Fit for Purpose and for Practice

Advice to the Minister of Health on the Issues Concerning the Medical Workforce in New Zealand

Health Workforce Advisory Committee
Kōmiti Taunaki Kaimahi Hauora

Medical Reference Group
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<tr>
<td>ACCC</td>
<td>Australian Competition and Consumer Commission</td>
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<tr>
<td>ANZCA</td>
<td>Australian and New Zealand College of Anaesthetists</td>
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<tr>
<td>CTA</td>
<td>Clinical Training Agency</td>
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<tr>
<td>DHB</td>
<td>District Health Board</td>
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<td>DHBNZ</td>
<td>District Health Boards New Zealand</td>
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<td>DiTWR</td>
<td>Doctors in Training Workforce Roundtable</td>
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<td>EFTS</td>
<td>Effective Full-time Student</td>
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<td>EWTD</td>
<td>European Working Time Directive</td>
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<td>GPEP</td>
<td>General Practice Education Programme</td>
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<td>HPCA</td>
<td>Health Practitioners Competence Assurance Act 2003</td>
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<td>HWAC</td>
<td>Health Workforce Advisory Committee</td>
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<tr>
<td>JFICM</td>
<td>Joint Faculty of Intensive Care Medicine</td>
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<td>MCNZ</td>
<td>Medical Council of New Zealand</td>
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<td>MOSS</td>
<td>medical officer special scale</td>
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<td>MRG</td>
<td>Medical Reference Group</td>
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<tr>
<td>NGOs</td>
<td>non-governmental organisations</td>
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<tr>
<td>NZAPP</td>
<td>New Zealand Association of Pathology Practices</td>
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<td>NZMA</td>
<td>New Zealand Medical Association</td>
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<tr>
<td>NZREX</td>
<td>New Zealand Registration Examination</td>
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<tr>
<td>NZRGPN</td>
<td>New Zealand Rural General Practitioner Network</td>
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<tr>
<td>PHO</td>
<td>Primary Health Organisation</td>
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<tr>
<td>RACS</td>
<td>Royal Australasian College of Surgeons</td>
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<td>RANZCP</td>
<td>Royal Australian and New Zealand College of Psychiatrists</td>
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<tr>
<td>RDA</td>
<td>Resident Doctors Association</td>
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<tr>
<td>RNZCGP</td>
<td>Royal New Zealand College of General Practitioners</td>
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EXECUTIVE SUMMARY

The issues

The available evidence clearly shows that New Zealand faces critical issues with the current capacity and ongoing development of its medical workforce. There is an overall shortage of medical practitioners, which is particularly noticeable in vocations such as general practice, pathology and psychiatry. These shortages are evidenced by the current use of locums and temporary appointments to fill positions within New Zealand – along with the extensive efforts currently undertaken to recruit practitioners from overseas into these vocational branches. This has lead to a cost to the New Zealand health sector in terms of the high rates paid to locums and the expenses of sophisticated recruitment processes to entice workers from overseas.

Anecdotally, many New Zealanders experience difficulty in accessing a general practitioner (GP). This increases the burden on acute secondary care facilities and incurs non-financial costs to the community, due to lack of adequate or appropriate public health care. There also appears to be a ‘maldistribution’ of the available medical workforce, with rural and non-metropolitan areas finding it increasingly difficult to recruit and retain doctors.

There is evidence that the shortage will worsen. Models produced by the New Zealand Institute of Economic Research (NZIER 2004) forecast a shortage of health workers, including medical practitioners. The ageing population, increased incidence of key chronic diseases and changing expectations of consumers are creating increasing national demand. Internationally there is increased demand for medical practitioners due to changes in employment conditions, such as the European Working Time Directive in the United Kingdom. The international labour market for medical practitioners is becoming increasingly competitive, with New Zealand losing many practitioners to other countries able to offer better remuneration and working conditions.

In addition to demand pressures, there are a number of factors limiting the supply of medical practitioners in New Zealand. The cap on the number of places of medical students at New Zealand universities limits the overall number of medical practitioners we can produce, increasing our reliance on overseas-trained doctors in times of shortage. Cabinet recently increased the cap by 40 places; these were allocated to students from rural settings. However, it is unlikely this increase in places will be sufficient to meet the projected increase in demand for medical practitioners. New Zealand needs to increase the number of medical school places for New Zealand citizens and residents.

Any increase in the number of medical school places will need to be mirrored by a similar increase in the number of ‘runs’ (clinical placements) for undergraduates and postgraduates, in order for them to meet their registration requirements. The Medical Reference Group (MRG) believes runs need to be configured to provide experience in the health care areas that New Zealand will need most: in primary and community-based health care and community-based disability care.

The total number and relative distribution of vocational training posts require review in light of the changing demands for health services. There is a lack of cohesive information on the true cost of vocational training to the health sector, which makes it difficult to determine the financial implications of changing the number of vocational training programmes.
Lifestyle decisions, an ageing medical workforce and changing work patterns (such as people seeking part-time work) are contributing to a decline in the availability of medical practitioners in the workforce. Of all New Zealand medical practitioners under retirement age, 2965 (36%) no longer hold annual practising certificates. It is probable that many of these doctors have emigrated overseas. The health sector needs to improve its retention of New Zealand doctors.

New Zealand has the highest proportion of overseas-trained doctors (34.5% of its medical workforce) of any Western country. Whatever happens, the New Zealand health sector is likely to rely on overseas-trained doctors to supplement its medical workforce needs for the short to medium term. It therefore needs to ensure that registration requirements are transparent and that overseas-trained doctors receive continuing medical education in order to maintain their skills.

Nationally focused strategic planning is urgently required to address current and forecast shortages. It takes six years to train a doctor and a further five years to train a registered GP. It takes longer again to train other specialist medical practitioners. Yet New Zealand could face a shortage of between 2412 and 3618 practitioners within 15 years. Urgent and cohesive action is required to address this problem.

The funding for medical education and vocational training spans Vote: Health and Vote: Education. Lack of co-ordination between the education and health sectors is a major barrier to achieving coherent planning for the medical workforce. In the tertiary education sector there is now a clearer focus on higher-value education. Better co-ordination and linkages between the two sectors would support this process and ensure that the investment of educational resources into medical education (and into health workforce tertiary education in general) is optimised and improved. The MRG believes that payment to medical schools should be based on the number of medical graduates produced to agreed standards, rather than the effect of the full-time student system, which is, in effect, a payment system based on attendance.

Within the medical profession there is a need to re-evaluate issues concerning professionalism. The changing nature of disease, population requirements and the medical workforce itself will drive changes in the roles of all health professionals working within the sector. Models of care are shifting away from the more traditional one-on-one approach towards multidisciplinary team-based care, centred much more around the needs of the patient, and spanning community-based care, primary and secondary settings.

The medical workforce must be able to meet the changing needs and expectations of the community. There are increasing expectations on medical practitioners to provide greater leadership in the planning and delivery of patient care, and in the underlying processes of workforce planning and information systems development. Patients have higher expectations of the quality of services, and of being fully informed about treatment options. Teamwork is increasingly emphasised, with all health professionals expected to maintain working relationships both within and across disciplines.

The management of chronic conditions is an example where multidisciplinary teams are required to work in a more patient-centred way, and across primary, secondary and community-based care settings. Effective management of the increasing burden of chronic conditions is essential, and will drive ongoing changes in health service delivery. Doctors will need to be able to work within multidisciplinary teams that focus not only on medical interventions, but also on changing patient lifestyles and empowering them to manage their own conditions. Multidisciplinary teams will become even more important in managing patients with multiple morbidities.
Chronic conditions can exacerbate socioeconomic inequalities within New Zealand society. Lower socioeconomic groups have a higher incidence of chronic conditions and less access to health services. Chronic conditions contribute to loss of quality of life as well as reducing life expectancy. The MRG believes it is increasingly important and desirable to provide services in community and primary health care settings. This change in focus has implications for the type of medical training required, and the composition of the medical workforce.

The development of a culturally adept workforce, particularly for Māori and Pacific peoples, is important to ensure the effectiveness of service delivery and ongoing reduction in inequalities.

The changing emphasis in health professionalism, and in service delivery, has implications for the medical education curriculum and professional development programmes. Medical education at all levels, and at all stages of a doctor’s career, will need to include a focus on teamwork, professionalism, interpersonal skills and leadership skills.

To alleviate these problems and to ensure a future medical workforce that is ‘Fit for Purpose and for Practice’, the following tactics need to be employed.

- The production of New Zealand medical graduates should be increased.
- A higher proportion of local graduates must be retained in New Zealand in both the short and longer term.
- Dependence on overseas-trained doctors should be decreased.
- Undergraduate, postgraduate and continuing medical education, vocational training, and career development should be regularly appraised and adjusted to meet changing requirements.

The MRG believes that strategic planning is critical to underpinning the tactics outlined above, and to effectively address current and forecast medical workforce shortages. The two strategic work streams required to support these tactics are:

1. There needs to be a group that has responsibility for nationally focused strategic workforce planning, and co-ordination across all the different stakeholders.
2. Workforce planning must occur along a continuum, from undergraduate and postgraduate education, through to vocational training, and continued medical education.

Despite efforts in New Zealand and internationally, there is no accepted or established way of objectively measuring a nation’s need for doctors. However, given the medical workforce information we do have, a co-ordinated and prompt response is clearly needed. A lack of information must not deter action, because there is a cost to doing nothing. An ongoing process of medical workforce surveillance that informs decision-making would enable progress to be made on workforce planning issues while also broadening the information base available for such decision-making.

The MRG believes there is a need for a group with responsibility for a strategic national workforce planning process. We believe that the strategic aim should be for New Zealand to be self-sufficient in its production of medical practitioners, that all medical practitioners should be vocationally trained, and that they should be appropriately distributed across vocational branches and geographically within New Zealand. The responsible group will require strong collaborative links, and agreed working arrangements with the many stakeholders involved in the training, ongoing education and deployment of the medical workforce, including universities, District Health Boards, regulatory bodies, accreditation agencies, funding agencies, and medical colleges.
Ten critical recommendations

After considering the issues above, the MRG has developed the following 10 critical recommendations for the planning, recruitment and development requirements of the medical workforce of New Zealand.

1. To improve the current health–education interface and reduce inefficiencies, there needs to be nationally focused strategic workforce planning. The Medical Reference Group believes that the best structure to achieve this is an inter-agency steering group, with a ministerial mandate to provide advice to the Ministers of Education and Health, and their agencies. Advice would cover medical education and vocational training, funding and curriculum issues, professionalism of the medical workforce, and innovations in service delivery. Planning responsibilities would include monitoring the supply of, and demand for, vocational expertise to identify areas of potential shortages and to address them as required. The governance of the body responsible for the planning function needs to have sector-wide representation, with key representation from the Ministries of Health and Education (see pages 27 to 31).

2. The total output of resident medical graduates should be increased by lifting or removing the cap on the number of undergraduate medical school placements. There are a number of options for increasing the total output of medical graduates, which are discussed in the body of the report (see pages 9 to 14).

3. The education sector should move to a method of ‘payment for output’ for medical education, in order to remove disincentives for change (see page 14).

4. Planning should be undertaken, as a matter of urgency, to ensure there are sufficient postgraduate year 1 and 2 runs to accommodate the extra 40 places per annum for undergraduates from rural settings (see pages 16 to 17).

5. Runs should be reconfigured to reflect the needs of the New Zealand health sector by including, for example, runs with community-based health care and disability community-based care, and by making primary care runs mandatory for trainee intern, postgraduate year 1 and postgraduate year 2 students (see pages 16 to 17).

6. New Zealand should educate its medical workforce to match the health, geographic and cultural requirements of the New Zealand population, including recruitment into vocations with shortages, particularly psychiatrists, pathologists, and primary care doctors (see pages 18 to 20).

7. The true costs, public and private, of vocational medical education in New Zealand should be established (see pages 19 to 20).

8. New Zealand should improve its retention of New Zealand-trained doctors, in particular by:
   - supporting part-time specialist training roles for practitioners
   - developing job-share roles for those who may want to practise on a part-time basis
   - engaging community support networks, particularly for doctors in a rural setting (see pages 21 to 23).

9. Given that the New Zealand health sector will continue to depend on overseas-trained doctors in the short to medium term, the Medical Council of New Zealand and the medical colleges should establish transparency in the competencies and standards against which overseas-trained doctors are assessed, especially for overseas-trained specialists, and scopes of practice should be commensurate with the achievement of those competencies and standards (see pages 24 to 25).

10. The medical education curriculum and professional development programmes should include teamwork and collaboration, professionalism, communication, interpersonal skills, and leadership skills training. All practitioners should also be skilled in the management of patients with chronic conditions, and these skills should be maintained and enhanced throughout the entire lifetime of medical education and practice (see pages 33 to 34).
INTRODUCTION

Background

The Health Workforce Advisory Committee (HWAC) was established in 2001 to provide strategic advice to the Minister of Health on the health and disability support sector workforce. In November 2003, at the request of the Minister, HWAC established the Medical Reference Group (MRG) to formulate specific policy advice on medical practitioner supply and demand, and on the education and deployment of doctors. The MRG had its first meeting in January 2004.

The MRG was required to provide independent advice to HWAC and to work within HWAC’s terms of reference. The MRG was initially tasked with:

- assessing medical workforce information requirements for supply and demand analysis, including:
  - the demand for doctors, including how they deliver services and medical workforce capacity requirements
  - the current supply from the education sector and immigration, and recruitment and retention issues
  - planning processes to improve information systems, and the use of short- and long-term measures to ensure capacity
  - professional issues, including professional development, flexible employment opportunities and career pathways
- reviewing the structure of medical service delivery, including exploring doctors’ work in terms of specialist, generalist and resident medical officer roles in an environment of patient-centred service delivery.

The full terms of reference for HWAC and the MRG are set out in Appendix 1 and 2, respectively.

The MRG began by reviewing the history over the last 40 years of health and medical workforce development in New Zealand. The result of these deliberations was a consultation document, Fit for Purpose and for Practice: A review of the medical workforce in New Zealand. The consultation document was released in May 2005, and submissions were invited. Ninety-seven submissions were received from a wide range of medical and non-medical individuals and organisations. A list of submissions and an analysis of the issues raised are included in Appendix 3.

Following analysis of the submissions and further deliberations, the MRG has prepared and submitted this report and recommendations to HWAC for its consideration and transmission to the Minister of Health. It should be noted that while this advice discusses the issues relating to the medical workforce, many of the issues are also relevant for the wider health and disability support workforce and allied professions.
Relationship with other work

In October 2004 the Minister of Health established the Doctors in Training Workforce Roundtable (DiTWR) to address issues relating to the clinical training of junior doctors, the relationship with undergraduate medical education, and the environment that supports the development of the trained workforce. Dr George Salmond, Chair of the MRG, was a member of the DiTWR for the full duration of its deliberations.

- The MRG made its consultation document and the resulting submissions freely available to the DiTWR. The Roundtable completed its work at the end of 2005, and has reported back to the Minister of Health. The central focus of the Roundtable has been doctors in training, while the MRG has enjoyed a wider brief. Although the terms of reference of the MRG and the DiTWR differ in their focus, the two groups have worked together to ensure that the respective recommendations do not conflict, and the MRG concurs with many of the recommendations of the DiTWR.

In reaching its conclusions and in drafting its recommendations, the MRG has also taken into account a number of other concurrent medical workforce development initiatives.

- The Clinical Training Agency (CTA) has been working on a number of medical workforce issues, the most relevant being work on the vocational training and continuing professional development of medical officers, and the vocational training of primary care practitioners in rural settings. The MRG has had access to papers on these projects.

- The 21 District Health Boards, through District Health Boards New Zealand (DHBNZ), have recently reported on the Future Workforce project. This has resulted in a number of subgroups, one of which is focused on medical workforce issues.

- DHBNZ has also established a Resident Medical Officers Working Group, which is working through the implications of, and the administrative problems associated with, the collective agreement with the New Zealand Resident Doctors’ Association. This work has clear and direct workforce development implications.

- HWAC is developing a strategic framework and principles for health workforce development, and has developed guidelines for healthy workplace environments. Other HWAC work of direct relevance and importance includes projects undertaken by its Māori Sub-Committee.

Readers seeking more detail on the key issues and recommendations discussed in this report should refer to the Medical Reference Group consultation document *Fit for Purpose and for Practice: A review of the medical workforce in New Zealand*, and to the Bibliography and References at the end of this document for more background on the projects above.

Recommendations

The MRG has developed two levels of recommendations. The first level is what it considers to be ‘critical recommendations’. These are the recommendations that it sees as imperative and that need to be addressed urgently. The second level of recommendations has been classified as ‘auxiliary recommendations’. While important, the MRG see these as needing a little less urgency than the critical recommendations.
I. BRIEF INTERNATIONAL BACKGROUND

The international labour market for medical practitioners is characterised by a highly mobile workforce. Medical practitioners’ skills are becoming increasingly transferable between countries and the high quality of New Zealand-trained doctors is recognised world-wide. As a result, changes to the supply of and demand for doctors internationally have a direct impact on New Zealand’s medical workforce requirements.

Like New Zealand, other Western countries are facing increases in demand for medical practitioners. This increase is primarily caused by the effects of population ageing and changes to employment conditions. Most countries are using two broad strategies to address these issues: train more doctors and recruit doctors trained overseas.

United Kingdom

In October 1998 the European Community initiated major changes to the way medical practitioners work with the introduction of the European Working Time Directive (EWTD). This directive lays down minimum periods of rest for workers and a maximum working week of 48 hours. Initially applying only to consultants, legislation passed in 2001 extended it to include doctors in training from 2004, with implementation to be completed by 2009.

It is expected that the EWTD will have the biggest impact on the United Kingdom (UK), which has the lowest ratio of doctors per 1000 head of population of the countries affected by the EWTD. The Royal College of Physicians Medical Workforce Unit (2005) estimated that there needs to be an increase of 28.2% in the number of full-time equivalent consultants in the UK to meet the EWTD requirements.

The National Health Service in the UK has already developed a strategy to recruit more general practitioners (GPs). This strategy, in conjunction with the EWTD, will increase the demand for doctors in the UK, which would most likely increase the demand for New Zealand doctors in the UK. It would also reduce the supply of UK-trained doctors for the New Zealand health service.

Scotland has four universities with medical schools. In 2004, a report titled Review of Basic Medical Education in Scotland recommended that the output of medical graduates each year be increased from 850 to 1000. Scotland has a population of five million people, and trains a large number of doctors in proportion to its population. This is in part due to historical reasons, but also to Scotland’s high reputation for medical education and consequent international demand for graduates.

