Template 1: Budget Initiative template

There are five sections of this template agencies need to fill out:

- Overview and context
- Detail on the investment proposal
- Wellbeing impacts and analysis
- Cost understanding and options
- Collaboration

Overview and context

Key Question/area	Comment/answer
Agency to complete	
Portfolio of lead Minister	Hon Dr David Clark, Ministry of Health
Portfolio(s) of other Ministers involved (if this is a joint initiative)	N/A
Votes impacted	Vote Health
Initiative title	Workforce Training and Development s 9(2)(f)(iv) [redacted]
Initiative description	This funding will provide additional funding to support investment for training and development of the health and disability workforce. [redacted] subsidises the costs of vocational (specialist) training [redacted]
Type of initiative	Non-discretionary cost pressure
If this initiative relates to a priority, please outline the specific priority/ies it contributes to	This initiative aligns with Budget 2019 priorities: • Priority C: Lifting Māori and Pacific incomes, skills and opportunities. • Priority D: Reducing child poverty and improving child wellbeing, including addressing family violence. • Priority E: Supporting mental wellbeing for all New Zealanders with a special focus on under 24s.
Does this initiative relate to a commitment in the Coalition Agreement, Confidence and Supply Agreement, or the Speech from the Throne?	This initiative also aligns with the following health deliverables committed to in the **Speech from the Throne**: • Restore funding to the health system to allow access for all • Invest in the health system to provide the highest levels of care, support and treatment, wherever people live in New Zealand • Place a real focus on primary health e.g. GP subsidies will be increased to reduce costs to patients by $10 a visit, and the longer term funding system will be reviewed to ensure doctor visits remain affordable • Increase resources for frontline health workers. Through supporting and managing [redacted], and in particular, supporting 30 additional GP trainees and resident medical doctors in training, this initiative supports the following Coalition Health priorities set out

	in the Coalition agreement between the New Zealand Labour Party and New Zealand First Party: • Annual Free Health Check for Seniors including an eye check as part of the SuperGold Card. • Teen Health Checks for all Year 9 students. • Free doctors' visits for all under 14s. • Progressively increase the age for free breast screening to 74. As these priorities are likely to increase the number of people accessing services, the health workforce will need to be sufficient to support New Zealanders to seamlessly access health services.
Agency contact	Claire Austin (Group Manager, Health Workforce, Ministry of Health, phone: [redacted]
Responsible Vote Analyst	s 9(2)(a) [redacted]

Funding

Funding Sought ($m)	2018/19 [1]	2019/20	2020/21	2021/22	2022/23 & outyears [2]	TOTAL
Operating	s 9(2)(f)(iv) [redacted]					

Funding Sought ($m)	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	TOTAL
Capital [3]	-	-	-	-	-	-	-	-	-	-	-

1. Executive Summary

1.1 EXECUTIVE SUMMARY

A. Short summary of the proposed initiative and expected outcomes.

The initiative supports increasing New Zealand's medical workforce which will bring more doctors into the health system to work and ensures government decisions to increase investment in medical students is followed through with increased investment in postgraduate medical training [redacted] district health boards (DHBs) and general practices (also referred to as primary care practices). This builds resilience in the workforce as New Zealand-trained doctors have higher long term retention in the New Zealand workforce compared to international medical graduates.

This initiative covers the increased cost of training:

- An additional 30 GPEP1 trainees (in rural locations)
- s 9(2)(f)(iv) [redacted]

[1] If there is no funding required in 2018/19, then please delete this column

[2] If funding is time-limited and does not carry on into out-years please delete the reference to "& outyears"

[3] The first 10 years of capital investment is counted against the multi-year capital allowance. Please reflect the full 10 year profile in the table.

s 9(2)(f)(iv)

s 9(2)(f)(iv)

2. The Investment Proposal

This section asks you to outline your overall investment proposal and intervention logic. It should be supplemented with a one page intervention logic map showing the progression from outputs, outcomes and impacts of the initiative. See template 5 for an example of an intervention logic map that you can use as a template or guide.

