Treating People Well

Report of the Director-General of Health’s Commission on the Resident Medical Officer Workforce

11 June 2009
Acknowledgements

We want to acknowledge all those who have provided their views and given their time and information to assist us with our investigation into the issues affecting the resident medical officer workforce. You have helped us to understand the challenges for individuals, for organisations and for the sector, and many of you have suggested creative solutions that have helped us to form our recommendations.

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Executive Summary

Introduction
The Commission on the Resident Medical Officer Workforce (RMO Commission) was set up to investigate issues facing the resident doctor workforce and to make recommendations on the medical workforce needed to deliver services now and in the future.

The RMO Commission members are Don Hunn (chair), Professor Peter Crampton, Angela Foulkes and Professor Des Gorman.

Who are resident medical officers
The term ‘resident medical officer (RMO)’ covers resident doctors from their last year of undergraduate training until they complete their vocational training.

The RMO workforce is not homogenous. RMOs range in age from early 20s to over 50, and include undergraduate students as well as those with six or more years’ post-registration experience. Various job titles, including trainee intern, intern, junior doctor, house officer, house surgeon, senior house officer/surgeon, registrar and advanced trainee, are used for RMOs at different stages of their training.

Why change is needed
Status quo cannot continue
New Zealand’s RMO workforce is characterised by dissatisfaction, industrial conflict and fragmented approaches to workforce management and planning. Associated issues, including the shortage of RMOs and the increasing cost of providing RMO cover, are a threat to the ongoing effective management of the public health system. The issues with the resident doctor workforce are long-standing, complex issues that are becoming increasingly urgent; they must be resolved and there is an opportunity to do that now.

Coherence and quality of education and training
The requirements of service delivery too frequently take precedence over RMO training. Many RMOs, particularly those in postgraduate year (PGY) 1 and PGY2, are dissatisfied with this situation; not only are they not receiving the teaching to which they are entitled, but the clinical and administrative tasks assigned to them they frequently see as low level and professionally unrewarding.

Workplace culture and practice
The RMO Commission has received a consistent message from resident doctors that they do not feel valued in the workplace. They report feeling that their employers view them as units of labour to be deployed to cover service need rather than professionals in training, with families and lives outside the workplace. Management of RMOs within the workplace is inconsistent. Employment practices such as induction, performance management, support systems and record-keeping are uneven at best and outdated at worst, leading to further frustration. There is a serious deficiency in the level of pastoral care for RMOs, especially those in PGY2 and PGY3.
Recruitment and retention

There is widespread and well-based concern that New Zealand does not have enough doctors to meet its health needs now and in the future. We rely heavily on international medical graduates to maintain doctor numbers. International medical graduates made up 40 percent of the practising medical workforce in 2006. Despite encouraging increases in the number of doctors being trained, it is essential that New Zealand retains as many of the RMOs who graduate here as possible. Unfortunately, we know little about why resident doctors leave New Zealand or what encourages many of them to return.

Use and cost of locums

Locums have long been a feature of the medical landscape, but evidence suggests that this practice has been increasing rapidly in New Zealand over the past 10 years, largely as a result of the introduction of safe-staffing formulae, RMO shortages in the face of increasing health service demand, and locum positions that offer better financial rewards and more flexibility than permanent hospital positions.

While locums will always be needed, the current widespread, costly use of locums is unsustainable, and having no limit on or monitoring of locum working hours is unacceptable and potentially dangerous.

What to retain and strengthen

Apprenticeship model

The apprenticeship model of learning, where the balance between learning and patient care gradually shifts as practitioner competence increases, has been the core of training in medicine for hundreds of years. Apprenticeship teaches more than technical competence; the guidance of a senior practitioner is vital as RMOs develop skills in approaching the doctor–patient relationship and navigate the ethical issues they encounter. An increasing clinical workload, increases in RMO numbers, changes to RMO working hours, and a lack of clearly defined teaching responsibilities and duties in employment contracts have all adversely affected the apprenticeship relationship. We believe the relationship between resident doctors and their senior colleagues needs to be strengthened and that the way to do this is by formally supporting the apprenticeship relationship through which knowledge, skills and professional ethics are taught and learned.

Collective employment agreement

Collective bargaining and the resulting collective agreement should be designed to meet the changing needs of both employer and doctors in work-based training. It should provide a firm foundation of reward and protection, while at the same time providing a platform of good practice on which innovation and improvement can be built. Achieving an empowering rather than restrictive agreement should be a priority.

Developing remuneration structures within a national employment agreement that make permanent employment more attractive than locum work and moonlighting has the attraction of releasing funds for both permanent staff remuneration and patient services.
Role of the medical officer
We think that the role of the medical officer needs to be strengthened to provide a better-recognised career option for resident doctors who choose not to pursue vocational training.

What needs to change

Being valued and supported
RMOs enter the profession committed to serving the population; they want to make and be valued for their contribution as doctors. However, the experience of their first few years leaves many of them feeling they are regarded and deployed as glorified clerks who spend the bulk of their time on paperwork and other record-keeping and are required to use cumbersome, manual and outdated information technology systems. Furthermore, adversarial industrial negotiations have eroded goodwill between RMOs and their employers.

Doctors in training
It is our view that RMOs should be treated as an in-training workforce with an operational service component. Strong collaboration is required between all parties to ensure an education and training focus that is well co-ordinated and aligned with prior and subsequent training is maintained for this group.

Employment arrangements
For RMOs to be treated primarily as an in-training workforce requires changes to a system that relies on them as a frontline workforce. In our view it is too difficult for 21 separate employers (ie, the district health boards) to make those changes, and national leadership and changes to employment arrangements are needed to support the national direction being proposed for medical training.

Accountabilities
At each level, clear accountabilities for RMO training need to be established, monitored and reported. Defining the nature of these accountabilities falls within the ambit of a new medical education co-ordination body, and is seen as critical by this commission.

Workforce planning
The RMO Commission believes national leadership of RMO workforce development is needed. The RMO Commission’s efforts to understand the issues facing the resident doctor workforce and to make recommendations have been hampered by a lack of high-quality, aggregate and individual quantitative data.

Ethos, values and ethics
RMOs who spoke with the RMO Commission were clear and positive about their ethos of service to individual patients and the ethical frameworks associated with this, but few were able to articulate a coherent set of values about the New Zealand public health system. The RMO Commission sees benefit in such a set of public health system values that is widely understood and provide RMOs with a context for their practice.
Human resource practices

The RMO workforce is highly mobile, changing employers frequently. With each employment the full range of human resource tasks is required. Furthermore, each employer has its own systems, which do not communicate with other employers’ systems, so oversight of resident doctors’ progress and performance is severely hampered. It is our view that achieving a consistent, high standard of human resource practice to which resident doctors are entitled is a priority.

Private health system training capacity

There are many challenges in exploring private sector training capacity but we believe such exploration is required. We acknowledge the work that is under way in this area and offer our encouragement and support to those doing it.

Data collection and analysis

The RMO Commission’s efforts to understand the issues facing the resident doctor workforce and to make recommendations have been hampered by a lack of high quality, aggregate and individual quantitative data. We are left with unanswered questions about patterns of RMO employment in New Zealand and overseas, the hours residents work in their permanent and locum positions, and why doctors leave, how long they are away and why some return to our health workforce.

Incentives

The issue of RMO remuneration has not been easy for the RMO Commission to assess. Salary was not often raised as an issue by those we spoke to, but the length and bitterness of recent industrial campaigns would seem to indicate that it should not be ignored. It is our view that focusing on how better to value RMOs while ensuring they have a fair disposable income may be the best response.

Options for change

The options the RMO Commission has identified have been developed in cognisance of other, recent work. The RMO Commission endorses the recommendations of the Medical Training Board and Clinical Training Agency review group for a single agency with the capacity to co-ordinate medical education and training across the entire continuum of learning. We believe this is essential if training is to be restored as the driving force of the resident doctor experience.

The options developed by the RMO Commission are based on the understanding that the RMO training experience and career path will be overseen by the new national training body, which will take RMO preferences, the country’s health needs, and professional requirements into account. For this reason, the options considered by the RMO Commission focus on the employment arrangements of RMOs.

The four options we considered are:

1. the status quo – employment to remain with district health boards, but with modifications
2. a regional employment model
3. a stand-alone, national body to employ RMOs
4. a national body with oversight of medical education to employ RMOs.
RMO Commission’s view

Our view is that resident doctors’ engagement in education and training needs to determine their role in the workplace rather than the reverse. Strong collaboration is required between all parties involved with RMOs to ensure an education and training focus that is well co-ordinated and aligned with prior and subsequent training is maintained for this group.

We have identified issues of great complexity that cannot be solved by structural changes alone. However, it is our view that structural change is most likely to deliver a solution. We support option 3 – a stand-alone body responsible for the employment of RMOs. We recommend a single national employer and a national collective employment agreement that governs pay, terms and conditions for resident doctors. Developing national employment arrangements that support flexible service delivery for patients and strong mentoring relationships between RMOs and clinical teams is an urgent issue.

While we recognise that the sector is already fragmented, and a clear justification is needed for recommending an additional body, we believe that providing oversight and setting standards for medical education and training and good employment practice require different skills that one body cannot do to a high level.

Recommendations

The RMO Commission recommends the following.

1. The status quo is rejected, and immediate steps are taken to effect essential changes following best practice principles in change management.

2. A New Zealand health system ethos is developed and articulated that outlines the rights, responsibilities and privileges of those working within the system.

3. Leadership of and accountability for RMO training is assigned. The RMO Commission supports the directions of the Medical Training Board and Clinical Training Agency review group for a new national training body. We recommend such a training leadership body:
   - takes responsibility for health workforce planning in response to service configuration and models of care and, in turn, to national, regional and district service plans
   - ensures training time is protected in RMO job descriptions
   - increases RMO training opportunities in the primary health care sector
   - ensures locum positions do not count towards training requirements.

4. A stand-alone national employer for RMOs is established, supported by regional or local RMO units. We recommend such an employer:
   - ensures a national review of RMO numbers
   - collects robust data to ensure RMOs can be tracked through their careers
   - increases emphasis on pastoral care and career planning.

5. A new national collective employment agreement focused on pay and conditions is negotiated. The negotiation process should take account of financial incentives.

6. District heath boards are held formally accountable for training RMOs and for ensuring protected time for senior medical officers to do the training.
1 Introduction

1.1 Commission on the Resident Medical Officer Workforce

In October 2008, the Director-General of Health established his Commission on the Resident Medical Officer Workforce (RMO Commission). The RMO Commission was set up to investigate issues facing the resident doctor workforce and to make recommendations on the medical workforce needed to deliver services now and into the future. In particular, the RMO Commission was asked to make recommendations to the Director-General of Health on:

- the medical workforce needed to deliver services to meet the New Zealand population’s health needs, in the context of changes in those needs, as well as changing models of service delivery
- where the role of resident medical officers (RMOs) sits within the required medical workforce, how this aligns with the current RMO role, and whether aspects of the current role, including RMO deployment, act as enablers of, or barriers to, ensuring a medical workforce that can deliver services to meet New Zealanders’ health needs now and into the future
- whether there are RMO workforce supply and demand influences that act as enablers of, or as barriers to, ensuring a medical workforce that can deliver services to meet New Zealanders’ health needs now and into the future
- the changes, if any, that might be necessary to support the identified enablers or counter the identified barriers and how these changes could be implemented.

The terms of reference for the RMO Commission are in Appendix 1.

The RMO Commission members are:

- Don Hunn (chair), former State Services Commissioner
- Professor Peter Crampton, Dean and Head of Campus, University of Otago, Wellington
- Angela Foulkes, former Secretary of the New Zealand Council of Trade Unions
- Professor Des Gorman, Head of School of Medicine, University of Auckland.

Brief biographies of the commission members are in Appendix 2.

1.2 The RMO Commission’s process

Through the term of its investigation the RMO Commission met with individuals, groups and organisations to better understand problems and explore potential solutions. A list of those consulted is in Appendix 3. The RMO Commission also invited and received written submissions. The summary of submissions is reproduced in Appendix 4.

Mindful that much work has already been undertaken in New Zealand and overseas on medical workforce issues, the RMO Commission reviewed local and international literature as well as work in progress in order to ensure its recommendations were well informed and as far as possible aligned to other work.

Finally, in areas where the RMO Commission wanted to know more, it gathered and analysed data from a variety of sources. Many of these analyses appear in the appendices to this report.
1.3 Other work

Over the past 20 years, many reports have addressed aspects of doctor education and training and/or medical workforce issues. Since 2005 three major reports have included a plethora of recommendations for the medical workforce. These reports are:

- *Reshaping Medical Education and Training to Meet the Challenges of the 21st Century: A report to the Ministers of Health and for Tertiary Education from the Workforce Taskforce*¹
- *Training the Medical Workforce 2006 and beyond*²
- *Fit for Purpose and for Practice: Advice to the Minister of Health on the issues concerning medical workforce in New Zealand.*³

Progress has been made towards implementing recommendations in some areas. There have been recent increases in the number of funded undergraduate medical places and further increases are planned. The Medical Training Board has been established and is providing strategic oversight of the education and training of medical practitioners and has produced two major reports: *The Future of the Medical Workforce*⁴ and *Foundations of Excellence*.⁵ However, in other areas progress is harder to see, and serious problems, outlined in chapter 2 of this report, remain. Further information on implementation is in Appendix 5.

We want to acknowledge other work under way to address the complexity of issues affecting the medical workforce. In addition to the work of the Medical Training Board and the recently released *In Good Hands: Transforming clinical governance in New Zealand,*⁶ the Director-General of Health’s Commission on Competitive and Sustainable Terms and Conditions of Employment for Senior Medical and Dental Officers Employed by District Health Boards (SMO Commission) and a review of the Clinical Training Agency have been running concurrently with the RMO Commission.

We recognise that some of the problems and challenges discussed in our report are shared by senior medical practitioners and other health professionals, but we have focused our thinking on the RMO workforce in order to stay within our terms of reference and have endeavoured to propose practical, manageable solutions.

1.4 This report

Chapter 2 of this report briefly describes some of the characteristics of the RMO workforce. Chapter 3 outlines the RMO Commission’s view on why change is needed. Chapter 4 identifies elements within current systems and structures that need to be

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³ Medical Reference Group, Health Workforce Advisory Committee. 2006. *Fit for Purpose and for Practice: Advice to the Minister of Health on the issues concerning medical workforce in New Zealand.* Wellington: Health Workforce Advisory Committee.


Chapter 5 describes the things that need to change. Chapter 6 outlines the options identified by the RMO Commission, and chapter 7 gives the RMO Commission’s recommendations. Chapter 8 provides some direction as to the next steps in progressing the recommendations outlined in the report.
2 Resident Medical Officer Workforce

2.1 Resident medical officers
The term ‘RMO' covers resident doctors from their last year of undergraduate training until they complete their vocational training. A range of job titles, including trainee intern, intern, junior doctor, house officer, house surgeon, senior house officer/surgeon, registrar and advanced trainee, are used for RMOs at different stages of their training.

The RMO workforce is not a homogenous group. RMOs range in age from early 20s to over 50 and include undergraduate students as well as those with six or more years post-registration experience.

2.2 Workforce profile of resident medical officers
In 2008, Medical Council of New Zealand data recorded 2544 RMOs registered in New Zealand, of whom 68 percent were New Zealand graduates and 32 percent were international medical graduates (IMGs). Almost two-thirds (65 percent) of the RMO workforce in 2008 were registrars with just over a third recorded as house officers.

The RMO population in 2008 was relatively young, with 75 percent aged under 35. Men and women made up 51 percent and 49 percent of the RMO population respectively. However, men were more prominent in senior RMO roles with 54 percent of registrars being male and 56 percent of house officers being female.

In 2008, 40 percent of RMOs identified as New Zealand European, 5 percent as Māori, 3 percent as Pacific, and 51 percent indicated they were of other ethnic backgrounds.

2.3 Changes in workforce profile
In comparison with 10 years earlier, the RMO workforce has increased 24 percent and the proportion of IMGs within that workforce has increased from 28 percent to 32 percent. The balance of the RMO workforce has changed too. In 1998, registrars made up 56 percent of the RMO workforce compared with 65 percent 10 years later.

The RMO workforce was slightly older in 2008 than in 1998 when 81 percent were aged under 35 compared with 75 percent 10 years later.

The representation of women in the RMO workforce has increased from 42 percent in 1998 to 49 percent in 2008, and the proportion of women in registrar roles has increased from 35 percent to 46 percent.

Medical Council of New Zealand ethnicity data was collected differently in 1998 than in 2008, making most comparisons risky. However, we do know that in 1998 Māori made up 3 percent of the RMO workforce compared with 5 percent 10 years later, and Pacific people comprised 2 percent in 1998 and 3 percent in 2008.

More details on the RMO workforce are in Appendix 6. More information on Māori and Pacific medical workforce issues are in Appendices 7 and 8 respectively.
2.4 International medical graduates

New Zealand has the largest proportion of IMGs among OECD countries. The proportion of foreign-born doctors in New Zealand increased by 10 percentage points between 1991 and 2006. At the same time, New Zealand also has high rates of emigration of health workers, mainly to other OECD countries.7

IMGs tend to stay only a short time in New Zealand. A year after initial registration fewer than 50 percent of IMGs remain in New Zealand, dropping to 33 percent in the third year after registration. The reasons so many overseas trained doctors stay only a short time are not fully understood, but could include the fact many had never intended to stay long, engaging in a form of ‘medical tourism’ or they have difficulties getting their qualifications fully recognised.8 Further detail on IMG retention is in Appendix 9.

Evidence suggests increasing international competition for health workers.9 With its heavy reliance on IMGs, New Zealand is particularly vulnerable to any sudden changes in international migration flows. Even should New Zealand continue to be able to attract IMGs, the critical issue is how to retain them, for the failure to retain IMGs in our health system seriously compromises New Zealand’s ability to provide adequate health services into the future.

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8 Ibid.
3 Why Change is Needed

3.1 Status quo cannot continue

New Zealand’s RMO workforce is characterised by dissatisfaction, industrial conflict and fragmented approaches to workforce management and planning. Associated issues, including the shortage of RMOs and the increasing cost of providing RMO cover, are a threat to the ongoing effective management of the public health system. The problems besetting the workforce and flow-on effects to the system are not new, and repeated attempts have been made to solve them. However, despite improvements in some areas, the quality of patient care that New Zealanders expect is getting harder and more expensive to provide as a result of ineffective RMO workforce policies.