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1 A fifth university, St Andrews, currently provides an undergraduate science degree which is used as a basis for medical education at Manchester University. The medical programme at St Andrews is set to be expanded, however, so it will be producing medical graduates.

2 This increase comes from the expansion of the programme at St Andrews University.

3 More than a quarter of medical students are from England, and over 50% of medical students at Edinburgh University are from England.
Canada

Canada, with a population of 32 million, has 16 medical schools and in recent years has increased its intake of medical students. The number of first-year enrolments for the 2003/04 academic year was 2096. Canada also has a long history of using overseas-trained doctors to supplement its medical workforce.

Australia

Australia, with a population of almost 20.5 million, has recently moved to increase the number of medical schools. It aims to increase the total number of medical graduates by 60%, from 1300 a year currently to 2100 a year by 2011. This would raise Australia's ratio of medical graduates per 100,000 population from 6.5 currently to 10.5. Australia also has a policy of actively recruiting overseas-trained doctors.

Impact on New Zealand

In this highly globalised and competitive market for medical practitioners, changes in other countries – such as the number of medical students being educated, medical graduates undergoing specialist training, and employment conditions of doctors – have an ongoing impact on the available pool of New Zealand- and overseas-trained doctors able to provide services in New Zealand. The fluid nature of this comparatively specialised workforce highlights the difficulties in predicting workforce supply, and creates the need for a systematic, ongoing monitoring of developments in other countries and their potential impact on New Zealand. Currently there is no body that performs this analysis in a co-ordinated way.
THE DEMAND FOR MEDICAL PRACTITIONERS IN NEW ZEALAND

The growing demand for health and medical practitioners

The main factor influencing the demand for medical practitioners in the next 20 years will be demographic changes. New Zealand, like most other Western countries, has an ageing population. This will influence both the workforce available and the demographics of disease. As the population ages, the incidence of chronic conditions associated with older people will increase. This, in turn, will affect the demand for the number of medical (and other health) practitioners, and the range of services required.

The Ministry of Health commissioned the New Zealand Institute of Economic Research (NZIER) to report on the implications of the changing demographics for the health and disability workforce. The resulting report, Ageing New Zealand Health and Disability Services: Demand projections and workforce implications, 2002 – 2021 (NZIER 2004), developed scenarios for the regulated health workforce,4 of which the medical workforce is a part.

Based on various scenarios of the potential future demand for health and disability support services and an assumption of zero labour productivity growth, the report projects that the excess of demand for labour in the regulated health and disability workforce will exceed supply by 2011. Assuming that numbers of health professionals being trained, entering and leaving the workforce remain stable, by 2021 there will be a 40 to 69% increase in the number of registered health professionals required.

In 2001 there were 8615 medical practitioners in New Zealand. If the increase in demand applies equally across the medical workforce there could be between 3446 and 5944 additional medical practitioners required in 15 years’ time. Given the current net flows of the workforce, this could equate to a shortage of between 2412 and 3618 medical practitioners. However, the demand for additional medical practitioners is unlikely to be consistent across all specialities or areas of the health sector. The increasing incidence of chronic conditions will require a workforce able to provide services for the management of diseases and conditions such as diabetes, dementia, asthma, and chronic pulmonary disease.

Chronic conditions impact significantly on an individual’s quality of life as well as reducing life expectancy. What’s more, individuals experiencing chronic conditions tend to have co-morbidities. Caring for this increasing population of patients will require multidisciplinary teams that have a broader focus than solely medicine, with the management of social and environmental matters becoming increasingly important.

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4 The regulated health workforce is all those health professionals who are regulated under the Health Practitioners Competence Act 2003.
Chronic conditions also exacerbate inequalities, with lower socioeconomic groups often having a higher incidence of chronic conditions and less access to health services (see, for example, Marmot et al 2001).

There will be a demand for a culturally adept workforce, particularly for Māori and Pacific peoples, to ensure the effectiveness of service delivery and the reduction in inequalities. The delivery of services for disease management may also be re-focused to provide more care in community settings. This could impact on the demand for different types of medical care, as well as the numbers of medical practitioners required.

Reducing overall demand

Tactics that re-configure service delivery models and strategies with the aim of reducing the incidence of preventable diseases will have some effect on reducing future demand on the medical workforce. Predicting the impact of this against the effects of an ageing population with increased chronic conditions is difficult and is outside the remit of the MRG. It is worth noting, however, that the NZIER models did not take into account any potential public health programmes to change the lifestyle, diet or nutrition of the population.

Strategies specifically aiming to improve the health of older people will also impact on the future demand for health services. Any increase in investment in such strategies should be evaluated for its impact on the demand for medical and health practitioners alike.

Conclusions

The greatest changes in demand for medical practitioners will come from New Zealand’s ageing population and the accompanying increasing incidence of chronic conditions. This will continue to drive a growing demand on services, which will impact not only on the quantity of services required but also on the focus of services, and where they are likely to be delivered in the future. These demand increases will be paralleled overseas.

New Zealand’s current dependence on overseas-trained doctors highlights our vulnerability to the highly mobile and internationally competitive market place. The process of anticipating medical workforce supply and demand in New Zealand requires strategic planning and co-ordination that is currently lacking.
3. THE SUPPLY OF MEDICAL PRACTITIONERS IN NEW ZEALAND

Capacity and capability

There are two aspects to the supply of the medical workforce. One is capacity — the number and source of doctors and their retention in the workforce. While the overall number of doctors required can be modelled, it is more difficult to ascertain the future distribution of doctors within different vocational scopes. Thus the second aspect of medical workforce supply is capability — the type of education and training doctors receive: are they ‘fit for purpose’? The skill sets expected of doctors is greater than just medical and clinical knowledge. Doctors need leadership skills and communication expertise, an ability to work within teams (both intra- and interdisciplinary) and to develop collegial relationships.

The supply of medical practitioners in New Zealand is influenced by:

- the number and type of medical students admitted into medical courses, and the number graduating
- the amount and type of vocational training funded by the Clinical Training Agency and DHBs
- recruitment and retention issues, such as doctors going overseas, lifestyle decisions and retirement
- the number of overseas-trained doctors who immigrate to New Zealand and are registered to work here.

There are ‘pressure points’ along the continuum of medical education, at the undergraduate, postgraduate and vocational training stages. These pressure points are illustrated in Figure 1 and will be discussed in the text. Note that Figure 1 is a simplified representation and may in places over-simplify the medical education system as a whole.

The medical undergraduate

The number and type of medical students admitted into medical courses

There is known to be a mismatch between the demographic and ethnic make-up of the medical workforce and that of New Zealand society as a whole. There is no shortage of interested and suitably qualified New Zealanders wishing to access medical education in New Zealand, but the range of applicants may well not reflect the demographic and ethnic profile of New Zealand.
FIT FOR PURPOSE AND FOR PRACTICE

Figure 1: The medical education system

<table>
<thead>
<tr>
<th>YEAR</th>
<th>EDUCATION FUNDING</th>
<th>PRESSURE POINTS</th>
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<tr>
<td>1</td>
<td>1st YEAR General health sciences training</td>
<td>Cap on number of medical students</td>
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<tr>
<td>2/3</td>
<td>2nd AND 3rd YEAR MEDICAL STUDENTS Pre-clinical training</td>
<td>Numbers and types of trainee interns</td>
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<tr>
<td>4/5</td>
<td>4th AND 5th YEAR MEDICAL STUDENTS Clinical training</td>
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<tr>
<td>6</td>
<td>6th YEAR Trainee intern</td>
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GRADUATION. PROBATIONARY REGISTRATION WITH MCNZ

7 PGY1 – 1st YEAR HOUSE OFFICER PGY1 runs

GENERAL REGISTRATION WITH THE MCNZ

8 + PGY2 – 2nd YEAR HOUSE OFFICER PGY2 runs

ACCEPTANCE INTO A VOCATIONAL TRAINING PROGRAMME

9 GP REGISTRAR Specialist training in general practice in the community

10 ADVANCED VOCATIONAL TRAINING (AVE) Partial CTAs & funding

11 FELLOWSHIP OF A COLLEGE AND VOCATIONAL REGISTRATION WITH THE MCNZ

1. Rural hospital medical officers
2. Single speciality medical officers
3. Multi-speciality medical officers

No specific funding for training

No vocational qualification

Limits to the number of vocational places funded and posts accredited (for some specialties)

Cap on number of medical students

CTAs/DHBs

Tertiary Education Commission

Partially CTAs funding

MCNZ

PGY3+ SENIOR HOUSE OFFICER Aka Medical Officer Special Scale (MOSS)

No specific funding for training
Universities collect information on the socioeconomic profile of medical students, but little is known about the profile of applicants. Research is required in this area to confirm if the health professions need to be promoted to specific groups within secondary schools. If a targeted promotional programme is required, the Ministry of Health, the Ministry of Education and DHBNZ should work together to develop an appropriate ‘branding’ project.

Entry to medical school is highly competitive. The number of students entering medical schools is restricted and can only be changed by a decision by Cabinet. The limit on the number of students is referred to as the ‘cap’. The current cap is set at 325 students per year for the two medical schools in New Zealand (at the University of Otago and Auckland University). This cap on numbers was last raised in 2004, when 40 additional places were made available for students from rural backgrounds.

If kept at this level, the maximum number of graduates produced over the next 15 years would be 4715. As current withdrawal rates from medical school are between 6 and 10%, the likely number of graduates from medical schools over the next 15 years is between 4240 and 4430.

The MRG has looked at the four main reasons given for having the cap outlined in the DiTWR report, and has commented on each of these.

1. The cap limits the cost to government of funding a specialised programme. This is the most substantial of the arguments. The medical degree is the most expensive undergraduate degree in New Zealand, but this investment in the medical workforce needs to be weighed against the costs of insufficient numbers of medical practitioners, and the costs and risks of relying on overseas-trained doctors.

2. The programme provides education and training in a specialist profession and the skills of surplus doctors are not readily transferable to other jobs. It is difficult to see how a Bachelor of Medicine and Bachelor of Surgery are less transferable than some other non-medical degrees, such as a Bachelor in Engineering in Mechatronics. The criteria for determining the ‘transferability’ of skills need to be made more transparent and explicit for this argument to be valid.

3. The graduating students need to be placed in a limited number of clinical attachments (runs) in the health sector. Medical students and graduates need runs to obtain practical experience and, ultimately, their registration. Any apparent limitation in numbers has not taken into consideration using the primary sector. It should be possible to create more runs, or provide structured simulated training in conjunction with the current education curriculum, to give a greater exposure to the clinical situation.

4. Producing an unlimited supply of doctors may put pressure on health expenditure as they subsequently establish practices and are eligible for government-funded health services. This rationale assumes that all doctors work in arrangements where they can generate limitless work and income. The reality is that current funding arrangements for public secondary and primary care already have a range of mechanisms limiting possible expenditure. For example, DHBs are subject to finite budgets, and public funding for primary health care is tied to the resident population base today. The rationale also assumes that there are no altruistic motives for obtaining a medical degree, and that medical education is accessed purely out of financial self-interest.

The MRG believes that the cap on medical student numbers needs to be reviewed to determine if it is still an appropriate or effective mechanism. If the cap is to be retained, then the level of the cap should be regularly reviewed in light of the anticipated demand for medical practitioners.
Proposals for increasing and funding the cap

The two medical schools have between 30 and 40 places that are currently filled by full fee-paying international students. The MRG have discussed the following options to increase the number of domestic students at medical school.

**Option 1:** These places could be made available to domestic students by increasing the number of places the government subsidises, resulting in increased investment by the government. This is the option favoured by the MRG. Undergraduate training currently requires a government investment of $199,000 per student, and basic postgraduate training currently receives a $53,000 government investment.

**Option 2:** The current level of government funding could be kept the same but spread over a greater number of places. This would increase the costs faced by students. However, fees for medical undergraduate courses are already some of the highest of all undergraduate courses. The MRG believes that even with the current Step-up Scholarship Scheme, this could discourage students from lower socioeconomic groups from attending medical school and further increase the ethnic and demographic imbalance between the medical workforce and New Zealand society.

**Option 3:** Domestic students could be allowed to take the places of international students and pay full fees. This raises the following equity, retention and potential administrative issues.

- Medical education could become the domain of the wealthy. International students currently pay a total of $221,560 for the five years of the medical undergraduate degree. Students from lower socioeconomic groups are unlikely to afford full-fee-paying positions. Māori and Pacific peoples have a higher representation in lower socioeconomic groups and are already under-represented in medical schools. This option could further skew the ethnic, socioeconomic and demographic profile of the medical workforce.
- Women take longer to repay their loans and may be less likely to take up full-fee-paying positions.
- A two-tier system raises the issue of fairness. Presumably all applicants to medical school would still need to meet academic and personal characteristic criteria for entry to the undergraduate course, so which of the successful applicants would pay full fees? The ‘bottom’ 40 or so, or those in the successful group of applicants who are ‘most able to afford it’?
- High fees would encourage full-fee-paying graduates into speciality areas where salaries are higher, and these may not be the areas where New Zealand has workforce shortages. Alternatively, full-fee-paying graduates may feel compelled to leave New Zealand completely for higher-paid overseas positions.
- There is an element of public good in all education – society benefits from having an educated population – and this holds true for medical graduates. Having full-fee-paying positions implies that medical education is purely a private good.
- There may be complicated logistical issues. For example, what happens if a subsidised student withdraws from a medical school? If their subsidised place becomes available to a full-fee-paying student, there would need to be a process to allocate it. If a full-fee-paying student gets the top grades in a subsequent year of study, it could be seen as unfair for them not to get a subsidised place – but addressing this may be at the expense of a subsidised student. The funding of graduate entrants under a subsidised versus full-fee-paying system would also have to be considered.
Beyond current medical school capacity

Increasing the cap to the capacity of the two medical schools will not produce enough medical graduates to fill the deficit forecast by the NZIER model, even if New Zealand increased its retention rate of doctors to 100%, an unlikely scenario (see below for a discussion on the retention of New Zealand doctors). Options for increasing the number of medical students beyond the capacity of the two medical schools in New Zealand therefore need to be considered.

New Zealand could fund students to study medicine overseas (eg, in Australian medical schools, which accept full-fee-paying students). New Zealand students could be funded to train in Australia and be bonded to return to New Zealand. Alternatively, a third medical school could be established in New Zealand. This would serve to increase the number of New Zealand citizen / permanent resident medical graduates, increase choice for medical school applicants, and perhaps give rise to more ‘radical’ undergraduate curriculum development (eg, a shorter programme, a specific community-care focus).

The demographic and ethnic balance of medical students

Māori and Pacific peoples, and those from lower socioeconomic backgrounds, are currently under-represented in the medical profession in New Zealand. They are also under-represented at the medical schools. Students from Māori and Pacific backgrounds, from rural areas, and from lower socioeconomic backgrounds need to receive active encouragement into sciences at school, and into the health professions, in order to achieve a fairer representation in the medical workforce.

The benefit of considering ethnicity in selection is that people are more likely to use health services if they feel culturally safe and identify with the provider (Ekeroma and Harilal 2003), thus reducing a common barrier to accessibility for many Māori, consistent with article three of the Treaty of Waitangi. The proposed benefit of considering the socioeconomic background of applicants is that students from rural and lower socioeconomic backgrounds are more likely than others to return to their home areas to provide medical and health services (Thomson et al 2003). There is currently no strong international or New Zealand evidence to support either rationale, but the recent introduction of the Rural Origin Medical Preferential Entry (ROMPE) scheme at the two New Zealand medical schools and the Step-up Scholarship Scheme will provide an opportunity to evaluate the impact of these selection policies in the New Zealand setting.

Student selection has been the subject of extensive research, both in New Zealand and internationally (Adams 2001). Evidence suggests that the vast majority of students able to meet established entry standards, including those from ‘preferential entry’ programmes, complete their medical training and go on to become competent doctors.

To assist with the recruitment and retention of an appropriately diverse range of students in undergraduate programmes, mentoring and role modelling programmes could be developed, and then sustained into all postgraduate medical education curricula. HWAC, together with other agencies such as DHBNZ and the Careers Advisory Service, could conduct research into successful mentoring programmes with a view to developing recommendations. Programmes researched could include the likes of Project K5 or Futureintech.6

5 Project K is a youth development programme to help 13-15-year-olds reach their potential through building self-confidence, promoting good health and education, and teaching life skills such as goal setting and teamwork.
6 Futureintech is an initiative of the Institution of Professional Engineers New Zealand designed to encourage more school-leavers into technology, engineering and science careers. They have set up a pilot mentoring programme which features young mentors working alongside caregivers, iwi, and teachers in mentoring year 9–11 secondary school students until they are well established at university.
Both New Zealand medical schools have been working to improve their student selection procedures so that they achieve a balance between direct entrants from secondary school, those with previous tertiary qualifications, and those with a history of successful work experience in other fields. Both schools also encourage and facilitate student entry that fairly reflects New Zealand’s ethnic and socioeconomic profiles.

**Length of the undergraduate medical course**

The length of the undergraduate course has been subject to much discussion within the MRG. Comparisons with other countries are difficult because many overseas medical schools have postgraduate entry into medicine, in preference to direct undergraduate entry at an earlier age. In most Western countries the medical course is now five years for undergraduates and four years for graduates. Thus the Auckland and Otago six-year course for undergraduates and five years for graduates is longer than many other medical courses in developed countries.

A shortened undergraduate course would enable medical students to enter the medical workforce earlier. A reduction of one year in undergraduate medical training would have the same effect as increasing the current cap by 10 to 11 places per annum over a 30-year period. A reduction to a five-year course would need to be managed carefully, however, given the implications for both the undergraduate curriculum and postgraduate courses, which are dependent on prior learning objectives being met. It would also create a one-off year when there would be two classes of graduates requiring pre-registration programmes, which is a doubling of the number of runs required.

At present there is no financial incentive for universities to reduce the length of the undergraduate course. Like all undergraduate university courses, medical schools are currently funded on the basis of effective full-time students (EFTS). The cap prevents a substantial increase in student numbers, and EFTS funding makes it desirable to have as many full-time students for as long as possible. To reduce the length of the undergraduate course under this funding system would result in a net loss of income to the universities.