2.1 Description of the initiative and problem definition

What is this initiative seeking funding for?

s 9(2)(f)(iv)

Supporting extra General Practice (GP) training positions will support the Government's commitment to giving people better access to primary care services. The Government has previously announced its commitment to increasing the number of GP trainees in New Zealand. It has also made a commitment to strengthening the rural health workforce.

	Supporting trainees in practices where extended access to low-cost general practice visits for all Community Services Card holders, and extended zero-fee general practice visits for children under the age of 14 are in place means that our most vulnerable populations will benefit from an expanded GP workforce.
Why is it required?	s 9(2)(f)(iv) [redacted] • meeting the costs associated with increasing the number of medical graduates into general practice/primary care, to support the Government's commitment to improve access to primary care. • building resilience in the workforce to be able to better respond to future demands and challenges (eg ageing population and an ageing medical workforce) s 9(2)(f)(iv) [redacted]

2.2 Options analysis and fit with existing activity

What other options were considered in addressing the problem or opportunity?	There are reviews across medical vocational training that are at various stages, such as, a review of the general practice education training programme and a systems capacity review – which is looking at training capacity across the health system and across disciplines and professions. These reviews may identify other options to improve and streamline training placements for health workforces. s 9(2)(f)(iv) [redacted] Medical practitioners may undertake vocational training in a medical specialty such as surgery once they are accepted into the requisite training programme managed by a medical vocational college (which are likely to Australasian based, rather than specific to New Zealand). Medical vocational colleges may confer Fellowship on trainees once they meet specific requirements for registration in a vocational scope of practice. There are a limited number of medical colleges who may provide training programmes across a number of specialties. Medical vocational colleges set the number of trainees that may be accepted onto a training programme in any one year and do this independently of the number of trainees needed to maintain service delivery in the health system. The limited number of training providers for medical practitioners at prevocational and vocational levels are likely to remain at the same levels, putting increasing pressure on providers to accommodate an increasing volume of trainees.

	In the meantime, the current cost pressures must be addressed. Any change as a result of current reviews will also require time to develop and implement. Training costs for medical graduates must be maintained during that period. The criteria for the additional 30 places will require that these places be targeted to rural locations, thus also working to improve rural communities' access to care.
What other similar initiatives or services are currently being delivered?	s 9(2)(f)(iv) [redacted] Medical and midwifery graduates are the only health professions who are guaranteed postgraduate training placements, leading to cost pressures when the volume of graduates increases. As part of the Safer Staffing Accord, DHBs will also be required to train all nursing graduates – this will place increasing pressure on DHBs to provide appropriate supervision and training for the graduates of the nursing and medical professions. From 2015, it is mandatory for midwifery graduates to complete the Midwifery First Year of Practice programme and government funding, through the Vote Health: Health workforce appropriation is available for this. s 9(2)(f)(iv) [redacted]
What other, non-spending arrangements in pursuit of the same objective are also in place, or have been proposed?	Currently no other arrangements are in place. As indicated above, reviews under way may provide some non-spending arrangements that may offer some assistance to address the cost pressures.
Strategic alignment and Government's priorities/direction	This initiative aligns with Budget 2019 Priority C: Lifting Māori and Pacific incomes, skills and opportunities. It contributes to increasing Maori and Pacific representation in the medical workforce to reflect the national population. <u>Government priorities</u> Priority 3 – Child wellbeing • Ensuring children experience optimal development in their first 100 days: safe and positive pregnancy, birth and parenting • Supporting children's mental wellbeing. Priority 4 – Achieving equity in health outcomes • Giving the most vulnerable children the best start in life • Ensuring people have faster access and high quality services where they need them most • Increasing confidence that communities have services that work for their unique needs close to home • Enabling best practice to be followed, and enabling the most able health practitioners to continue to serve communities and ensure sustainable service provision for the future. <u>Functions of DHBs</u> DHBs are required under the New Zealand Public Health and Disability Act 2000, to undertake various functions which include processes that enable Māori participation and the development of Māori capacity to participate in the health disability sector and to participate, where appropriate, in the training of health practitioners and other workers in the health and disability sector. s 9(2)(f)(iv) [redacted]

