In Confidence

Office of the Minister of Health

Office of the Minister of Education

Chair, Cabinet Social Wellbeing Committee

School of Rural Medicine proposal: An alternative approach

Purpose

1 This paper seeks agreement to rescind the Cabinet decision to establish a School of Rural Medicine. A wider programme of work to address the issues associated with access to health care, and the lack of availability of health professionals, including general practitioners, in some rural areas, will be established as an alternative to address rural healthcare issues.

Executive Summary

2 There are issues with access to health services in rural areas due to a lack of health professionals working in these areas. This is supported by an analysis of the data held by Health Workforce New Zealand (HWNZ) and is regularly raised in the media.

3 There have been two recent proposals to address the rural workforce issues. The first was from the University of Waikato and the Waikato District Health Board (DHB), which proposed establishing a new post-graduate entry medical school (the Waikato proposal) based in Hamilton with rural training centres in surrounding areas. This would train 60 more doctors per year.

4 The second proposal from the University of Auckland and University of Otago proposed establishing a National School of Rural Health (the Auckland/Otago proposal). This would provide undergraduate and postgraduate training experiences for a range of health professionals in rural areas. The proposal is based on expanding a similar initiative already operating for medical students at these two Universities and it would increase the number of medical students going through this process. At maximum capacity, around 300 medical students per year would undertake some study in a rural environment – either in-depth training, or a short placement – which is significantly more than the current state. This rural training experience would also be open to other health professionals.

5 The previous Government agreed to establish a School of Rural Medicine through a competitive tender process. This was to allow the University of Auckland/University of Otago and University of Waikato/Waikato DHB, as well as any other parties, to submit proposals. The best option to address shortages of health practitioners in rural areas was to be selected through this process. It was deliberately decided to not be specific about the nature and type of services to be provided within the School of Rural Medicine to encourage innovation and creative solutions to be explored. The selected proposal could have been either of the existing proposals, a blend, or something different.

6 However, a School of Rural Medicine is only one way of addressing the issue of a lack of health professionals, and therefore health services in rural areas. It does not necessarily take account of the wide range of other possible alternative strategies that could be used, for example: better support for existing practitioners by providing locums to cover out of hours and emergency work; continuing professional development and holidays; funding changes to provide transport costs; and, community and social support for families of practitioners. It also only involves one workforce group – doctors – and doesn't address other important workforce groups such as nurses, midwives and allied health practitioners.

7 Undergraduate training in rural locations may have a positive impact attracting graduates to rural locations but does not in itself guarantee graduates will practice in rural locations.

8 The Ministry of Health is commencing a programme of work to develop options which better support health professionals practising in rural areas and encourage general practitioners and others to take up the option of rural practice. As part of this programme, there is merit in exploring ways to proactively engage with students from rural and regional New Zealand to encourage them to enter undergraduate training in medical, nursing and other health professions.

9 In light of this, we recommend that Cabinet rescinds the previous decision to establish a School of Rural Medicine and directs the Ministry of Health to undertake a wider programme of work to address the issues associated with access to rural health care, and the health workforce in rural areas.

Background

10 In September 2017, Cabinet agreed in principle to establish a School of Rural Medicine [CAB -17-MIN-0464 refers] through a competitive tender process. It was hoped this would at least in part address issues with rural health provision. At that time, the previous Government had been considering two different rural health proposals - the Waikato Graduate Entry Medical School and the National School of Rural Health.

First proposal: Waikato Graduate Entry Medical School

11 The University of Waikato and the Waikato DHB propose establishing a new post-graduate entry medical school (the Waikato proposal) based in Hamilton with rural training centres in the surrounding areas. Once established, this new School would train 60 graduates per year and would focus on recruiting students likely to go on to practice in rural areas. Training in rural health would be provided as part of the qualification. This sort of approach has been successfully used overseas, usually alongside a wider suite of activities to improve rural health professional attraction and retention. Medical schools are also contributors to research capability and a third medical school would provide further opportunity to contribute to health sector research priorities.