We have long relied on the goodwill and professionalism of the health workforce. In the face of endemic workforce shortages, increasing demand, health system restructuring and poorly performing information technology, resident doctors have often put the needs of patients and of the health system before their own. In recent years it is clear that some are reviewing this decision.

The goodwill on which the health service has relied has been eroded. RMOs feel that they are not valued by their employers and have sought solutions through industrial means. Employers, committed to meeting the service needs of their communities, report that providing care in a way that is compliant with the RMO employment agreement and within budget is now almost impossible.

We are not arguing that this is a point of crisis. These are long-standing, complex issues that are becoming increasingly urgent. They must be resolved and there is an opportunity to do that now. The global financial crisis means that all areas of government funding are under a pressure that has been unknown in recent years, and for that reason alone, solutions other than financial ones must be explored. The recommendations in this report may well require money spent on the RMO workforce to be allocated differently. However, the recommendations also include a range of other cultural, structural and management improvements that, in our view, have more power to bring about change than simply applying more money to the problem.

The issues facing the sector vary from centre to centre and from service to service. Solutions will vary, and flexible responses are required to respond to changes to both clinical practice and available technologies and resources.

The issues with the resident doctor workforce are by no means the only problem facing the health system, but they are the problem this commission was asked to address. The status quo is not an option. If we do nothing our public health service will continue to be stressed to the point where services will be unavailable and those who need them will be at risk.

3.2 Coherence and quality of education and training

Following graduation, medical training transitions into the clinical setting with first-year postgraduate doctors (interns) acting under provisional Medical Council of New Zealand registration in a general scope. Postgraduate, clinical medical training is based on an apprenticeship model. This means that most clinical training occurs in district health boards (DHBs) that are the employers of both the trainees and the specialist staff who provide the training. This is a source of some tension for DHBs
whose primary focus and accountabilities are towards service provision within resource limits. Further information on the roles and responsibilities of the key agencies involved in medical education are in Appendix 10.

Feedback to the RMO Commission through consultation meetings and submissions is that the requirements of service delivery frequently take precedence over RMO training. Many RMOs, particularly those in postgraduate year (PGY) 1 and PGY2, are dissatisfied with this situation; not only are they not receiving the teaching to which they are entitled, but they frequently see the clinical and administrative tasks assigned to them as low level and professionally unrewarding. Their frustration is compounded by working in an environment where increasingly sophisticated diagnostic and treatment processes are required for increasingly complex patients, yet RMOs feel they are not learning what they need to know to treat such patients effectively. Instead, they are required to maintain often cumbersome and outdated manual processes around inpatient care.

The frustration with being made responsible for apparently routine administrative tasks is not peculiar to the medical profession. Learning the trade through attending to the nuts and bolts of practice is a legitimate and unavoidable early stage of many careers. The dissatisfaction RMOs express with this may be in part to do with generational expectations but may also be to do with work allocation practices that can see RMOs responsible for completing paperwork on patients they have never met.\(^{10}\) Added to that is the frustration of a technologically sophisticated generation working in environments that frequently have antediluvian information technology systems.

### 3.3 Workplace culture and practice

The RMO Commission received a consistent message from resident doctors that they do not feel valued in the workplace. They report feeling that their employers view them as units of labour to be deployed to cover service need rather than professionals in training, with families and lives outside the workplace.

The lack of simple resources such as common rooms and lockers, minimal provision of support services, inadequate supervision and education, and rostering practices are among the things that lead resident doctors to feel unvalued. The generation of RMOs currently entering the workforce has different life experiences and expectations than those before them. They tend to be older and thus more likely to be establishing homes and families during their RMO years, so require the flexibility that all parents need if they are to stay in the workforce when their children are young. RMOs say that on the rare occasions they need to take sick leave for themselves or their children this is treated as an inconvenience and that little flexibility is offered to help them accommodate the demands of family and children. Evidence suggests that those entering the workforce now and recently see work as just one component of a balanced life that includes family, friends and recreation. However, while pursuing a balanced life they still seek professional challenge, diversity and career progression.\(^{11}\)

Management of RMOs within the workplace is inconsistent. Employment practices such as induction, performance management, support systems and record-keeping are uneven at best and outdated at worst, leading to further frustration.

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Our resident doctors are highly technologically literate and for that reason quickly become impatient with the outdated manual and electronic information systems some are required to use.

There is a serious deficiency in the level of pastoral care for RMOs, especially in PGY2 and PGY3. By this we mean a sense that someone is interested in their career and supporting them as they make their way through the early years of practice. After the years as a medical student and in PGY1 where practice is heavily regulated by the Medical Council of New Zealand, resident doctors enter a time, for many of them the first time in their lives, when they have some room to explore their work environment and career options. This, they tell us, is a mixed blessing. PGY2 and PGY3 bring both a freedom that they value, but also a sense of being regarded as a disposable unit of labour within the system. It is our view that the lack of professional support and mentoring in these years has contributed to the value RMOs place on the support offered by the New Zealand Resident Doctors’ Association (NZRDA).

High-profile industrial issues over recent years have led to the perception of a troubled workforce where doctors are stressed and in conflict with health managers, causing doctors to question their future within such an environment. Rebuilding a trusting, mutually respectful relationship between resident doctors and their employer is, in our view, a priority.

### 3.4 Recruitment and retention

A widespread and well-based concern is that New Zealand does not have enough doctors to meet its health needs now and in the future. In 2006, New Zealand had a doctor–patient ratio of 2.2 doctors for every 1,000 people compared with an OECD average of 3.1. New Zealand’s doctor–patient ratio has been below the OECD average since at least 1980, and from that time the gap has widened.\(^{12}\)

The actual number of RMOs required in New Zealand is difficult to assess. Several submitters to the RMO Commission indicated that the provisions of the RMO multi-employer collective agreement (MECA) distort RMO requirements in ways that overstate the need for RMOs.

Since 2004 the number of funded domestic medical places at New Zealand’s medical schools has been increased twice, by 40 in 2004 and by a further 40 in 2007 to 365. The current government has recently undertaken to boost the number of funded medical student places by 200 students over five years, which will further lift the number of funded domestic places from 365 students a year in 2008 to 565 in 2013.\(^{13}\)

Despite encouraging increases in the number of doctors being trained, it is essential that New Zealand retains as many of the RMOs who graduate here as possible. Table 3.1 shows that of the doctors who graduated from Auckland and Otago medical schools in 2000, almost 80 percent were practising in New Zealand six years later.

Analysis shows that despite these retention rates, New Zealand lost about 100 locally trained doctors from each graduation cohort from 1995 to 2007 within the first nine years after registration (Figure 3.1).

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\(^{13}\) Minister of Health, Hon Tony Ryall, Press release 28 May 2009.
Table 3.1: Retention of registered medical school graduates 1995–2006

<table>
<thead>
<tr>
<th>Final class year</th>
<th>Number registered</th>
<th>Percentage of graduates retained (by final postgraduate year)</th>
</tr>
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Notes:

a ‘Final class year’ is used because the Auckland and Otago medical schools identify graduate year differently.

b ‘Registered’ is defined as those from the class year who have been registered at some time.

c ‘Year’ gives those who held one or more annual practising certificates in the year April to March as a percentage of the graduates from the class year who registered in New Zealand.


However, analysis shows that despite these retention rates, New Zealand lost about 100 locally trained doctors from each graduation cohort 1995–2007 within the first nine years post-registration (Figure 3.1).

Figure 3.1: New Zealand medical graduates retained during postgraduate years, 1995–2007

Source: Data tables provided by the Medical Council of New Zealand, May 2009.

When numbers retained are calculated as a proportion of the previous year’s registered doctors rather than as a proportion of the original cohort, PGY2 and PGY3 emerge as times of increased risk for losing RMOs from the health system (Figure 3.2).
In 2008, 35 percent of students at the University of Auckland School of Medicine identified as Asian.\(^{14}\) Even when foreign fee-paying students are excluded, the proportion of medical students born outside New Zealand exceeds 40 percent.\(^{15}\) It is likely that some of this group, which includes both citizens and permanent residents, may never have intended to practise medicine in New Zealand, casting a different light on retention figures.

Something we do not know is how many of our doctors, apparently lost to the system in the early post-registration years, are simply engaging in the common practice of ‘OE’ (overseas experience) that graduate New Zealanders have pursued for generations, nor do we know how many of them return enriched and up-skilled by their experiences.

At present there is little systematic tracking of New Zealand doctors who travel overseas and this is a lost opportunity. Should this group be identified they could be given assistance to locate career opportunities during their period overseas, and links could be maintained with them that might both encourage their return and ease their re-entry to New Zealand’s medical workforce. The RMO Commission has been made aware of cases where doctors have wanted to return to New Zealand but that difficulties re-establishing registration or limited employment prospects for themselves or their partners have discouraged them from doing so.

New Zealand relies heavily on IMGs to maintain doctor numbers. Medical Council of New Zealand data shows that 40 percent of the practising workforce in 2006 was made up of IMGs,\(^{16}\) and two-thirds of IMGs who come to practise in this country are gone within three years of registering here\(^{17}\) (Appendix 9).

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\(^{15}\) Des Gorman, Dean of University of Auckland School of Medicine, personal communication to the RMO Commission.


Although it seems clear that New Zealand needs more RMOs, the extent of that need is unclear. There are numerous vacancies for RMOs and a widespread view that while some vacancies are based on service need, others are vacancies created by the need to ensure a compliant roster.

3.5 Use and cost of locums

The RMO MECA describes a locum is a casual employee employed to cover an absent RMO for periods of up to one month to be paid as a minimum at the additional duties rate.

New Zealand’s locum workforce is made up of:

- career locums – medics who do choose not to hold a permanent job but to locum often as a way of providing flexibility to accommodate child-rearing or other interests
- moonlighters – permanently employed full-time or part-time employees who supplement earnings by additional locum work when rostered off
- permanent employees on zero hours (Christchurch region) – effectively a relief pool, these doctors have permanent jobs and are deployed where needed.

Locums are a necessary feature of the medical landscape but anecdotal and limited statistical evidence suggests the practice has been increasing rapidly in New Zealand over the past 10 years with momentum still building. The main reasons for this increase appear to be:

- the regulation of working hours and the introduction of safe-staffing formulae have increased the number of doctors required to provide adequate cover
- RMO shortages in the face of increasing health service demand from an ageing population and a primary care sector also under pressure
- locum positions offer higher remuneration and more flexibility (which RMOs who are also parents particularly value) than permanent hospital positions.

Trend data from the Auckland region shows the number of RMO locums used each month by the three Auckland DHBs increased 48 percent, from 125 in January 2006 to 185 in January 2009. The hours worked by each locum RMO showed a 30 percent increase over the same period, from 30 hours a month in January 2006 to 39 hours a month in January 2009. However, the average costs of each temporary RMO increased 188 percent in that time, from $1,350 in the month of January 2006 to $3,900 in the month of January 2009.\(^\text{18}\)

The reliance of DHBs on locum cover arises from the mismatch between supply and demand of RMOs. Being in short supply, and with DHBs committed to maintaining service, RMOs are in a position to command significantly higher payment for locum work than rates paid under the MECA to those in permanent positions. Agencies have sprung up to supply RMOs, and the fees charged by these agencies further inflate the cost to DHBs. Locum rates are known to affect the satisfaction of permanent employees, who perceive locum rates as inequitable and have been the catalyst for permanent employees negotiating locum rates for additional duties.

It is thought that a significant proportion of those providing locum cover are current DHB employees who are on leave or who have completed their regular shift. There is currently no mechanism for recording how many hours a resident doctor covering a

\(^{18}\) Auckland region DHBs data supplied to the RMO Commission, March 2009.
shift as a locum has already completed that day or that week in another position or DHB, which raises safety concerns.

Locums, although they can technically be in training, are generally regarded as having tenuous ties to support, supervision and any training they may nominally be involved in.

A serious potential threat to long-term medical workforce sustainability is posed by the diversion of medical graduates into the locum market. In a time of workforce shortage, locum work, which offers better remuneration and flexibility, appeals to an increasing number of RMOs, diverting them away from vocational training programmes and thereby reducing the number of specialists in the system in the longer term. Further information on locum issues is in Appendix 11.

We believe that while locums will always be needed, the current widespread, costly use of locums is unsustainable, and that having no limit on or monitoring of working hours is unacceptable and potentially dangerous. We recommend that training and employment arrangements be revisited in a way that would enhance permanent positions and reduce the need for and appeal of locum work. To this end we are of the view that locum positions should not be considered part of resident doctor training.
4 What to Retain and Strengthen

4.1 Apprenticeship model

The apprenticeship model of learning, where the balance between learning and patient care gradually shifts as practitioner competence increases, has been the core of training in medicine for hundreds of years. The apprenticeship model is based on the trainee practitioner observing, practising and gradually acquiring ‘the competencies of the senior practitioner through graded supervision and experience. The senior practitioner delegates increasing responsibility and independence to the apprentice, according to the individual’s progress and abilities’. Further information on the apprenticeship model is in Appendix 12.

Apprenticeship teaches more than just technical competence. The guidance of a senior practitioner is vital as RMOs develop skills in approaching the doctor–patient relationship and navigate the ethical issues they encounter. The years between provisional registration and starting vocational training is a time when RMOs particularly benefit from the mentoring and career guidance a senior colleague can provide.

Recently, the shortage of doctors in much of the Western world along with the rapid expansion in biomedical knowledge doctors in training have to absorb, have reduced the time devoted to problem-based learning at the side of an experienced practitioner. A common complaint of doctors in training is that more and more time during RMO years is spent on paperwork and other tasks that do not require medical training, and less time is spent on the activity that develops expertise – diagnosing and treating patients under the supervision of a more expert colleague.

In addition, several factors impact adversely on the availability of senior doctors to teach resident doctors, including:

- an increasing clinical workload, which reduces the time available to teach
- changes to RMO working hours and rosters, which reduce contact (and therefore teaching opportunities) between senior medical officers (SMOs) and RMOs
- an increase in RMO numbers and the associated additional teaching and training workload
- the lack of clearly defined teaching responsibilities and duties in employment contracts.

We believe that the apprenticeship relationship between a doctor in training and a senior specialist or team should be the context for a learning programme that incorporates scheduled and on-the-job teaching, performance review and assessment. The apprenticeship relationship should be of sufficient duration for meaningful assessment of competence to take place. Further, trainee support, mentoring and career navigation should be discussed, agreed and documented between the parties.


For accredited trainees we understand that the apprenticeship model is working more successfully; the challenge is to ensure it is working well for all RMOs not just those in vocational training positions. In part, because of RMO contractual rostering and cover requirements, such as reliever cover and other clauses, PGY1 and PGY2 trainees in particular are not spending enough time working with their teams, and this fractures the daily working relationship with the supervisor. In addition, some relievers and rotating cover RMOs do not have the same opportunities for education and training as those aligned to a particular service, particularly in small services where they do not have their own relievers.

We believe that the training role should be formally assigned to senior doctors and the training component of their role factored into staffing requirements. This should also apply to experienced RMOs filling registrar positions who contribute to the training of more junior doctors. RMOs need to have protected time available for training. We need greater clarity over the structure of the training requirements for those not in college-mandated training positions so that this can be delivered.

The RMO Commission is aware that strengthening the teaching and learning role will have to stand alongside the service delivery functions of DHBs. Innovation in use of resources and service design will be needed to ensure that patient access is maintained or improved. Flexible solutions at each DHB will be a key to strengthening the training environment.

4.2 A single profession

Through a series of industrial negotiations New Zealand has agreed a limit on RMO working hours that are some of the lowest in the world, and working conditions for our resident doctors are widely regarded as favourable. There is some evidence that, while applauding the improvements in resident doctor hours, senior doctors have concerns about aspects of the recent negotiation process and the terms and conditions of the resulting RMO MECA. There is now a significant difference between the senior clinicians’ own experiences as trainees and the experiences of current trainees, in particular in relation to the industrial environment, changing workforce expectations, and the make-up of clinical service demands.

It is of serious concern to any profession when senior and junior members are divided. It is of even greater concern in a profession that relies on an apprenticeship model of training in which residents are expected to receive training, support and mentoring from more senior members of the profession. Divergence in views and any resulting tension has the potential to affect the quality of training, the quality of doctors produced and, ultimately, service delivery to the New Zealand public.

We believe there is a need to strengthen the relationship between resident doctors and their senior colleagues and that the way to do this is by formally supporting the apprenticeship relationship through which knowledge, skills and professional ethics are taught and learned.

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21 The SMO multi-employer collective agreement (MECA) provides guidance on the content of job descriptions for senior doctors including ‘non-clinical and other professional activities’ that ‘should make up at least 30% of the total job size’. Included in the MECA list of non-clinical activities are research; teaching, including preparation time; supervision; and oversight of others (New Zealand District Health Boards, Senior Medical and Dental Officers Collective Agreement, 1 July 2007 until 30 April 2010, section 48.1).

We are also somewhat persuaded by evidence that patient safety is compromised more commonly by doctor handover than by doctor fatigue. This strengthens our view that greater efforts should be made to bring more consistency and continuity to patient treatment through strengthening the apprenticeship relationship.23

4.3 A collective employment agreement

Since the mid-1980s the health sector has gone through a range of reforms, including moving from a professional training and clinical model of resident doctor employment to one reflective of the service delivery and output focus of current health service provision.

A widely held view is that current employment arrangements, rather than clinical or service requirements, drive service delivery and staffing in hospitals. This is not the role of collective agreements.

A strong and effective union presence and the lack of a consistent focus on the needs of RMOs by DHBs over the years have contributed to significant commitments being made to RMOs within collective agreements, particularly around hours of work and ensuring RMO income levels reflect fair market wages in the New Zealand graduate market. Commitments to both these principles is important to the security of RMOs during years when they are regularly changing employers and when employment options are often driven by the clinical experience required to achieve specialisation.

We consider that continuation of a collective employment agreement is vital for the successful retention of RMOs. Developing national industrial arrangements that protect RMOs, support flexible service delivery for patients, and promote strong mentoring relationships between RMOs and clinical teams is an urgent issue.

Collective bargaining and the resulting collective agreement should be designed to meet the changing needs of both the employer and the doctor in work-based training. It should provide a firm foundation of reward and protection, while at the same time providing a platform of good practice upon which innovation and improvement can be built. Achieving an empowering rather than restrictive agreement should be a priority.

Equally, developing remuneration structures that make permanent employment more attractive than locum work and moonlighting has the attraction of releasing funds for both permanent staff remuneration and patient services.