In its submission on the MRG’s consultation document, the Ministry of Education indicated that it might be possible for the length of the medical undergraduate course to be shortened without any financial disadvantage to the universities. The MRG believes that the possibility of shortening the undergraduate medical course without loss of income for medical schools should be investigated, and recommends that medical undergraduate courses be funded on the basis of output to increase the financial incentive for universities to reduce the length of the course. Universities can then focus more on delivering knowledge and skills to medical students that meet the requirements of the employment sector, in an appropriate and timely manner.

The main arguments for retaining the length of the undergraduate course at six years are that:

- New Zealand students enter university younger than students in other countries, and the first year of health sciences gives them time to decide if they do actually want to pursue a career in medicine
- the final trainee intern year (sixth year) gives students practical clinical experience within different areas of medicine.

Nowadays, however, there are career advisory services in schools that help students make career choices while at secondary school, and there is an increasing number of mature and graduate-entry students in medical courses. Aside from this, the significance of a student’s age at entry into medical courses is not known.
The trainee intern year was developed to deliver high levels of practical clinical experience to a final-year medical student. Trainee interns were originally responsible for up to a third of the patients on a consultant’s list, but this now varies considerably with the specialty and placement. Currently there is little procedural work that trainee interns are permitted to do. They may perform similar duties to house surgeons but with less frequency, greater supervision and less responsibility. House surgeons themselves are having less contact with patients due to reduced patient hospital stay, and this flows on, in turn, to reduced levels of clinical experience and exposure for trainee interns.

The trainee intern year could be expanded to include responsibilities more aligned with that of a junior house officer. Any such expansion would be dependent on a review of the undergraduate curriculum that results in the introduction of earlier clinical contact, earlier acquisition of clinical skills and greater systems knowledge. This would also require modification to the house surgeon role and an expansion in their training, such as through increased use of primary care (see below under ‘Post graduate clinical training’ on pages 17 to 20).

Given that these complex issues cross many boundaries in funding and medical care, there would need to be a high-level government body which could co-ordinate the relevant health and education bodies involved in the development of the medical curriculum. A body that takes responsibility for the strategic planning of the medical workforce in New Zealand could be in a position to co-ordinate a review of these matters.

The MRG believes that the Ministry of Health should establish a process to co-ordinate issues that may arise in the education and training of medical practitioners. There needs to be representation from the bodies responsible for courses and accreditation, such as the universities, Medical Council of New Zealand (MCNZ), the medical colleges, the funding agencies (the Tertiary Education Commission and the Clinical Training Agency), and the DHBs and DHBNZ. Possible mechanisms to achieve this are discussed in section 5: Planning issues.

The undergraduate curriculum

Analysis of the submissions to the MRG consultation document highlighted a growing debate about the nature and content of the medical curriculum for the undergraduate course. Specifically, there is a general feeling that the curriculum should be better geared to the changing nature and requirements of medical practice. Students should be better prepared for careers as generalists (as opposed to sub-specialists) and for primary care and other community settings. By graduation they should be more clinically competent than is currently the case, and better socialised in the workplace environment. It was also proposed that the curriculum should cover the development of professionalism for doctors (see, for example, Royal College of Physicians 2005).

The development, assessment and delivery of the undergraduate medical curriculum involves a number of bodies, with different functions.

- The universities are respective owners of their course content and length.
- The Committee on University Academic Programmes is responsible for the quality assurance of university courses.
- The MCNZ has the authority to say whether a course is sufficient for the training of doctors.
- The Australian Medical Council audits the courses approved by the MCNZ.
- The MCNZ and the Australian Medical Council jointly accredit medical schools in Australia and New Zealand.
Both the Auckland and the Otago medical schools have ongoing programmes to align the undergraduate medical curriculum to better meet changing workforce requirements. The MRG believes that these programmes should be supported. Co-ordinated and sustained interaction between the education and employment sectors is an excellent way to increase the focus on curriculum development into the future.

For universities to consider substantial changes to their courses, there are two quality assurance standards that need to be met: those of the Committee on University Academic Programmes and the Australian Medical Council. The financial and resource implications of a review or proposed change can be substantial. (There have been recent Australian Medical Council reviews of both the Auckland and Otago medical schools.)

Links between undergraduate work and the early years of postgraduate vocational training should be strengthened. The MRG did not reach any conclusion as to the best way to do this, but options considered included introducing ‘foundation training’ similar to that being introduced in the UK. The Foundation Programme is a two-year planned programme of general training, which forms the bridge between medical school and specialist/general practice training. It comprises a series of placements in a variety of specialties and health care settings. Learning objectives for each stage are specified, and the focus is on demonstrating clinical competencies. A foundation course could also provide an opportunity to look at broader areas relevant to the health sector, such as epidemiology, health economics and public health. Alternatively, a concerted programme that increases the scope of work and the level of responsibility given to trainee interns in their sixth year could be considered.

Vocational guidance, mentoring and support for early career development should play a more substantial part in medical education – at all stages. Vocational streaming at the undergraduate stage was not widely favoured by those who responded to the MRG consultation document, but the development and use of well-structured electives could enable students to identify and then develop aptitudes and vocational interests during their undergraduate training.

**Critical recommendations:**

**Undergraduate medical education**

**CR1.** The total output of resident medical graduates should be increased by lifting or removing the cap on the number of undergraduate medical school placements.

**CR2.** The education sector should move to a method of ‘payment for output’ for medical education, in order to remove disincentives for change.

**Auxiliary recommendations:**

**Undergraduate medical education**

**AR1.** Vocational guidance, including mentoring and role modelling programmes, should be developed for secondary students, made available to all undergraduate medical education students, and sustained into postgraduate medical education and all medical careers for those that wish to access them.

**AR2.** If retained, the cap should be regularly reviewed.
Postgraduate clinical training

As noted in the DiTWR report, the training format for doctors has been based on the apprenticeship model since the development of guilds over 800 years ago. The inclusion of practical aspects to training, in addition to theoretical ones, is crucial in the training of doctors. As the term ‘medical practitioner’ suggests, the work of doctors is ‘hands on’ and practical, and requires kinaesthetic elements in training programmes. Apprenticeship learning has its advantages and disadvantages, which have also been noted in the DiTWR report, as have the impact of changes in service delivery.

The MRG does not propose to re-iterate the issues already covered by the DiTWR, but notes that there have been developments in the use of the apprenticeship model for other industries. There is a need for further research into effective training programmes that complement apprenticeship training schemes, both in New Zealand and overseas, and to develop options for delivering these to medical trainees in New Zealand and/or accessing them from overseas.

In particular, New Zealand has developed the ‘modern apprenticeship’ system, administered though the Tertiary Education Commission, which is currently being evaluated. The Commission also fund mentors who work with the modern apprentice to arrange a personalised training plan, as well as handling the administration and paperwork associated with the training. This could offer some useful ideas for the development of the medical training system. A further model currently in use in New Zealand is the Northern Clinical Training Network, which could be developed and extended, as proposed by the DiTWR.

The MCNZ is currently considering the issue of the length of postgraduate training. In particular, it is considering moving to a two-year pre-registration course, with a more structured training programme which would support vocational training. This would be dependent on a shortened medical course.

Given the calls for an increased emphasis to be placed on preparation for generalist roles and practice in community settings, the MRG believes that the number of training positions in such settings and the associated infrastructure support should be strengthened. In New Zealand, this should include the smaller provincial hospitals and outreach services. The medical schools of Auckland and Otago have put forward a proposal for a dedicated training programme to produce more rural GPs and hospital doctors, as well as nurses and pharmacists, but this programme has not yet received funding.

Innovative new ways are needed to supplement the apprenticeship model given the changes that have occurred in the length of patients’ stay in hospitals and the acuteness of medical conditions that clinicians are treating. For example, the Royal Australasian College of Surgeons are using skills labs, that is, the simulation of procedures in a laboratory setting. This is an area that can be expanded as a means of improving learning opportunities where patient numbers are limited.

Auxiliary recommendation: Postgraduate training

AR3. The ‘learning on the job’ or apprenticeship model should be retained as an effective method of delivering training to postgraduate trainees, but the model should be complemented by developing:

- clinical skills laboratories
- simulation exercises
- postgraduate inter-professional clinical skills training and simulation exercises.
Pre-registration training: Postgraduate year 1 (PGY1)

The first year of postgraduate training (usually referred to as PGY1) aims to provide medical graduates with the practical skills they need for their general registration with the MCNZ as a doctor. The MCNZ is the course owner and accredits ‘runs’ in hospitals which can be used for PGY1 training.

The Clinical Training Agency (CTA) funds places for all eligible medical graduates, including international students if they have residence. After satisfactory completion of this year, medical students are eligible for registration as doctors.

All graduates requesting PGY1 runs for 2006 have been placed (via the DHBNZ ACE programme). However, there is pressure on the number of placements available. This pressure will increase when the 40 extra medical students start to graduate from the end of 2008 onwards, and could be an issue if the cap is lifted for the number of domestic students unless additional runs are developed and accredited.

The PGY1 training involves satisfactory completion of various ‘runs’, comprising three months’ experience in particular medical areas (e.g., general medicine, general surgery/orthopaedics). The runs accepted as part of a doctor’s registration need to be reviewed to ensure they are relevant to the needs of today’s society. As the MCNZ has the mandate to accredit the PGY1 runs, any review of the PGY1 runs will have to be agreed with them. The MRG would like to see the development of runs that focus on community-based health care and disability community-based care. The central government agencies would then need to agree to fund the new runs.

A proposal for a primary care run is currently under development, although there are a number of issues that need to be worked through. One of these is funding, because the cost of the run will be greater than hospital-based runs due in part to the economies of scale that hospitals have. The increased costs can, however, be offset by the contribution junior doctors can make to the health care services. A study from South Australia (Mugford et al 2001) showed that junior doctors and undergraduates were able to contribute to the income of rural primary care facilities through the services they provided.

The broader scope of practice may only be available in private hospitals or consulting rooms. Many non-acute medical conditions are no longer commonly dealt with in the public sector, and so junior doctors need to train in private or not-for-profit providers to get experience in some surgical procedures. Psychiatric registrars are unlikely to see post-natal depression, as psychiatric wards more and more deal only with only acute psychoses. The funding for private providers of training must be assessed, but could be similar to the public system where the CTA partially funds the salary of the resident medical officer incurring the training costs, and the provider employing the resident medical officer pays the service component of the salary.

Private hospitals can be (and some are) involved in medical education and training. One example is Mercy Ascot Hospital, which has an agreement with the Auckland Medical School to provide training in surgical skills. The potential for private providers to contribute to undergraduate and postgraduate education of medical students could be investigated further.
Critical recommendation: PGY1 and PGY2 clinical attachments

**CR3.** Planning should be undertaken, as a matter of urgency, to ensure that there are sufficient postgraduate year 1 and 2 runs to accommodate the extra 40 places per annum for undergraduates from rural settings.

Critical recommendation: Medical education clinical placements

**CR4.** Runs should be reconfigured to reflect the needs of the New Zealand health sector by including, for example, runs with community-based health care and disability community-based care, and by making primary health care runs mandatory for trainee interns, postgraduate year 1 and postgraduate year 2 students.

Pre-vocational training: Postgraduate year 2 (PGY2)

After doctors are registered, they usually undertake a second year of postgraduate training (referred to as PGY2). The purpose of this training is to provide pre-vocational experience for doctors before they apply for vocational training with one of the medical colleges.

Currently there are no placements accredited for the PGY2, although some placements are funded. The CTA believes that the current training in the PGY2 offers little in the way of measurable outcomes. This could be due to the various purposes for which the pre-vocational training year is used.

As noted in the DiTWR report, however, there are a number of arguments for retaining the second year. For example:

- many doctors use this time to experience different specialties before they decide which career path to pursue
- even doctors who have decided on their career specialty may wish to spend some time in specialties complementary to their chosen path
- breadth of medical experience and training can only enhance any doctor’s practice
- some health delivery services rely on this pool of second-year graduates to provide hospital services.

There is no analysis currently available to determine the significance of each of these arguments, and therefore the weight that should be applied to them. It is worth noting that the use of the pool of doctors to provide hospital services creates a tension between what is best for the training of the doctor and what is best in terms of service delivery for the hospital, which is common to the PGY1, PGY2 and trainee intern years. This tension could be contributing to the lack of measurable training outcomes.

There is also currently no course specification for pre-vocational education. The CTA has developed a specification but does not have a mandate to be a course owner. Furthermore, course development is not the CTA’s core business, and as a funding agency there is the potential for a conflict of interest if the CTA funds courses that it also owns. The ownership of the course should lie with the providers. The CTA has not been able to get agreement on the
specification for PGY2 education from the DHBs who would be providing the placements. This issue is further complicated by the fact that the doctors undertaking pre-vocational education are often important sources of ‘pool’ personnel for DHBs. These DHBs also potentially have a conflict of interest in determining an appropriate education programme for this year.

Ownership of PGY2 education and PGY2 course specification is unclear. The MRG believes this is an issue where the Ministry of Health could take a leadership role in facilitating agreement among all the parties involved.

**Auxiliary recommendations: DHB participation in medical education**

**AR4.** The Minister should endorse the following DiTWR recommendations.

- The Ministry of Health should require DHBs to recognise the training of medical practitioners for the national good as an essential part of the workforce action plans that are included in their district annual plans.
- DHBNZ's Workforce Development Group should be supported and appropriately funded to provide input to the providers of medical education and training on the demand for and role of medical practitioners in the future, in both community and hospital settings.

**AR5.** Employers (DHBs and others) and DHBNZ should recognise their responsibility to support and provide training for the PGY1 and PGY2 years, and, in particular, district action plans should include DHBs’ responsibilities regarding training of this workforce.

**Vocational training**

Once doctors have completed pre-vocational training, they are eligible to apply for vocational training with one of the 12 medical colleges in New Zealand.

Vocational training occurs within various scopes of practice, which are defined by an accredited postgraduate training programme and qualification. The training programmes are owned by the relevant medical college, which accredit posts within hospitals or general practices to provide the training. Once a doctor successfully completes the vocational training of a college, they can be registered for a vocational scope of practice with the MCNZ.

**Recognition of prior learning**

A significant issue in postgraduate education is the lack of recognition of prior learning. When doctors change between vocational training programmes, few colleges offer a mechanism by which their prior learning can be assessed and possibly credited towards their new vocational training choice.

One option for recognising prior learning would be to develop a national standards system. As an example, the modern apprenticeship scheme works in tandem with national standards. Each unit standard has a defined credit value and sits at a specified level on the National Qualifications Framework. Credits can be accumulated from different learning institutions or workplaces towards a single qualification. All organisations accredited to assess against
standards recognise credits awarded by others. The MRG supports the DiTWR suggestion for the use of a ‘personal training portfolio’ which would record the acquisition of practical skills. This could also assist with the recognition of prior learning.

**Australian Competition and Consumer Commission (ACCC) issues**

In 2003 the Australian Competition and Consumer Commission (ACCC) authorised the Royal Australasian College of Surgeons (RACS) processes for the ‘selection of trainees, accreditation of training facilities and assessing trainees and overseas trained surgeons’. This authorisation was given subject to the reform of a number of RACS policies and procedures that would help balance the need for the RACS to remain involved in the setting of safety and practice standards for the profession, against the need for transparency, stakeholder participation and procedural fairness in RACS processes.

Following this authorisation, the ACCC and the Australian Health Workforce Officials Committee decided to extend a similar review to the remaining Australian medical colleges. The findings of this review were published in July 2005. In short, the review found that all of the colleges should incorporate the principles underlying the conditions in the RACS authorisation – transparency, accountability, procedural fairness and stakeholder participation. The review found that some colleges were nearer to achieving this than others, and that there were key issues with respect to transparent processes, objective guidelines for the accreditation of training sites, and the assessment of overseas-trained doctors.

Of the 11 colleges in the subsequent review, 10 were Australasian or Australian and New Zealand medical colleges. Of all the New Zealand-based medical colleges, the only one that would not have been directly impacted by the ACCC review was the Royal New Zealand College of General Practitioners (RNZCGP). It would be appropriate to consider the actions the New Zealand branches of the Australasian colleges are taking to address the ACCC findings, and to discuss with the RNZCGP their evaluation of the impact and relevance of the ACCC findings on their vocational training scheme.

**Funding of vocational training**

The CTA provides the majority of funding for vocational training. It determines its funding of vocational placements using the ratio of specialists to population as a proxy for population need, previous funding decisions, and needs highlighted by the Minister of Health. The specialist-to-population ratios are sourced from medical colleges, international standards specified by the World Health Organization, and the Australian Medical Workforce Advisory Committee. The CTA only funds posts accredited by the medical colleges. The CTA has recognised deficiencies in its funding models and has been working with stakeholders in an attempt to produce robust demand-side information.

Where the CTA does not fund a post, DHBs may fund the training. In the case of the General Practice Education Programme (GPEP), individuals may self-fund.

The MRG believes there is a case for increasing the funding for the number of general practice vocational training positions to 100 immediately. Approximately one-third of medical practitioners are GPs, yet only 50 out of 864 vocational placements funded by the CTA are in general practice. This needs to be reviewed given the declining number of GPs per 100,000 population (section 7 discusses this further). There are workforce shortages in other specialties, which the CTA is attempting to rectify, but its fundamental model will need to be reviewed if there is agreement that more generalist doctors are needed.
The primary–secondary interface is considered to be one area where a move towards more care being delivered by holistic, community-based services would result in significant economic efficiencies. More research needs to be done to identify these efficiencies and in what way GP training and continuing medical education could be reconfigured to provide the necessary skill base. Community-based geriatric care, mental health care, minor surgery, rural hospital care, public/community health and maternity care are all areas where a GP workforce can develop special interests. Ways of meeting the educational needs of these special interest areas need to be explored and implemented in a timely manner.

Due to a lack of co-ordinated information, there is no overview of the vocational training posts in New Zealand for the whole profession, or an understanding of which posts are funded by the CTA, which are funded by the DHBs or which are self-funded. The MRG believes that for the true costs to be established, a stocktake of all vocational training posts should be undertaken to provide information on the current training capacity, and to establish the total costs of vocational training to the health sector. This would contribute to the planning of future workforce training requirements.

Critical recommendations: Vocational education and training

CR5. New Zealand should educate its medical workforce to match the health, geographic and cultural requirements of the New Zealand population, including recruitment into vocations with shortages, particularly psychiatrists, pathologists, and primary care doctors. The planning function discussed below in section 5 needs to include monitoring the supply of, and demand for, vocational education to identify areas of potential shortage and to address them as required.