12 The proposal was estimated to cost s 9(2)(f)(iv) to establish and then, once fully operational, s 9(2)(f)(iv). Financing this would require new funding to be made available from Vote: Tertiary Education and Vote: Health.

Second proposal: National School of Rural Health

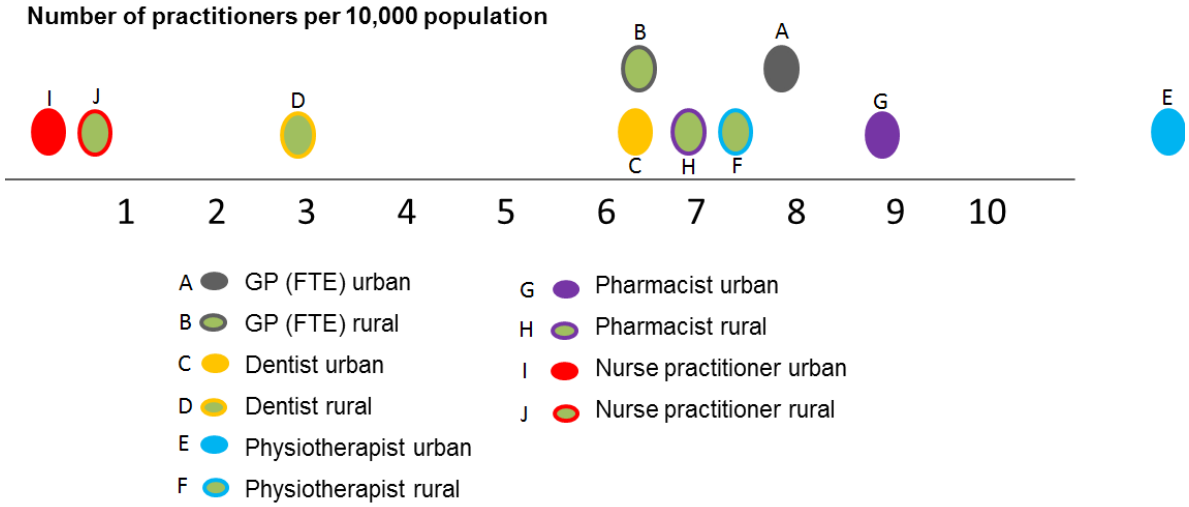
13 The University of Otago and University of Auckland propose to establish a School of Rural Health (the Auckland/Otago proposal) to provide undergraduate and postgraduate training experiences for a range of health professionals in rural areas. This training would be based in smaller rural hospitals (hubs) with outplacement into rural health practices (spokes). It is modelled on existing initiatives in place at each medical school that would be expanded to encompass a range of other primary care professional training e.g. nursing, allied health and midwifery.

14 This proposal does not intend to increase the number of students undertaking medical training. However, it would add an element of rural training as part of the overall programme of study for the approximate 600 medical students per year. The Universities estimated the proposal would cost Government s 9(2)(f)(iv) [redacted] in addition to the standards Student Achievement Component (SAC) tuition subsidy and postgraduate medical training that Government already funds, plus any capital costs. However, officials are of the view that these costings require further development and are very light.

The problem: there are fewer health practitioners in most rural areas

15 Nationally, urban areas have on average greater access to general doctors than rural areas. HWNZ data from 2014 illustrates that whilst mostly urban DHBs such as Capital and Coast have high numbers of general doctors (87 per 100,000 population), rural DHBs such as West Coast and Taranaki have fewer general doctors (61 and 60 per 100,000 population respectively).

16 The inequality in the distribution of doctors also extends to other health professions as illustrated below.



The difficulties of attracting practitioners into rural areas are complex

17 Factors which contribute to difficulties in recruiting and retaining health professionals in rural locations include:

17.1 a general lack of support, including cover for professional development or holidays, due to nationwide shortages of some health professional groups and lower numbers of rural practitioners;

17.2 perceptions of long hours and reduced down-time in rural practice (particularly relevant for doctors, nurses and midwives who are often 'on-call' outside of working hours);

17.3 practices are often located in remote areas with few facilities and few opportunities for partners and children;

17.4 geographic distance between patients (this particularly applies to midwives and other professions that undertake home visits) or practices (relevant to professions that undertake clinics at differing locations); and

17.5 lower intensity than urban practices, which leads to lower salaries for those remunerated on a per patient or per hour basis.