4.4 Role of the medical officer

Medical officers are senior doctors who have undertaken registrar training but are not vocationally qualified. Medical officers may have completed their Part One but not their Part Two examinations, and have discontinued their vocational training either temporarily or permanently. They are regarded as senior doctors and are paid on a special scale that reflects their experience and a wider scope of practice. Medical officers currently come under the SMO MECA.

We are of the view that the role of the medical officer needs to be strengthened to provide a better-recognised career option for resident doctors who choose not to pursue vocational training.

5  What Needs to Change

5.1  Being valued and supported

RMOs enter the profession committed to serving the population; they want to make and be valued for their contribution as doctors. However, the experience of their first few years leaves many of them feeling they are regarded and deployed as glorified clerks who spend the bulk of their time on paperwork and other record-keeping and are required to use outdated information technology systems. Furthermore, adversarial industrial negotiations have created a tension with employers that has eroded goodwill on both sides. Later in their RMO career most will decide on an area of specialist practice and enter a vocational training programme, from which point relationships with senior staff become stronger and RMOs find their careers more rewarding.

Many residents have their own ideas about what they want to achieve in the years after general scope registration and before entering a training programme. They may want to achieve more experience in several disciplines, to establish a broad base for future general practice, to fill gaps identified in their learning, or to do house officer runs in the specialties they are considering for advanced training. Others will undertake diplomas in areas such as paediatrics or obstetrics and gynaecology. Many do not want to commit to a training programme in these years.

We need to find ways of supporting and valuing RMOs early in their career, particularly in PGY2 and PGY3. This is not of itself an argument for earlier entry into a vocational training programme, but rather that the RMO Commission considers that a lack of mentoring, training, support, oversight, professional interest and recognition contributes to RMOs feeling unvalued and, in some cases, leaving the country or leaving the profession.

5.2  Doctors in training

It is our view that RMOs should be treated as an in-training workforce with an operational service component. Strong collaboration is required between all parties involved to ensure an education and training focus that is well co-ordinated and aligned with prior and subsequent training is maintained for this group.

Submissions propose, and the RMO Commission agrees, that retention would be assisted by establishing a culture that reflects the importance of ongoing learning and training. Building a quality teaching environment within DHBs would include dedicated teaching time, adequate teaching and studying facilities, and access to libraries and computers. This would require a review of establishment levels of RMOs nationwide, taking account of training requirements rather than contractual compliance. It is important that the gains in safe working hours negotiated by the New Zealand Resident Doctors’ Association are not lost. However, the situations in which hours are unnecessarily restricted, thereby inflating the number of RMOs who must be employed to staff a compliant roster, must be identified and reduced.
5.3 Employment arrangements

To gain a range of clinical experience, RMOs move frequently between New Zealand's 21 DHBs. Each clinical placement or ‘run’ usually lasts for three months. As each DHB is fully autonomous in this respect, when RMOs change runs they also change employers. For an individual RMO this can mean up to four different employers in a year and requires them to establish not only new relationships with SMO colleagues in each run but also with other medical and nursing personnel, management, human resources, payroll and other branches of administration. In addition to the relationship demands on RMOs and other DHB staff, associated employment costs are incurred each time an RMO changes employer.

Although the terms and conditions of RMO appointment are governed by the MECA, submissions received by the RMO Commission indicate that DHBs apply provisions of the MECA inconsistently, creating additional potential for competition between them. RMOs make up only 5 percent of a DHB’s workforce and DHBs’ primary focus is on service delivery, so there is a risk that the training and employment experience of RMOs can be overlooked. Within the current key performance indicators against which DHBs are required to report, there is no incentive for them to improve their place of work or support for RMOs.

Apart from Auckland Regional RMO Services (ARRMOS), which administers the deployment of RMOs for the three DHBs in the Auckland region, there is no national or regional strategic oversight of RMO employment. This is likely to lead to competition among DHBs to fill runs, less desirable runs being harder to fill, high vacancy rates in some DHBs, the creation of a locum market, and the less than ideal distribution of RMOs across the country.

The burgeoning use of locums, paid rates well above those of permanent employees, is an increasing cost within a limited health budget. The competition between DHBs for the RMO resource in order to maintain service delivery further inflates the cost.

Recent reports of the Medical Training Board and the Clinical Training Agency review group recommend a single body for the training of RMOs. The RMO Commission supports these recommendations and is of the view that enhancing both RMOs’ clinical training experience and reconfiguring their employment arrangements will lead to improved attraction and retention of RMOs, thereby enabling the development of the future medical workforce while DHBs’ service delivery needs are met.

For RMOs to be treated primarily as an in-training workforce requires changes to a system that relies on them as a frontline workforce. Our view is that it is too difficult for 21 separate employers to make those changes and that national leadership and changes to employment arrangements are needed to support the national direction being proposed for medical training.

5.4 Accountabilities

The health system has a number of clear and tightly monitored areas of accountability. DHBs have funding, output and timeliness targets. The New Zealand Public Health and Disability Act 2000 provides a variety of mechanisms for monitoring the delivery of services to the patient as well as for ensuring safety and quality. However, there are no explicit accountability mechanisms for the training and pastoral care of the RMO workforce, and much relies on the professionalism and ethics of SMOs within each workplace. This is a group also under pressure and disenchanted with the value placed on it by the system.
At each level from the Minister of Health to the Ministry of Health, DHBs, services, colleges and professional associations, clear accountabilities for RMO training need to be established, monitored and reported. Defining the nature of these accountabilities falls within the ambit of a new medical education co-ordination body, but is seen as critical by the RMO Commission.

5.5 Workforce planning

Prior to the adoption of a market-oriented approach in the 1990s, New Zealand had centrally co-ordinated health workforce planning. Following the reforms of the 1990s, such planning became less important as market mechanisms were believed to be the most effective determinant of current and future health workforce needs. Previous health workforce planning structures and processes were dismantled. Ten years later it became clear that this was not working well. There were persistent recruitment and retention difficulties, a lack of infrastructure to support health workforce planning and development, and an inadequate information base in almost all areas. Alongside this, a lack of communication and co-operation between stakeholders, including among the 21 DHBs, all pointed to the fact that centralised, effective health workforce planning was once again needed.24

The Health Workforce Advisory Committee was established in 2001 and produced a series of reports addressing health workforce issues before being disestablished in 2006. More recently, the Health Workforce Taskforce was established to take a more action-oriented approach to issues of training, recruitment and the retention of health professionals. DHBs are also involved in health workforce planning and in 2005 DHBNZ produced its Future Workforce strategy. While health workforce policy has been the object of greater attention in New Zealand over the past decade, at the same time the growing number of stakeholders involved in health workforce policy developments has contributed to fragmentation and duplication of activities in health workforce planning.25

Through submissions and consultation meetings, the RMO Commission has been told national leadership of RMO workforce development is needed. We agree.

5.6 Ethos, values and ethics

The RMO Commission gained the impression that medical students graduate with positive and idealistic views of the future. They have a strong sense of their roles in providing service to New Zealand’s population and, to an extent, service to people in need elsewhere in the world. That said, it seems that universities do not convey to medical students a coherent set of public health system values (or private health system values) and that students are exposed to a variety of implicit and explicit role models and values.

The RMO Commission became aware that, following graduation, particularly during the first two or three postgraduate years, RMOs become more cynical and less idealistic about their role in the health system. Through the consultation process we noted that registrars were considerably more positive about their futures and the value of their place in the system than were house officers.


25 Ibid.
RMOs who spoke with the RMO Commission were clear and positive about their ethos of service to individual patients and the ethical frameworks associated with this, but very few could articulate a coherent set of values about the New Zealand public health system. The exceptions were the Māori RMOs who stated a clear commitment to their own communities, which had supported them through their education and training. Junior RMOs expressed little or no sense of loyalty to their DHB employers. This latter issue may be partly addressed by DHBs more explicitly valuing RMOs in a variety of ways, but the broader issue of public health system values and ethos requires leadership and communication from medical schools, chief medical officers, chief executive officers, chairs of boards and so on.

5.7 Human resource practice

The nature of a resident doctor’s on-the-job training produces unique human resource requirements. Over six or more years doctors move between employers in New Zealand and overseas to obtain the clinical knowledge they need to fully qualify in their chosen speciality.

With each employment the full range of human resource tasks is required. Good practice requires personnel records to be created and maintained, induction to be organised, support and mentoring to be put in place, performance management processes and responsibilities to be defined, and exit interviews to be undertaken. Information about the quality and nature of these employment practices is variable. Furthermore, each employer has its own systems, which do not communicate with other employers’ systems, so oversight of resident doctors’ progress and performance is severely hampered.

Some RMOs move between employers quarterly in the early years of their training. Constantly changing human resource practices affect everything from accessing holidays (and correct holiday pay) to building relationships with senior doctors and the broader medical team. These failings are intensified in two circumstances. When a resident doctor undertakes locum duties here or overseas, there are no methods to track the amount or nature of this work, raising question of safety and security for both the doctor and patients. When an RMO leaves New Zealand for further training or travel, there are no formal mechanisms for maintaining contact and encouraging the doctor to return to New Zealand. Having invested hundreds of thousands of dollars in the development of each doctor, there is no national strategy to retain or return them to our workforce. DHBs that have implemented strong recruitment and human resource practices report close to a 100 percent retention or return of RMOs. It may be that over time this will drive improvement in others, but until that happens national health workforce capacity is put at risk.

Variable human resource practice also affects IMGs. Fragmented recruiting, slow and uneven processing of medical registration and a lack of pastoral care can lead to applicants abandoning their intent to work in New Zealand or impose substantial recruitment costs as employment agencies fill the vacuum created by a lack of effective systems.

It is our view that achieving a consistent, high standard of human resource practice across more than 20 employers in way that will ensure resident doctors are engaged, supported, trained and managed effectively is not feasible. We think employment arrangements need to be revisited in order to provide the resident doctors with the consistent, high standard of human resource practice to which they are entitled.
5.8 Exploring private health system training capacity

The New Zealand health care system is predominantly publicly financed with private health insurance payments and individuals accounting for around 20 percent of national health expenditure.\(^{26}\) Regardless of the predominance of publicly funded health care, there are numerous interdependencies between the public and private health sectors, the most critical of which is the medical workforce. Many specialists work in both sectors, and there is competition between public and private providers for this workforce. Further information on the public–private training interface is in Appendix 13.

Teaching and training are, and have always been, key functions of the public health sector. The opportunity to be involved in teaching has traditionally been regarded as one of the main attractions of work in the public sector for medical specialists.

The worldwide demand for doctors is seeing significant growth in the numbers of medical students. In the near future, this growth will flow through to increased training demands on hospitals, general practices and medical specialists. Australia has already begun grappling with this issue and significant, recent increases in the numbers of doctors being trained in Australia may well reduce the opportunities for New Zealand resident doctors to take up places in Australian training programmes.\(^{27}\)

There have been recent, encouraging increases in general practice training opportunities and more are needed. The Clinical Training Agency funds 104 general practitioner registrar training places, and the Government has made a commitment to increase general practitioner registrar training places to 154. This increase in numbers has begun, and is designed as a short-term measure to address New Zealand’s general practitioner workforce shortage.\(^{28}\)

Beyond general practice, private sector training opportunities are likely to be in non-urgent surgery where patients frequently lack the complexity of health problems of many of the patients treated in public hospitals. It will be important to ensure that resident doctors taking up private sector training opportunities are exposed to complexity as well as to surgical expertise.

There are many challenges in exploring private sector training capacity. Many SMOs working in the private system also work in the public sector, and increasing their training role in the private sector may be at the expense of the same role in the public sector.\(^{29}\) Funding the training of RMOs in the private sector may create resentment among SMOs in the public system who currently train resident doctors as part of their role. Further, in expanding publicly funded training opportunities in the private sector thought would need to be given to how a public service ethos would be maintained.


\(^{28}\) Tony Ryall, Minister of Health, 30 March 2009.

The RMO Commission accepts that these are not easy matters to get right. We acknowledge the work that is already under way in this area and offer our encouragement and support to those doing it.

5.9 Data collection and analysis

The RMO Commission’s efforts to understand the issues facing the resident doctor workforce and to make recommendations have been hampered by a lack of high-quality, aggregate and individual quantitative data. The Ministry of Health, the Medical Council of New Zealand and DHBs were all approached and responded to the RMO Commission’s requests for data on the RMO workforce and related issues. However, we are left with unanswered questions about patterns of RMO employment both here and overseas, the hours residents work in their permanent and locum positions, and about why doctors leave, how long they are away and why some return to our health workforce.

Each of the bodies mentioned above collects and analyses data to meet its own needs. Without clear responsibility for the RMO workforce or accountability for workforce planning and management, no agency is focused on collecting and analysing data with which to better understand and make decisions that will improve RMO training, employment and retention.

The RMO Commission’s view is that national leadership and accountability for RMO workforce planning and development is needed, which would include the collection and analysis of comprehensive and reliable data on the resident doctor workforce.

5.10 Incentives

The issue of RMO remuneration has not been easy for the RMO Commission to assess. Salary was not often raised as an issue by those doctors with whom we spoke, but the length and bitterness of recent industrial campaigns seem to indicate it is a relevant matter.

The entry-level salary for RMOs appears to align with that of other globally mobile professionals when they join the labour market. However, the MECA allows room for interpretation in the setting of rates, and the prevalence of additional allowances and locum work makes actual remuneration unclear. There are different views on the size of wage movement that RMOs sought in recent negotiations but figures ranging from 15 percent to 40 percent have been quoted.

Australia, although different states take somewhat different approaches, generally calculates resident doctors’ pay on the basis of a standard ordinary time and overtime regime rather than by payment of a salary as in New Zealand.

Addressing the remuneration structure has become more difficult as the number of RMOs has increased. Any significant pay movement for this group of employees would have implications for SMOs and other health professionals. However, modest additional investment to purchase the flexibility required by DHBs may be justified if significant productivity gains can be achieved.
The length of medical training and the mobility of the workforce have placed doctors in the forefront of debate over student loans. The RMO Commission expected that student loans would figure prominently in discussion with RMOs and submissions, but this was not the case. Changes to the student loan scheme, the recent introduction of a bonding scheme for difficult-to-staff areas and the availability of more highly paid locum opportunities may account for the cooling of the issue.

However, some people argued eloquently that the introduction of loans and high levels of student debt contributed to a breakdown in the social contract between RMOs and the country. Incurring such a financial debt during the course of their education in some way lessened the emotional debt or commitment and increased the focus on future income. A submission from medical students showed that the student loan issue has not gone away and they see risks that levels of debt incurred will exclude some students from pursuing medicine as a career. However, it is our view that focusing on how better to value RMOS and ensuring they have a fair disposable income may be the best response.
6 Options for Change

6.1 What any changes must address

RMOs receive much of their training in clinical settings. Too often resident doctors’ contribution to service delivery takes precedence over their training. While the two elements both form essential parts of the resident doctor experience, the focus on RMOs as doctors in training must be restored.

The apprenticeship model is not working as it should. It is being adversely affected by increasing clinical workload reducing the time available to teach, by changes to RMO working hours, which reduce contact between RMOs and SMOs, and by an increase in RMO numbers with a concomitant increase in the teaching and training workload.

Resident doctors feel undervalued in their workplaces and there is evidence that their relationship with employers is fragile. Rebuilding a trusting, mutually respectful relationship between resident doctors and their employers is a priority. Ways of supporting and valuing RMOs early in their career, particularly in PGY2 and PGY3, must be found.

DHB representatives conveyed a sense of desperation to the RMO Commission. They reported huge frustration with being unable to meet their commitments to patients, to resident doctors and to budgets under the current arrangements. While locums will always be needed, the increasingly widespread, increasingly costly use of locums is unsustainable. Permanent employment must be enhanced and moonlighting made less attractive.

National leadership of workforce development is needed. No group carries the responsibility for planning and developing the RMO workforce. One result of the lack of such leadership is an absence of comprehensive and reliable data on that workforce on which decisions and strategies for the future can be based.

Employment practices are highly variable. This creates a risk to the engagement, support, training, management and retention of resident doctors.

6.2 Options

The options the RMO Commission has identified have been developed in cognisance of other, recent work. The RMO Commission endorses the recommendations of the Medical Training Board and Clinical Training Agency review group for a single agency with the capacity to co-ordinate medical education and training across the entire continuum of learning. We believe this is essential if training is to be restored as the driving force of the resident doctor experience.

The options the RMO Commission developed are based on the understanding that the RMO training experience and career path will be overseen by the new national training body, which will take RMO preferences, the country’s health needs, and professional requirements into account. For this reason, the options the RMO Commission considered focus on the employment arrangements of RMOs.
The four options we considered are as follows.
1. The status quo – employment to remain with DHBs – with modifications.
2. A regional employment model.
3. A stand-alone, national body to employ RMOs.
4. A national body with oversight of medical education to employ RMOs.

**Option 1: Status quo with modifications**
Option 1 requires the least change of all the options.

Modifications to the status quo that might address some of the issues the RMO Commission identified include:
- a new and better-articulated vision of the future of the health sector, so the public and the sector are more aware of what is needed to achieve the nation’s health goals
- better RMO management
- more deliberate strategies to manage the RMO–SMO relationship
- renegotiating the collective employment agreement to refocus it on pay and conditions, and greater central involvement in the industrial relations process
- more explicit requirements in contracts between the Crown and DHBs in respect of the employment and training of doctors
- additional incentives to support RMO retention or return
- the regulation of the hours an RMO can work.

**Option 2: Regional employment model**
Option 2 could be a further development of the collaboration between DHBs on RMO employment matters that is already in evidence in some regions of the country.

- Regional employers would employ all RMOs working at DHBs in their region, including casual locums. DHBs would not separately employ or contract RMOs.
- Regional employers would hold all the legal responsibilities and obligations of the employer.
- Regional employers and the DHBs in that region would collaborate over RMO employment and management issues. DHBs would still carry responsibility for RMOs in their workplace.
- Operating principles, business rules and delegated authorities for the regional RMO employers and the DHBs would be agreed and formally defined.
- Regional employers would operate regional human resource systems, including payroll.
Option 3: Stand-alone, national body to employ resident medical officers

Option 3 establishes a new national body to employ RMOs.

- A national employer would employ all RMOs. DHBs would not separately employ or contract RMOs.
- A national employer would hold all the legal responsibilities and obligations of the employer.
- Regional or local RMO units would be RMOs’ point of contact for day-to-day human resource issues.
- The national employer and the DHBs would collaborate over RMO employment and management issues. DHBs would still carry responsibility for RMOs in their workplace.
- Operating principles, business rules and delegated authorities for the national employer and the DHBs would be agreed and formally defined.
- A national employer would operate a single human resource system, including payroll.