CR6. The true costs, public and private, of vocational medical education in New Zealand should be established.
Once trainee doctors have obtained general registration, the continued participation rate in the New Zealand health sector starts to drop. Data from the 2002 MCNZ workforce survey indicates that only 64% of doctors under retirement age continued to have an annual practising certificate. Of the approximately 8200 medical graduates since 1964, 2965 (36%) doctors of working age no longer hold annual practising certificates. If this continues, New Zealand can expect to lose approximately 1500 of the 4240 to 4430 new doctors expected to graduate between now and 2021. At this stage, there is no clear picture of what is happening to these doctors. Possible scenarios include parenthood, overseas travel, permanent emigration, change of career, loss of their annual practising certificate, and death.

New Zealand-trained doctors emigrating overseas

A large number of New Zealand-trained doctors do go overseas, often to pursue further postgraduate training. The New Zealand health sector faces international competition for its trained medical staff, and generally is unable to match salaries for similar positions in other countries. In Australia, physicians and proceduralists in public hospitals can access Medicare fee-for-service payments for ambulatory care on top of their hospital salary, thus earning considerably more that their New Zealand counterparts in many specialist vocations (eg, cardiology). In the UK, government funding of the National Health Service Modernisation Strategy, and salary increases through negotiated contract rounds, have substantially increased specialist and GP salaries.

The migration of New Zealand medical practitioners to overseas positions should not be confused with the traditional movement of doctors to further their training off-shore (or young New Zealanders doing their ‘OE’). It has long been recognised that New Zealand does not have the population to support some of the more specialised training programmes, and doctors may leave for five years or more to further their area of expertise. Many of these doctors may intend to return to New Zealand, but the immigration service takes absences of one year or more to be permanent departures.

There is no formal human resource management programme for doctors who do further their training overseas, so there is no guarantee they will return. We simply don’t know whether doctors who leave New Zealand are leaving for further training and intend to return, or are leaving permanently. Therefore the scale and the scope of the issue are unknown.
The implementation of the Health Practitioners Competence Assurance Act 2003 (HPCA Act) may help to provide data on this. Under the old Medical Practitioners Act, doctors who were overseas for more than three years could be deregistered from the New Zealand medical register unless they were studying a postgraduate course. Under the HPCA Act, doctors can remain on the register regardless of how long they are overseas. This will enable future analysis on New Zealand doctors practising overseas. Analysis of the register data from September 2005 (which includes doctors with temporary registration and those without annual practising certificates) gave 419 New Zealand-trained doctors with overseas addresses. Of these doctors, 59% had addresses in Australia, while England, Scotland, Ireland, the US and Canada accounted for a further 31% of the New Zealand doctors residing overseas.

This international spread of doctors is roughly aligned with the information provided by Mullan (2005). In an analysis of overseas-trained doctors in the US, Canada, the UK and Australia, Australia accounted for 70% of the New Zealand-trained doctors identified in the study. The numbers involved were more substantial than those obtained through an analysis of the New Zealand register data: in 1999 there were 2483 New Zealand-trained doctors in the four countries studied, with Australia accounting for 1742 of them. It appears that large numbers of New Zealand doctors are emigrating to Australia.

Overall, though, information is still lacking on exactly how many New Zealand-trained doctors are practising overseas today and why they are there. Research to establish why doctors emigrate and their original intentions with respect to returning could help to inform strategies for retaining more in the New Zealand health sector, and/or ensuring their return.

Student debt

The extent to which debt influences the work/life decisions of students and young doctors in areas such as vocational training, career choice, work location and deciding if and when to leave or return to New Zealand is unclear. Recent moves by the government — including the increase to the trainee intern grant and the move to forgo interest on the debt of graduates working in New Zealand — should be helpful.

Analysis supplied by the Ministry of Education indicates that medical students leave university with higher levels of debt than non-medical students, but they repay the loans at a much faster rate than other graduates. Some medical students go overseas to pay off their loans, but there is no system in place to encourage and manage their return to New Zealand. At an investment of $199,000 each, New Zealand needs to manage these human resources better.

The MRG supports measures to reduce debt for all students, but recognises that the issues are complex and have implications that stretch far beyond the health sector.

As a start, the health sector could develop employment arrangements, including career development arrangements and incentive schemes, that:

- assist young doctors with debt relief
- help students and young doctors to identify and take advantage of employment, training and career development opportunities in New Zealand
- encourage a higher proportion of graduates to start their vocational training in New Zealand
- where appropriate, help to organise vocational training and experience overseas
- keep track of those who are overseas and, where mutual benefit is established, facilitate their return to New Zealand.
Lifestyle decisions and mid to late career issues

In the 2002 workforce survey, doctors with about 10 years before their retirement age had a participation rate of just over 50%. Many doctors in mid or late career seek opportunities to change the direction of their working lives. Some seek new and different challenges; others seek more flexible employment to enable them to balance changing work abilities and interests with personal life circumstances and commitments. Opportunities for career breaks and sabbaticals, and effective career and succession planning, can improve job satisfaction and boost recruitment and retention in the medical workforce.

Of those medical practitioners who had reached retirement age, the average participation rate was 28%. This compares well with the average across all New Zealanders over 65, where the workforce participation rate is 11.8% (Statistics New Zealand 2005).

By 2021 New Zealand can expect to lose about 1190 doctors of its current medical workforce to retirement. Older doctors can often provide clinical knowledge, skill, wisdom and much-needed experience in teaching, management and mentoring junior staff and colleagues. The credentialing process could provide a mechanism whereby changes to employment conditions for individual doctors (eg, on-call requirements, clinical/practice requirements) could be made.

Recruitment and retention strategies

There are a number of recruitment and retention strategies that could be promoted within the health sector. The MRG believes that a co-ordinated intersectoral approach between the education, health and employment sectors is required to effectively develop, implement and evaluate recruitment strategies.

Many smaller hospitals have difficulty recruiting specialists. DHBs should be encouraged to share clinical appointments and rotations across DHB areas and hospitals. This would strengthen the formation of regional clinical networks, improve collegial relationships, and provide opportunities for doctors to spend time in rural and provincial areas, as well as allowing access to greater support and training in the larger urban centres. This occurs already in some specialist appointments in the Midland DHBs, and in the way resident medical officers are offered rotations across the four major Auckland hospitals.

Critical recommendation: Retention

CR7. New Zealand should improve its retention of New Zealand-trained doctors, in particular by:

i. supporting part-time specialist training roles for practitioners

ii. for those who require it, a decrease in on-call requirements for practitioners reaching the end of their working years, with the aim of retaining experienced practitioners in the workforce for as long as possible

iii. for those who require it, a decrease in clinical/practice requirements for practitioners reaching the end of their working years

iv. the development of job-share roles for those who may want to practise on a part-time basis

v. developing support networks, particularly for doctors in a rural setting

vi. the possible impact of debt

vii. the various options of bonding, scholarship, incentive schemes and debt relief to attract health professionals into areas of need.
Overseas-trained doctors\(^7\) in New Zealand

In line with the international mobility of the medical workforce, New Zealand has long had some dependence on overseas-trained doctors, and this dependence has increased over recent years. An analysis of overseas-trained doctors with general registration\(^8\) at September 2005 shows that 28.4% (1076) gained their final registration in the five years to 31 December 2004, and 47% (1779) gained their final registration in the 10 years to 31 December 2004. Overall, New Zealand has the highest proportion of overseas-trained doctors (34.5% of the medical workforce) in the Western world (Mullan 2005).

The MRG believes that New Zealand should aim to be more self-sufficient in providing and sustaining its own medical workforce, although it recognises that the New Zealand health sector will continue to rely on overseas-trained doctors in the short to medium term.

There are two broad groups of overseas-trained doctors: vocationally trained (including GPs) and non-vocationally trained. The first group need to have their qualifications and experience assessed by the relevant college to determine if they meet the standards of the college. If they do, the college will recommend to the MCNZ that the doctor be registered for a vocational scope of practice, and they would also get fellowship into some colleges.

Overseas-trained doctors who are in the non-vocationally trained group are required to sit the New Zealand Registration Examination (NZREx). The CTA purchases training programmes designed to help overseas-trained doctors to complete the registration requirements, including sitting the NZREx.

There are four main issues with overseas-trained doctors in the domestic workforce.

- They are not familiar with the New Zealand health system and can take time to acquire the knowledge of how to work within the hospital system.
- Lack of English skills can be a serious barrier for some.
- New Zealand medical courses place significant emphasis on cultural training for domestic students. For example a lack of awareness of Māori protocols may impede an overseas-trained doctor’s ability to establish good patient–doctor relationships.
- There is the ethical question of employing doctors from developing countries, given that this deprives developing countries of their trained medical workforce (Commonwealth Secretariat 2003). A counter-argument is that overseas-trained doctors may have limited employment opportunities in their home country and may be able to send remittances back to support their families if they are employed in New Zealand (Chen and Boufford 2005).

The issue of integrating overseas-trained doctors into a country’s health care workforce is one that is shared by other countries with similar health systems, such as Australia, Canada.

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\(^7\) Also known as ‘international medical graduates’ (IMGs).

\(^8\) Data sourced from the register of medical practitioners of the MCNZ.
and the UK. In Australia, the past five years have seen rapidly growing numbers of overseas-trained doctors working in areas with workforce shortages, such as outer metropolitan and rural hospitals and general practices. These overseas-trained doctors have varied background training, communication skills, clinical skills, and orientation to the Australian health care system, posing some safety problems. In 2003 the Australian government announced a package which included a number of initiatives relating to overseas-trained doctors. The initiatives included recruitment strategies, additional training support programmes, assistance for employers and overseas-trained doctors in arranging placements, and the formation of a Medical Specialist Training Taskforce.

It should be noted that Australian states have implemented these initiatives differently, and a criticism has been that there is no agreed national standardisation of orientation, communication, education and training programmes, or assessment processes for overseas-trained doctors. Australian states also have designated ‘areas of need’. Doctors prepared to work in these areas sometimes do not have to achieve the same registration requirements as overseas-trained doctors in other areas. They may not have the right to charge for Medicare fee-for-service, and they may be bonded to work there for a specified period of time.

Given New Zealand’s continued reliance on overseas doctors in the short to medium term, the Australian experience should provide some ready lessons. New Zealand does not have designated areas of need, and it is often hard for more isolated places to retain doctors for any length of time. Overseas-trained doctors (as with New Zealand-trained doctors) can ‘vote with their feet’ and find better employment opportunities elsewhere.

Efforts should be made to better co-ordinate the recruitment of overseas-trained doctors. For a start, they should be recruited to a specific post for which there is no appropriately qualified and experienced New Zealand applicant. Doctors so recruited should take part in a suitably structured orientation programme, and once settled should have full access to all of the training opportunities and other resources available to their New Zealand-trained colleagues, such as continuing medical education. The MRG notes that the CTA has contracted a pilot for a ready-to-work programme for overseas-trained doctors, which will be evaluated by the MCNZ.

Critical recommendation: Overseas-trained doctors

CR8. Given that the New Zealand health sector will continue to depend on overseas-trained doctors in the short to medium term, the Medical Council of New Zealand and the medical colleges should establish transparency in the competencies and standards against which overseas-trained doctors are assessed, especially for overseas-trained specialists, and scopes of practice should be commensurate with the achievement of those competencies and standards.

Auxiliary recommendation: Overseas-trained doctors

AR7. New Zealand should continue to invest in the cultural training and continued medical education of overseas-trained doctors.
Conclusions

The undergraduate curriculum needs to be reviewed for content and for appropriate course length. Postgraduate education should be reviewed to ensure there is an appropriate number of runs, and the types of runs reflect a much-needed increased focus on community-based care. Vocational training programmes require structured planning and overview to ensure there is a better needs analysis of the number and type of vocational specialists New Zealand should be training and improved responsiveness to change.

New Zealand is not currently producing and retaining sufficient medical practitioners to meet its forecast needs. Even if the cap on the number of medical students were lifted to the capacity of the two medical schools, the current retention rate and retirement rate of doctors would mean that New Zealand would only produce a total net increase in the number of doctors of between 1730 and 1900. This is well short of the 3446 to 5944 doctors needed given the forecasts of the NZIER. A short-term strategy could be to fund New Zealand students to attend Australian medical schools. A long-term strategy could be to establish a third medical school for New Zealand.

Retention of its trained doctors must be a priority for New Zealand. A large percentage of our working-age doctors do not hold current annual practising certificates, and it appears New Zealand is losing many doctors to emigration, predominantly to Australia. There is a great deal of mobility of doctors within the international market, and if New Zealand does not actively work to retain its medical practitioners it faces the risk of losing many more of its high-quality doctors.

New Zealand is highly reliant on the supply of overseas-trained doctors complementing the output of the two medical schools. New Zealand will continue to rely on overseas-trained doctors in the short to medium term and therefore needs to invest in ensuring they are fit to practice within the cultural context of the New Zealand health sector, and in their professional development.
The need for a strategic overview

A historical perspective of medical workforce planning was provided in the MRG’s consultation document Fit for Purpose and for Practice: A review of the medical workforce in New Zealand. The MRG believes that workforce planning is currently done in an ad hoc manner, and often in response to perceived crises. There is an accompanying lack of overview planning within the sector.

There are also a myriad of agencies involved across the education and health sectors. Medical education involves a number of agencies, including the Ministry of Health, the Tertiary Education Commission and the universities, which are involved in undergraduate medical education and in some postgraduate medical education courses. There is a poor interface between the health sector and education sector in terms of assessing the curriculum development needs for medical courses in relation to emerging and developing needs of the community and health services delivery.

Some agencies within the health sector do not have the workforce as their primary focus, and face conflicts when trying to manage workforce issues among other competing priorities. The DHBs, for example, have a primary focus on service delivery, and each DHB has a local vision for how its services should be delivered. DHBNZ has established a Workforce Development Group to provide high-level strategic direction for DHBs. However, DHBs do not cover all circumstances in which the medical professional may work, and they do not necessarily have access to international data and information on medical workforce issues, or the resources to analyse it.

Within the Ministry of Health, both the Public Health and Mental Health Directorates do workforce planning for their respective workforces, but there is little co-ordination of the information and processes used. The medical workforce as a whole needs to be planned and developed. Issues to be addressed include the potential size of the workforce, the specialty areas required, and the extent of the education and training curriculum to ensure medical practitioners are fit for practice and for purpose.

The CTA’s primary role is the funding of training programmes. It has a set mandate and budget to work within, yet it is often expected to develop and fund education and training curricula. This would be analogous to the Tertiary Education Commission developing a training curriculum. Course ownership needs to sit independently of the funding function to prevent potential conflicts of interest.

Although universities own the undergraduate medical courses, ownership of postgraduate training courses sits with a variety of bodies, and there does not appear to be any one body that owns the postgraduate year 2 programme. The various medical colleges own the vocational training courses but do not have a body that can co-ordinate recognition of prior learning, as the universities do with undergraduate courses. The national body of the combined medical colleges, the Council of Medical Colleges, does not currently have this role.
Suggestions for a national body

The MRG recommends that a national body be developed with a co-ordinated planning function. This body will establish a national strategy for the development of the health and disability workforce in New Zealand. The body undertaking this function will need the mandate to co-ordinate the various parties involved in the education and training of doctors, and particularly to co-ordinate assessments of the medical education curriculum to ensure that doctors are fit for practice and for purpose in the New Zealand context. Such a body could be tasked with co-ordinating the implementation of recommendations from the DiTWR report and this report. An intersectoral approach is needed, given the involvement of the education sector and the implications of policy recommendations for operational implementation.

The MRG believes that this body could ensure that workforce issues are explicitly and comprehensively addressed in all health and disability strategies and service delivery reviews (eg, of the Primary Health Care Strategy and the Chronic Care Strategy), and that the principles for healthy working environments developed by HWAC are addressed in any service delivery review, or health and disability strategy.

With specific reference to the medical workforce, such a body could aim to:

- produce a national workforce framework and plan, and then oversee, facilitate, monitor and review the implementation of that plan
- work to improve capability and capacity for workforce planning in the health sector, including the development and ongoing oversight of a fully integrated national workforce planning information system
- advise the Minister of Health on all aspects of workforce development
- guide DHBs and the DHBNZ in the preparation of regional and individual DHB workforce plans, and work with DHBs to develop models and toolkits for workforce planning
- monitor and provide feedback to DHBs on regional and individual board workforce plans
- ensure that health sector strategies and policies are co-ordinated with the Government’s social, economic, labour market and other workforce-related activities
- work with the education sector on all matters of common interest pertaining to the undergraduate, postgraduate and continuing education of medical practitioners
- lead and oversee the national workforce development effort in certain key areas, such as the development of new and extended roles in the workforce, innovation and workforce redesign and development, and design and development of the primary care workforce
- target and support innovative workforce approaches and solutions that add value to health sector activities in New Zealand
- undertake research into innovative health workforce projects within New Zealand and overseas, and disseminate findings with the aim of accelerating innovative health service delivery nationally (the research areas covered should include, among other things, recruitment and retention initiatives, and skill mix/transfer innovations)
- develop a national evidence base to inform strategies and policies to recruit, retain and sustain the supply of key workers
- work to determine medical school intakes and the number of training posts for specialists, including GPs (it may also make similar determinations in other key areas).
The MRG considered a number of options for the governance of a body that would be needed to implement the planning and leadership functions required, and determined that it would need to:

- have national co-ordination
- take a total sector approach that covers the primary secondary, tertiary and quaternary health sectors
- link policy and funding to operational requirements
- link health and education sectors with regard to education of the medical workforce
- gather and use information
- evaluate and review policies to ensure their effectiveness
- develop a long-term strategic overview
- have key stakeholder participation, including decision-making and dialogue
- cover the spectrum of education and medical workforce development
- integrate readily with the rest of the health professional workforce
- rationalise medical workforce resources within the Ministry of Health.

It is vital, whatever body has the overall responsibility for the planning of the workforce, that there be high-level representation from the Ministries of Health and Education given the links between the health and education sectors, and the funding implications that are likely to flow out of advice from such a body.

The following three options were considered to best fulfil these criteria.

**Option A**: a directorate within the Ministry of Health that reports to the Director-General of Health. It would have standing advisory committee(s) and short-term project groups, as needed. This would meet all the criteria as long as there were senior education advisors involved on the committee(s).

**Option B**: a group within the Ministry of Health which has a governance board. This would be similar to HWAC, but could have the CTA operational function. It would be accountable to a Deputy Director-General.