18 In addition the age profile of the current medical workforce means a significant number of existing rural doctors will retire in the near future. Around 50 percent of the trainees who

started the GP training programme are aged below 30. If this trend continues New Zealand will make good progress in building a younger GP workforce to replace GPs reaching retirement age, but this alone will not ensure appropriate distribution across rural and urban communities.

International Medical Graduates (IMGs) fill the gaps

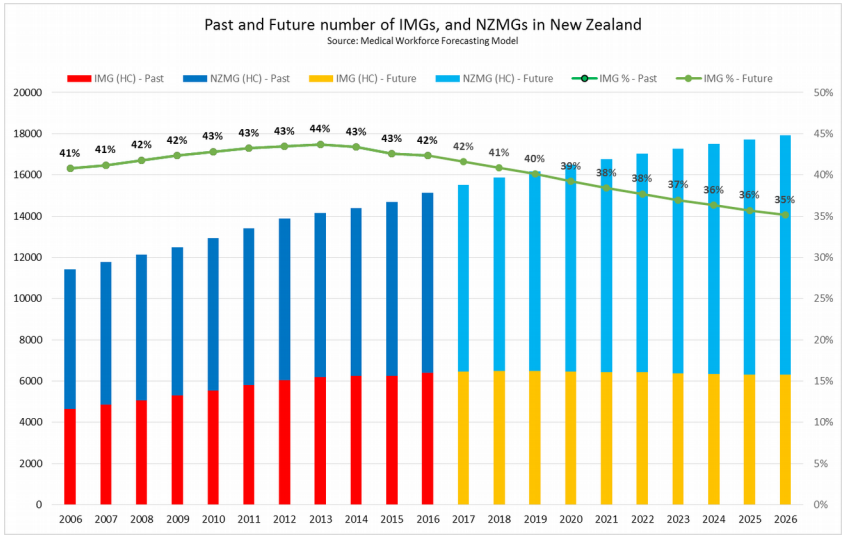
19 International Medical Graduates could also be considered to increase numbers of health professionals in rural locations.

20 New Zealand imports approximately 1,100 IMGs per year. In 2016, IMGs made up around 35 percent of the registrar[1] workforce.

21 Three distinct groups of IMGs come to New Zealand. First, junior doctors on short-term (one to two years) contracts having a working overseas holiday, who help fill a short-term service need. This category is reducing with the rise in the number of domestic graduates. The second group of IMGs come to obtain specialist training in New Zealand's high quality training programmes. Many of these are retained in New Zealand when they obtain employment as a specialist at the end of their training. Finally, there are IMGs who obtained their undergraduate and specialist training overseas, or are working in New Zealand as locum generalists.

22 In 2017, IMGs made up 43 percent of the senior medical officer (SMO) workforce[2]. HWNZ estimates that 51 percent of IMG SMOs have a New Zealand or Australasian vocational qualification and are committed to practising in New Zealand. Importing SMOs assists with the ability to provide high quality specialist training programmes.

23 The following chart shows the past, current and forecast future number of IMGs and New Zealand medical graduates in the health workforce. Between 2006 and 2013, the number of IMGs employed in New Zealand rose. However, reliance on IMGs from 2018 onwards is forecast to level off or slightly reduce with increased numbers of New Zealand medical graduates meeting New Zealand health needs.



Both proposals have some merit

24 Both proposals include student recruitment practices that are likely to encourage more medical graduates to seek a rural career. The rural workforce is also largely primary and community based, which supports a key priority of improved access to and sustainability of primary care.

1 Registrars are resident doctors who have been employed for at least two years. Depending on experience, a doctor may be eligible to work as a registrar in their third year post graduation).

2 Based on the number of practising SMOs as at May 2017 according to Medical Council of New Zealand data. An SMO is also referred to as a consultant/specialist.