Option 4: National body with oversight of medical education to employ RMOs

Option 4 sets up a body to co-ordinate medical education and training and also employ RMOs. This body would operate under the terms outlined in Option 3.

Importance of appropriate design

The RMO Commission is aware that the success of any new arrangement will be contingent on the design of the arrangement, and any such design needs to be carefully considered. Options 2, 3 and 4 would all require legislative change, and separate advice will be provided to the Director-General of Health on this matter.
7 The Commission’s View

7.1 Opportunity for change

The issues with the resident doctor workforce are long-standing, complex issues that are becoming increasingly urgent. They must be resolved and there is an opportunity to do that now. As a result of the global financial crisis all areas of government funding are under pressure and recommendations must be mindful of this.

A number of boards, commissions and review groups are currently or have recently investigated aspects of medical workforce employment and training in order to make recommendations for improvement. The Medical Training Board, the Clinical Training Agency review group, the SMO Commission, and the Ministerial Review Group as well as this commission are all providing advice to the Government. We believe, after discussion with these other groups, that the alignment of views and congruence of advice creates a unique opportunity for change.

7.2 Conclusions

Our view is that resident doctors’ engagement in education and training needs to determine their role in the workplace rather than the reverse. Strong collaboration is required between all parties involved with RMOs to ensure an education and training focus that is well co-ordinated and aligned with prior and subsequent training is maintained for this group.

We think the training role should be formally assigned to senior doctors and registrars and the training component of their role factored into staffing requirements. RMOs need to have protected time available for training. There needs to be greater clarity over the structure of the training requirements for those not in college-mandated training positions so that this can be delivered. We believe that any service gaps that may emerge as RMOs are refocused on training will create an opportunity for innovation.

We have identified a complexity of issues which that cannot be solved by structural changes alone. However, it is our view that structural change is most likely to deliver a solution, and for that reason we think employment arrangements need to be revisited. In our view it is unrealistic to expect the changes needed to RMO employment to be made by all 21 DHBs within a reasonable timeframe – or perhaps ever. While a regional employment structure would reduce competition between employers it would not eliminate it; multiple human resource systems would remain.

For these reasons we support option 3 – a stand-alone body responsible for the employment of RMOs. We recommend a single national employer and a national collective employment agreement that governs pay, terms and conditions for resident doctors. Developing national employment arrangements that support flexible and innovative service delivery for patients and strong mentoring relationships between RMOs and clinical teams is an urgent issue.

We recognise that the sector is already fragmented and clear justification for recommending an additional body is needed, but we are of the view that providing oversight and setting standards for medical education and training and good employment practice require different skills that cannot be done to a high level by one body.
Basic human resource practice is a well-defined technical skill set that needs to be done properly. By contrast, the oversight of education and training requires a high level of sophistication and engagement with a range of stakeholders, including universities, colleges, the Medical Training Board and others. The complex task of improving training means an organisation charged with that responsibility will need to be headed by those with expertise in this area, creating a risk that the essential work required to be a good employer may take lower priority.

Furthermore, the changes to employment arrangements and human resource practices are pressing. The improvements needed to the training and education framework and delivery will take some time to achieve, and by linking the two functions in one agency there is a risk that employment matters will not be addressed with the required urgency. Good clinical training and experience will attract and retain RMOs but this is a medium- to long-term initiative that will take several years to realise its full benefits.

It will be crucial that a national training agency and a national employer remain in close alignment for which reason the RMO Commission is attracted to the idea of a common governance body.

We believe that a national employer for RMOs alongside a national training body is the best way to ensure that training drives resident doctors’ experience. However, should this not be an option the Director-General of Health wishes to consider, there are things, outlined in option 1 (in chapter 6) that could be done within existing structures to improve the RMO experience and the contribution of the RMO workforce to the quality and safety of the health system.

### 7.3 Recommendations

The RMO Commission recommends that:

1. **The status quo is rejected and immediate steps are taken to effect essential changes following best practice principles in change management.**

2. **A New Zealand health system ethos is developed and articulated that outlines the rights, responsibilities and privileges of those working within the system.**

3. **Leadership of and accountability for RMO training is assigned.** The RMO Commission supports the directions of the Medical Training Board and the Clinical Training Agency review group for a new national training body. We recommend such a training body:
   - takes responsibility for health workforce planning in response to service configuration and models of care and, in turn, to national, regional and district service plans
   - ensures training time is protected in RMO job descriptions
   - increases RMO training opportunities in the primary health care sector
   - ensures locum positions do not count towards training requirements.

4. **A stand-alone national employer for RMOs is established, supported by regional or local RMO units.** We recommend such an employer:
   - ensures a national review of RMO numbers
   - collects robust data to ensure RMOs can be tracked through their careers
   - increases emphasis on pastoral care and career planning.

5. **A new national collective employment agreement focused on pay and conditions is negotiated.** The negotiation process should take account of financial incentives.
DHBs are held formally accountable for training of RMOs and for ensuring protected time for SMOs to do the training.
8  Next Steps

8.1  Implementation group
Subject to the acceptance of the recommendations of this report, we suggest a group is
established to expedite the implementation of the recommendations.

8.2  Implementation tasks
The early tasks of an implementation group would include:

- a stocktake of RMO workforce activity, including the identification of groups actively
  involved in workforce planning and review of existing contracts and conditions of
  service
- establishing a framework for the management of change, which would include:
  – establishing objectives
  – developing strategies
  – formulating a transition plan
  – preparing an announcement.

The implementation group would need to be alert to any unanticipated consequences
of the recommendations of this report, and, where they have been identified and where
management is required, propose how such consequences could be managed.

8.3  Implementation timetable
The transition plan should be prepared by 31 August 2009.
Appendix 1: Terms of Reference for the Commission on the Resident Medical Officer Workforce

Director-General of Health’s Commission on the Resident Medical Officer (RMO) Workforce

Preamble
The Director-General of Health, with the endorsement of the Minister of Health, will establish a Director-General’s Commission on the Resident Medical Officer (RMO) workforce (the Commission). The focus of the Commission is on the RMO workforce in the context of meeting New Zealand’s future medical workforce needs.

The Commission acknowledges the need for comprehensive and appropriate training and support for the RMO workforce to ensure a relevant and valuable learning experience.

In establishing the Commission, it is also acknowledged:
- that the RMO workforce makes a significant contribution to meeting the current and future service delivery needs of the New Zealand health system
- that the RMO workforce is a critical source of recruitment to the overall medical workforce, that includes Senior Medical Officers (SMOs) employed by district health boards, and general practitioners
- that the role of RMOs in the public health sector comprises a mix of training and service provision
- that the current RMO workforce context reflects complex supply and demand dynamics.

In establishing the Commission, the Director-General of Health specifically acknowledges the appropriate roles of the District Health Boards, the New Zealand Resident Doctors’ Association, and Resident Medical Officers, in negotiating terms and conditions of employment for RMOs.

The Commission is separate from and not part of the current collective agreement negotiations between the New Zealand Resident Doctors’ Association and the District Health Boards.

Purpose
The Commission will investigate and make recommendations to the Director-General of Health on:
- the medical workforce needed to deliver services to meet the New Zealand population’s health needs, in the context of changes in these needs, as well as changing models of service delivery
- where the role of RMOs sits within the required medical workforce, how this aligns with the current RMO role, and whether there are aspects of the current role, including RMO deployment, that act as enablers of, or barriers to, ensuring a medical workforce that can deliver services to meet New Zealanders’ health needs now and into the future
whether there are RMO workforce supply and demand influences that act as enablers of, or as barriers to, ensuring a medical workforce that can deliver services to meet New Zealanders' health needs now and into the future

the changes, if any, which may be necessary to support the identified enablers or counter the identified barriers, and how these changes could be implemented.

The Commission’s recommendations should be based on robust evidence and analysis, and should be sustainable.

The Commission’s recommendations will not be binding on any party.

Scope

The Commission will engage broadly within the public health sector. This will include engagement with the appropriate medical training bodies, including the Medical Training Board and the specialist medical colleges, and other relevant professional organisations. It will also seek to engage with members of the SMO and RMO workforces, their representatives, and the District Health Boards.

In its deliberations, and in coming to its recommendations, the Commission will:

- make use of existing research into the nature and role(s) of New Zealand’s medical workforce, including the report of the Doctor-in-Training Roundtable (established by the then Minister of Health, Hon Annette King) and the reports of the Health Workforce Advisory Committee
- take into account the Government’s priorities and health targets
- have regard to, but not necessarily be bound by, other national conversations and work programmes including the current work of the Medical Training Board
- identify and examine other factors that it considers relevant.

The Commission may also conduct its own research, although it is not the intention of the Commission to duplicate existing or current work.

Deliverables

The Commission will provide a final report to the Minister of Health, outlining its recommendations. This report will be due by Monday, 6 April 2009.

The Commission's final report will be made publicly available for interested parties to consider.
Appendix 2: Commission Members’ Biographies

Biographies of the four members of the Director-General’s Commission on the Resident Medical Officer Workforce are as follows.

**Don Hunn (chair)**

Don Hunn was State Services Commissioner from 1987 to 1997. Since 1997 he has been consulting in public sector management in New Zealand and overseas, including projects in South Australia, Tonga and Niue as well as New Zealand. Don’s government appointments include chair of NZ on Air and the National Advisory Panel, Department of Building and Housing. Don’s non-government organisation involvement includes the IHC Board, Royal New Zealand Ballet Board, St Johns (chair of the Otaki Committee) and the Kapiti Coast Recreational Turf Trust (chair). He also farms at Te Horo.

**Angela Foulkes – consultant**

Angela Foulkes is a former Secretary of the New Zealand Council of Trade Unions. She has extensive governance experience, having served on a variety of advisory boards and commissions over the past 15 years, and is currently consulting for her own company. Angela is a member of the Remuneration Authority Board, New Zealand Qualifications Authority Board, New Zealand Fire Service Commission, and Crown Forestry Rental Trust.

**Professor Peter Crampton**

Professor Peter Crampton is Dean and Head of Campus, University of Otago, Wellington. Peter has a background in public health medicine and general practice. His research is focused in two broad areas: social indicators and social epidemiology; and health services research, particularly related to primary health care funding and organisation. He has strong links with a variety of public health and primary health care organisations. Peter has taught undergraduate and postgraduate courses related to public health and health systems, and has an interest in undergraduate medical curriculum development.

**Professor Des Gorman**

Professor Des Gorman, who is of Ngāpuhi descent, is Head of the School of Medicine at the University of Auckland’s Faculty of Medical and Health Sciences. Des was a professional chair in medicine at the University of Auckland from 2000 and Head of the occupational medicine department from 1995. He was also Director of Medical Services for the Royal New Zealand Navy from 1989 to 1995. Des is a member of the Liggins Institute and has been a director of admissions for medical programmes since 2003. Des has had over 200 academic papers published internationally and has presented at numerous international conferences in his specialist field of diving and hyperbaric medicine.
Appendix 3: People and Organisations Consulted

Auckland District Health Board (DHB) – chair, chief executive, senior managers, clinicians and resident medical officers (RMOs)
Auckland Regional RMO Services (ARRMOS)
Bay of Plenty DHB – chief executive, senior managers, clinicians and RMOs
Buddle Findlay
Canterbury DHB – chair, chief executive, senior managers, clinicians and RMOs
Capital & Coast DHB – chief executive, senior managers, clinicians and RMOs
Clinical Training Agency – Tony Gibling
College of Physicians – Geoff Robinson
Counts Manukau DHB – chief executive, senior managers, clinicians and RMOs
Crown Law
District Health Board Chairs of Governance meeting
District Health Boards New Zealand – Employment relations and workforce
Hawke’s Bay DHB – senior managers, clinicians and RMOs
Health and Disability Commissioner, Ron Paterson
Hutt Valley DHB – chair, chief executive, COO, senior clinicians
Medical Council of New Zealand
Ministry of Health – Anthony Hill (Deputy Director-General Sector Accountability and Funding) and Deborah Roche (Deputy Director-General Health and Disability Systems Strategy)
Ministry of Health – Strategic Policy, Sector Employment Relations, Workforce and Maori Health units
Nelson-Marlborough DHB – chair, senior managers, clinicians and RMOs
New Zealand Medical Association – Doctors in Training Council
New Zealand Medical Students Association
New Zealand Resident Doctors’ Association
Northland DHB – chair, chief executive, senior managers, clinicians and RMOs
Otago DHB – chair, chief executive, senior managers, clinicians and RMOs
Otago Medical School – Dean
Professor Lou Landau, Chair of Confederation of Post-Graduate Medical Education Councils, Australia, and Chair of Western Australian Post-Graduate Medical Education Council
Royal Australasian College of Surgeons
Southland DHB – chief executive, senior managers, clinicians and RMOs
Tairawhiti DHB – chair, chief executive, senior managers, clinicians and RMOs
Taranaki DHB – chair, senior managers, clinicians and RMOs
Waikato DHB – chair, chief executive, senior managers, clinicians and RMOs
Waitemata DHB – senior managers, clinicians and RMOs
West Coast DHB – senior managers
Whanganui DHB – chair, chief executive, senior managers, clinicians and RMOs
Appendix 4: Commission on the Resident Medical Officer Workforce: Submissions Summary

This appendix contains a paper prepared by the secretariat for the Director-General of Health's Commission on the Resident Medical Officer Workforce (RMO Commission). The paper summarises the submissions to the RMO Commission.

Executive summary

The Resident Medical Officer Workforce Commission was established by the Director-General of Health in October 2008 to investigate the issues facing the junior doctor workforce and to make recommendations on the medical workforce needed now and in the future.

As part of its investigation of the issues, the Commission sought written submissions from interested parties. Submitters were invited to provide any information they thought would assist the Commission in its deliberations. Nineteen written submissions were received, of which 17 were from organisations.

Submitters voiced pride in New Zealand’s medical workforce and expressed concern about the issues seen to be undermining its stability and quality. They observed that previous attempts to address the issues have not been successful and many conveyed a sense that some problems have become urgent and resolution is critical.

Submissions contained a range of themes and issues, which can be grouped broadly into four areas.

Recruitment and retention

Almost all the submissions noted that recruitment and retention are major issues, with the number of medical students now being trained insufficient to meet current and projected demand.

Several submitters asserted that Resident Medical Officers (RMOs) do not feel valued and this, above anything else, makes it hard to retain them in New Zealand’s medical workforce. They said that as well as addressing workplace issues, retention would be assisted by establishing a culture that reflects the importance of training.

Rebuilding a trusting and reciprocal relationship between RMOs and District Health Boards (DHBs) was seen as being a priority, as was improving the relationship between RMOs and Senior Medical Officers (SMOs).

The lack of a career pathway for RMOs in Post Graduate Year (PGY) 2 and PGY3 places them at particular risk of becoming disenfranchised, disenchanted or even lost to the medical workforce.

A voluntary incentive-based debt relief package was proposed by several submitters. Such a scheme, they said, could encourage junior doctors to stay in New Zealand thus increasing the likelihood that they will pursue vocational training here.
The relationship between service delivery, education and training

There was a clear view that DHBs focus on service delivery to the detriment of RMOs’ training. DHBs themselves suggested that the relative priority of training and the service components of the RMO role need to be clarified.

Submissions generally supported maintaining the apprenticeship model, even though it is under pressure and the pedagogical relationship has been undermined by the change towards an industrial workplace model.

The lack of clear education and training pathways through PGY1 and PGY2 was an issue raised in several submissions.

Employment contracts and collective bargaining

While strong collective bargaining has achieved many gains for the RMO workforce, submissions clearly indicated that this has come at a price with the adversarial relationship between DHBs and the Resident Doctors Association (RDA) a major contributor to a workplace environment that results in RMOs feeling undervalued. The RMO Multi Employer Collective Agreement (MECA) was seen as a cumbersome, inflexible and costly agreement that is inconsistently applied.

In order to meet the provisions of the MECA for a 55 hour working week, DHBs are increasingly dependent on a locum workforce, which is commonly paid substantially above MECA rates. The cost of locums was viewed as excessive and unsustainable. Competition between DHBs for RMOs makes it difficult for DHBs to take and maintain a collaborative stance on locum employment.

Submissions raised the question as to whether some employment processes for RMOs could be rationalised to a central source. This could range from career management and its associated components to a single employer, particularly for those in training.

Workforce planning, stakeholder alignment and sector leadership

Several submissions addressed the need for better workforce planning, noting that although there have been several attempts at workforce planning, none yet have provided the necessary platform for workforce development.

Submitters observed that relationships between all parties need to be improved and alignment strengthened if the problems facing the RMO workforce are to be resolved. Submitters wrote of the different agendas and priorities of stakeholders, including RMOs, SMOs, RMO and SMO representative organisations, employers and their representative organisations, colleges, universities and the Medical Council of New Zealand (the Medical Council).

Virtually all submissions discussed the need for leadership in resolving the issues surrounding the RMO workforce. However, there was little detail or consensus about the type of leadership required.

1 Introduction

In October 2008 the Director-General of Health established his Commission on the Resident Medical Officer Workforce (the RMO Commission). The RMO Commission is to investigate issues facing the junior doctor workforce and make recommendations on the medical workforce needed to deliver services now and into the future.
In particular, the Commission will make recommendations to the Director-General of Health on:

- the medical workforce needed to deliver services to meet the New Zealand population’s health needs, in the context of changes in those needs as well as changing models of service delivery
- where the role of RMOs sits within the required medical workforce, how this aligns with the current RMO role, and whether there are aspects of the current role, including RMO deployment, that act as enablers of, or barriers to, ensuring a medical workforce that can deliver services to meet New Zealanders’ health needs now and into the future
- whether there are RMO workforce supply and demand influences that act as enablers for, or barriers to, ensuring a medical workforce that can deliver services to meet New Zealanders’ health needs now and into the future
- the changes, if any, that may be necessary to support the identified enablers or counter the identified barriers and how these changes could be implemented.

The Commission invited written submissions. Submitters were free to provide any information they thought would assist the Commission in its deliberations. A list of indicative questions was also provided for the guidance of those who wanted it. Written submissions were in addition to consultation meetings held by Commission members around the country with interested stakeholders. The closing date for submissions was 30 January 2009, although late submissions were also considered.

By 20 April 2009, 19 written submissions had been received of which 17 were from organisations and two from individuals. A list of submitters is included as Appendix 2.