District Annual Plans

Both DHBs and Shared Service Agencies (who support regional activities) are expected to develop workforce actions in their plans that address issues of equity. Regions and DHBs are expected to undertake work to:

- increase Māori participation and retention in the health workforce and ensure that Māori have equitable access to training opportunities as others
- build cultural competence across the whole workforce
- increase participation of Māori and Pacific in the health workforce
- form alliances with educational institutes (including secondary and tertiary) and local iwi to identify and implement best practices to achieve the Māori health workforce that matches the proportion of Māori in the population.

s 9(2)(f)(iv) [redacted]

Schools of Medicine work to increase proportion of Māori and Pacific students in training

The Schools of Medicine within both the University of Otago and University of Auckland have policies in place to increase the number of Māori and Pacific students in their training programmes.

As a result of such policies and strategies which are aimed at achieving increased engagement with Māori and Pacific communities and investment in structures and processes for supporting academic attainment, the Universities are able to track increases in the number of Māori and Pacific medical students.

In June 2018, the University of Otago published an article in the New Zealand Medical Journal in which they sought to describe the sociodemographic characteristics of students accepted into eight health professional programmes in 2016.

In 2016, the proportion of Māori students who identified as Māori in the Bachelor of Medicine and Bachelor of Surgery programme was 15.8 percent (218 students) compared with 14.1 percent of the national population. Between 2010 and 2016, the proportion of Māori students in the Bachelor of Medicine and Bachelor of Surgery programme rose by 8.2 percentage points from 78 to 218 students (179 percent increase). The proportion of Pacific students in the Bachelor of Medicine and Bachelor of Surgery programme was 5.6 percent, compared with 7 percent of the national population. In addition, greater participation of Maori and Pacific peoples in the health workforce improves broader economic participation and whanau well-being.

This initiative also aligns with Budget 2019 Priority D: Reducing child poverty and improving child wellbeing, including addressing family violence.

This initiative aligns with the Labour Party's commitment to reducing GP fees of which one initiative is increasing funding for GP training places, taking the intake to 300 per year. This is one of the measures that is intended to be put in place to support primary care services while a review of primary care funding to further reduce barriers to primary care and ensure the financial sustainability of practices is carried out.

This initiative supports the following priorities set out in the Ministry of Health's Output Plan 2018/19:

Supporting priorities

- Māori health – develop a Māori health workforce action plan
- Pacific health – Through the refresh of Pacific health strategic priorities and action plan – supporting system performance, participation and leadership for Pacific people across all levels of the health systems
- National Health and Disability Workforce Strategy – Development of national Health & Disability Workforce Strategy

System priorities

Priority 1: Improving DHB performance

An improved monitoring and intervention regime is expected to deliver:

- Improved equity and access

	• Improved patient experience • s 9(2)(f)(iv) [redacted]

2.3 Outcomes

Overall outcomes expected from this initiative	The overall outcomes of this initiative are: • To build resilience in the medical workforce to better meet current and future challenges and demands • A safe and competent medical workforce, sufficient to meet New Zealand's health care needs • [redacted] The number of medical students has been increasing over recent years in order to meet New Zealanders' health needs as the population grows and ages. As these students graduate, DHBs need to [redacted] s 9(2)(f)(iv) [redacted] We need to both increase our medical workforces and maximise the utilisation of services to ensure all New Zealanders are able to access health care to support their overall wellbeing.