25 Each has some capacity to incorporate training for other health professions. This is stronger for the Auckland/Otago proposal where integrated learning between professions is a key feature. This facilitates closer interdisciplinary working relationships, postgraduate learning opportunities, and the introduction of alternative models of care that would support existing rural general practices.

26 Both proposals could contribute to the Government's provincial development goals. The Waikato proposal specifically identifies the key economic benefits that the medical school would bring to that region, including increased GDP, increased direct and indirect employment, training opportunities, and increased innovation. The Auckland/Otago proposal would also have an impact, given it proposes to spread the 10 hubs and spokes in rural areas throughout provincial New Zealand.

27 The proposals could also contribute to He kai kei aku ringa, the Crown-Māori economic growth partnership goals. Areas of contribution include growing the future Māori workforce, and strengthening Māori educational participation and performance.

28 Each proposal indicates that it would incorporate a research component. The outputs from this research would bring benefits to DHBs, primary care providers, community groups and local iwi, as well as tertiary education providers. There is also significant opportunity for the research to contribute to the wider aims of government, including the Health Research Strategy. This can be considered further as part of the Ministry of Health's work programme.

But there are issues and risks associated with each of them

29 The main concern with both proposals is that it is not clear how many medical graduates would enter rural practice or how long they would be retained in the rural health workforce. They will both need to have other programmes and support measures built around them to support doctors practicing in rural and remote areas.

30 The Waikato proposal is very costly. There is also potential for the costs of both proposals to increase, as they were only in the early stages of development when submitted to Government.

31 An important concern with the Waikato proposal is Waikato DHB's ability to focus on this work when it has a number of current issues to deal with. These include its financial performance, updating core IT systems, and relationships with Midland Health Network (primary healthcare organisation).

32 Any increase in the number of medical students may also further affect the availability of clinical placements and required funding for these placements. It is noted that Waikato DHB had informed the Auckland Medical School that if the Waikato proposal is successful, it will look to reduce the number of University of Auckland students undertaking clinical placements in its hospitals. The Universities of Auckland and Otago already report difficulties in securing enough clinical placements for their students. One of the issues behind this appears to be funding, and the demands on already busy practitioners resulting from having students in their practice. However, the Waikato proposal intends to tackle this by broadening the range of clinical placements.

33 There may also be system capacity issues associated with training additional doctors, who will need further placements, mentoring and supervision when they enter the workforce. This can also have an impact upon other health care professionals seeking clinical placements, particularly in primary care.

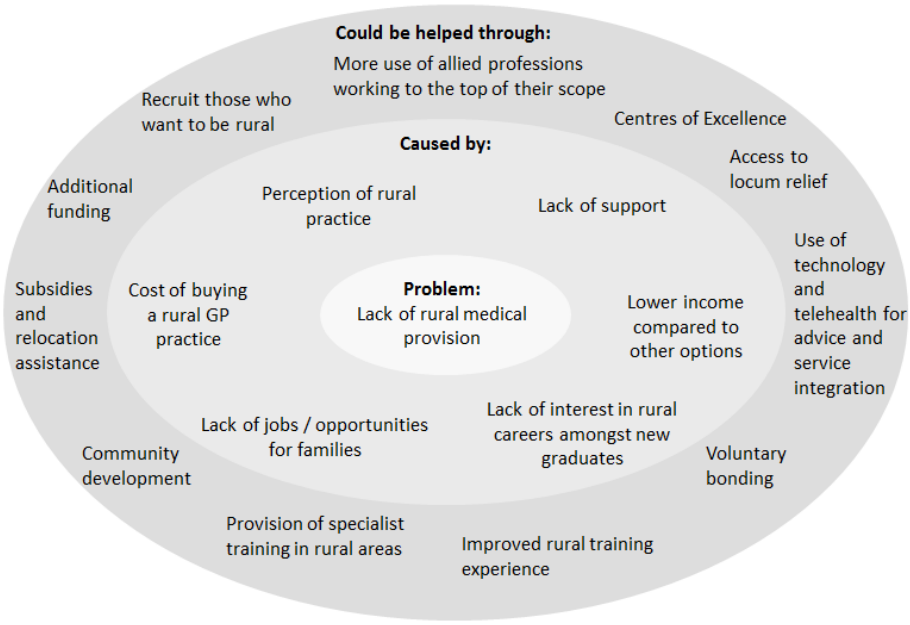
Multiple factors make rural careers less appealing to many health professionals