2 The need for change

Submissions addressed a wide range of problems with the recruitment, retention, training, support, deployment and working conditions of RMOs. They described the impact of the problems on the career development, satisfaction and commitment of RMOs as well as the effects on the wider system, including the cost to professional relationships and service delivery. While submissions individually addressed aspects of the problem, taken together they described a system in which quality is compromised and costs are rapidly escalating, and where change is urgently needed.

3 Recruitment and retention

3.1 Recruitment

Almost all the submissions noted that recruitment and retention are major issues with the number of medical students now being trained insufficient to meet current and projected demand. Although virtually all DHBs and all specialties struggle to maintain RMO numbers, some are particularly severely affected with the shortage of RMOs getting worse as the year progresses. There is a view that the provisions and/or applications of the MECA have exacerbated this situation by limiting job sizes in such a way that additional positions – then hard to fill – have had to be created.

There is general agreement that Māori and Pacific people are under-represented in the RMO workforce. However, few suggestions (scholarships and affirmative action) were made of ways to address this issue, with a number of submitters commenting that the reasons for, and solutions to, this under-representation lie much earlier in the education system.
Several submissions expressed concern that the country is not training enough vocationally registered primary care practitioners to meet current or anticipated demand. The shortage of primary care training was seen as the reason, with the solution being to resource more primary care training places.

One submission suggested that present Medical Council, recruitment and employment processes do not support New Zealand’s known reliance on imported doctors, adding to the supply problem.

3.2 Retention

The working environment

Several submitters asserted that RMOs do not feel valued and this, more than anything else, makes it hard to retain them in New Zealand’s medical workforce.

‘The first goal should be to fill the gaps by improving retention. The key to this is by making RMOs at house officer level feel valued and able to see themselves as part of the solution.’

The lack of simple resources, such as common rooms and lockers, and minimal provision of support services and adequate supervision are a few examples of poor working environments. Rostering practices are mentioned as a source of tension for RMOs. Submitters said that RMOs at times defer taking leave, reluctant to exacerbate the pressures of understaffing.

As well as addressing workplace issues, submissions proposed that retention would be helped by establishing a culture that reflects the importance of training. A quality teaching environment within DHBs would include dedicated teaching time, adequate teaching and studying facilities, access to libraries and computers. While New Zealand salaries may never equal those in Australia, submitters suggested that ensuring training is of high quality may in some measure compensate for the difference.

Submitters also suggested that high profile industrial issues over recent years may have led RMOs to the perception of a troubled workforce where doctors are stressed and in conflict with health managers, causing them to question their future within such an environment. Rebuilding a trusting and reciprocal relationship between RMOs and DHB was seen as being a priority. A related issue identified is the relationship between RMOs and SMOs, which has been somewhat eroded through rostering arrangements and other pressures. Mentoring and support from SMOs, which may enhance the job satisfaction of RMOs, is no longer as available as in the past and needs to be recovered.

Addressing RMOs’ desire for flexibility and work life balance was suggested as another aid to retention, as was reversing the trend towards an increasing administrative load and a decreasing clinical load.

The career pathway

Submissions noted that the lack of a career pathway for RMOs in PGY2 and PGY3 places them at particular risk of becoming disenfranchised, disenchanted or even lost to the medical workforce.

Ideas for developing the career pathway for RMOs in PGY2 and PGY3 include: the colleges establishing some pre-training programme standards for RMOs; using these
years as an opportunity to provide all doctors in training with a general practice run; the inclusion of competency based assessment; and including more clinically challenging/interesting practice.

‘Selection of career is crucial to later workforce. Specialties need to be able to support and nurture those students and house surgeons who show an interest in their specialty. We are not supportive of early specialty training. However, there needs to be some connection between the service arrangements and the later career interests.’

Submissions also suggested that there may also be potential for new medical roles through assessing service models and working with clinical leaders and the profession generally to identify the training and career development needs of those doctors who do not want to pursue vocational training.

Remuneration and incentives

Submissions had relatively little to say on RMO remuneration, aside from a number of comments about pay relativity with Australia.

A voluntary incentive-based debt relief package was proposed by several submitters. Such a scheme, they said, could encourage junior doctors to stay in New Zealand in order to reduce their debt, thus increasing the likelihood that such doctors would pursue vocational training within New Zealand and settle here.

A further suggestion was to have the discrepancy between standard rates and locum rates reduced. Doing this would remove the incentive to become a ‘permanent’ locum.

A few submitters suggested that retention be made part of DHB performance indicators.

4 The relationship between service delivery, education and training

4.1 The relationship between service delivery, education and training

There was a clear view that DHBs focus on service delivery to the detriment of RMOs’ training. DHBs themselves suggested that the relative priority of training and service components of the RMO role need to be clarified. Several submissions suggested that RMO training should feature in the KPIs of DHBs, and some added that they should be adequately resourced to support this.

‘The current reliance on doctors in training to provide service has often been at the expense of training, and we believe that this needs to be corrected. The introduction of protected time for formal teaching sessions and assessments, alongside the inclusion of medical training as part of DHBs’ KPIs would go some way to creating a solution.’

The apprenticeship model, in which RMOs learn from those further advanced in their training and teach those following them, was identified as an area in which the tensions between service delivery and education and training become particularly apparent. Submissions generally supported maintaining the apprenticeship model even though it is under pressure and the pedagogical relationship has been undermined by the change towards an industrial workplace model through which RMOs become commodities to fill rosters. Three month rotations were considered less than optimal, and at times counterproductive, as they make it more likely that poor performance will
not be addressed in the knowledge that it will be only a few weeks until an underperforming RMO moves on.

It was proposed that in order for the apprenticeship model to work, teaching must be seen as a legitimate part of the role of house surgeons and registrars, and senior clinicians need to be encouraged to take a greater role in teaching. Submitters who addressed this issue had a range of suggestions, which included:

- the introduction of protected time for formal teaching sessions and assessments
- making training responsibilities explicit in employment contracts
- accrediting SMOs who provide training support
- changing requirements for practice certification renewal
- providing academic fellowships to enable RMOs to take time in their training for research
- placing a salary premium on higher academic qualifications.

4.2 Education and training issues

There was a desire to see the priority of RMO education and training restored.

‘... the junior doctor years should encompass some of the most important progressions in clinical knowledge and skill in any doctor’s career. It is essential that the training provided and the learning experiences encountered are of the highest quality. They need to inspire and drive RMOs, fuelling their passion for medicine and ensuring that they strive to provide best practice. With a little more passion, in a supportive clinical environment, should come a greater dedication to the workforce.’

The lack of clear education and training pathways through PGY1 and PGY2 was an issue raised in several submissions. Some submitters favoured colleges establishing pre-training programme standards for PGY1 and PGY2, which would provide more focus and structure for RMOs at this point in their careers. A smaller number considered PGY1 and PGY2 to be an essential opportunity to experience a range of medical settings before committing to a vocational path. Others believed that DHBs and universities should collaborate to provide a seamless learning experience from graduation through PGY1 and PGY2.

‘There is generally a lack of structure in the ongoing training and education offered to this group, who are often seen simply as providing 'service' within the hospital with no real commitment from the hospital to further their education. Clearly putting these years within a continuing education framework would lead to better retention and a more positive environment.’

Views expressed on the introduction of competency based assessment were divided. Those in support of competency based assessment considered that it would clarify professional standards and expectations and might provide assurance that RMOs at PGY1 and PGY2 have a set of essential competencies in communication, diagnosis and patient management. Those opposing were of the view that a checklist cannot replace clinical judgment and professional care; will not solve the inconsistencies and deficiencies in trainees’ learning, skills and experience; and may distort the learning priorities of trainees away from core competencies that are difficult to assess. One submitter supported the introduction of competency based assessments as long as they included competencies in the areas of communication, ethics and compassionate practice.
With regard to the curriculum, submitters suggested that universities, colleges and DHBs all have a meaningful role in the development of the curriculum and all should be involved. Several suggested that colleges in particular should be involved earlier and have input into pre-vocational training and curriculum development.

A few submissions addressed the need for the private sector to be more actively engaged in the education and training of doctors. Their argument was that not only is there unutilised training capacity within the private sector but that an increasing number of operations are being done privately, reducing trainees’ exposure to some procedures in the public sector.

A few submissions addressed the difficulties in recruiting and retaining doctors in academic posts, noting that this will have to be addressed before any meaningful increase in medical student numbers can be achieved.

5 Employment contracts and collective bargaining

Submissions contained a lot of comments about the impact of employment contracts and collective bargaining on the RMO workforce. A few submitters acknowledged that the improvement in the working conditions for RMOs in the last 20 years has been a direct result of strong collective bargaining and that it is the practice rather than the principle of collective bargaining that is at fault.

5.1 A single employer

One submission from an employer body said there is logic in examining whether some employment processes for RMOs could be rationalised to a central source. This could range from career management and its associated components to a single employer, particularly for those in training. The Auckland region already has such a structure, and the Midland region is looking at options for greater regional alignment of recruitment and career placement.

5.2 Adversarial stance

Some submitters thought that the adversarial relationship between DHBs and the RDA is a major contributor to a fraught workplace environment that results in RMOs feeling undervalued.

There were several comments about the RDA’s overly industrial and at times unco-operative approach to negotiations. There is a view that the RDA resists attempts by DHBs to introduce creative solutions to RMO shortages and uses the threat of industrial action to prevent change from occurring.

The adversarial industrial relations environment has also created tension and eroded respect between RMOs and SMOs in the view of some submitters.

There were many pleas for a return to ‘reasonableness’ and good faith bargaining.

5.3 MECA cumbersome, inflexible and costly

The RMO MECA is seen by some as a difficult document that is the result of an amalgamation of local documents and specific provisions negotiated over time to meet the needs of the day. The application of the MECA was seen as directly contributing to unsafe practice.
‘The RMO MECA as it stands is unworkable and leads to unsafe practices. Whilst rosters need to be compliant to ensure that RMOs do not work for more than an average of 55 hours a week, the reality is that this creates shortfalls, which are then filled by locum agencies who in turn employ RMOs under contract to DHBs. There is no formal monitoring of the RMOs’ hours of work, and it is likely that a number of RMOs are working upwards of 80 hours a week in performing locum duties on top of regular work.’

The MECA has dramatically increased the cost of continuity of care according to some submissions, primarily through the provisions regulating cross cover and the inability of PGY1 house officers to work at night unless they have performed three months of general medical cover.

5.4 Inconsistent application of the MECA

Submitters commented that the shortage of RMOs places DHBs under extreme pressure. As a result, many DHBs will pay high premiums in order to be adequately staffed at nights and weekends. It was noted that the pressure to cover also leads to many RMOs being required to work in non-compliant roster schedules.

5.5 Locuming

In order to meet the requirements of the MECA regarding average hours to be worked, DHBs commented that they are reliant on expensive ‘professional locums’ to maintain essential services. The cost of locums, including agency costs, was viewed as excessive and unsustainable. The premium paid for locum cover also acts an incentive, drawing some RMOs away from regular work into locuming. There was support for reducing the pay disparity between permanent employees and locums. Competition between DHBs for RMOs in an environment where it is challenging to maintain services makes it difficult for DHBs to take and maintain a collaborative stance on locum employment.

Submitters noted that there is no monitoring of the hours an RMO has worked, and a shortage of RMOs makes employers seeking locum cover reluctant to ask how many hours a potential locum has worked that day or week. Submitters reported unsafe practices where RMOs work in excess of 80 hours a week, locuming on top of regular hours.

The impact of locuming on RMOs’ training was another issue raised. Locums are generally regarded as being poorly supported and supervised with tenuous ties to any training they may nominally be involved in.

6 Workforce planning, stakeholder alignment and sector leadership

The submissions discussed a range of problems with the RMO workforce. Some submissions also explored reasons for and potential solutions to the problems.

6.1 Workforce planning

Several submissions addressed the need for better workforce planning. One, which identified a lack of vision as well as a lack of planning, referred to ‘the fragmentation and conservatism of governance and education bodies involved in RMO training’.
Although there have been several attempts at workforce planning, none yet have provided the necessary platform for workforce development.

There was a plea from some for much better alignment between workforce planning and health service demand. Submitters provided a hospital-level example of where such alignment is lacking – students who requested psychiatry runs were not allocated these runs despite a critical shortage of psychiatrists in New Zealand.

A submission on behalf of employers asked that workforce planning and development for RMOs be consistent with and support overall development of the medical workforce.

### 6.2 Stakeholder alignment

Submitters observed that relationships between all parties need to be improved and alignment strengthened if the problems facing the RMO workforce are to be resolved. Submitters wrote of the different agendas and priorities of stakeholders including RMOs, SMOs, RMO and SMO representative organisations, employers and their representative organisations, colleges, universities and the Medical Council.

‘The fragmentation and conservatism of governance and education bodies involved in RMO training [is a key issue]. There needs to be increased discussion and co-ordination between these bodies for an aligned vision of RMO education and training.’

Several submitters wrote of a loss of trust, goodwill and co-operation between the medical profession and the employer bodies that now stands in the way of a productive relationship.

### 6.3 Sector leadership

Virtually all submissions discussed the need for leadership towards resolution of the issues surrounding the RMO workforce. However, there was little detail or consensus about the type of leadership required.

Opinion was divided on the need for a national training board. Some submitters expressed concern that a national training body might lead to a ‘one size fits all’ solution to workforce issues, and several expressed the need for leadership to be at national, regional and local levels. There was general support for the work of the Medical Training Board (MTB), which some suggested could take on a broader role.

## Appendix 1: List of submitters

<table>
<thead>
<tr>
<th>Number</th>
<th>Organisation</th>
<th>Submitter</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Bay of Plenty DHB</td>
<td>Graham Dyer, Chief Operating Officer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dr John Kyngdon, Medical Director</td>
</tr>
<tr>
<td>2</td>
<td>New Zealand College of Midwives</td>
<td>Karen Guilliland CEO</td>
</tr>
<tr>
<td>3</td>
<td>College of Nurses Aotearoa (NZ) Inc</td>
<td>Prof Jenny Carryer, Executive Director</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ms Sue Wood, Fellow of the College</td>
</tr>
<tr>
<td>4</td>
<td>Middlemore Hospital Division of Medicine</td>
<td>Prof Jeff Garrett, Clinical Director of Medicine</td>
</tr>
<tr>
<td>Number</td>
<td>Name</td>
<td>Position</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>5</td>
<td>Nelson Marlborough DHB</td>
<td>Denise Hutchins, GM Organisational Development</td>
</tr>
<tr>
<td>6</td>
<td>New Zealand Medical Association</td>
<td>Dr Peter Foley, Chair</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dr Brandon Adams, Chair, Doctors in Training Council</td>
</tr>
<tr>
<td>7</td>
<td>New Zealand Medical Council</td>
<td>unsigned (email only)</td>
</tr>
<tr>
<td>8</td>
<td>New Zealand Medical Students Association</td>
<td>William Perry, President</td>
</tr>
<tr>
<td>9</td>
<td>Otago University Dunedin School of Medicine</td>
<td>Dr John B Adams, Dean</td>
</tr>
<tr>
<td>10</td>
<td>Taranaki DHB</td>
<td>John Doran, Chief Medical Officer</td>
</tr>
<tr>
<td>11</td>
<td>Wairarapa DHB</td>
<td>Alan J Shirley, Chief Medical Adviser and Chairman, Clinical Board</td>
</tr>
<tr>
<td>12</td>
<td>Royal New Zealand College of GPs</td>
<td>Karen Thomas, CEO</td>
</tr>
<tr>
<td>13</td>
<td>District Health Boards of New Zealand</td>
<td>Julian Inch, CEO</td>
</tr>
<tr>
<td>14</td>
<td>Association of Salaried Medical Specialists</td>
<td>Ian Powell, Executive Director</td>
</tr>
<tr>
<td>15</td>
<td>Otago DHB</td>
<td>unsigned</td>
</tr>
<tr>
<td>16</td>
<td>MidCentral DHB</td>
<td>unsigned email</td>
</tr>
<tr>
<td>17</td>
<td>DHBNZ</td>
<td>Gary Smith, Chair, DHB CE Group</td>
</tr>
</tbody>
</table>

**Individuals**

<table>
<thead>
<tr>
<th>Number</th>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ind 1</td>
<td>John Grant</td>
<td>SMO, Dunedin</td>
</tr>
<tr>
<td>Ind 2</td>
<td>Anthony Chen</td>
<td>RMO, Middlemore</td>
</tr>
</tbody>
</table>
Appendix 5: Implementation of Earlier RMO Workforce Reports

This appendix contains a paper prepared by the secretariat to the Commission on the Resident Medical Officer Workforce (RMO Commission) as background to the RMO Commission’s deliberations. It explores progress towards implementation of recommendations made in previous reports on RMO workforce issues.

1 Introduction

Over the past 20 years there has been a large number of reports addressing aspects of doctor education and training and/or medical workforce issues.

Since 2005 three major reports have included a range of recommendations for the medical workforce. These reports are:

- Health Workforce Advisory Committee. 2006. *Fit for Purpose and for Practice*[^32]

Summary tables of the recommendations contained in these reports can be found as Appendix 1. Included in the table is an indication of the type of recommendation (eg, training, workforce supply, registration, etc) and some indication of the extent of progress towards meeting the recommendation.

Many of the recommendations address similar issues. Appendix 2 groups the recommendations by type, describes the work undertaken in that area and attempts to identify barriers to recommendation implementation.

The purpose of this short paper is to identify recommendation areas in which progress has been made or is being made, and those recommendations areas in which progress is harder to see.

2 Where progress has been or is being made

2.1 Medical education – continuity, the curriculum and link to service delivery

The reports include a number of recommendations relating to:

- improving the continuity of medical education from undergraduate through to vocational training
- the undergraduate curriculum
- improving the training/service delivery interface.

[^32]: Medical Reference Group, Health Workforce Advisory Committee. 2006. *Fit for Purpose and for Practice: Advice to the Minister of Health on the issues concerning medical workforce in New Zealand*. Wellington: Health Workforce Advisory Committee.
The most recent Ministry of Health report *Reshaping Medical Education (2007)* recommended the establishment of the Medical Training Board (MTB) and gave clear direction as to what the roles of the Board should be.

The MTB is charged with providing strategic oversight of the education and training of medical practitioners, and working towards a system that produces practitioners who are fit for purpose and for practice meets the needs of the health sector. It does not have an operational mandate.

To date, the MTB has produced two major reports – *The Future of the Medical Workforce* early in 2009 and *Foundations of Excellence* in April 2009.