2.4 Implementation, Monitoring and Evaluation[4]

How will the initiative be delivered?	This initiative will be delivered through existing contracting mechanisms that are set in place for Vote Health: Health workforce appropriation funding. s 9(2)(f)(iv) [redacted] For the GPEP[5] Outcome Agreement, reporting includes numbers and a broad breakdown on the ethnicity of trainees. In 2017, all Health Workforce contracts shifted to Outcome Agreements and the narrative report was introduced. It is too soon to tell if narrative reporting has made a difference either way to the quality of reporting. As this initiative is a non-discretionary cost pressure for Outcome Agreements that are already in place there are unlikely to be any risks or uncertainties.

[4] This doesn't necessarily have to include a full implementation and evaluation plan, however the information provided must provide confidence that the proposal will be successfully delivered and there is a plan to ensure that the outcomes described are actually achieved.

[5] General Practitioner Education Programme, the vocational (specialist) training programme for medical practitioners to become vocationally qualified general practitioners.

How will the implementation of the initiative be monitored?	The Health Workforce Group within the Ministry reviews Outcome Agreements annually in discussion with service providers – DHBs and Medical Vocational Colleges. The Outcomes Agreements allow for a more regular review if it is possible that outcomes are unlikely to be met or if training providers have issues that may impact on the delivery of training programmes. s 9(2)(f)(iv) [redacted] r the GPEP programme, reporting is done on the activities completed during training, the number of Registrars participating in training events and themes arising from quality measures outlined in the Outcome Agreement and the actions taken to correct any difficulties identified.
Describe how the initiative will be evaluated	The Outcome Agreements contain clauses which allow for the "wash up" of funds and means that if training providers do not train the required number of trainees as set out in the Outcome Agreement they may be required to return unused funds to the Ministry. If the required number of trainees are not trained within the Outcome Agreement timeframe the Ministry will ask for unused funds to be returned.

3. Wellbeing Impacts and Analysis

This section builds on the information provided in section 2 above and goes into further detail on the impacts, evidence and assumptions underpinning the intervention logic. It also asks that you demonstrate how your initiative will impact on wellbeing domains, the four capitals and risk and resilience.

The focus is on showing a strong narrative underpinned by evidence rather than monetisation of benefits and showing a positive return on investment. However, the use of the CBAx tool and monetisation is encouraged for key impacts with good evidence where it will strengthen the case for intervention.

Completion of this section is strictly limited to a maximum of three pages. This section helps the Treasury to assess and advise how the proposed initiative will impact the wellbeing of New Zealanders relative to the counterfactual. It may be provided to Ministers to support Budget prioritisation.

Impact summaries need to be framed against the three components of the Living Standards Framework, with supporting evidence where available:

- ***Wellbeing domains** – identify the value to New Zealand, magnitude and timeframe (up to 50 years) for impacts on the primary and (up to three) secondary domains targeted.*
- ***Four capitals** – identify the draw-downs, build-ups and/or transfers across the four capitals (physical, social, natural, human) resulting from funding the initiative.*
- ***Risk and resilience** – linking to the counterfactual and intervention logic, explain how the initiative adapts to or absorbs risk and/or how it maintains or builds resilience*

Please be aware that impacts or evidence are not mutually exclusive between wellbeing domains, capitals, and risk and resilience. They are interrelated cuts of the same information, we would expect that some answers may be duplicated.

3.1 Wellbeing domains – People's experience of wellbeing over time	
Identify and quantify how the initiative impacts on wellbeing domains	Please fill in Table 3.1 below. Impacts need to be grouped under the relevant domains, as provided in the key below. Use the relevant domains, ordering them from top to bottom according

to which domain your initiative achieves the greatest impact in. This analysis must also capture any negative impacts.