34 There are a number of factors that contribute to overall low perceptions of a rural career including a general lack of support, spending more free time 'on call', few opportunities for partners and children, large amount of travel between practices, and lower salaries.

35 The National Health Committee[3] looked at measures that could be introduced to mitigate some of these problems. It included recommendations around: service delivery including the use of technology; different models of care, such as extending the scope of practice for paramedics and nurse-led clinics; establishing outreach clinics or integrated health centres; and, provision of transport subsidies.

36 System performance improvements are also being implemented. These include alternative ownership models in primary care, integrating health and other social sector funding schemes, and funding the development of Māori health providers.

37 A diagram setting out the issues faced by the rural medical workforce is provided below:



A School of Rural Medicine could only address some of these issues

38 Whilst a School of Rural Medicine is likely to impact the number of students training in rural areas and selecting a rural career, it is unlikely to address many of the factors that affect the attractiveness of rural practice. For example, it is unlikely to provide better support for existing practitioners by providing locums to cover out of hours and emergency work; increase salaries, address the costs of buying into a practice, or provide social support for families of practitioners.

39 We are therefore proposing not to proceed with the establishment of the School of Rural Medicine at this point. Instead, it is proposed that we direct the Ministry of Health to develop a work programme to address the issues of access to health services in rural areas and the availability of health practitioners in rural areas.

The proposed Ministry of Health short and medium-term work programme

40 As well as providing health services, rural health workers are also an important part of a region's infrastructure. There are a number of opportunities to strengthen linkages between the Ministry of Health's workforce development programmes and other Crown agencies' provincial and rural and regional development initiatives.

3 The National Health Committee (NHC) was an independent statutory body charged with prioritising new and existing health technologies and making recommendations to the Minister of Health. The NHC was disestablished in March 2016 and their functions streamlined into the Ministry of Health.

41 Initiatives to support and retain existing graduates (both international and domestic) have proven successful in Australia, and are likely to be cheaper than increasing the domestic supply and would help address maldistribution and capacity.

42 There is also an opportunity to generate efficiencies and reduce pressures on DHBs by providing greater orientation and support for rural medical practitioners and their families. This may help reduce turnover. DHBs spend a significant amount on medical outsourcing.

43 The rural health workforce development programme led by the Ministry of Health will include short and medium-term measures.

44 A number of short-term measures are currently in our draft Vote Health and Vote Education budget packages. These will build upon existing initiatives to strengthen rural health sector and infrastructure capacity including:

44.1 allocate the additional GP training places targeted in Budget 2019 to generalist and GP training in rural locations. (30 additional places $ 4.032 million)

44.2 investing in the professional development of rural primary health care nurses and midwives in order to both provide an infrastructure of support to attract nurses and midwives to rural locations, strengthen peer networks, and allow them practise to the top of their scope, optimising their skills and contribution to the rural health care team ($0.500 million.)

44.3 extending the provision of rural inter-professional education programmes, by expanding the existing rural immersion programmes to an additional rural setting ($0.500 million.)

44.4 leveraging the role of technology in improving connectivity, collaboration, cross sectoral and professional support. This would involve working with DHBs, training organisations and professional colleges to improve service integration, primary health care support and learning opportunities.

44.5 examining the potential for DHBs to employ GPs and opportunities to improve support to rural locums.

45 These short-term solutions could be funded through a mix of reprioritising existing funding and as part of Budget 2019.

46 The medium-term development of a programme of work will draw on the ideas put forward in the two proposals and involve stakeholder engagement to canvas broader ideas and potential solutions. This will include opportunity for any interested parties to participate, including but not limited to the health and education sectors.