In September 2008 the MTB released a series of documents on the medical workforce and on the need to achieve integration and co-ordination in medical education and training. The papers clarified issues and generated suggestions and proposals. Following consultation and analysis of feedback, the MTB released *Foundations of Excellence*, which focuses on what change is needed and how it could occur, and proposes a framework for the structure and governance of an integrated medical training system.

Recommendations from the report were forwarded to the Minister of Health on 28 April 2009.

The key Medical Training Board publications are summarised in Table App 5.1.

<table>
<thead>
<tr>
<th>Table App 5.1: Summary of Medical Training Board publications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Training Board (2008) The Future of the Medical Workforce</strong></td>
</tr>
<tr>
<td>This large paper addresses the key question, of ‘How many doctors should we train?’ The paper reviews all of the major drivers for both supply and demand of the future medical workforce and identifies our limitations in accurate information for predictions. The paper makes a recommendation for increased medical student numbers in an effort to meet the principle of net self sufficiency in New Zealand. This recommendation, however, is only a small part of the changes that are required to meet future demand and will have a long lag time before any benefits would be potentially gained.</td>
</tr>
<tr>
<td><strong>Medical Training Board (2008) Integrated and co-ordinated medical training</strong></td>
</tr>
<tr>
<td>The paper outlines the need for a continuum of learning as well as a nationally integrated framework for learning. It proposes a potential structure for education and outlines some of the principles of a competency-based education system.</td>
</tr>
<tr>
<td><strong>Medical Training Board (2008) The curriculum framework</strong></td>
</tr>
<tr>
<td>The paper proposes the adoption of a modified set of competencies from the Australian Junior Doctor Curriculum Framework, and defines the competency levels. It attempts to integrate these competencies with the New Zealand undergraduate curriculum and Australasian post-graduate framework in an effort to smooth the continuum of learning. Finally, it discusses a potential assessment programme and educational delivery system.</td>
</tr>
<tr>
<td><strong>Medical Training Board (2009) Foundations of excellence</strong></td>
</tr>
<tr>
<td>This paper recommends a new body be established with the capacity to co-ordinate medical education and training across the entire continuum of learning and govern the transition from the current system.</td>
</tr>
</tbody>
</table>

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36 Ibid.
The Clinical Training Agency (CTA) is responsible for planning and managing the purchase of post-entry clinical training for New Zealand health professionals and as such is critical to the interface between training and service delivery. The budget for the CTA has increased significantly over the last two financial years. The CTA is working in partnership with the MTB.

Both medical schools are involved in a range of work to strengthen the undergraduate curriculum, and both medical school deans are members of the MTB.

### 2.2 Workforce supply

Since 2004 the number of funded medical place has been increased twice, by 40 in 2004 and by a further 40 in 2007 to the current number of 365.

The MTB recommends a further increase of 100 places a year by 2012.

The current Government has undertaken to boost the number of funded medical student places by 200 students over five years, which would lift the total number of funded medical student places from 365 students a year in 2008 to 565 in 2013.

### 2.3 Workforce planning

There appears to have been no centralised medical workforce planning in New Zealand for over 20 years. Within the Ministry of Health workforce development activity is spread across a range of business groups and capacity has recently been increased, although there appears to be no co-ordinating workforce development strategy.

District Health Boards New Zealand (DHBNZ) has been leading workforce development since 2001 for the reason that DHBs have the best understanding of service demand and are therefore best placed to assess workforce requirements. The Ministry of Health has actively supported this workforce development since its inception, and has required each DHB to include a section on workforce planning in its district annual plan.

In 2005 DHBNZ produced *Future Workforce 2005–010*, the DHBs' strategic plan to progress the goal of a coherent, sector-wide approach to developing the health and disability workforce. From the plan, the Future Workforce Programme has developed a vision for connected and co-ordinated workforce planning.

Co-ordinated by a Future Workforce lead group, seven workforce strategy groups are each responsible for developing a strategy and a programme of activity for that workforce. The Medical Workforce Strategy Group, established early in 2008, includes representatives from DHBs, the Ministry of Health, senior representatives from Auckland and Otago medical schools, members from three royal colleges, and has positions (currently vacant) for representatives from the Association of Salaried Medical Specialists and the Resident Doctors’ Association. The Medical Workforce Strategy Group recently (March 2009) released a vision paper for the future role of the doctor. A summary of the Future Workforce report can be found in Appendix 2.

The strength of the DHBNZ initiative appears to be strong cross-sectoral representation, a prerequisite to co-ordinated and effective workforce planning. However, DHBNZ has no formal mandate or authority, even among the 21 DHBs, and must rely on consensus and voluntary adherence to any strategies developed.
Furthermore, DHBs’ resources are virtually all applied to service delivery leaving scant capacity for workforce development.

2.4 Increased profile of primary care in medical training

The Universities of Auckland and Otago and the Royal New Zealand College of General Practitioners have jointly funded the establishment of a national general practice clinical placement co-ordination position. This position is a co-ordinated attempt to plan and build basic infrastructure for primary care-based medical education in the hope of meeting the medical needs of New Zealand’s population in 20 and 30 years’ time.

The CTA currently funds 104 GP registrar training places. The Government has made a commitment to increase GP registrar training places to 154 per annum. This increase in numbers has begun, and is designed as a short-term measure to address New Zealand’s GP workforce shortage.37

Rural programmes have been set up at both medical schools, increasing the use of general practice in undergraduate medical education. Otago has a five-week module in community practice in the fourth year, and a trainee intern general practice run in the sixth year.

3 Where progress is harder to see

Areas of recommendation on which there seems to be widespread agreement, but where progress is hard to see, include:

- improved sector alignment and co-ordination
- retention strategies (although likely to be diverse and widespread, no obvious co-ordinated activity)
- DHBs’ accountability for training
- addressing the funding split between health and education
- improving data for decision-making
- exploring private sector training capacity.

4 Barriers to the implementation of recommendations

There are a myriad of challenges to resolving the issues facing the RMO workforce. Challenges include:

- system complexity – both inherent and avoidable
- a history of high professional autonomy
- a devolved health sector lacking centralised leadership/authority
- multiple, competing employers
- adapting a traditional medical employment model to a modern workforce
- the industrial framework.

Most of these challenges are acknowledged in the earlier reports, with recommendations designed to address them and bring about improvements in the

system. Therefore, these challenges are not of themselves barriers to implementation, but rather the areas in which progress is needed.

The single biggest barrier to implementation has been the lack of political will to mandate and resource the recommendations of the three previous reports. In other words, implementation has never really been attempted. Each of the reports was commissioned by one health minister and received by another.

Since the first report, *Fit for Purpose and for Practice*, in 2006 there have been four ministers of health, and rather than implementing the recommendations, the response of each incoming minister has been to set up another committee to investigate the issues.

There is some risk that this pattern could continue. Both the MTB and the RMO Commission were established under one minister and are reporting to another.

**References**


Medical Reference Group, Health Workforce Advisory Committee. 2006. *Fit for Purpose and for Practice: Advice to the Minister of Health on the issues concerning medical workforce in New Zealand*. Wellington: Health Workforce Advisory Committee.


## Appendix 1: Recommendations from previous reports on RMO workforce issues

**Ministry of Health. 2007. *Reshaping medical education and training to meet the challenges of the 21st century.***

### Workforce taskforce

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Recommendation type</th>
<th>Implementation/progress</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> Establishment of Medical Training Board to:</td>
<td>Oversight and co-ordination</td>
<td>Medical Training Board established with ToR largely derived from these recommendations.</td>
</tr>
<tr>
<td>• oversee and co-ordinate</td>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>• develop educational framework</td>
<td>Training/service delivery interface</td>
<td></td>
</tr>
<tr>
<td>• take advice from DHBs and other providers on workforce needs</td>
<td>Clinical specifications</td>
<td></td>
</tr>
<tr>
<td>• develop a national view on training requirements</td>
<td>Recruitment and retention</td>
<td></td>
</tr>
<tr>
<td>• approve clinical training specifications and funding intentions</td>
<td>Data</td>
<td></td>
</tr>
<tr>
<td>• promote the recruitment and retention of medical trainees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• improve data collection</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2</strong> NZMC asked to develop limited registration for trainee interns</td>
<td>Limited registration</td>
<td></td>
</tr>
<tr>
<td><strong>3</strong> NZMC and MTB develop competency based assessment</td>
<td>Training standards</td>
<td>MTB and NZMC investigating competency based assessment.</td>
</tr>
<tr>
<td><strong>4</strong> Number of medical graduates be increased and number regularly reviewed by MTB</td>
<td>Workforce supply</td>
<td>Since 2004 the number has been raised twice, by 40 in 2004 and a further 40 in 2007 to a current number of 365. MTB recommends a further increase of 100 places a year by 2012. National has undertaken to boost the number of funded medical student places by 200 students over five years bringing the total number of funded medical student places from 365 students a year to 565.</td>
</tr>
<tr>
<td><strong>5</strong> MTB in consultation with health care providers and consumers considers new roles to support medical practitioners</td>
<td>Workforce development</td>
<td></td>
</tr>
<tr>
<td><strong>6</strong> Inter-professional collaboration and care, communication and teamwork be taught and assessed</td>
<td>Curriculum</td>
<td></td>
</tr>
<tr>
<td><strong>7</strong> DHBs required to demonstrate and report on commitment to education and training</td>
<td>Accountability for training</td>
<td></td>
</tr>
<tr>
<td><strong>8</strong> National curriculum developed by MTB for transition years</td>
<td>Curriculum</td>
<td>Curriculum under development.</td>
</tr>
<tr>
<td><strong>9</strong> MTB to develop contracts for training to ensure funding is spent on training</td>
<td>Accountability for training</td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Recommendation type</th>
<th>Implementation/progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 DHBs ensure senior doctors trained and supported to deliver training to junior doctors</td>
<td>Accountability for training</td>
<td></td>
</tr>
<tr>
<td>11 DHBs appoint directors of clinical training</td>
<td>Training/service delivery interface</td>
<td>Some larger ones have DoCT (Auckland, Waitemata, BoP, Capital and Coast). Others may call the position something else or may not have them.</td>
</tr>
<tr>
<td>12 MTB to ensure all training providers meet appropriate standards and have external accreditation</td>
<td>Curriculum and standards</td>
<td>MTB</td>
</tr>
<tr>
<td>13 Training settings to include both public and private</td>
<td>Private</td>
<td>Private settings little used and only informally.</td>
</tr>
<tr>
<td>14 MTB work with education and training organisations to ensure that all medical practitioners acquire a broad general foundation including community and regional hospital experience before entering vocational training</td>
<td>Training</td>
<td>MTB</td>
</tr>
<tr>
<td>15 Training produces sufficient numbers with training in general vocational scopes of practice</td>
<td>Training</td>
<td></td>
</tr>
<tr>
<td>16 Universities invited to put forward proposals for a primary care based undergraduate programme</td>
<td>Primary care</td>
<td>The Universities of Auckland and Otago and the RNZCGP have jointly funded the establishment of a National General Practice Clinical Placement Co-ordination position.</td>
</tr>
<tr>
<td>17 Education and training programme for general practice to meet New Zealand’s needs</td>
<td>Primary care</td>
<td>Rural programmes have been set up at both medical schools the increasing use of general practice in undergraduate medical education. Otago has a five-week module in community practice in fourth year, and a trainee intern general practice run in sixth year.</td>
</tr>
<tr>
<td>18 Identify and foster factors that influence students to choose general practice as a career</td>
<td>Primary care</td>
<td></td>
</tr>
</tbody>
</table>

*Treating People Well: Report of the RMO Commission*
## Recommendations

<table>
<thead>
<tr>
<th>Recommendation type</th>
<th>Implementation/progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>MTB initiatives move things in this direction</td>
<td></td>
</tr>
<tr>
<td>CTA funded GP training places currently 104. Government commitment to increase GP registrar training places to 154 per annum.</td>
<td></td>
</tr>
<tr>
<td>Rural programmes established.</td>
<td></td>
</tr>
<tr>
<td>&quot;Circuit breakers’ to include:</td>
<td></td>
</tr>
<tr>
<td>address salary gap between education and health</td>
<td>Funding</td>
</tr>
<tr>
<td>require DHBs to recognise and plan for the training of medical practitioners</td>
<td>Accountability for training</td>
</tr>
<tr>
<td>establish regional medical education units to liaise between NZMC, universities and colleges</td>
<td>Sector alignment and co-ordination</td>
</tr>
<tr>
<td>Some increase, more planned</td>
<td></td>
</tr>
<tr>
<td>Limited registration</td>
<td></td>
</tr>
<tr>
<td>Sector alignment and co-ordination</td>
<td></td>
</tr>
<tr>
<td>Funding</td>
<td></td>
</tr>
</tbody>
</table>

## MINISTRY OF HEALTH

- establish and maintain better links between those involved in the education and training of medical practitioners
- review, with other stakeholders, current provision and funding of undergraduate medical education
### Recommendations

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Recommendation type</th>
<th>Implementation/progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>contract a critique of how apprenticeship training could be enhanced within current service delivery environment</td>
<td>Training/service delivery interface</td>
<td></td>
</tr>
<tr>
<td>DHBNZ be funded to provide information on future service demand</td>
<td>Data</td>
<td>Health Workforce Information Programme (HWIP). A DHBNZ initiative (2006) to collect and analyse workforce information from throughout the health sector.</td>
</tr>
<tr>
<td>HBNZ, RMO strategy group and RDA work through the problems with the MECA</td>
<td>Industrial relations</td>
<td></td>
</tr>
</tbody>
</table>

### Health Workforce Advisory Committee. 2006. *Fit for Purpose and for Practice.*

**Medical Reference Group, Health Workforce Advisory Committee (disestablished)**

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Recommendation type</th>
<th>Implementation/progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Interagency steering group with a ministerial mandate, and sector-wide governance representation to undertake nationally focused, strategic workforce planning</td>
<td>Workforce development Sector alignment</td>
<td></td>
</tr>
<tr>
<td>2 Lift or remove the cap on undergraduate medical school placement</td>
<td>Workforce supply</td>
<td>Since 2004 the number has been raised twice, by 40 in 2004 and a further 40 in 2007 to a current number of 365. MTB recommends a further increase of 100 places a year by 2012. National has undertaken to boost the number of funded medical student places by 200 students over five years bringing the total number of funded medical student places from 365 students a year to 565.</td>
</tr>
<tr>
<td>3 Move to ‘payment for output’ for medical education in order to remove disincentives for change</td>
<td>Funding</td>
<td></td>
</tr>
<tr>
<td>4 Plan for sufficient PGY1 and 2 runs to accommodate undergraduates from rural settings</td>
<td>Training</td>
<td>CTA funded GP training places currently 104. Government commitment to increase GP registrar training places to 154 per annum.</td>
</tr>
<tr>
<td>5 Runs to match service demand – especially primary care</td>
<td>Primary care</td>
<td></td>
</tr>
<tr>
<td>6 Match training to service demand</td>
<td>Supply/demand planning</td>
<td></td>
</tr>
<tr>
<td>7 True costs of public, private and vocational medicine should be established</td>
<td>Data</td>
<td>Health Workforce Information Programme (HWIP). A DHBNZ initiative (2006) to collect and analyse workforce information from throughout the health sector.</td>
</tr>
<tr>
<td>Recommendations</td>
<td>Recommendation type</td>
<td>Implementation/progress</td>
</tr>
<tr>
<td>------------------</td>
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<td>------------------------</td>
</tr>
<tr>
<td>8 Improve retention of New Zealand trained doctors by:</td>
<td>Retention</td>
<td></td>
</tr>
<tr>
<td>- part-time specialist training</td>
<td></td>
<td></td>
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<tr>
<td>- job share roles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- community support networks in rural settings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Establish transparency in competency and standards for IMGs, particularly specialists</td>
<td>IMGs</td>
<td></td>
</tr>
<tr>
<td>10 Curriculum and professional development to include teamwork, collaboration, professionalism, communication, interpersonal skills and leadership training</td>
<td>Curriculum</td>
<td>All covered in MTB and MCNZ education framework out for consultation</td>
</tr>
<tr>
<td>11 MTB to ensure all practitioners have a broad general foundation including community and regional hospital experience before entering vocational training</td>
<td>Training</td>
<td>Being addressed by MTB education framework out for consultation</td>
</tr>
<tr>
<td>12 Profile and experience of general practice increased within undergraduate training</td>
<td>Primary care</td>
<td>Rural programmes have been set up at both medical schools the increasing use of general practice in undergraduate medical education. Otago has a five-week module in community practice in fourth year, and a trainee intern general practice run in sixth year.</td>
</tr>
</tbody>
</table>
### Appendix 2: Summary table of recommendation types and progress

<table>
<thead>
<tr>
<th>Recommendation type</th>
<th>Progress</th>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Curriculum</td>
<td>MTB has picked this up</td>
<td></td>
</tr>
<tr>
<td>Training continuity</td>
<td>MTB addressing this</td>
<td></td>
</tr>
<tr>
<td>Training / service delivery interface</td>
<td>MTB has picked this up</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Some larger DHBs have appointed directors of clinical training</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Smaller DHBs may not be able to commit to a dedicated DoCT position.</td>
</tr>
<tr>
<td>DHBs accountability for training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sector alignment and co-ordination</td>
<td>Health Sector Relationship Agreement (NZRDA not a signatory). Four projects:</td>
<td>The sector is characterised by a high degree of autonomy, commercial sensitivities, strong professional allegiances and an adversarial industrial environment.</td>
</tr>
<tr>
<td></td>
<td>- constructive engagement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- improving pay and conditions for low paid workers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- measurably improving productivity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- collective bargaining</td>
<td></td>
</tr>
<tr>
<td>Funding arrangements – funding split between health/education addressed</td>
<td>Since 2004 the number has been raised twice to a current number of 365. MTB recommends a further increase of 100 places a year by 2012. National has undertaken to boost the number of funded medical student places by 200 students over five years bringing the total number of funded medical student places from 365 students a year to 565.</td>
<td></td>
</tr>
<tr>
<td>Workforce supply</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workforce planning and development</td>
<td>DHBNZ Future Workforce Programme has developed a comprehensive vision for connected and co-ordinated workforce planning. Led by the Medical Workforce Strategy Group, a vision of the medical workforce in 2030 is under development. Sever workforce strategy groups are each responsible for linking with the networks specific to that workforce. The medical workforce strategy group is currently focused on the future role of the doctor. MoH workforce development activity is currently not centralised and is spread across the Ministry.</td>
<td></td>
</tr>
</tbody>
</table>
Government has announced a “voluntary bonding” scheme offering student loan debt write-off to graduate doctors, nurses, and midwives agreeing to work in hard-to-staff communities or specialties. In return for working in these areas for three to five years after graduation, Government will provide New Zealand graduates with student-loan write-offs.

