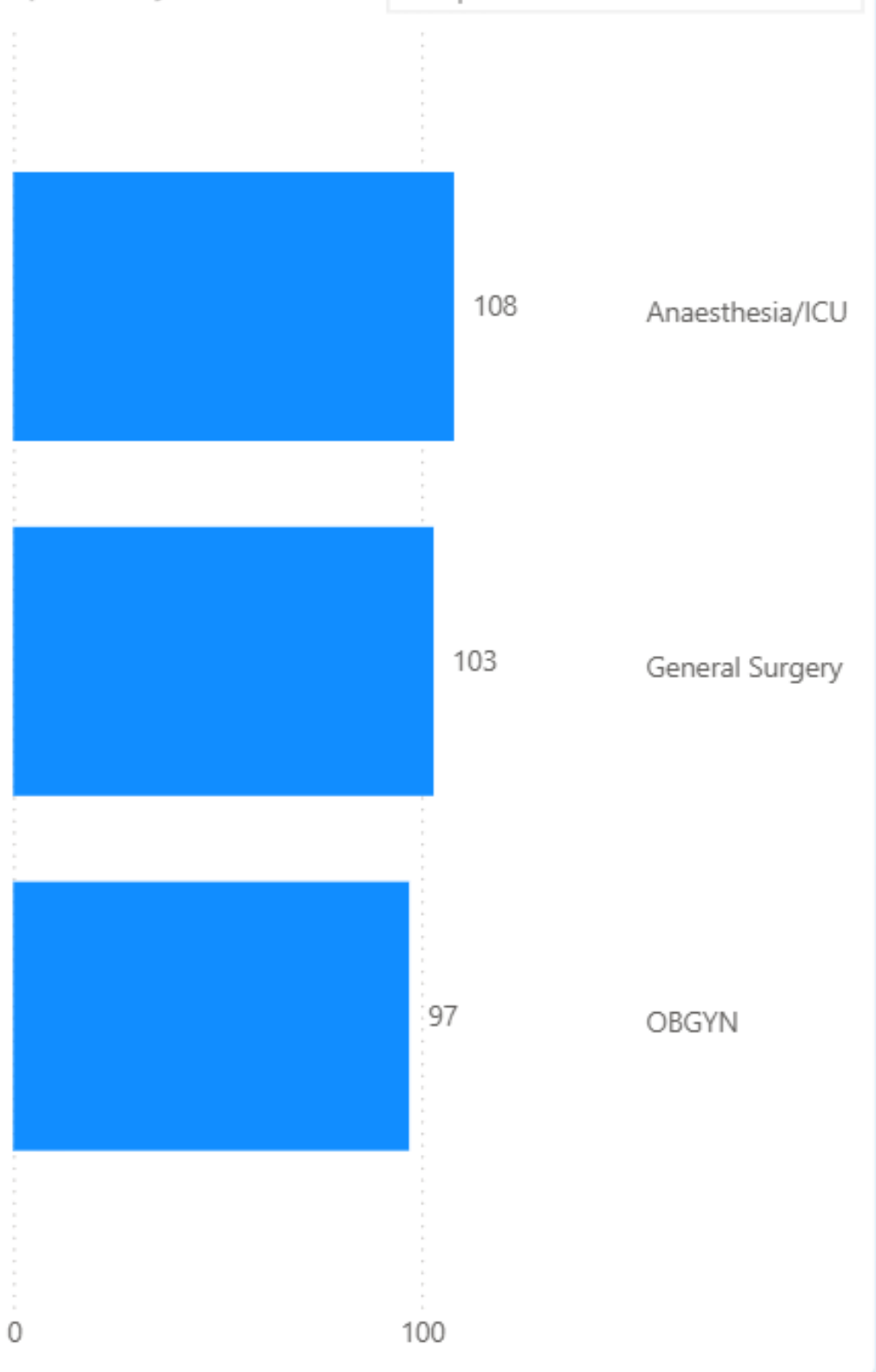
Highest Qualification



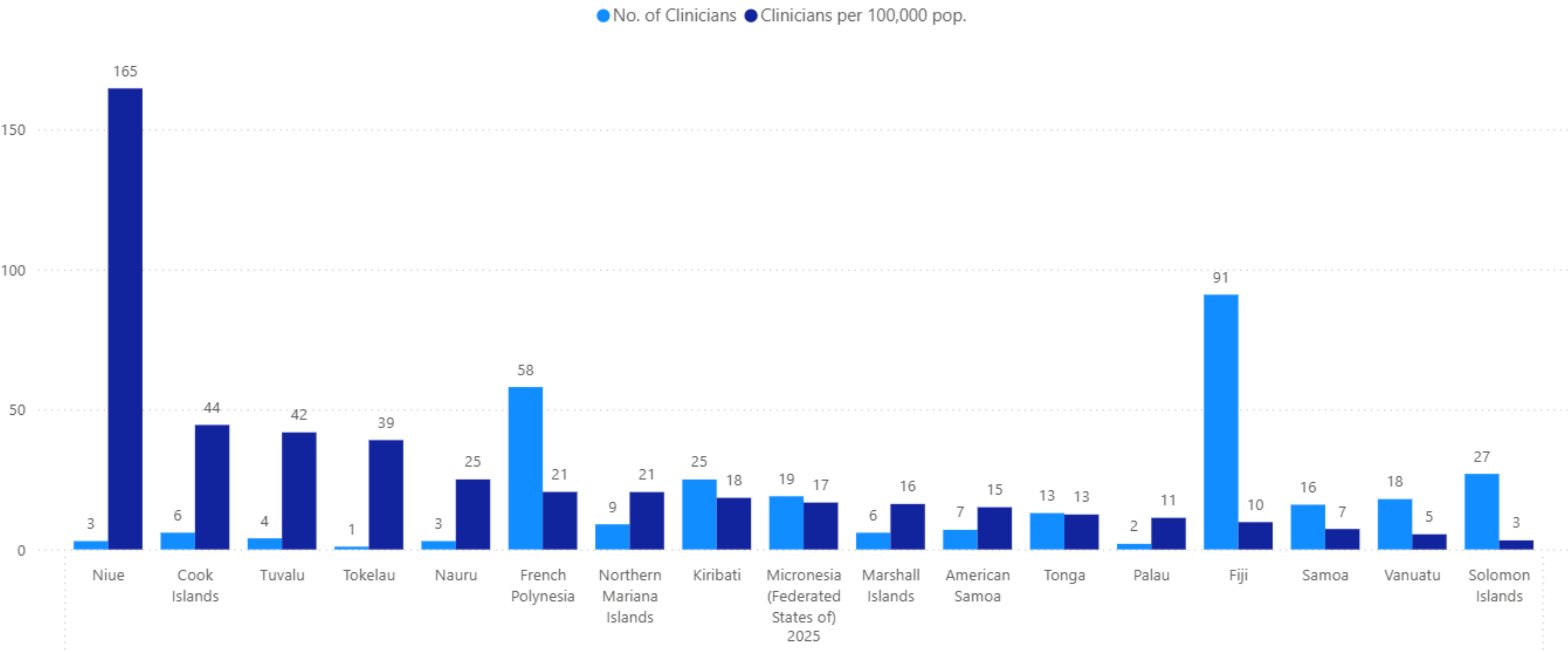
Clinician Density by Population



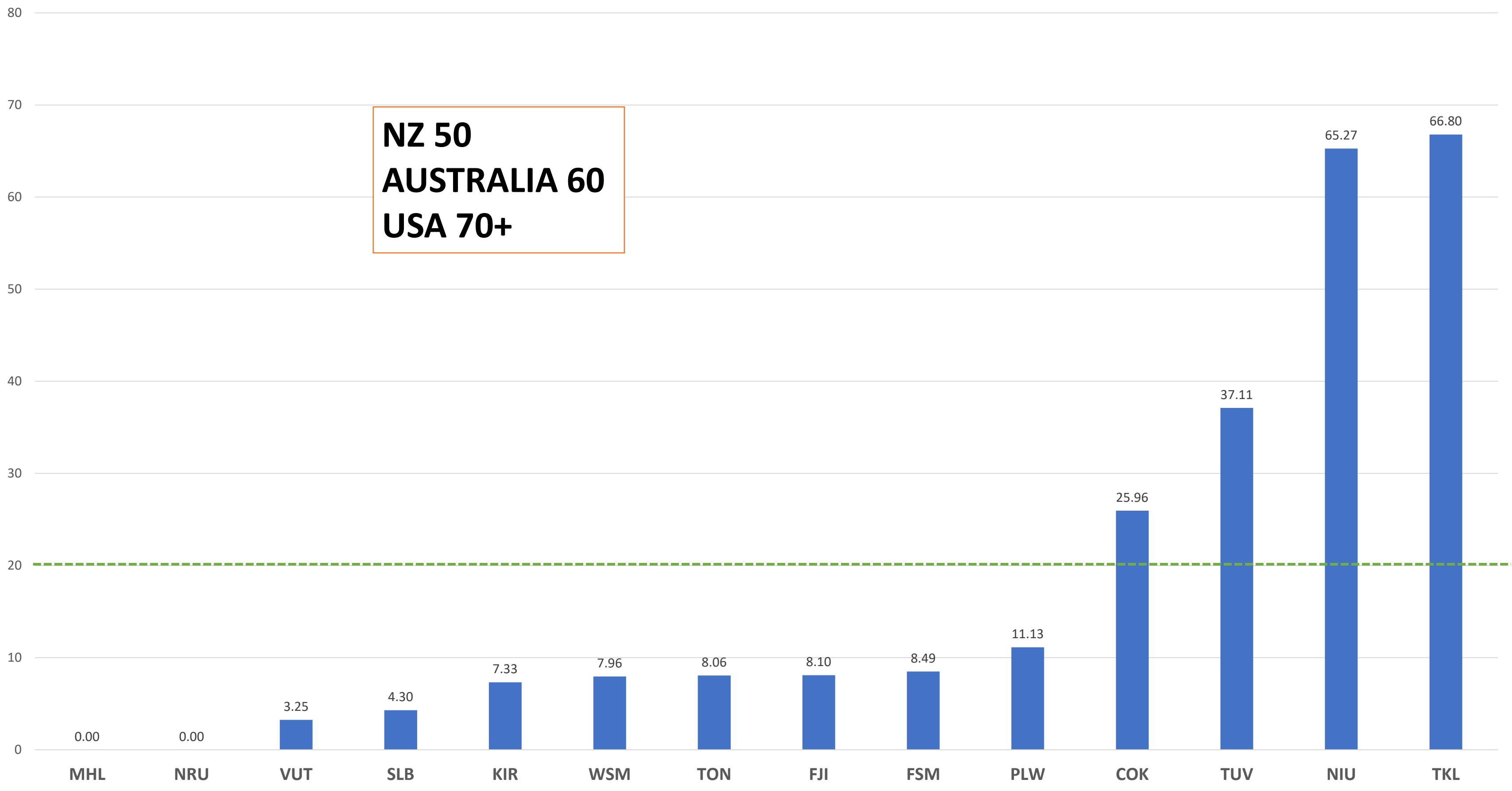
Speciality



Clinicians by Country (SOA) - 2025



Local SAO (Surgery, Anaesthesia, O&G) Density 2023



NSOAP IN THE REGION

Country	Qualitative Interviews	Facility Assessment	Situational Analysis	Stakeholder Meeting	NSOAP
TONGA	Completed	Completed	Completed	Completed	Launch April 2024
SAMOA	Completed	Completed	Completed	Completed	Launch Feb 2026
FIJI	Completed	Completed	Completed	Completed	In Progress
VANUATU	Completed	Completed	Completed	Completed	In Progress
COOK ISLANDS	Completed	Completed	Completed	Completed	In Progress
PALAU	Completed	Completed	Completed	In Progress	In Progress

Departing Clinical Staff

```
graph LR; A[Departing Clinical Staff] --- B[Skilled Migration]; A --- C[Labour Mobility Schemes]; A --- D[Internal Migration]; A --- E[Exit from the Profession];
```

Skilled Migration

Moving to AU/NZ with full registration and scope.
Builds diaspora capital.

Labour Mobility Schemes