**Option C**: an inter-agency entity such as a steering group between the Ministry of Health and the Ministry of Education. It should include representatives from other organisations such as DHBs and education agencies, and workforce representatives. It would be essential that it have ministerial sign-off in order to have mandate, and would use memoranda of understanding with relevant organisations. It would provide advice to Education and Health, but could have a mandate to determine policy for how funding for under- and postgraduate courses is spent. It would require funding for a secretariat.

The MRG believes that Option C would best achieve the objective of strengthening the interface between health and education, and strategic planning for the medical workforce. The MRG also suggests that this model, while initially only dealing with the planning of the medical workforce, could be extended to include the whole of the health workforce, particularly those health professions where education and training occur in the education and health sectors. It is worth noting here that there are existing models of inter-agency collaboration and planning (eg, the Intersectoral Pandemic Group, and the governance mechanisms for biosecurity, which include a ministerial committee, a chief executives forum and a ministerial advisory committee).

If the Minister seeks further advice on these options, HWAC would be able to provide advice on their strengths and weaknesses.
Information requirements

The MRG considers that the systematic collation and analysis of information is vital to effective workforce planning. It believes that this national body should be tasked with having an overview of all health workforce information and databases, including:

- developing and maintaining a meta-database, which links all known databases and information sources
- developing an integrated register of all health professionals
- critically analysing all current databases and information for their usefulness to informing national strategies for the development of the health and disability workforce
- setting standards for all health workforce information.

The central body's work programme would also include:

- deciding an appropriate repository for health workforce information (including a capacity check on the Health Practitioner Index to see whether this is a possible repository, and its co-ordination with the DHB/DHBNZ Health Workforce Information Programme (HWIP) project)
- deciding who or what organisations will be required to provide information to the repository (professional bodies, non-government organisations, private organisations, students, health professionals, among others)
- addressing whether information supply should be voluntary or compulsory
- developing efficient methods of data transfer that minimise data information handling between organisations and the repository, and reduce time between data collection and reporting outcomes
- developing roles and responsibilities within each organisation and the repository to manage the accuracy, consistency and analysis of the data supplied
- developing leading and lagging measures that allow an accurate and timely understanding of the health workforce at a point in time, and allow an understanding of change over time (ie, measuring the effectiveness of changes and policies over time)
- deciding whether international comparisons with workforce data are helpful/appropriate, and if so evaluate and/or develop international comparative measures.

Research should also be undertaken on the medical workforce, including:

- undertaking a stocktake of all available information sources
- critically reviewing information requirements and the availability for medical workforce planning
- identifying any gaps
- developing recommendations to fill identified gaps
- developing a list of possible measures to be used for the analysis of workforce issues, which could readily be developed (eg, the number and quality of applicants for medical school over a five-year period).
Critical recommendation: Planning, leadership and co-ordination

CR9. To improve the current health–education interface and reduce inefficiencies, there needs to be nationally focused strategic workforce planning. The Medical Reference Group believes that the best structure to achieve this is an inter-agency steering group, with a ministerial mandate to provide advice to the Ministers of Education and Health, and their agencies. Advice would cover medical education and vocational training, funding and curriculum issues, professionalism of the medical workforce, and innovations in service delivery. Planning responsibilities would include monitoring the supply of, and demand for, vocational expertise to identify areas of potential shortages and to address them as required. The governance of the body responsible for the planning function needs to have sector-wide representation, with key representation from the Ministries of Health and Education.
6. PROFESSIONAL ISSUES

Professionalism

Within the medical profession there is a need to re-evaluate the issues of professionalism. Roles are changing within the health sector, and will continue to do so given the changing nature of disease and population requirements. There are increased expectations on medical practitioners, who are being required to provide more leadership in terms of involvement in the process of workforce planning and service delivery. There is more emphasis on teamwork, and patients have higher expectations for the quality of services they receive, being fully informed of treatment options, and so on. Doctors are expected to maintain working relationships both within and across disciplines. The management of chronic conditions provides good examples of multidisciplinary teams working in a more patient-centred manner, across primary, secondary and community-based care settings.

Appraising what medical professionalism should look like has been the subject of projects and working parties around the world. In December 2005 the Royal College of Physicians released their working party’s report titled *Doctors in Society: Medical professionalism in a changing world*. The working party set out to define the nature and role of medical professionalism in modern society, and produced the following definition:

*Medical professionalism signifies a set of values, behaviours, and relationships that underpins the trust the public has in doctors.*

The working party felt its definition had implications for leadership, teamwork, medical education, appraisal of a doctor’s performance and development, and medical careers and research, and it made a number of recommendations.

In its consultation document, the MRG explored many of the same areas in terms of defining a new professionalism. These included:

- teamwork
- interdependent decision-making processes, including patient empowerment
- colleagues engaged as equals
- collective learning, responsibility and accountability
- engagement
- reflective practice.

The Canadian Royal College of Physicians and Surgeons CanMEDS 2000 Project presented a model of what ‘new professionalism’ could mean for medicine. The project developed a roles and competency framework entitled ‘Skills for the New Millennium’, which was initially designed for use in Canada, but has been adopted internationally. Modified CanMEDS competencies are already being used to guide the vocational training of doctors in Australia and New Zealand.

Many submissions commented that their organisations were already engaging in ‘new professionalism’, and in some instances it wasn’t seen as ‘new’ at all. The MRG believes that professionalism needs to be supported and encouraged throughout the medical profession. This requires implementing the concepts at all levels of education and service delivery.
Critical recommendation: Meeting the needs of the New Zealand population

CR10. The medical education curriculum and professional development programmes should include teamwork and collaboration, professionalism, communication and interpersonal skills, and leadership skills training. All practitioners should also be skilled in the management of patients with chronic illnesses, and these skills should be maintained and enhanced throughout the entire lifetime of medical education and practice.

Professional development for medical officers

Medical officers are non-vocationally trained doctors working in hospitals. They are divided into junior doctors, who work as house surgeons; registrars, who ideally should be engaged in vocational training programmes; and those operating in a variety of positions that do not involve vocational training.

In the last group there are three distinct categories:

- rural hospital doctors, for whom a vocational scope of practice is being developed
- medical officers within a single specialty, whose continuing professional programme may be covered by the specialist college covering their scope of work
- medical officers across a number of specialties, whose training is not covered by any recognised programme.

Professional development is essential for all doctors and is required by the MCNZ for all doctors who wish to maintain their certification to practise. The MRG believes that medical colleges should be encouraged to develop professional development schemes for medical officers that allow them to access ongoing professional support and continuing medical education. Currently some colleges are engaging in this.

The MRG also believes that colleges and employers should work together to develop and implement career pathways for medical officers. Currently the rural hospital doctors are engaged with the Royal New Zealand College of General Practitioners in the development of a vocational pathway.

With respect to medical officers in a single specialty field, the MRG believes that their training goal should be vocational registration in that field; in other words, fellowship of the relevant college. Any lesser standard would be inappropriate for reasons of patient safety.

There remains an issue with professional development for those medical officers covering multiple specialities. They have no vocational programme, and cannot be easily attached to any college and therefore do not get recognised as a distinct workforce group with their own training needs. Their future role in the New Zealand health system is unclear. The CTA has developed a vocational training specification for medical officers, and is in the process of discussing the specification with the medical colleges. A vocational training programme for medical officers could help them to meet the requirements for recognising the scope of practice under the Health Practitioners’ Competence Assurance Act 2003. The fact that they cover a number of specialty areas and that there is sometimes significant variation in scopes of practice from doctor to doctor poses some significant problems in terms of education and training, both in content and delivery.
Developments in service delivery models could well hold the key to managing the increase in demand for medical services. Service delivery issues include changing employment conditions, developments in skills transfer/mix, the team-based delivery of health services, and the increasing needs in general practice and primary care as a result of our ageing population. Many DHBs throughout New Zealand are working on developing a range of innovations, particularly in the realm of managing chronic conditions in the community.

Changing employment conditions

How health services are delivered to patients is closely related to employment conditions and the numbers and types of medical practitioners required. The DiTWR report noted that changes to working conditions and to service delivery have had an impact on the effectiveness of the apprenticeship model. The MRG notes the various workplace innovations mentioned in the DiTWR report, and re-iterates its belief that there is a need for these types of innovations to be disseminated.

For example, the M10 determination by the Higher Salaries Commission in 1985 led to a reduction in the number of hours that trainee doctors and resident medical officers can work, which increased the demand for the total number of medical practitioners in hospital settings. The Hospitals at Night project (discussed in the DiTWR report) is one example of how service delivery and work processes are being remodelled in order to accommodate the constraints faced by hospitals.

Skill mix / skill sharing

Future medical and technical developments will affect service delivery, and will result in new specialist skills and knowledge being introduced. As technology and information have advanced, more common procedures have evolved both within the medical profession and between other health professions. This process is referred to as ‘skills sharing’ or ‘skills mix’. It has been occurring in an evolutionary manner for many years.

The issue now, given the forecast increase in demand for health care services, is whether it can be evolved and accelerated in a systematic and strategic manner. There are quality and safety issues around skill sharing / mix innovations, and any policy considering skill sharing should look at the full range of costs and benefits of such a move.

A number of countries are looking at new ways of addressing the issues relating to skill sharing/mix. The physician assistant in the US is an example of a developed health professional role. Physician assistants are formally trained to provide diagnostic, therapeutic and preventive health care services, as delegated by a physician. Working as members of the health care team, they:
• take medical histories, examine and treat patients, order and interpret laboratory tests and X-rays, and make diagnoses
• treat minor injuries, including suturing, splinting and casting
• record progress notes, instruct and counsel patients, and order or carry out therapy (US Department of Labour website www.bls.gov).

Team-based delivery of health services

Other changes in service delivery models include the move towards team-based delivery. As we have seen, multidisciplinary teams are required to work in a more patient-centred manner, and across primary, secondary and community-based care settings. Effective team-building requires time, and employers need to ensure teamwork is valued and seen as valid. For example, within hospital settings, processes such as patient handovers need to be allowed for in doctors’ workloads.

In primary health care and community-based care settings, the need for teamwork is even more pronounced. This is particularly relevant in the delivery of services for chronic conditions, especially where there may be co-morbidities. Patients will require many different types of health care, and doctors need to be able to work within teams that will have a broad focus, with medicine being used alongside lifestyle changes in order to effect a cure, or at least manage the disease. The management of type 2 diabetes provides a good example of the multidisciplinary approach needed.

Primary health organisations (PHOs) will continue to provide core services, such as high-quality community-based health care, immunisations, participation in various screening programmes and the management of chronic conditions. Generally, these programmes are being delivered by health professionals other than doctors.

A suggestion that arose from the submissions process was for the development of post-diagnostic service delivery models (e.g., diabetic nurse educators). A number of submissions felt that the roles of NGOs and voluntary bodies have not been adequately recognised. There were also concerns expressed that the community does not have enough involvement in the development and delivery of health services. Systematic evaluation of the various post-diagnostic service models currently operating in New Zealand to identify the characteristics that promote successful health management would provide a foundation for co-ordinated development in this area.

In the move towards team-based delivery, the MRG notes that there remain some reservations among medial practitioners. Many doctors believe that there will be still be an expectation that doctors will be ultimately accountable for patient outcomes and therefore will be liable in the event of medical mishap. This risk can be mitigated through the development of appropriate systems of clinical governance and business organisation, especially where there are clear lines of responsibility. These essential features will be critical if the future service delivery model is to allow skills mix and team-based delivery.

General practice and primary health care

Primary health care is a critical area for medical workforce development, and it has seen substantial change over the past 10 years. The big primary health care reforms were initiated in 2002 with the formation of PHOs and substantial increases in funding for the provision of primary health care services from Vote:Health. For most GPs these changes have come on
top of a decade of change that has included the formation of independent practitioner associations, computerisation, increased bureaucratic requirements for funding, quality assurance and re-accreditation. This has been stressful for many GPs, but has resulted in many improvements and innovations to the delivery of primary health care.

New concepts and standards for the provision of primary health care have led to the need for GPs to incorporate themselves into a team environment, both within their own practices and with others who provide primary health care services. The need for administrative support in the form of practice managers has now become mandatory. As a consequence of all this activity, practices have become larger and more complex.

There is, however, a major problem in developing and sustaining a medical workforce fit for purpose and for practice in this new primary health care environment. For some time now there has been a declining interest among new graduates to enter into general practice (HWAC 2005; Moore et al in press), and workforce numbers have seen a decline in absolute numbers over the last few years. In part, this is because relatively little investment has been made in vocational training and career development in general practice.

General practice is also seen to be poorly remunerated relative to other medical specialists. The workforce is ageing, and practitioners increasingly want to achieve a more satisfactory work–life balance. These trends have resulted in a shortage of GPs, and the situation is set to deteriorate over the next few years, particularly as the bulge of ‘baby boomer’ GPs starts entering retirement. Action needs to be taken to ameliorate the situation.

Self-employed GPs make up 56% of the GP workforce, with 15% being salaried and 13.5% working in locum positions. The remaining 15% work in a variety of academic, non-clinical and specialist roles (RNZCGP 2005). Overseas-trained doctors make up 34% of the vocationally trained GP workforce and temporary registrants comprise another 7%.

With many salaried GPs being employed by other GPs, the small business model of service delivery remains the predominant form of employment for most GPs, and given current policy settings there is no evidence of this situation changing rapidly. The majority of GPs have educational, administrative and style of service delivery input into their practices from management service organisations, who in turn are responsible to PHOs.

**Auxiliary recommendation 8: Primary workforce development**

**AR8.** The Ministry of Health and DHBs should include a workforce development plan as a major component in the implementation of the Primary Health Care Strategy.

More needs to be done to attract young graduates into the speciality of general practice. The MRG has already made many recommendations that will aid this process, including:

- increasing the exposure of undergraduates, postgraduate year 1 students and postgraduate year 2 students to general practice, including general practice in a rural setting
- continuing to improve the recruitment and retention of doctors in a rural setting
- addressing the various options of bonding, scholarships, incentive schemes and debt relief to attract health professionals into areas of need
emphasising a more rounded generalist education, where skills in communication, leadership and working within teams are encouraged and valued

- increasing the recruitment of New Zealand-trained graduates into general practice (among others)
- a more co-ordinated approach to workforce development through a central agency, as outlined in section 5.

Professionalism as it applies to delivering health care in a community-based setting needs to be studied. The Royal College of Physicians (2005) provide a good starting point in establishing new directions for professionalism, but more needs to be done to define the relationship between professionalism and small business ownership.

General Practice Education Programme (GPEP)

The MRG anticipates that difficulties in accessing vocational training posts by young graduates will remain a bottleneck for increasing New Zealand’s GP workforce. A straightforward solution would be to increase the number of funded positions in the RNZCP’s General Practice Education Programme (GPEP) first-year registrar training course. The educational infrastructure and the availability of suitable host practitioners could immediately accommodate an increase from 55 to around 100 funded positions.

Consideration ought to be given to making first-year registrar training a year-round activity, so that training practices can make more efficient use of their premises, have a stable patient base for registrars, and have more stable staffing arrangements. Innovative strategies need to be examined in order to retain the bulge of the baby boomer generation who are now entering retirement age.

**Auxiliary recommendation: Increase the number of places funded for GPEP vocational training**

AR9. The number of CTA-funded vocational training posts in the General Practice Education Programme should be increased to 100 per annum.

Conclusions

Service delivery issues include changing employment conditions, developments in skills transfer/mix, the team-based delivery of health services and the increasing demands for primary care. The medical profession is wary of some of these changes, given the safety and professional liability issues that are involved in innovations such as skills transfer/mix, but is not necessarily closed to such ideas. However, further proposals and innovations aimed at reorganising service delivery involving skills transfer/mix, collaborative models and teamwork should have a transparent process for their consideration so that issues such as safety, quality and professional liability are dealt with appropriately.

Major developments in service delivery have been driven by an increased focus on primary health care in response to an ageing population, an increase in the incidence of disability and chronic conditions, and more people wishing to remain in the community rather than going into care. This will require an appropriately trained workforce and increased numbers of primary health care providers, including GPs. In this new environment, collaboration will be important, both between primary and secondary care provision and among all health professions.

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9 Currently the registrar payments only cover 40 weeks of the year.
APPENDIX 1: HWAC’s Terms of Reference

Objectives

The Health Workforce Advisory Committee (HWAC) is established under Section 11 of the New Zealand Public Health and Disability Act 2000. The role of the committee is to advise the Minister of Health on health workforce issues that the Minister specifies by notice to the committee.

The advice given by the committee to the Minister is to be formulated after consultation with people involved in the funding and provision of services and any other people that the committee considers appropriate.

The committee will report its advice to the Minister of Health.

Accountability

The committee is established by and accountable to the Minister of Health.

Key tasks

The committee’s key tasks, in line with the requirements of section 15 of the New Zealand Public Health and Disability Act 2000, are to:

1. provide an independent assessment for the Minister of Health of current workforce capacity and foreseeable workforce needs to meet the objectives of the New Zealand Health and Disability Strategies
2. advise the Minister on national goals for the health workforce and recommend strategies to develop an appropriate workforce capacity
3. facilitate co-operation between organisations involved in health workforce education and training to ensure a strategic approach to health workforce supply, demand and development
4. report progress on the effectiveness of recommended strategies and identify required changes.

Other tasks may be undertaken as agreed between the Minister and the committee.

In developing its advice, the committee may consider:

- what is currently known about workforce, in particular:
  - a stocktake or analysis of previous reviews and reports
  - patterns of shortage, excess or other imbalance in existing workforce capacity, geographically or in specific service areas
• the type of workforce required for the future
• taking account of service, educational, societal and technological trends and public expectations
• the changes necessary to move from the present to a recommended health workforce capacity:
  • utilising current system strengths that can be built on
  • identifying barriers and possible resolutions
• co-ordinated strategies or co-operative approaches to achieve necessary changes in education, training, recruitment and retention and occupational regulation
• any other issues impacting on workforce (e.g., inter-agency or intersectoral issues, funding, training support)
• such other matters as the Minister specifies by notice to the committee.

Working arrangements

After discussion with the Ministry of Health, the committee will agree an annual work programme with the Minister of Health. A committee secretariat providing professional and advisory support to HWAC will be based in the Ministry of Health.

In developing its advice the committee should:
• adopt an evidence-based approach
• where possible, build on existing and previous reports and policy work or models for describing and predicting future workforce requirements, and make use of existing statistics or information collected by other sector organisations
• consult with organisations and individuals as appropriate, including, among others, statutory bodies or policy agencies, health and disability support service providers, education or training organisations, registration bodies, professional organisations and unions, and consumer interest groups
• commission, co-ordinate or undertake research projects for the development of advice
• evaluate progress towards achieving the recommended workforce balance, including the effectiveness of current strategies
• publish committee advice at least annually.