The wellbeing domains are outlined here for you to use in your table:

Civic engagement and governance	Jobs and earnings
Cultural identity	Knowledge and skills
Environment	Safety
Health	Social connections
Housing	Subjective wellbeing
Income and consumption	Time-use
	Other

3.1 Wellbeing domains – People's experience of wellbeing over time

Domains List domains, using the key above, where there is an impact. Order domains by magnitude of impact, i.e. largest impact domain first[6].	**Impact(s) description** Identify the impacts, with a separate line for each impact relating to a specific domain *Note you can identify multiple impacts for a particular domain. Delete/add rows as needed.*	**Who are affected?** Individuals/families/government/etc? Be as specific as possible. Are there distributional differences?	**Magnitude of impact** Relative to the counterfactual key assumptions, quantified to extent possible, and where possible monetised	**How big?** High/ Moderate/ Low, or where possible present value	**Realised** in <5 / 5-10 / 10+ years	**Evidence base** Nature of evidence and key references	**Evidence quality** High/ Medium/ Low
Health ✚ Primary	s 9(2)(f)(iv) [redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Increased number of GPs working in primary care services	GPs / primary care Individuals Families	Primary Care Services are able to fill vacancies for GP positions and primary care practices are able to increase the number of patients they can manage on their books, enabling individuals and families to access care closer to home.	Moderate	5 – 10 years	Medical practitioner workforce data, including but not limited to numbers, specialties, ethnicity, and main work setting New Zealand Health Survey	Medium
Knowledge and skills Secondary	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Jobs and earnings Secondary	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Income and consumption Secondary	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

[6] *Please note that in CFISnet, you will need to include the primary domain impacted, and up to two secondary domains impacted by the initiative. You can include as many domains as relevant in this table.*

3.2 Wellbeing capitals – Sustainability for future wellbeing

Wellbeing capitals	Please fill out the table below to demonstrate how your initiative may contribute positively, negatively or neutrally to the four capitals.

Capitals	**Describe the impact and its magnitude**	**Realised in** <5 / 5-10 / 10+ years
Financial/Physical	**Increase.** In the short term, this initiative draws down on financial capital to alleviate cost pressures associated with an increased cohort of graduating medical students. However, over time it is expected to generate significant financial capital in the health, research and development sectors. Physical capital will also be generated through models of care that will impact on where and how health services are delivered.	10 + years
Human	**Increase** This initiative will increase the number of trained doctors in New Zealand's health system and will also contribute to increasing the global health workforce. This helps to build the stock and distribution of human capital that is available to provide health services to New Zealanders in a timely and efficient fashion. More doctors = healthier New Zealanders = increased labour productivity and more GPs = savings in tertiary health services	10 + years
Natural	**Maintain** This initiative has no impact on natural capital	N/A, as no impact
Social	**Increase** This initiative will improve social capital, by increasing New Zealanders' sense of trust, respect, and pride in the health system, based on increased availability of health services, and demonstration of increased health workforce capacity and capability and increased medical research capacity and capability. Investing sooner will increase the overall impact on the capital.	10 + years

3.3 Risk and resilience narrative

Does the initiative respond to or build resilience?	s 9(2)(f)(iv) [redacted] more specifically, the general practice/primary care and rural workforce, and further support to increase the representation of Māori and Pacific doctors in the medical workforce.

4. Costing understanding and options

This section will provide further information on the costs of delivering the initiative and options for scaling and phasing to support assessment, prioritisation and decision-making.

4.1 Detailed funding breakdown	
Please provide a breakdown of the costs of this initiative	s 9(2)(f)(iv) [redacted]

s 9(2)(f)(iv)

[redacted]

	[redacted]

5. Collaboration

This section provides information on how agencies have engaged both within and outside of their own departments in the development of this initiative. Cross-agency and cross-portfolio collaboration are both important in this context. Please ensure this section is clear and succinct, and no longer than one page.

5.1 Collaboration and evidence	
What type of cross-agency and/or cross-portfolio initiative is this?	This initiative is not a cross-agency and/or cross-portfolio bid where there is collective responsibility, but there are cross-agency relationships and implications with the Tertiary Education Commission and Ministry of Education as postgraduate medical training flows on from government-funded medical undergraduate education and aligning future medical workforce supply and demand.
Agencies and Ministers that have been engaged in initiative development	s 9(2)(f)(iv) [redacted]
Impact of cross-agency collaboration	
Risks and challenges	