Supply/demand planning  
Aligning training to future demand  
Primary care

**Undergraduate:** Rural programmes have been set up at both medical schools increasing the profile of general practice in undergraduate medical education (P Crampton, 2009).

The Universities of Auckland and Otago and the RNZCGP have jointly funded the establishment of a National General Practice Clinical Placement Co-ordination position. The first-year objectives of this project are to:

- co-ordinate student and registrar placements in general practice settings
- establish a common database of teaching practices
- develop and implement a joint communications plan to promote GP teaching
- initiate liaison with DHBs to link with second-year house surgeon placements
- provide project management support for combined University and College policy development.

This project is a co-ordinated attempt to plan and build basic infrastructure for primary care-based medical education in the hope of meeting the medical needs of New Zealand’s population in 20 and 30 years’ time (*Journal of Primary Health Care*, Peter Crampton, March 2009).

**Vocational:** CTA funded GP training places currently 104. Government commitment: ‘We are aiming to increase the number of GP registrar training places to 154 per annum. This increase in numbers has begun, and is designed as a short term measure to address New Zealand’s GP workforce shortage’ (Tony Ryall, Minister of Health, 30 March 2009).

The barriers to increasing primary care-based medical education are numerous. Not least is the lack of a long-established tradition of widespread, routine, undergraduate medical education in primary care, resulting in weak or absent basic physical infrastructure for teaching, the absence of a well-established pattern of GP registrars teaching undergraduate medical students as occurs in hospitals, and poor career structure for primary care-based teachers. Added to this is the relatively low level of government support for specialist GP vocational training compared with other specialist training programmes ... Then there is the sticky problem of ownership; we need to find mechanisms for government to invest in basic infrastructure for primary care-based education in a way that secures and protects public investment and simultaneously meets the needs of trainers” (Peter Crampton, *Journal of Primary Health Care*, March 2009).

**Data**

Health Workforce Information Programme (HWIP). A DHBNZ initiative (2006) to collect and analyse workforce information from throughout the health sector.

The sector is characterised by a high degree of autonomy, commercial sensitivities and strong professional allegiances. 21 DHBs, four medical schools and eight royal colleges make systematic data collection challenging.
<table>
<thead>
<tr>
<th>Recommendation type</th>
<th>Progress</th>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited registration</td>
<td></td>
<td>Safety concerns</td>
</tr>
<tr>
<td></td>
<td></td>
<td>RDA opposed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NZMC position?</td>
</tr>
<tr>
<td>Private sector training</td>
<td>capacity explored</td>
<td></td>
</tr>
<tr>
<td>IMGs registration</td>
<td>process simplified</td>
<td></td>
</tr>
<tr>
<td>IR / HR issues</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Appendix 3: Future workforce


<table>
<thead>
<tr>
<th>Priority areas relevant to medical careers</th>
<th>Recommendation type</th>
<th>Implementation/progress</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1 Foster supportive environments and positive cultures:</strong></td>
<td>Culture shift</td>
<td>Health Sector Relationship Agreement (2008) between all 21 DHBs, MoH, NZCTU and affiliated health sector unions (including ASMS but not RDA)</td>
</tr>
<tr>
<td>- promote appropriate shared management, clinical and cultural leadership</td>
<td></td>
<td>Included stocktake of ‘constructive engagement practices’</td>
</tr>
<tr>
<td>- share best practice tools for fostering supportive environments and positive cultures across DHBs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- support new graduates’ transition to clinical practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- establish mentoring training and networks for clinicians and management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- ensure HR capacity and capability for a positive environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2 Enhancing people strategies:</strong></td>
<td>HR strategies</td>
<td></td>
</tr>
<tr>
<td>- affirmative action to attract and retain older people</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- alternative career pathways vertical and lateral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- quality information to inform IR strategies and negotiations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- policies and programmes for work life balance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- integrate organisational values in everyday activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- resource workforce planning</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3 Education and training:</strong></td>
<td>Training / service demand interface Recruitment</td>
<td></td>
</tr>
<tr>
<td>- create relationship with education sector to enable formal engagement on workforce supply issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- improve inter-sectoral communication and planning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- develop a brand to increase attractiveness of careers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- establish national e-learning systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- agree and establish portable competencies</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>4 Models of care:</strong></td>
<td>System improvement Increased flexibility</td>
<td></td>
</tr>
<tr>
<td>- incentivise innovative models of care especially those that support team building and shared competencies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- identify and remove regulatory and contractual barriers that prevent practitioners fully exercising their scope of practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- support flexible employment/contracting models</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- fund new models of team working</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Priority areas relevant to medical careers</td>
<td>Recommendation type</td>
<td>Implementation/progress</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>---------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>5 Primary health care:</td>
<td>Primary care</td>
<td></td>
</tr>
<tr>
<td>• primary health care models to recognise diversity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• primary care integrated with secondary sector</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• align funding mechanisms to enable coherent workforce development reflecting service direction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• develop IT tools to support integration and team approach</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Maori health workforce:</td>
<td>Workforce development</td>
<td>Maori Health Workforce Development Plan (MoH 2006) 10–15 year plan with three major goals</td>
</tr>
<tr>
<td>• resource collection of ethnic specific data for planning and workforce development</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• engage with TEC to increase successful Maori participation in education and training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• engage with schools to increase successful Maori participation in education and training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• ensure all staff have access to Maori health/hauora competency development and training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• invest in and develop Maori workforce capacity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Pacific health workforce:</td>
<td>Workforce development</td>
<td>Pacific Health and Disability Workforce Development Plan (MoH 2004) was already in place</td>
</tr>
<tr>
<td>• create organisational environments that recognise and support culturally diverse workforce</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• greater recognition of prior learning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• develop an action programme for promoting health and disability careers to Pacific people</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• create incentives for Pacific people to go further in education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• increase access to leadership and professional development for Pacific health and disability professionals</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MoH has a Maori directorate

No major work obvious since then although MoH has a Pacific Health workstream
### Appendix 6: Resident Medical Officer Demographic Data

#### Table App 6.1: Resident medical officers – age group by employment capacity, 1998–2008

<table>
<thead>
<tr>
<th>Employment capacity</th>
<th>Age range</th>
<th>2008</th>
<th>2003</th>
<th>1998</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>≤24</td>
<td>25–29</td>
<td>30–34</td>
<td>35–39</td>
</tr>
<tr>
<td>House officers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registrars</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>House officers</td>
<td>146</td>
<td>512</td>
<td>128</td>
<td>55</td>
</tr>
<tr>
<td>Registrars</td>
<td>0</td>
<td>435</td>
<td>685</td>
<td>303</td>
</tr>
<tr>
<td>Total</td>
<td>146</td>
<td>947</td>
<td>813</td>
<td>358</td>
</tr>
<tr>
<td>2003</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>House officers</td>
<td>157</td>
<td>466</td>
<td>83</td>
<td>69</td>
</tr>
<tr>
<td>Registrars</td>
<td>0</td>
<td>326</td>
<td>578</td>
<td>217</td>
</tr>
<tr>
<td>Total</td>
<td>157</td>
<td>792</td>
<td>661</td>
<td>286</td>
</tr>
<tr>
<td>1998</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>House officers</td>
<td>175</td>
<td>510</td>
<td>108</td>
<td>69</td>
</tr>
<tr>
<td>Registrars</td>
<td>0</td>
<td>363</td>
<td>500</td>
<td>187</td>
</tr>
<tr>
<td>Total</td>
<td>175</td>
<td>873</td>
<td>608</td>
<td>256</td>
</tr>
</tbody>
</table>

#### Table App 6.2: Resident medical officers – gender by employment capacity, 1998–2008

<table>
<thead>
<tr>
<th>Employment capacity</th>
<th>Male</th>
<th>Female</th>
<th>Total number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
</tr>
<tr>
<td>2008</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>House officers</td>
<td>395</td>
<td>44</td>
<td>496</td>
</tr>
<tr>
<td>Registrars</td>
<td>899</td>
<td>54</td>
<td>754</td>
</tr>
<tr>
<td>Total</td>
<td>1294</td>
<td>51</td>
<td>1250</td>
</tr>
<tr>
<td>2003</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>House officers</td>
<td>411</td>
<td>49</td>
<td>431</td>
</tr>
<tr>
<td>Registrars</td>
<td>793</td>
<td>60</td>
<td>526</td>
</tr>
<tr>
<td>Total</td>
<td>1204</td>
<td>56</td>
<td>957</td>
</tr>
<tr>
<td>1998</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>House officers</td>
<td>448</td>
<td>49</td>
<td>462</td>
</tr>
<tr>
<td>Registrars</td>
<td>749</td>
<td>65</td>
<td>398</td>
</tr>
<tr>
<td>Total</td>
<td>1197</td>
<td>58</td>
<td>860</td>
</tr>
</tbody>
</table>
### Table App 6.3: Resident medical officers – ethnicity by employment capacity, 1998–2008

<table>
<thead>
<tr>
<th>Employment capacity</th>
<th>NZ European</th>
<th>Other European</th>
<th>NZ Māori</th>
<th>Pacific Island</th>
<th>Chinese</th>
<th>Indian</th>
<th>Other</th>
<th>No response</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2008</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>House officers</td>
<td>344</td>
<td>103</td>
<td>65</td>
<td>26</td>
<td>115</td>
<td>70</td>
<td>160</td>
<td>8</td>
<td>891</td>
</tr>
<tr>
<td>Registrars</td>
<td>675</td>
<td>277</td>
<td>56</td>
<td>48</td>
<td>191</td>
<td>126</td>
<td>263</td>
<td>17</td>
<td>1653</td>
</tr>
<tr>
<td>Total</td>
<td>1019</td>
<td>380</td>
<td>121</td>
<td>74</td>
<td>306</td>
<td>196</td>
<td>423</td>
<td>25</td>
<td>2544</td>
</tr>
<tr>
<td><strong>2003</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>House officers</td>
<td>416</td>
<td>49</td>
<td>34</td>
<td>17</td>
<td>122</td>
<td>43</td>
<td>145</td>
<td>16</td>
<td>842</td>
</tr>
<tr>
<td>Registrars</td>
<td>643</td>
<td>175</td>
<td>53</td>
<td>24</td>
<td>112</td>
<td>98</td>
<td>187</td>
<td>27</td>
<td>1319</td>
</tr>
<tr>
<td>Total</td>
<td>1059</td>
<td>224</td>
<td>87</td>
<td>41</td>
<td>234</td>
<td>141</td>
<td>332</td>
<td>43</td>
<td>2161</td>
</tr>
<tr>
<td><strong>1998</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>House officers</td>
<td>609</td>
<td>**</td>
<td>39</td>
<td>19</td>
<td>48</td>
<td>76</td>
<td>109</td>
<td>10</td>
<td>910</td>
</tr>
<tr>
<td>Registrars</td>
<td>845</td>
<td>**</td>
<td>29</td>
<td>20</td>
<td>75</td>
<td>90</td>
<td>81</td>
<td>7</td>
<td>1147</td>
</tr>
<tr>
<td>Total</td>
<td>1454</td>
<td>0</td>
<td>68</td>
<td>39</td>
<td>123</td>
<td>166</td>
<td>190</td>
<td>17</td>
<td>2057</td>
</tr>
</tbody>
</table>

** Not a defined category in this collection.

### Table App 6.4: Resident medical officers – country of graduation by employment capacity, 1998–2008

<table>
<thead>
<tr>
<th>Medical practitioner</th>
<th>New Zealand</th>
<th>Overseas</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
</tr>
<tr>
<td><strong>2008</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>House officer</td>
<td>702</td>
<td>79</td>
<td>189</td>
</tr>
<tr>
<td>Registrar</td>
<td>1037</td>
<td>63</td>
<td>616</td>
</tr>
<tr>
<td>Total</td>
<td>1739</td>
<td>68</td>
<td>805</td>
</tr>
<tr>
<td><strong>2003</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>House officer</td>
<td>700</td>
<td>83</td>
<td>142</td>
</tr>
<tr>
<td>Registrar</td>
<td>878</td>
<td>67</td>
<td>441</td>
</tr>
<tr>
<td>Total</td>
<td>1578</td>
<td>73</td>
<td>583</td>
</tr>
<tr>
<td><strong>1998</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>House officer</td>
<td>727</td>
<td>80</td>
<td>183</td>
</tr>
<tr>
<td>Registrar</td>
<td>751</td>
<td>65</td>
<td>396</td>
</tr>
<tr>
<td>Total</td>
<td>1478</td>
<td>72</td>
<td>579</td>
</tr>
</tbody>
</table>
Appendix 7: Māori Medical Workforce

This appendix contains a paper prepared by the secretariat to the Commission on the Resident Medical Officer Workforce (RMO Commission) as background to the RMO Commission’s deliberations.

Introduction

The Director-General’s Commission on the Resident Medical Officer Workforce (RMO Commission) asked for a background paper on the Māori medical workforce. This paper considers:

- the current status of the Māori medical workforce
- the rationale for increasing participation of Māori in the medical workforce
- how we can develop the Māori medical workforce.

What we already know about the Māori medical workforce

Despite some improvements over time, Māori are under-represented in the health and disability workforce. In 2006, Māori comprised only 2.5 percent of the active medical practitioner workforce. In many specialist areas, Māori are not represented or are vastly under-represented.

In terms of retention in the workforce, where workforce data enables measurement, it appears that there are generally moderate levels of Māori retention (60 to 80 percent) across health professions. Te Ohu Rata o Aotearoa – Māori Medical Practitioners’ Association of Aotearoa (Te ORA) has indicated that while a number of its members are RMOs, there are very few senior medical officers (SMOs) in its membership.

Developing the Māori medical workforce

There are strong rationale for increasing and strengthening the Māori medical practitioner workforce. It has been predicted that in New Zealand there will be an excess in health workforce demand by the year 2021. Giving attention to the recruitment and retention of more Māori medical practitioners will help address the shortfall. Also, Statistics New Zealand projections for the period 2006–2021 predict a 20 percent growth in the size of the Māori population compared to a 10 percent increase in the same period for non-Māori. The changing demographic profile will result in more Māori requiring quality health care, and more Māori with the potential to study toward and enter a health profession. Māori medical practitioners are also seen as pivotal for providing appropriate care to Māori and their whānau, and to improving Māori health outcomes.

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38 New Zealand Information Service (2004).
39 Auckland University of Technology (2007).
42 Auckland University of Technology (2007).
Recruitment of Māori in the medical workforce

Achieving an optimal Māori medical practitioner workforce needs a comprehensive approach. Individuals progress through educational institutions and graduate with the qualifications and skills that enable them to then be recruited by employers into the medical workforce. As such, the education sector has a major role in increasing the number of Māori medical practitioners.

Without high school science qualifications, students are unable to proceed to tertiary health science training, which is required to enter most health professions. Regrettably, Māori are less likely than non-Māori to enrol in and pass secondary school science subjects. In 2007, 48 percent of Years 11 to 13 Māori candidates studying within the National Qualifications Framework participated in a science subject, and of these 41 percent attained 14 or more credits. In comparison, 62.5 percent of Years 11 to 13 non-Māori candidates participated in a science subject, and of these 64 percent attained 14 or more credits.

There is a need to promote health as a career option to raise the awareness from a young age continuing through to Year 13. Improvements to the way in which career advice and educational information is presented so that it is relevant for Māori is also important.

The Whakapiki Ake Project is a Ministry of Health funded initiative. It is operated as a partnership project between the University of Auckland and selected secondary schools to encourage young Māori to pursue a career in medical and health sciences. It facilitates student entry into Hikitia Te Ora/the Certificate in Health Sciences course, and aims to recruit 100 Māori year. A range of health careers are promoted through school based presentations and the provision of career information to students and whānau, and there are opportunities for work experience. The Project provides assistance with applications and course costs, and ensures access to learning and other support throughout programmes of study. A similar programme has been developed by Otago University this year.

As well as increasing the number of Māori secondary school students entering tertiary health and science courses, numbers can also be increased by attracting second-chance learners who have already left the formal education system. Bridging courses, such as Auckland University’s Health Sciences Certificate, and training programmes are useful for attracting second-chance learners to enter the health and disability workforce.

The financial cost of education has been identified as a barrier to tertiary study. Māori scholarships, such as the Hauora Māori scholarship programme, Manaaki Tauira and iwi grants, are a key support mechanisms to assist Māori students.

44 Ibid.
45 Auckland University of Technology, 2007.
Retention of Māori in the medical workforce

Once tertiary qualifications are achieved, there can often be challenges with the progression from education institutions to the health and disability workforce. Mentoring programmes to support medical workers in the transition from study into the workforce are helpful. Māori health professionals as role models and mentors can influence other Māori to choose a career in health and continue working in the sector. Māori role models and mentors are also good support mechanisms for Māori medical students during their tertiary education.

Te ORA has identified that there can be some pressure on Māori doctors to be competent in a range of areas, including te reo Māori and Māori tikanga. Māori doctors and other Māori health professionals often seek further development so that they can make the most effective and appropriate contribution to Māori health outcomes. There is a need to further recognise and support the development of Māori doctors in these areas. Options could include looking at Clinical Training Agency funding tagged for Māori workforce development, which currently is focussed on the portion of the health workforce without any formal qualifications.

Te ORA has also recognised that few second year postgraduate doctors are accessing the rural general practice placement opportunity. However, the Māori doctors who have been fortunate enough to access the programme are predominantly successful in making the transition to general practice. There is a need to recognise the importance of utilising such programmes to prepare and support junior doctors into community medicine. District health boards can assist with this through the prioritisation of community-based placements, in particular in the Māori provider setting.

Importance of quality ethnicity data

The New Zealand Health Information Service (NZHIS) collects health and disability workforce registration data as part of the renewal of annual practising certificates for those occupations where professional registration is required. NZHIS does not collate data from all health and disability occupational groups, and there is evidence that many professional bodies in the health and disability area have very poor quality ethnicity data, in some case no ethnicity data at all is collected. It is important that professional bodies collect ethnicity data in accordance with national guidelines to enable informed planning and action for New Zealand health workforce development.