Membership

The committee shall comprise a maximum of 11 members, including the Chair and Deputy Chair, and all appointments will be made by the Minister.

Members will have strategic skills, sector experience, understanding and credibility, and knowledge of health workforce issues. Membership will be drawn from health professional groups, including medical, nursing and disability support interests, employer groups, educational and consumer groups, and people representing Māori and Pacific people’s interests.

Nominations will be sought from health sector and consumer groups.

The committee may appoint specialist, professional or other subcommittees or establish working parties relevant to its agreed work plan.
Terms of committee members

Members of the committee shall be appointed for a term of up to three years. Members shall be eligible to serve a second consecutive term to allow for continuity and full use of increased experience and knowledge. Members shall have staggered retiring dates to ensure a degree of continuity.

Treaty of Waitangi

The committee shall undertake its tasks in a manner consistent with the principles of the treaty of Waitangi.

Performance measures

The committee will effectively be meeting its key tasks when it provides relevant and timely advice to the Minister of Health based on research, analysis and consultation with appropriate groups and organisations.

The committee must achieve its agreed work programme.

The committee must stay within its allocated budget.

Reporting requirements

Any discussion documents or working papers for consultation shall be provided for the Minister’s consideration prior to dissemination.

The committee is required to:

- report as necessary, but at least once a year, to the Minister of Health on the outcome of its key tasks; the report is to include the committee’s rationale for its advice and any relevant evidence and/or documentation
- report on such other matters as the Minister specifies by notice to the committee, these reports to include the committee’s rationale for its advice and any relevant evidence and/or documentation
- keep a record of all committee meetings which outline the issues discussed, and include a clear note of any decisions taken or recommendations made
- provide a brief performance report to the Minister of Health within two months of the end of the financial year, detailing the work undertaken by the committee for the past year, and comparing its performance to its agreed work programme.

Frequency of meetings

The timing and frequency of meetings will be determined by the tasks the committee is obliged to fulfil. All meetings will be convened by the Chair (or Deputy Chair, as appropriate).
APPENDIX 2:
Medical Reference Group’s Terms of Reference

The Minister of Health, Hon Annette King, approved the setting up of and support for a Medical Reference Group in September 2003. The Reference Group reports to the Health Workforce Advisory Committee (HWAC).

Accountability

The Medical Reference Group provides independent advice to HWAC and works within HWAC’s Terms of Reference.

Key tasks

The Reference Group is initially tasked with:
- assessing medical workforce information requirements for supply and demand analysis. This analysis will take into account:
  - demand for doctors, including how they deliver services and medical workforce capacity requirements
  - current supply from the education sector and immigration, also recruitment and retention issues
  - planning processes, to improve information systems and use of short- and long-term measures to ensure capacity
  - professional issues, including professional development, flexible employment opportunities, career pathways, etc.
- reviewing the structure of medical service delivery. This project will explore doctors’ work in terms of specialist, generalist and resident medical officer roles in an environment of patient-centred service delivery. Primary care, cancer control and diabetes may be used as examples to explore this issue.

Membership

Members of the Medical Reference Group are appointed in an individual capacity rather than as representatives of other groups. The combined membership of the Reference Group brings strengths and expertise from across the medical workforce.

Appointments to the Medical Reference Group are for a period of 12 months, with the possibility of extension subject to review of both the Reference Group’s key tasks and the appropriateness of the membership for these tasks.
Members

Dr George Salmond (Chair)
Professor John Campbell
Dr Dwayne Crombie
Dr David Galler
Mrs Anne Kolbe
Dr Peter Leslie
Dr Don Simmers
Ms Cindy Towns
Dr Ralph Wiles (until September 2005)
Ms Jane Lawless (until September 2005)
Dr Jim Vause (from September 2005)
Professor Frances Hughes (from September 2005)
APPENDIX 3:
Analysis of Submissions (including list of submissions)

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<td>Professor Don</td>
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<td>David Rankin</td>
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<td>Dr Debra Graves</td>
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<td>19</td>
<td>Iain G Martin</td>
<td>University of Auckland, School of Medicine, Faculty of Medical and Health Sciences</td>
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<td>Andy Cumming</td>
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<td>26</td>
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SUBMISSION ANALYSIS

Fit for Purpose and for Practice

A review of the Medical Workforce in New Zealand
Consultation Document
May 2005

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CHAPTER 1: KEY ISSUES AFFECTING HEALTH WORKFORCE DEVELOPMENT

A number of submissions suggested that there are other areas that need to be considered by the Medical Reference Group (MRG). These include:

- the impact of short-term governments on achieving adequate long-term workforce planning horizons
- the impact of globalisation on a country/system like New Zealand’s (eg, de-regulation of the international pharmaceutical industry)
- the growing demands by consumers for ‘health knowledge’
- the contribution and potential of non-government organisations (NGOs) and community health workers to the delivery of health care services
- the dual system of funding (public/private)
- the likely duration of ‘no-fault’ coverage
- the increasing focus on procedures rather than time spent in practice
- the increasing willingness of the public to enforce their rights under the Health and Disability Commission Act
- the implementation and further potential of nurse practitioners, mental health community workers and other recently developed health workforce roles
- the impact of screening programmes
- increasing elder care requirements
- the implementation of phone- and internet-based initiatives (eg, Quitline and Healthline)
- the possible effects of health education programmes in schools, and general public health promotion and illness prevention initiatives.

Many submissions highlighted a belief that it is the Ministry of Health that is required to take a key leadership role in addressing the problems identified in the medical workforce.

There was also some comment on the importance the MRG placed on the Scottish experience. The indigenous population of New Zealand was cited as a specific point of difference, and it was suggested that other countries may provide alternative models appropriate to New Zealand (France, Canada, Sweden, Denmark, Australia). It was also noted that any model requires careful consideration and adaptation for the New Zealand environment rather than being ‘slavishly adopted’. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists noted that:

While such committees give direction, there is an absolute need to look at working areas, to identify problems, to pilot and encourage innovative changes and modification. It is at the coalface where workforce issues are most keenly felt.

They also felt that, given the vagaries of the expansion and contraction of the Ministry’s policies regarding its structure over the last two decades, there is a risk that any such New Zealand committee or workforce planning section under the Ministry of Health could risk being restructured out of existence.
Other submissions highlighted that workplace change is a process of evolution, and that there is a need for an ongoing process of review and change based on health care needs. Future focus should include continual quality improvement, systems solutions, and horizontal and vertical service integration.

The Royal New Zealand College of GPs (RNZCGP) suggested that a full and thorough analysis of current economic and human resources (ie, needs analysis) would enhance the MRG document. The New Zealand Medical Association (NZMA) supported the key findings in the document, and felt that the messages were neither new nor unique to New Zealand. The Joint Faculty of Intensive Care Medicine (JFICM) felt that the possibility of increasing the number of doctors in New Zealand had been too easily dismissed by the MRG.

Many submissions highlighted that the private sector could not be excluded from any medical workforce review on the basis that:

- the private sector currently accounts for a large proportion of the specialist workforce (either full- or part-time)
- it provides a high proportion of elective surgery in New Zealand (77% according to Health Funds Association of New Zealand)
- most general practice services are delivered through the private sector
- the private sector is both a receiver and provider of current vocational training programmes
- with appropriate funding, the private sector could play a vital role in vocational guidance and support to doctors in training for specialities that are now predominantly privately based (eg, vascular surgery, pathology).

The NZMA suggested that a longer-term definition of the private service role and the public-private interface was required if the full capacity of the private sector was to be realised. A further submission suggested that it might be more efficient if the public system concentrated on health promotion, illness prevention and emergency medicine, and all elective procedures were done privately. The New Zealand Association of Pathology Practices (NZAPP) argued that private sector practice might also provide a model for more flexible work roles.

It was commented that further effort should be made to comprehend, acknowledge and develop the contribution made to health care by NGOs and voluntary associations to the delivery of health care services.

The ethics of recruiting overseas-trained doctors from developing countries was highlighted in a number of submissions.

The JFICM felt that ideological factors that increase tension between employers and employees at multiple levels within the sector have not been adequately recognised.

The NZMA submitted that two further points should be added to health practitioner expectations: remuneration and professional autonomy.

Auckland DHB felt that the definition of ‘allied health professional’ was incorrect and requested a revision in the glossary.

The New Zealand CCS Inc were disappointed that the disabled were described solely as users of the health system, and that their contribution to health service delivery was not acknowledged.
CHAPTER 2: THE MEDICAL WORKFORCE IN NEW ZEALAND – A STOCKTAKE

2.1 Is the workforce data and other information presented in Chapter 2 complete and accurate from your point of view?

It was pointed out in a number of submissions that general practitioners (GPs) are specialists and should be analysed accordingly. The RNZCGP advised that the MRG needed to highlight that while the Medical Council of New Zealand (MCNZ) data quoted was published in 2004, the data itself related to 2002; and also that they were currently analysing data collected in their own 2005 workforce survey. The RNZCGP emphasised that an information strategy was required to assist workforce development.

Many of the colleges and associations that made submissions advised that they did their own regular workforce surveys and would be happy to share any information or be consulted on the content of future workforce surveys. Many had supplied information to the Australian Government Productivity Commission.

It was also noted that the Health Practitioner Index is a depository for multiple sources of information, and that the possibilities of this information source should not be overlooked.

There was general agreement that comprehensive workforce data was lacking. Suggestions for improving this included:

- an integrated register of all health professionals
- more information on rural practice, with a definition of ‘rural localities’ using the Geographical Information System software
- measures of participation of the disabled in the medical and health workforce
- further definition of specialities/sub-specialties and secondary/tertiary specialists
- further analysis of GPs pursuing or having obtained a specialty qualification
- the development of an information database on the NGO workforce and the community health worker workforce
- a turnover analysis (numbers and economic) of all health professional roles
- differentiating the MOSS position – specialty areas versus hospital generalist roles
- an analysis of the 30-plus percent of graduates who no longer applied for or held their annual practising certificates – are they going overseas or not?
- further breakdown and analysis of overseas-trained doctors
- development of a database and information centre to detail services available and how to access them
- nationwide implementation of exit interviews and a database to comprehend retention issues in the New Zealand health workforce.

The comparison with overseas countries was queried in several submissions. The main concerns expressed were whether the statistics were comparable between countries, whether the information was complete from other countries, and whether international comparison was warranted or a true indication of the effectiveness and efficiency of the New Zealand health system.
The Dental Council advised they would be happy to provide similar information for future workforce projects/planning and were in the process of signing an information contract with the Health Practitioner Index.

It was generally agreed that while medical school output reflecting the New Zealand demographic was highly desirable, a balance between academic achievement and demographic profile, combined with improving the attractiveness of the medical profession to under-represented groups, was required.

The low Māori and Pacific demographic representation at medical schools was commented on. A number of submissions requested evidence that Māori health providers necessarily returned to practise in their own communities, or that this was proven to be beneficial to their patients. Some submissions noted that the current preferential entry schemes should be bolstered, and that it was important to provide scholarships and address barriers at secondary school to entering medical training.

Many submissions highlighted the need for ‘culturally appropriate’ training for all, regardless of ethnicity. The nursing model of cultural safety was cited as an example the medical profession could consider. The Acting Health and Disability Commissioner pointed out the requirement for ‘culturally appropriate mainstream services’ in accordance with rights 3 and 4 of the Code of Health and Disability Services User Code.

Three submissions commented on the apparent over-representation of Asian students and a possible under-representation of male European students. A number of submissions queried the evidence for mature students entering medical school, including a question as to whether the working life of mature students might be shorter than that of direct-entry students.

Many submissions expressed concern at the falling GP-to-population ratio. More discussion around primary health care is included in the discussion in Chapters 5 and 6.

The New Zealand Rural General Practitioner Network (NZRGPN) noted that they wrote a paper in 2001 entitled Recommendations on Recruiting and Retaining Doctors to Work in Rural New Zealand. This report contained 29 recommendations relevant to the MRG review.

There were few specific comments on women in the workforce. The RNZCGP felt that the data on women needs to be explored more fully as they have a different demographic profile from that of the current GP workforce. It was suggested that there may be an argument to expand the proportion of women practitioners even further given that women live longer than men, and that they are estimated to have 80% of the total working life of their male counterparts.
CHAPTER 3: THE HEALTH PROFESSIONS IN A CHANGING LANDSCAPE

3.1 Have we accurately portrayed the changing environment in which the medical profession operates?

A number of submissions expressed concern that this chapter appeared to be based more on opinion than evidence. It was noted that a recent opinion poll in the National Business Review indicated that doctors are among the most highly respected professions in New Zealand.

The NZMA believed that discussion around ‘professionalism’ was still subject to ongoing debate within the profession and that this section over-emphasised individualism. They supported the need for evolutionary change but were not convinced that a model answer was contained in this chapter. The New Zealand Guidelines Group stated that the future competencies and skills of the medical workforce need to include an understanding of evidence-based best practice and its role in modern health care.

Concern was also expressed that ‘new professionalism’ might become a future ‘requirement’ for practice, which would not allow for different motivations within the medical workforce. Comment was made that professional bodies, associations or unions would influence how new professionalism is embraced, both positively and negatively, and that the medical profession need to acknowledge the necessity of change.

It was felt by many that the future role of technology was largely downplayed in the document: many submissions commented on the use of new technology being both ‘disruptive’ and ‘non-disruptive’ to practice, and the current and future impact on the work environment. Submissions canvassed the possibility of:

- outsourcing diagnostic services
- remote provision of some speciality care
- surgical buses
- telephone advice services
- Internet systems
- computerised expert systems
- robots.

Others commented on the value of information/data management systems that would allow the transfer of patient and workforce data between health providers.

3.2 Have we missed any significant environmental issues?

Concerns were raised that accountability and responsibility mechanisms within organisations and at a national level should be congruent, and that leadership roles need to be aligned with positions of responsibility within DHBs.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) acknowledged that there would be changes in multidisciplinary teams and different roles with the growth in NGOs and primary care. They felt more work was required to understand what that might mean in relation to clinical practice, accountability and responsibility with regard to the role of specialists and their respective colleges.
The medico-legal responsibilities of the doctor received much discussion. Comments covered a wide spectrum of opinion, including the following.

- ‘The particular expertise of doctors as specialist health care professionals who carry much of the medico-legal responsibility for care must be strongly supported as part of the process.’
- There is increasingly a focus on teams rather than institutions, and individuals are increasingly being held accountable for patient outcomes.
- The view that the doctor has sole responsibility for the patient and all subsequent medico-legal risk requires further analysis.
- The GP needs to remain the co-ordinator of care and the “trained health professional” should not try to take over that role.
- Complaints to Health and Disability Commissioner (HDC) often reflect poor communication between medical/health practitioners.
- The doctor should still be responsible for diagnosis, but provision and co-ordination of patient-centred care may become the responsibility of others.

The RANZCP endorsed a shared working vision for health that is not driven by populist culture but by the concept of collaboration across the professional and consumer groups, although they noted that this would be difficult to achieve given short government terms and the ‘thin layer of bureaucracy separating government from “frontline” health providers’.

Some felt there was currently a tension between clinicians and managers that needs to be addressed.

Many mentioned the increasing time and effort required to meet bureaucratic, quality, continuing medical education and accreditation requirements.

3.3 Is there anything else you would like to add or comment on?

The ANZCA noted that New Zealand is starting to move in the direction of outcomes and competencies, but probably needs to go further, moving towards a set of competencies as in the UK General Medical Council’s Tomorrow’s Doctors.

Submissions called for the development of planned, evolutionary change management, constant assessment, reflection and evaluation. Community and user involvement in health service delivery changes was highlighted. The New Zealand Guidelines Group suggested a revision of the term ‘users’ of health services to a broader term – ‘consumers’.

There were some comments on leadership, most advising clarity in roles and responsibilities.

Concern was expressed that doctors may find themselves in more stressful work environments if they are expected to provide leadership and management to a wide range of other health care workers. It was also suggested that interdisciplinary team approaches could lead to a reduction in continuity of care for the patient, due to a reduced opportunity to build a relationship with a health professional clearly responsible for his or her overall care.

The College of Nurses Aotearoa suggested that detail on governance for doctors could be improved, and could include responsibility for managing resources such as people, time and expenditure.

Diabetes New Zealand suggested that academic leadership was best delivered in expanded ‘university-type’ departments where time and people skills are available and good research and scholarship are produced.
CHAPTER 4: MEDICAL WORK IN A CHANGING WORKPLACE ENVIRONMENT

The NZMA summarised the general response to this chapter well:

... workforce shortages will need to be met in part by innovation, and changes in the way things are done. […] we agree that change is necessary, but strongly assert that it must build on the changes already made over recent years. It must also be evidence-based, and recognise the needs of the service delivery environment.

The ANZCA noted that there might be problems with career development, regulation and the impact on provision of services with some technology transfers, particularly when this involves a narrow range of practice and necessitates a high concentration of patients to maintain skills (e.g., anaesthetic technicians).

Both the NZMA and the RNZCGP felt the comment, ‘A national blueprint for medical workforce development is unlikely’ needed justification. The RNZCP thought a blueprint was essential, and that professional standards and regulations enable the medical workforce to move between locations with minimal disruption and retraining. They did acknowledge that local roles and employment mixes may change between locations, depending on need.

4.1 Does this chapter give an accurate picture of the changing work environment?

The NZMA felt that the importance of the Stolarek and Sibbald research on skill mix and other issues had been overstated. They thought that the research was not well founded. The NZMA agreed to a more limited form of skill mix where ‘well trained, highly competent nurses can add substantial value in teams when medical support is available’. The JFICM also contested the Stolarek and Sibbald papers.

A number of submissions felt that national collective contracts were the main drivers behind safe working hours and that lack of flexibility in this area might be an impediment to innovation in health service delivery. The RDA was not in agreement with these views.

The discussion of the magnet principles of human resource management drew variable responses. Some felt this was a good model for the medical profession to utilise, and so warranted further development and discussion in the document. Others felt that models like magnet were too uni-disciplinary.

4.2 Have we missed any issues?

Submissions outlined the need for skill mix innovations to be evidence-based and not at the expense of professionalism, or at the expense of a medical workforce that has critical skills to evaluate and take patient care forward.