PALM, RSE, and aged-care recruitment. Highly trained professionals deployed in lower-tier roles with unrecognised qualifications.

Internal Migration

Moving from public facilities to private clinics, NGOs, or donor-funded project roles.

Exit from the Profession

Leaving healthcare entirely.

The Ecosystem: The 3 Main Partners



Step 1:
Assess the
Demand

Step 2:
Identify
the Gap

Step 3:
Recognize the
Supply Chain /
Production
Pipeline

Step 4:
Determine Pacific
Solutions

A localized problem requires an ecosystem response. No single partner can repair the production pipeline alone.

1. Distributed Training Hubs:
Simulation, emergency
obstetric care, and ultrasound
closer to home.

2. Diaspora Networks:
Remote mentoring and
visiting appointments from
Pacific clinicians abroad.

3. Regional Shared Pathways:
Professional clinical networks
as workforce infrastructure

Migration is a reality. The goal is Managed Mobility: bilateral agreements with reciprocity, backfill funding, and guaranteed return pathways.

Where to From Here? The RANZCOG Role

Phase 3: Local Leadership

Once Masters-trained clinicians graduate, they become the embedded local leadership required to strengthen and own the health system long-term.

Phase 1: Attachment

Facilitate 6-12 month remote or rural attachments in the Pacific for visiting clinicians.

Phase 2: Supervision

Provide crucial clinical supervision for Masters trainees.



Lack of supervision is the single biggest barrier to having in-country specialist training.

Takeaway: RANZCOG's role is to provide the scaffolding that builds local capacity, not to create dependency.

OPPORTUNITIES

- **UNIVERSAL HEALTH COVERAGE**
 - Primary Health Care
- **HEALTH & CLIMATE CHANGE (HCC)**
- **DISABILITY/GEDSI**
- **DIGITAL HEALTH**
- **RESEARCH**

Navigating the Complexity: The 3 Ships



1. Leadership

Local champions are required to hold the flag, provide the vision, and offer the reassurance needed to keep teams strong through constraints.



2. Ownership

Programs must be country-owned and frontline-led. Frontline staff often need to make sacrifices to kick-start a project with low-hanging fruit; once momentum builds, management catches on.



3. Partnerships

“Friends with benefits.” No island is isolated. Mutual technical support driven by shared passions striving for the same goal.

Malo Aupito!