47 This programme of work will include:

47.1 using vocational training agreements as a lever for improved distribution of practitioners;

47.2 targeting the Voluntary Bonding Scheme[4] criteria to areas and professions of need;

47.3 evidence-based investment in multi-disciplinary rural vocational education pathways;

4 The Voluntary Bonding Scheme (VBS) is a practical initiative run by HWNZ to encourage newly qualified health professionals to work in the communities and specialties that need them most, and to retain essential health professionals in New Zealand.

47.4 building upon existing investment in rural workforce initiatives to strengthen international medical graduate orientation and practitioner support – both in DHBs and rural practice;

47.5 perspectives from regional development, rural local government, rural communities, educators, immigration, rural business, and health professionals;

47.6 attraction, recruitment, pastoral and practical placement support for health professionals and their families;

47.7 ensuring that personal and professional support is provided to both international and New Zealand medical graduates and their families in rural practice; and

47.8 an evidence based, inter-professional rural education pathway.

New workforce planning models have been developed that take into account these factors

48 HWNZ has recently developed workforce planning and demand modelling frameworks. These take into account patient and community need, system level measures, ambulatory sensitive (preventable) hospital hospitalisations, access to services and workforce distribution to identify gaps and inform investment decisions.

49 These demand modelling frameworks will be used to inform the proposed programme of work to address rural healthcare issues.

Timeframes for this programme of work

50 Short-term initiatives will be presented to the Minister of Health by the end of November 2018 with options for reprioritising existing funding and/or consideration as part of Budget 2019. A recommended (medium-term) programme of work with specific solutions to increase and strengthen the rural health workforce will be provided to the Minister of Health for consideration by 28 February 2019. This will allow time for the establishment of a work programme, consultation with the sector and the programme of work to be drafted and resource options identified.

Consultation

51 This paper has been co-drafted by the Tertiary Education Commission and the Ministry of Health. HWNZ contributed data on New Zealand's health workforce and material about the proposed alternative approach in the section entitled 'The Ministry of Health work programme'.

52 Comments were sought and included from the Treasury, the Ministry of Business, Innovation and Employment (MBIE), and the Ministry of Education.

53 The Department of Prime Minister and Cabinet (DPMC) has been informed.

Financial implications

54 There are no financial implications associated with this paper. However, funding is likely to be needed to support some of the new initiatives proposed by the Ministry of Health. We are intending refining these proposals for consideration as part of the Budget 2019 processes.

Other Implications

55 Other implications are as follows:

Human Rights	None
Legislative	None
Regulatory Impact Analysis	Not required
Gender Implications	None
Disability Perspectives	Access to health services is particularly important for some people with disabilities and chronic diseases. The Ministry of Health will consider the particular needs of people with disabilities in the work programme.

Publicity

56 The Minister of Health will advise the University of Waikato and Waikato DHB and the Universities of Auckland and Otago about this decision before it is announced publicly.

57 The Minister of Health and Minister of Education will make a joint press release to announce the decision and details of the Ministry of Health work programme. This will also provide information on how stakeholders can get involved in the development of the new initiatives.

58 We intend to publicly release this paper. Some redactions may need to be made about costs associated with the two proposals.

Recommendations

59 The Minister of Education and the Minister of Health recommend that the Cabinet Social Wellbeing Committee:

59.1 **note** that there is a shortage of doctors and other health professionals in rural areas, which results in decreased access to medical care in rural areas;

59.2 **note** that improving access to health services for rural communities will require multiple solutions;

59.3 **note** that the establishment of a School of Rural Medicine would only address some of the issues;

59.4 **rescind** the Cabinet decision to establish a School of Rural Medicine – CAB-17-MIN-0464;

59.5 **invite** the Minister of Health to report back to the Cabinet Social Wellbeing Committee in November 2018 with an update on short-term actions and March 2019 on the proposed actions and solutions to address the maldistribution of health professionals in rural areas and to improve access to health services in these areas.

Authorised for lodgement

Hon David Clark

Minister of Health

Hon Chris Hipkins

Minister of Education