Many noted that the idea of skill mix between health professions implied that there is no shortage of other health professions. The RNZCGP asked what type of ‘less highly qualified and remunerated workers’ the MRG had in mind for skill mix innovation. The RNZCGP also advised that their Primary Membership Examination (Primex) training and Cornerstone Programme (which teaches the communication, reflection, critical thinking skills and general practice concepts of care necessary to practice safely as a general practitioner during Advanced Vocational Training) might prove to be good models for the development of training in teamwork and team quality indicators, respectively.
The ANZCA noted that many good, keen potential managers had been ‘burnt out’ by the health reforms, and that re-engagement would take time.

Other points included:

- ‘the devil is in the detail’ – how to change is as important as what to change
- the Health Practitioners Competence Assurance Act allows for professional and inter-professional development of scopes of practice, thus enabling skill mix
- there would be a ‘dumbing down’ of the medical profession
- teaching implications should be taken into account
- there may be loss of skills in the medical profession that would not be to the benefit of patients – several quoted obstetrics as an example of this.

Several submissions discussed the duplicative nature of the 21 DHBs, and how this was not only inefficient but inherently gave rise to gross unevenness in the delivery of health services across the country and led to a disconnection between government intent and actual geographical practice.

It was also noted that ‘cost-effective’ did not mean ‘low-cost’, and that issues such as re-work, loss of skills and increased referrals need to be taken into account with any skill mix innovation.

There was general agreement that changes need to involve and/or be driven by medical professionals in order to reduce resistance to change.

4.3 Is there anything else you would like to add or comment on?

The RNZCGP commented that the principles quoted in this section needed to be explicit in the assumptions that lie behind them and might require further development.

The NZMA noted that innovative projects led by front-line practitioners are an ideal way to initiate change, but should be subject to the scrutiny of professional medical bodies to avoid fragmentation, duplication and inappropriate systems and processes. They also advised that regional network development would best occur within a strong national framework for workforce development.

The Canterbury Hospitals Medical Staff Association felt there was a need to acknowledge that some partnership models are as much about the aspirations of other health professional groups to attain equal standing alongside doctors.

The New Zealand Association of Pathology Practices (NZAPP) advised that while technology may lead to automation, these were merely ‘tools’ to carry out tasks, and there was still a requirement for an intelligent and clinical overlay in reaching diagnostic conclusions.

Many commented on the need for the funding and resourcing of research into changing models and patterns of work internationally and nationally, and into the health workforce as a whole.

A number of submissions queried the evidence base for PHOs, and whether this was in itself a ‘one-size-fits-all’ approach. Others queried whether PHOs are funded to train medical students and junior doctors.

The NZMA contended that:

- it is too soon to assume that PHOs offer the types of roles suggested by the MRG
- enhanced clinical roles are dependent on government policy, which currently limits some technologies and prescribing rights to the secondary health sector.

The NZAPP noted that while much time and effort had gone into resourcing the implementation of PHOs, little resource had gone into the development and assistance of the core support services that are aligned with PHOs. They also felt that PHOs had led to increased red tape in a ‘burgeoning bureaucracy.’
CHAPTER 5: EDUCATION, TRAINING AND CAREER DEVELOPMENT

5.1 Does this chapter give an accurate picture of the issues involved in the organisation of medical work, medical staffing, vocational training and professional and career development?

The RNZCGP felt that there needs to be greater clarity on the priorities for funding of training, education and professional development in primary or secondary care.

5.2 The MRG has outlined a case for the review of undergraduate medical education – do you agree with this case?

Many submissions considered undergraduate education. The majority were in agreement that undergraduate education should be reviewed, but with an informed understanding of what the future medical and health workforces would look like. The RNZCGP expressed concern at the level of physical examination and procedural skills of undergraduate medical students, and commented on a lack of vertical integration across the undergraduate and postgraduate medical sector.

The University of Auckland School of Medicine did not recognise the picture of medical education as it was portrayed in the document and highlighted the adherence of their curriculum to World Federation for Medical Education standards. One submission thought that the call for a review could be seen as dismissive of the high quality of undergraduate education already provided, and another felt that no review was required.

A number of submissions commented on the ‘distance’ of the education sector from the demands of the health sector, and whether this provided a disincentive to changing the undergraduate medical curriculum. The NZRGPN suggested that ‘universities who produce graduates who choose to work in New Zealand should be rewarded with extra places, taken from those producing graduates who leave and practise overseas.’

It was generally agreed that the community should be involved in any review process, as should students and doctors.

There was general agreement that there should be earlier exposure to clinical content, greater exposure to rural health and primary health care, and an increased focus on health promotion and population-based health care in the undergraduate curriculum. It was noted that increasing clinical content would require more teaching and supervisory resources, and the development of more rural and primary care placements would also have to be resourced. Several comments were made with respect to a rural medical curriculum that was still waiting on funding.

One submission noted that DHBs need to understand and fulfil their responsibility in training medical students and graduates towards competence, as well as balancing service requirements. It was also observed that at times the preparation of clinical teachers in fulfilling teaching requirements is inadequate.
Other common comments have been allocated to the following headings:

- the medical curriculum
- medical school selection
- the medical school cap
- the medical degree – duration and postgraduate entry
- the Health-Education interface.

**The medical curriculum**

A number of submissions highlighted the need for medical education to become evidence-based, for ongoing research and development of the undergraduate curriculum, and for greater support and understanding of the relative roles of teachers and students. There were several calls for increased adult and self-directed learning.

The issue of cultural training came up in a number of submissions. The Department of Public Health at the Wellington School of Medicine felt that a critique of the issue of institutional racism within the health system and within medical training would be appropriate, and advised that research material on ‘immersion’ as a training tool is available. They also suggested the ‘cultural safety’ curriculum in the nursing profession might provide a model for medical education.

Other comments included the need to change focus from episodic care to a whole person approach, and to the support of chronic and multiple disorders. The New Zealand Medical Students Association commented that they did not believe that ‘new professionalism’ was currently overtly included in the undergraduate curriculum.

There were requests for further curriculum enhancement and delivery of training on palliative care, sexual health, rehabilitation medicine, community pathology laboratories, management of the visually impaired, and management of those with disabilities. Specific suggestions for change included:

- develop a national unit to research and support evaluation, research, development and co-ordination of best practice across the health/education spectrum
- shift ownership for medical undergraduate education from universities to health–community–education partnerships
- involve other health professionals in the development and teaching of the undergraduate curriculum
- develop regional bodies responsible for the medical undergraduate curriculum
- regular supervised clinical sessions, increased clinical content, greater exposure to outpatient clinics and general practice surgeries
- develop provincial clinical medical schools
- develop a network of rural and primary health care teaching hubs with sustainable physical and human resources
- develop rural clinical and academic role models at universities
- require undergraduates to go to rural hospitals as part of their training
- create a new 5+2 undergraduate programme to allow for the inclusion of more primary health care time
• make the medical degree a three-year course, followed by a one-year probation period before becoming a general practitioner/medical officer; then a graduate can elect to take a further two-year training period which would allow them to pursue medical membership of a specialty college
• move to a vertically integrated, problem-based model
• find out what can be learnt from the development of the distance-learning medical degree in the UK and see what can be implemented in New Zealand in conjunction with the current curriculum.

Medical school selection

Many submissions highlighted the ongoing need to balance the diversity of medical students with their differing academic requirements and technical capabilities, with particular emphasis on non-European populations.

Comments included:
• selective demographic policies do not necessarily mean that ‘rural’ or ‘low socioeconomic status’ students will return to their communities to practice
• has it ever been demonstrated that selection by educators provides a better diversity or quality of students than a simple examination?
• Australia has had to open new provincial centres as a response to rural students remaining in the larger cities after completing their training
• is there now a low number of European male medical students by comparison with the New Zealand population, and will this become problematic in the future?
• there is no evidence to show that the Undergraduate Medicine and Health Sciences Admission Test is an effective selection tool, and its use should be reviewed
• the number of mature-entry graduates should be increased
• the possible down sides of graduate entry are the reduced mobility of mature students and the relatively shorter duration of their working lives.

There were many suggestions made for possible changes to the selection process at both medical schools. These included:
• increasing community involvement in the selection process
• interviewing all prospective students
• giving New Zealand residents (or citizens) priority entry into medical school
• encouraging a stronger demographic profile in undergraduate students
• increasing the breadth of prior learning and experience that would be recognised by medical schools for entry into the undergraduate programme
• increasing the number of places available to full-fee-paying students
• the use of bonding schemes and appropriate sabbatical leave to create an incentive for graduates to practise in areas of need and to travel elsewhere for training
• bonded and non-bonded positions specifically for rural practice.

The medical school cap

Opinion on the student cap was divided. On the one hand there were arguments for the cap to remain as it is and to focus on retaining medical graduates. Others argued that if the
intention was for the New Zealand medical workforce to become self-sufficient, the cap would need to be raised – the MCNZ suggested this could be by as much as 33%. Student representatives from the Christchurch School of Medicine argued for a cap that would be reviewed annually by the medical schools in conjunction with Cabinet. Both medical schools advised that they had the capacity to train more medical students and highlighted the number of international placements they currently made available to overseas students. Several submissions suggested the development of full-fee paying students.

In all cases where an increase in student numbers was called for, it was noted that a commensurate increase in facilities and teaching resources would be required. It was also noted that there was a potential bottleneck for progression into house officer positions in the DHBs, and that this would warrant a review of the development of the house officer position and how it is filled.

**Medical degree – duration and postgraduate entry**

Submissions were divided in this area, and somewhat inconclusive. In the words of Matthew Doogue, a practitioner who made a submission, ‘the devil is in the detail’. Many acknowledged that six years is a comparatively long undergraduate degree, and extension into postgraduate training makes it longer again. However, it was contended that direct comparison with other countries is not as straightforward as the MRG implied. Whanganui DHB argued that undergraduate medical training is focused towards high-end specialties, making it unnecessarily long and expensive.

The majority of submissions that made comment on the duration of the degree were concerned that shortening the programme may negatively impact on quality and reduce the knowledge base that is required in medical practice. The University of Auckland Faculty of Medicine was concerned that eliminating the health sciences (pre-med) year might lead to a less diverse selection of students entering medical schools directly from secondary schools. The NZMA expressed concern at the potential elimination of the trainee intern year.

The Auckland and Otago Schools of Medicine and the Ministry of Education discussed the concept of ‘compression’ funding to enable the universities to move from a six-year degree to a five-year degree without financial penalty. As yet this issue has not been resolved. The concept of funding for medical school ‘output’ rather than process was supported by MCNZ.

Support for further development of graduate-entry medical degrees was ambivalent. While generally supported by MCNZ and the Christchurch School of Medicine, student groups expressed concern at the increased number of years of university study to finally obtain a medical degree, and the extension of student debt that would be expected. The University of Auckland Faculty of Medical and Health Sciences argued there is currently no evidence for the superiority of postgraduate medical entry versus undergraduate medical entry, but expressed support for a limited graduate-entry programme nevertheless.

**Health–education interface**

Submissions that made comment in this area supported greater collaboration between the health and education sectors. There were calls for ‘durable and integrated Ministry of Health and Ministry of Education planning and processes’, and health and education sector ‘partnership in providing and overseeing effective educational models’. The New Zealand Medical Students Association suggested that a national health–education council should be established, which would include government departments and all stakeholders.
5.3 The MRG has outlined a case for the wide-ranging review of the organisation of medical work, staffing and training in New Zealand hospitals – do you agree with this case?

Few submissions actively endorsed a wide-ranging review of the organisation of medical work, staffing and training in New Zealand hospitals. However, the Australasian Faculty of Public Health Medicine – New Zealand Office, the NZRGPN, Hospice New Zealand, and the RANZCP strongly endorsed a review. Their comments included:

- a review of health service delivery is needed prior to any substantial workforce review
- a small independent body should be developed with a defined time frame and the commitment, mandate and resources to drive the infrastructure change that is needed
- a review should include hospices
- a review must have support at all levels and oversight to avoid ad hoc, partially informed decisions, as one change must be accompanied by others.

In conjunction with the RDA, the NZMA advised that there was no evidence for a move away from the current situation where junior doctors are frontline staff and deliver the bulk of medical services. The RDA commented that less dependence on doctors in training to deliver services did not seem possible given the current workforce demographics.

Across the remaining submissions there was general agreement that:

- the time is right for a ‘renaissance’ general medical career pathway, possibly in conjunction with community-based training programmes and early introduction of primary care specialist streams or module-based training
- any review ideally needs to be doctor-driven and led rather than imposed from ‘on high’
- the apprenticeship model of postgraduate training is appropriate and cost effective, although it is open to enhancement
- the training model should be supplemented with skills labs and simulation labs
- supervisors and clinical teachers need training in education and teaching
- more attention should be paid to training needs in contract negotiations between unions and employers.

There was disagreement over the apparently constrained hours that doctors in training work. The RDA felt that the MRG was inappropriately inferring a cause-effect relationship between RDA-negotiated working hours and difficulties in changing service delivery models. Others felt that the time constraints are an impediment to learning and clinical exposure. The New Zealand Occupational Health Nurses Association pointed out the need for more regular, established shifts and appropriate recovery times.

A number of submissions acknowledged a tension between an increasing drive to sub-specialisation and an increasing demand on primary health care services for chronic disease management. The RDA advised that an improvement in primary care services would not necessarily lead to a reduction in demand on secondary care. M Doogue argued that sub-specialisation is potentially harmful to patients as it may result in increased visits to an increasing number of doctors and poly-pharmacy, yet our training systems are oriented towards sub-specialisation. The New Zealand Rheumatology Association commented that an increasing focus on high-cost technical services is concentrating resources disproportionately at the tertiary level of service delivery.
Some submissions commented on the lack of recognition for some health professionals (nurses, resident medical officers) involved in the delivery of hospital-based training.

The Royal College of Pathologists of Australia did not feel that the MRG adequately recognised the role of the colleges in continuing medical education and maintaining professional standards. Professor John Scott believed that rigid postgraduate structures and service frameworks inhibit innovation.

C Paul, Professor of Preventive and Social Medicine, suggested an expanded role for universities in postgraduate education, and that a Master of Medicine would fit well with the concept of an expanded MOSS position.

5.4 Is there a case for the similar review of the training of doctors who work in primary health care settings?

This was specifically endorsed by the RANZCP. They felt that integrated service delivery had been slow to develop in New Zealand due to poor co-ordination and leadership across the sector, altered funding, and reforms over the last decade. The constant development of new relationships and processes resulted in a reduction of time for true reflection and innovation.

5.5 Why has inter-professional learning and practice been slow to develop in New Zealand – what should be done?

A number of submissions queried the evidence for inter-professional learning at the undergraduate level, but agreed there was evidence of benefit at the postgraduate level. Submissions also mentioned the Committee for Inter-professional Learning in the UK.

There were also specific cases cited of the ‘slowness’ of the Tertiary Education Commission to fund inter-professional learning initiatives and collaborative exercises. Two submissions cited an apparent unwillingness to learn from overseas systems and innovations. Comments were made with respect to the ongoing funding and development of the nurse practitioner role, and its consequent slow deployment.

Suggestions for improving inter-professional learning included:

- the development of simulated practice learning initiatives to bridge practice-education gaps
- emphasising the responsibility of employers to provide opportunities for inter-professional learning and development
- a core course for all health care workers.

The NZRGPN made the following comment:

Our members believe a sub-culture exists in some groups of medical people, specialties, hospitals and within and between where collegiality is not valued. This is manifested through hostility to other groups, or simply by being difficult to work or communicate with, or by being apparently unhelpful.

One submission thought inter-professional learning was a ‘daft idea’ anyway and should be abandoned.
CHAPTER 6: RECRUITING AND RETAINING DOCTORS IN A GLOBAL MARKET

6.1 This chapter covers a wide range of issues affecting recruitment and retention of doctors in a global market. Do you have any comments to make on the matters highlighted as key issues?

Submissions that addressed this question generally noted that retention should be a primary focus in the future. Some submissions quoted literature that supported this view, while others suggested that research should be done on the total cost of incentive and retention strategies versus the cost of turnover and recruitment of overseas-trained doctors. The JFICM asked, ‘What are we doing wrong that drives people away and does not attract them to places where they are needed?’ They suggested that Maslow’s Hierarchy of Needs would be a valuable tool in retention strategies: ‘we must be sure that more basic needs are met, security, family and work and freedom from financial worries.’

Competition with the global marketplace was acknowledged, as were the relative internal disparities between geography and medical practitioners in New Zealand. It was felt that a national approach to retention is required, because regionalisation of recruitment packages may maintain a ‘supply and demand’ cycle between New Zealand employers that would lead to further disparity.

Many suggested that New Zealand should become self-sufficient in the delivery of medical graduates to the workforce, and that reliance on overseas-trained doctors should be reduced. Some submissions also mentioned the need to develop programmes to tempt New Zealand medical graduates practising overseas back to New Zealand.

Although income disparity between medical practitioners and global competition was a focus of answers to this question, other comments and suggestions included a need for:

- research on ‘competitive cities’, which would require local and national government action
- national co-ordination of relocation packages for returning New Zealand graduates
- increased support for part-time work when returning to the medical workforce – this is currently done poorly between DHBs, and a more central approach is required
- recognition of part-time work against specialist training
- improved working conditions and working environment – contrasting a ‘big stick’ approach versus incentives
- debt forgiveness for semi-rural areas
- remuneration of GPs.

Questions were also asked:

- How can the medical profession be made appealing and rewarding; remuneration, professional satisfaction, career pathways, reduce the bureaucratic burden?
- Is there a declining popularity of medicine as a career choice overall: does the profession no longer attract the top students?

The Dental Council highlighted similar distribution and retention issues in rural New Zealand with respect to a specified dentist-to-population ratio. They reported oversupply in Auckland and other main centres, and low levels in Counties Manukau, Tairawhiti, Whanganui and West Coast DHBs.
6.2 Have we missed any issues affecting specific groups such as students, graduates, specialists, overseas-trained doctors and older doctors?

**Overseas-trained doctors**

Further comments on overseas-trained doctors included the need for standardisation of recruitment processes for overseas-trained doctors throughout New Zealand, and the need for cultural training and an understanding of how the New Zealand health system works. Once again, submissions highlighted the ethical considerations of recruiting overseas-trained doctors.

**Resident medical officers**

It was commented that the transition between undergraduate medical education and specialisation (postgraduate years 1 through to postgraduate years 3 and 4) is a crucial time in developing effective work skills and a medical career. Several submissions advised that further resources (both university and health) be allocated to this area, including increased rural health and primary health care placements, formal career guidance and mentoring between universities and clinical institutions, and increased involvement of the universities in postgraduate education. An article by Gorman and Scott (2005), ‘Twin dilemmas for medical education’, was mentioned in a number of submissions.

There was concern expressed that the Doctors in Training Workforce Roundtable did not include representation from resident medical officers, and the RNZCGP also noted the absence of GP representation on this group. The NZMA stressed that the appropriateness of the current conditions and hours of work of resident medical officers are key elements of future workforce planning and training.

Counties-Manukau DHB advised that their junior doctors are currently doing clerical work and their senior doctors are ‘buried in bureaucracy’. They felt that ‘carers should be more involved with care than compliance’.

**Medical officer special scale**

The RDA felt the MRG’s definition of medical officers special scale (MOSSes) was inaccurate: they are general registrants not vocational trainees and have no specified scope of practice. The RDA asserted that MOSSes come from two groups – those taking some time out, and overseas-trained doctors who are filling in ‘stagnant’ positions because they do not want to vocationally retrain on their arrival in New Zealand. The RDA felt that MOSSes should either be undertaking vocational training or participating in continuing medical education programmes as a vocational registrant. They advised that MOSSes could have qualified only three years previously, and it should not be assumed that they would be more senior to vocational registrants with whom they may be working.

The NZMA agreed there was some confusion as to the definition of a MOSS, but supported the idea of developing a MOSS training programme, and a model that would give ongoing definition to the roles and accountabilities of the MOSS.

ANZCA acknowledged the reality that a small number of MOSSes would be required to meet service requirements for anaesthesia in New Zealand, particularly in the rural hospital environment. They supported the development of a MOSS training programme for anaesthesia and cited the Australian Joint Consultative Committee in Anaesthesia training modules, which could be adapted to New Zealand conditions.
Primary health care

Primary health care was addressed in many submissions. The RNZCGP advised that the General Practice Vocational Training Programme was now outdated, and was renamed the General Practice Education Programme (GPEP) some years ago. They were concerned that although the GPEP was in two parts, only the equivalent of the first part was referred to in the consultation document. Entry to the first part is limited by CTA funding. The second part, GPEP 2 (Advanced Vocational Education), is funded by both GPs and the CTA, and there are no number restrictions to this part of the programme. They also advised that recent funding from the CTA goes some way towards addressing the base remuneration of graduates training to be GPs.

The RNZCGP also advocated the development of an evidence-based GP-to-population ratio that should be standardised across the sector.

The NZMA agreed that recruitment and retention of GPs is of particular concern, and that the viability of private general practice should be ensured when planning for future primary care in New Zealand. The Royal Australian and New Zealand College of Psychiatrists noted a lack of available GP resource in developing psychiatric services for primary care.

The Chairs of the PHOs in Canterbury suggested that a strategic plan for the development of the primary health care workforce involving all health professional groups should be developed.

The Head of the University of Auckland Waikato Clinical School provided a summary of the major issues in primary health care, as follows:

- a lack of GP vocational training places
- reduced career development opportunities
- poor work–life balance
- poor remuneration.

Many other submissions agreed that the attractiveness of primary care as a career for medical graduates needs to be addressed. M Doogue suggested that a high value is placed on sub-specialities, and that primary health care needs role models to show the value of primary health care and its associated sub-specialities.

Most commented on the poor remuneration of GPs relative to other medical specialists, and the failure of the business model in some areas of general practice. The Chairs of the PHOs in Canterbury suggested that research be done into salary models for GPs. Another submission (ACC) suggested the application of the multi-employer collective agreements to GPs.

It was also suggested that assistance be provided for clerical and administrative duties, and that compliance time and costs need to be reduced.

Senior medical officers

Few submissions specified further issues with respect to resident medical officers. However, the New Zealand Rheumatology Association advised that loss of sabbatical leave for senior medical officers was a backward step. There was a requirement for time away from the front line, and for professional development. This would help avoid burnout in senior medical staff.
Specialist services

Specific mention was made of specialist shortages in neurologists and vision services. The Canterbury DHB Planning and Funding Group expressed concern at an apparent shortage of psychiatrists, and a reliance on overseas-trained doctors to fill the gaps. They felt that overseas-trained doctors may lack an understanding of New Zealand culture and appear to have very short tenures. Hospice New Zealand requested a review of postgraduate palliative care that would include the identification of accredited training rotations and specified training numbers.

Dr Taylor queried accreditation policies on the Professional and Linguistic Assessments Board test and United States Medical Licensing Examination, and suggested that investment be made in researching and developing bridging programmes in order to widen the pool from which New Zealand recruited overseas-trained doctors.

Two submissions noted the difficulty in changing between specialties, and an apparent difficulty in changing careers. This was felt to be a barrier to the older workforce that may like to move to less physically demanding specialty areas. There was also discussion of re-entry plans and support for those who had taken time out from their careers or were returning to New Zealand. MCNZ advised that as a regulatory body for doctors, the Council was taking an active role in workforce issues and that it intended to include recognition of prior learning and flexibility in allowing doctors to move between specialties as a feature of future council policy.

Academics

It was agreed that remuneration and working conditions for academic staff make recruitment and retention in this area increasingly difficult. The Ministry of Education suggested that a tension exists between clinical teachers, who must share facilities, knowledge, staff and patients with their teaching hospitals, when the objectives and funding of the clinical training unit and hospital may not be the same.

Rural care

The Rural Hospital Doctors’ Working Party and the NZRGP provided comprehensive submissions on rural care. They advised that rural care is not solely primary care, but also includes secondary care, staff, services and facilities. They also advised that there is often a critical mass of doctors and other health care workers required for the effective delivery of rural health services. These organisations should be consulted further when addressing rural medical and health workforce issues.

The Rural Hospital Doctors’ Working Party outlined their immediate priorities for rural health as:

- a clear career pathway for rural doctors
- a professional body for rural New Zealand doctors that would allow national cover and co-ordination for leave, continuing medical education, etc and development of guidelines for treatment
- vocational training for rural hospital work
- enabling rural doctors to deliver broader services
- Association of Salaried Medical Specialists multi-employer collective contracts should be available for vocationally registered rural doctors, which would then allow for sabbaticals
- module-based training programmes for rural GPs and rural hospital medical officers
- shifting of the ‘purse strings’ and accountability to local bodies.
The NZRGPN provided information on their New Zealand locum GP team and their orientation programme for overseas-trained doctors. They advised that the term for which recruits are willing to commit to a rural general practice appears to be decreasing. Contracts used to be signed for two to three years, and now it seems more like 12 to 18 months. They suggested:

- the MCNZ should accredit more general practices as suitable for the ‘A’ and ‘B’ runs
- greater consideration should be given to the role of nurse specialists in providing on-call services in areas like the West Coast, Kurow and Great Barrier Island
- the development of a rural nurse locum network to piggy-back on the New Zealand locum GP service.

The Southland Otago Rural Hospital Doctors’ Group submitted that recruitment of overseas-trained doctors into rural health might ultimately be detrimental to the development of a stable rural health workforce, as overseas-trained doctors may see rural health positions as a stepping-stone into the New Zealand medical workforce, and thus provide only a short-term resource to the rural medical workforce. The RACS cited the Northland experience, which enables rural surgeons from rural locations to work in a larger facility with appropriate funding and staff support.

The Head of the University of Auckland Waikato Clinical School submitted that, despite a change in recruitment practice with the development of Rural Origin Medical Preferential Entry, students postgraduate training and career opportunities had not been addressed.

Whanganui DHB noted a need for provincial areas to be able to tap into research, and that poor funding makes the publication of local research difficult.

Other general comments included confusion over geographical location and the application of the Rural Ranking Score by DHBs, the isolation of rural GPs, and the ethical and financial burden on GPs to continue working in the event that they are unable to sell their practices.

Comments on student debt and the possibility of incentives for rural practice are addressed in the section on undergraduate medical education.

At retirement

The few submissions that addressed this issue suggested greater recognition of prior learning to allow changes between specialties, and noted the potential value of retired practitioners in both national and local emergencies.

6.3 Do you support the following recommendations:

6.3a That general measures should be taken to reduce debt for all students, including medical students?

It was generally acknowledged that there is no proven link between graduates leaving New Zealand and student debt. With the exception of the Ministry of Education, who provided further data on student debt, all submissions that responded to this question felt that something needs to be done to address student debt. There were many comments about student debt affecting the concept of ‘altruism’ within the medical profession, acting as a driver for graduates to move overseas and choose more highly specialised vocational training schemes with a potential private income.
Suggestions ranged from abolishing tuition fees altogether, to debt forgiveness or bonding schemes to encourage medical graduates into areas of need. A work bursary system was suggested, where graduates working for a certain length of time in the public health system would have a portion of their student loan paid for them. Several submissions suggested that such debt forgiveness or bonding schemes should include New Zealand medical graduates spending time in developing countries or areas such as South East Asia. It was also noted that any such schemes need to make allowance for continuing professional training and development overseas.

One submission suggested research into the effects that student loans might have on the choices of a potential lower socioeconomic student in choosing medicine as a career. A further submission suggested more scholarships for Māori and Pacific students.

Student representatives from the Christchurch School of Medicine recommended an independent review of student allowances, particularly addressing the age of eligibility and parental income cut-off levels.

Of note, the Dental Council commented that their first-year cohort retention for University of Otago graduates still practising in New Zealand was 48.4%. Many of their graduates are now working in Australia.

6.3b That students should be able to actively pursue vocational interests and aptitudes during the undergraduate medical course?

The Australian and New Zealand College of Anaesthetists suggested the proactive approach of addressing the primary health care issue by ‘streaming off’ a primary care branch of medical education earlier in the undergraduate process, perhaps followed by a trainee intern year and house surgeon posts in the community. Another submitter suggested a rural practice year be made available to undergraduate medical students.

The RANZCP were concerned that we might develop a workforce like the ‘Cuban/Russian model’, where they felt in practice the specialists were not able to transfer skills readily between locations and vocations.

Others were concerned that early streaming could undermine the strength of the ‘universal competence’ of current graduates, and that students were still relatively undecided about their vocational interests this early in their career. The elective in the trainee intern year was highlighted as an opportunity for students to explore vocations that were of interest to them.

6.3c That the capacity of the Royal New Zealand College of General Practitioners (RNZCGP) General Practice Vocational Training Programme be reviewed?

The initial stage of the Royal New Zealand College General Practice Vocational Training Programme is the General Practice Education Programme – Stage 1 (GPEP). The GPEP 1 provides education and training programmes to doctors to ensure they have the minimum standards of skills, knowledge and ability to practice safely as a general practitioner in New Zealand. Each year the College tests those skills with the Primary Membership Examination (Primex).

The RNZCGP advised that the CTA was carrying out a review of the GPEP in 2006, and that they were reviewing their own curriculum as a response to meeting the changing
needs of their profession. They supported calls for the resourcing of GPEP 1 to be increased and the training infrastructure to be strengthened. They also highlighted that extending the teamwork concept further into general practice would have training implications (eg, for palliative care, chronic care and mental health), and that the College would require support for education in these areas.

Ten further submissions supported a review of the GPEP, in association with a review of undergraduate and postgraduate education. Some felt that the current model works well but is under-resourced. Specific suggestions included:

- a three-month rotation into a rural practice as part of the training scheme
- increasing knowledge of palliative and end-of-life care
- improving the knowledge and management of visual impairment problems in the primary care setting
- the General Practice Education Programme should also have exposure to academic training – funding five academic positions a year to be taken up after completion of a vocational training year
- investment in general practice facilities or PHOs to provide expanded numbers of trainees with training
- requiring all general practice trainees to spend a minimum of three months in a rural or semi-rural setting.

**The Clinical Training Agency**

The CTA was the subject of a number of submissions. The NZMA noted that the CTA were responsible for the allocation of $100 million dollars (one-third) of the total Crown investment in health qualifications. There were various suggestions to improve the efficacy of the CTA, including:

- review the CTA's function, alignment with health care services and training
- disestablish the CTA in favour of a more fully integrated purchasing and leadership role
- move the CTA outside of the Ministry of Health, and make it responsible to a board that has strategic responsibilities for workforce development
- improve the transparency of CTA funding and decision-making
- improve the infrastructure and interfaces of the CTA
- improve the level of strategic direction given to the CTA, including specific workforce data and outcome measures
- address the funding ceiling at the CTA.

It was also suggested that CTA funding does not appear to be ‘tagged’ to an individual, and that doing this should allow a better analysis of the effectiveness of funding programmes.
CHAPTER 7: WORKING TOGETHER –
A SYSTEMIC SECTOR-WIDE APPROACH TO
HEALTH WORKFORCE DEVELOPMENT

7.1 Do you agree with the way we have conceptualised
the health/medical workforce in New Zealand?

There were few comments on whether submissions agreed or disagreed with the MRG’s
categorisation of the health/medical workforce in New Zealand. The point was made that
university medical schools should also have been included in the list of key stakeholders, and
that the Ministry of Economic Development and Treasury might have been included in the list
of statutory bodies. The NZRGPN were disappointed that the list of secondary players was
not complete, and felt this undervalued the contribution that many of these organisations are
making to the sector.

There were several comments on the total number of bodies with a stake in the development
of the health and medical workforce. It was felt that rationalisation of these bodies must be
possible, particularly within the current 21 DHBs.

7.2 Have the key issues been identified?

Addressing resistance to change was a theme that occurred commonly throughout the submissions.

7.3 Do you agree with the suggested changes?

While many endorsed the idea of a systemic sector-wide approach, few submissions explicitly
answered this question. One submission was quite opposed, stating that the last thing we need ‘is
another bunch of woolly thinkers, thank you.’

7.4 What problems, if any, do you foresee in making the
suggested changes?

The JFICM commented that the ‘health system is buried in a socio-political system that is
also terribly ineffective, unresponsive to information about why people do what they do
and demands flexibility from other people while decision-makers remain inflexible in their
attitudes and ideologies’, and that there are ‘disempowering environmental factors that lead
to burnout’.

The ANZCA noted that the workforce is stressed by workload and compliance issues, which
tend to create barriers to communication. The lack of time to identify and address issues of
contention could lead to the development of ‘silos’. They also suggested that change often
leads to practitioners feeling their standards of practice are threatened.
Other wider systemic issues included:

- a shame and blame culture
- media influence, particularly with respect to medico-legal issues
- a competitive ideology, which has stifled collegiality
- the increased time required for accreditation and attainment of ‘gold standard’ practices for such a small country
- a focus on outputs, which stresses already over-stretched staff.

Submitters also commented on the medical profession:

- needing to articulate a professional vision
- needing college support and collaboration
- being taught a lack of respect for allied health professions
- being taught conservative attitudes and behaviour through professional bodies and colleges
- having professional boundaries and hierarchies that are not welcoming to allied health professions.

Resistance to change was a feature of submissions that responded to this question. There were also comments about vested interests in the status quo, and inter-professional public positioning over proposed health changes.

Funding mechanisms were cited as an impediment to change, as well as a slow uptake and integration of technology into workplace practices.

7.5 What other steps could be taken to enable the various stakeholders to work together more productively?

There were several calls for a single point of leadership to co-ordinate workforce development in public and private service. Some felt this belonged to DHBNZ, some to HWAC, and some to central government ‘somewhere’. One submission believed that all the associations, bodies and unions should be ‘umbrella’ organisations to the central group.

The NZRGPN highlighted the fact that, historically, rural health care workers have been under-represented on centralised, Ministry-based groups. They were also concerned about who decides the make-up of a workforce development body, its terms of reference, reporting structure, and whether a more widespread approach across education and immigration agencies, as well as health, is required.

7.6 Do you have any other comments or suggestions to make?

The NZAPP advocated the development of a pathology advisory group to be established at Ministry level, to enable the government and the profession to address issues in pathology practice and to build constructive relationships between community pathology practice and the DHBs.

The JFICM felt that MRG would provide more help if ‘it were to write a less “high-level’ document that sets out in plain terms what is actually being proposed, within what would be a reasonable timeframe and support its arguments with valid and robust data.’
# Appendix 4: Demarcation of Responsibilities for the Provision of Medical Education and Training

<table>
<thead>
<tr>
<th>Medical education or training course</th>
<th>Funder</th>
<th>Provider</th>
<th>Course owner</th>
<th>External accreditation body</th>
<th>Quality auditor / course reviewer/ moderator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undergraduate degree:</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Bachelor of Medicine and Bachelor of</td>
<td>Tertiary Education Commission</td>
<td>University of Auckland and University of Otago</td>
<td>Respective university</td>
<td>Committee on University Academic Programmes&lt;sup&gt;*&lt;/sup&gt; (for courses to meet academic standards); Medical Council of New Zealand (for courses to meet professional registration requirements)</td>
<td>Australian Medical Council</td>
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<tr>
<td>Surgery</td>
<td></td>
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<td>General health science course – 1st year</td>
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<tr>
<td>Pre-clinical training: 2nd and 3rd year</td>
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<tr>
<td>Clinical training: 4th, 5th, and 6th (trainee intern) years</td>
<td></td>
<td>Associated clinical schools at Auckland, Hamilton, Wellington, Christchurch and Dunedin</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Pre-registration training (postgraduate year 1)</td>
<td>Clinical Training Agency</td>
<td>District Health Boards</td>
<td>Medical Council of New Zealand</td>
<td>Medical Council of New Zealand</td>
<td>Medical Council of New Zealand</td>
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<tr>
<td>Pre-vocational training (postgraduate year 2)</td>
<td>Clinical Training Agency / District Health Boards</td>
<td>District Health Boards</td>
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</tr>
<tr>
<td>Vocational training (specialist registrar)</td>
<td>Clinical Training Agency / District Health Boards</td>
<td>Accredited posts within District Health Boards</td>
<td>Respective medical college</td>
<td>Medical Council of New Zealand</td>
<td>Australian Medical Council</td>
</tr>
<tr>
<td>Vocational training – general practice (GP registrar)</td>
<td>Clinical Training Agency / self-funded</td>
<td>Accredited GP practices</td>
<td>Royal New Zealand College of General Practitioners</td>
<td>Medical Council of New Zealand</td>
<td>Health and Disability Audit New Zealand</td>
</tr>
</tbody>
</table>

<sup>*</sup> The Committee on University Academic Programmes also has the role of facilitating cross-crediting arrangements for students transferring between programmes and institutions.
BIBLIOGRAPHY
AND REFERENCES