Conclusion

As a sector, it is a priority to build a capable, skilled and experienced Māori health and disability workforce. The small percentage of Māori in health professions, particularly in frontline clinical roles, is of concern, given the need for a strong sustainable health and disability workforce, New Zealand’s changing demographics, and the existing health inequalities.

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As determinants of Māori participation impact along the entire workforce development pathway, multiple interventions to enhance Māori representation are required. Key recruitment facilitators include:

- increased provision of accessible information about health related study pathways and careers
- academic criteria for entry into health study that takes account of wide experience and skills
- the availability of financial support
- a strong Māori presence within health and education sectors.

Whānau also exert a strong influence on education and workforce choices, and so there is value in not only promoting health study and careers to potential candidates, but also to the wider Māori community.

Although there has been some progress in growing the number of Māori in the health and disability workforce, more can be done. A representative and culturally competent workforce is essential to improve the health of Māori, their whānau, and all New Zealanders.

**References**

Auckland University of Technology, 2007.


Appendix 8: Pacific Medical Workforce

This appendix contains a paper prepared by the secretariat to the Commission on the Resident Medical Officer Workforce (RMO Commission) as background to the RMO Commission’s deliberations.

Background

Pacific people are under-represented in the medical workforce. In 2006, Pacific people comprised 6.9 percent of New Zealand’s total population, however, only 1.6 percent of the medical workforce. Of the total number of doctors who identified as Pacific, 34 percent reported their main role as general practitioner, 26 percent as specialist, 18 percent as registrar, and 14 percent as house officer.

Key components for supporting and growing a Pacific medical workforce

There seems to be general agreement that the key components to increasing and supporting the Pacific medical workforce are:

- good-quality mentoring of medical students
- good links with schools.

Recruitment

The Health Workforce Advisory Committee (HWAC), along with a number of other groups, recognised that if Māori and Pacific populations were to be better represented in the health professions, including medicine, then the teaching of science to Māori and Pacific school students needed to improve and more needed to be encouraged into science at school.

Some initiatives such as the Incubator Programme (established in 2007 by Hawke’s Bay District Health Board (DHB)) aim to develop links between secondary school students and those working in the health sector to encourage Year 12 and Year 13 students to consider health careers, including medicine. Since 2007 the Incubator Programme has spread to Tairawhiti, Counties Manukau, West Coast and, most recently (March 2009), Southland DHBs.

The University of Auckland usually holds at least one careers day a year where students interested in a health career are invited to meet academic staff and providers. Pacific medical students at the University of Auckland and Pasifika Medical Association student representatives have also on occasion visited schools to talk at career days. There is no formal programme of recruitment for Pacific students.

There is a need to begin working with school careers advisors and interested students as early as Years 9 and 10 when students are making decisions about subject choices. The Pacific Health Section at the School of Population Health at the University of Auckland has just employed a pacific health student advisor, and one of her tasks will be to develop a plan of working with secondary schools in Auckland.

47 Statistics New Zealand 2007 population data.
Pacific medical student admission and graduation

The Universities of Otago and Auckland have preferential entry schemes for Māori and Pacific medical students. Applicants under these schemes are considered first and all those who meet the entry criteria are accepted. A few Pacific students choose to apply via the usual admissions process.

While preferential entry allows Pacific students admission to medical school with a lower academic achievement than non-preferential entry students, all students must achieve the same academic and professional standards to graduate. Using the Medical Council of New Zealand’s workforce data, the University of Auckland has estimated that of those Māori and Pacific students completing medical school from 2000 to 2007 the percentage remaining in New Zealand ranged from 70 percent to 100 percent (compared to with 79 percent to 93 percent for non-Māori and Pacific preferential- entry doctors). Further studies on attrition rates for Pacific students are planned over the next few years.

Support for Pacific medical students

Pasifika Medical Association

The Pasifika Medical Association was formed in 1996 by a group of Pacific medical professionals to:

- provide mentoring and support
- promote health professions as career paths in Pacific communities
- provide advice to academic and training institutions on Pacific health curriculum and student recruitment and retention
- work with partner organisations in the Pacific region
- provide a voice on Pacific issues relating to pacific health
- provide information on scholarships, training opportunities, funding and support for Pacific health practitioners
- provide policy advice to government departments on PACIFIC health issues.

The Pasifika Medical Association also supports doctors in the Pacific Islands and has commented that there is a considerable loss of the medical workforce from the Islands to Australia and New Zealand as doctors from the Pacific Islands enter specialty training in these countries. The Pasifika Medical Association recommends better co-ordination of the Pacific medical workforces in New Zealand, Australia and the Pacific Islands (eg, developing joint training/exchange of RMOs).

In Auckland, the Māori and Pacific Admission Scheme (MAPAS) seeks to provide a supportive environment where students, their whānau and staff accept a commitment to academic achievement within a Māori/Pacific context. A mentoring programme is currently being developed by Māori and Pacific students and supported by the Pasifika Medical Association and the university’s Pacific Health Section. This newly designed mentoring programme will begin in 2009.

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48 The University of Auckland’s scheme is called the Māori and Pacific Admission Scheme (MAPAS). Under this scheme students can may apply for entry into pharmacy, medicine, nursing, a bachelor of health sciences, and the certificate of health sciences.
A similar range of services to support Pacific students is available through the University of Otago’s Pacific Islands Centre. The university also has the Pacific Island Health Professional Students Association (the Pacific Students Association), whose membership includes students studying medicine, pharmacy, physiotherapy, dentistry, medical laboratory science and nursing. The Pacific Students Association provides support and mentoring, and is linked in to the Pacific Islands Centre.

The University of Otago is putting in place a foundation science programme to improve Māori entry into its existing science programme. Once in place, this programme could be extended to Pacific students.

The Pasifika Medical Association provides support for medical students at the Universities of both Otago and Auckland, holding regular meetings with Pacific doctors, mentoring, assisting with studentships, and holding conferences. Pacific medical students from the Universities of Otago and Auckland are on the Pasifika Medical Association’s executive and students are encouraged to assist with running Pasifika Medical Association conferences and workshops.

**Support for Pacific resident medical officers**

The Clinical Training Agency (CTA) has a Pacific Peoples Support Programme that provides funding to enhance the likelihood of Pacific trainees successfully completing CTA-funded training programmes. The CTA also has a Travel Assistance Grant Programme, which promotes equity of access to CTA-funded training programmes for trainees employed in areas that are remote from the location of their training programmes. This programme is not limited to Pacific trainees.

Some individual medical colleges have programmes in place to support Pacific RMOs (eg, the Royal Australasian College of Physicians). The Royal New Zealand College of General Practitioners usually holds a meeting with Pacific students once a year, but the Pasifika Medical Association noted that support for general practitioner trainees and encouraging Pacific doctors to enter general practice could be improved.

The Pasifika Medical Association provides support with members taking on a role to watch over Pacific house surgeons and registrars and provide career/vocation advice.

**Pacific resident medical officer data**

The Pasifika Medical Association has indicated that it can provide data on the numbers of Pacific RMOs in vocational training but this would take more time. This information will be provided to the Commission when it is available.
## Appendix 9: Retention of International Medical Graduates

### Table App 9.1: Medical practitioners – retention rates for international medical graduates (IMGs), 2000–2006

<table>
<thead>
<tr>
<th>First year registered(^a)</th>
<th>Number registered</th>
<th>Percentage of IMGs retained, by post-first year registration year 2</th>
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<tr>
<td>2006</td>
<td>969</td>
<td>50.5</td>
</tr>
</tbody>
</table>

Notes: The retention rate is expressed as a percentage and equals the number of doctors from the grouping who held a practising certificate at some point in that year compared with the number of doctors originally in that grouping.

\(^a\) International medical graduates are included in a grouping if they held a practising certificate in that year but not in the previous year. For example, for an international medical graduate to be included in the 2000 grouping, they must have held a practising certificate in 2000 and not held a practising certificate in 1999.

Appendix 10: Key Agencies in Medical Training and Education

This appendix contains a paper prepared by the secretariat to the Commission on the Resident Medical Officer Workforce (RMO Commission) as background to the RMO Commission’s deliberations. It explores the roles and responsibilities of key agencies with a role in medical training and continuing education.

Introduction

The Doctors in Training Workforce Roundtable aptly describes medical training as a continuum, “from the first days in medical school through a lifetime of academic learning, refining skills and developing a deeper understanding of the human condition in the service of the patient” 49

Undergraduate medical education in New Zealand spans six years and is provided through two universities, Auckland and Otago, with clinical teaching provided in clinical schools in Auckland, Hamilton, Wellington, Christchurch and Dunedin, in several provincial hospitals, and in general practice environments.50

Following graduation, medical training transitions into the clinical setting with first year post graduate doctors (interns) acting under provisional Medical Council of New Zealand registration in a general scope. Practice is supported by ongoing supervision, an obligatory educational programme, and regular assessments provided to the Medical Council. Most graduates achieve full registration in a general scope in their second post graduate year and continue to work for a year or more across a range of specialties until they decide on a future career pathway.51 General practice is notably absent from the postgraduate year (PGY) 1 to PGY 3 experience of most trainees.

The next step on the training continuum is post graduate training. Having identified a field of interest, doctors must seek acceptance into the vocational training programme with a medical college. Vocational training may take upwards of four years and culminates in vocational registration with the Medical Council and Fellowship with the appropriate medical college.

Once formal training is complete, doctors participate in continuing medical education (CME). This reflects requirements of the Health Practitioners Competence Assurance Act 2003, which requires the Medical Council to ensure that doctors are competent to practise, including a requirement to participate in continuing professional development.52 CME also is also intended to support doctors in keeping their knowledge and practice current.53

The structure of medical training and education is supported by a diverse range of agencies, whose responsibilities traverse delivery of curriculum and funding, through to registration and accreditation.

50 Ibid.
51 Ibid.
52 Advice on the Medical Council of New Zealand website (http://www.mcnz.org.nz).
Purpose
This paper responds to a request from the RMO Commission for information about the agencies, and their roles and responsibilities in the training and continuing medical education of New Zealand doctors.

The medical education and training system
Figure App10.1 provides a pictorial overview of the medical education system, including funding sources.

Figure App10.1: Overview of the medical education system, including funding sources

Training agencies

Universities

The Universities of Otago and Auckland are the two providers of medical undergraduate training. The Faculty of Medicine at the University of Auckland consists of three clinical schools based in Auckland, South Auckland and the Waikato. The Faculty of Medicine at the University of Otago consists of four schools: the Otago School of Medical Sciences; the Dunedin School of Medicine; the University of Otago, Christchurch School of Medicine and Health Sciences; and the University of Otago, Wellington School of Medicine and Health Sciences.

The University of Otago has the only Faculty and School of Dentistry in New Zealand. Like the Faculty of Medicine, it is located within the Division of Health Sciences within the University. It offers courses in all branches of dentistry, dental therapy, dental hygiene, dental technology, and clinical dental technology.

University funding is provided through the Tertiary Education Commission (see below) for teaching and learning (Student Achievement Component funding – SAC) and for research (the Performance-Based Research Fund). Additional research funding is also provided through Vote: Research and Science Technology.

The number of domestic students accepted into medical undergraduate training in New Zealand is subject to a cap. This is currently set at 365 full-time equivalent undergraduate students at the University of Otago and 155 full-time equivalent undergraduate students at the University of Auckland. The regulatory cap on placements was increased in both 2004 and 2007 by 40 places each time and split evenly between both universities.

Dental training places are not subject to a cap per se, but limited by available funding. There is a first year limit of 54 domestic students.

Undergraduate curriculum

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 (CUAP) is responsible for the quality assurance of university courses.
- The Medical Council of New Zealand 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 Medical Council of New Zealand.
- The Medical Council of New Zealand and the Australian Medical Council jointly accredit medical schools in Australia and New Zealand.\(^{54}\)

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\(^{54}\) Medical Reference Group, Health Workforce Advisory Committee. 2006. *Fit for Purpose and for Practice: Advice to the Minister of Health on the issues concerning medical workforce in New Zealand.* Wellington: Health Workforce Advisory Committee, p. 13.
The Dental Council of New Zealand accredits the bachelor of dental surgery (undergraduate) programme. (BDS) graduates are automatically eligible to register with the dental councils of both New Zealand and Australia without further training. The content of the BDS programme also has to be approved by the CUAP.

The accreditation process for the University of Otago Dental School and the Australian dental schools is organised under the auspices of a joint Committee of the Australian and New Zealand Dental Councils. Both the BDS and their Australian equivalents are recognised in both countries.

**Postgraduate programmes**

In addition to undergraduate training, the medical schools offer postgraduate programmes in health-related topics, for example the University of Otago Wellington offers a masters of health sciences, a postgraduate diploma in health sciences and a postgraduate certificate in health sciences; and conduct health-related research.

The School of Dentistry at Otago also offers postgraduate training at diploma, masters and doctoral levels and is developing programmes for all professional groups in dentistry.

**Medical colleges**

The medical colleges are the educational bodies responsible for organising, supervising, examining and subsequent recertification of medical practitioners in their vocational field. The duration and content of vocational training is dependent on individual college training programmes.

Colleges undertake the following functions:

- selecting medical graduates for vocational training, and providing training and assess trainees, including by administering written and clinical examinations
- assessing applications from specialists trained overseas who wish to practise in a specified clinical field in New Zealand
- accrediting hospitals for training positions
- providing specialist training, issuing a fellowship or other certification, attesting to the attainment or maintenance of appropriate levels of skills, knowledge and competencies appropriate to specialist practice
- providing continuing professional education and other educational opportunities for Fellows
- representing Fellows’ interests in various forums, including to government bodies or other organisations.

In addition, every college has guidelines about a broad range of matters relating to patient care, including training, equipment issues, staffing levels, safe practices, supervision and assistant skills.

The colleges themselves are generally combined Australian and New Zealand (Australasian) Colleges, with notable exceptions in the recently independent New Zealand College of Public Health Medicine and the Royal New Zealand College of General Practitioners. In all there are a total of 14 Colleges, listed below:

- Australian and New Zealand College of Anaesthetists
- The Royal Australasian College of Dental Surgeons
The Australasian College of Dermatologists
Australasian College for Emergency Medicine
The Royal New Zealand College of General Practitioners
The Royal Australasian College of Medical Administrators
The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
The Royal Australian and New Zealand College of Ophthalmologists
The Royal College of Pathologists of Australasia
The Royal Australasian College of Physicians
The Royal Australian and New Zealand College of Psychiatrists
New Zealand College of Public Health Medicine
The Royal Australian and New Zealand College of Radiologists
Royal Australasian College of Surgeons.

Some colleges have established faculties or divisions for sub-specialties. In some cases these are independent bodies offering their own vocational training programmes. The training and education programmes of the Colleges are accredited by the Medical Council of New Zealand and, in the case of the combined Colleges, the Australian Medical Council, to ensure they meet appropriate standards.

Training is delivered by fellows of the Colleges, without additional payment.

Medical training board

The Medical Training Board (MTB) was established in 2007 in response to a recommendation from the Workforce Taskforce. The MTB is accountable and provides advice to the Minister of Health and the Minister for Tertiary Education. Board members are appointed jointly by these ministers.

The purpose of the MTB is to provide strategic oversight of the education and training of medical practitioners, ensuring that practitioners are ‘fit for purpose’ and meet the current and future needs of the health sector.

Their terms of reference charge the MTB with the following:

- ensuring effective oversight and co-ordination of the continuum of medical education and training in New Zealand from entry to medical school to registration in a vocational scope of practice, with a specific focus initially on the transition years and training in general practice
- receiving advice from the district health boards (DHBs), other providers of health care and training providers on the number and mix of medical practitioners required to meet future health care needs
- developing a national view on the appropriate number and type of training positions required to provide an appropriate number and balance of vocationally trained medical practitioners to meet the needs of the New Zealand population
- reviewing clinical training specifications and funding intentions
- developing mechanisms to collect appropriate data to facilitate medical workforce development.
District health boards

Postgraduate, clinical medical training is based on an apprenticeship model. This means that most clinical training occurs in DHBs which are the employers of both the trainees and the specialist staff (Fellows of Colleges) who provide their training. This is a source of some tension for DHBs whose primary focus and accountabilities are in respect of service provision within the limits of the resources available.

Though clinical training occurs in DHBs, undergraduate medical training is the responsibility of the Universities, the Medical Council supervises PGY1 training and the Colleges have responsibility for vocational training. In the absence of formal oversight by any other organisation, DHBs effectively have responsibility for determining training and education content for PGY2 doctors (and onwards) until they move into a vocational training programme. They do this through clinical placements, day-to-day training opportunities and, in some cases, formal training programmes. Training for PGY2 doctors is generally relatively unstructured, though some DHBs offer a formal training programme for PGY2 doctors, and some are now putting such programmes in place.

Training funding

In 2004, the Tertiary Education Commission (TEC) and the Ministry of Health undertook a joint project to provide an insight into the tertiary education sector’s delivery of health sector qualifications and post-entry clinical training. In relation to medicine, the analysis, based on 2002 data, showed that of the $121 million per annum spent on medical education and clinical training by the Government, $43 million was spent by the TEC for both undergraduate and post graduate education, $62.9 million by the CTA on clinical training and an estimated $15 million was spent indirectly on clinical training by DHBs.

The regulator

The Medical Council of New Zealand

The Medical Council of New Zealand (the Council) operates under the Health Practitioners Competence Assurance Act 2003 (HPCAA) and has the following responsibilities:

- authorises the registration of practising doctors
- maintains a medical register of practising doctors
- issues annual practising certificates only to doctors who have maintained their competence to continue practising medicine
- monitors the training of medical students and new doctors to ensure their medical education is appropriate, including hospital accreditation
- requires doctors to continue their medical education once they enter the workforce
- can require a doctor to receive treatment if the doctor is suffering from an illness which is affecting the doctor’s practice
- can suspend a doctor’s practice
- carries out performance assessments of doctors in response to a concern expressed by a patient, colleague or any other person
- assesses and recognises new vocational scopes of practice.
The Medical Council is responsible for ensuring that medical practitioners are safe and fit to practise in New Zealand. This is managed initially through the registration process and then ongoing through annual certification (annual practising certificates). The Medical Council must be satisfied that New Zealand registered medical practitioners have reached 'a safe and acceptable standard and are maintaining and developing their competence as their careers progress'. The Medical Council is assisted in assessing this by 'the universities, hospitals and general practices accredited for intern training, and the medical colleges'. No person can claim to be a medical practitioner in New Zealand unless they are registered by the Medical Council and hold an annual practising certificate.

The Medical Council also, in association with the Australian Medical Council:
- accredits Australian and New Zealand medical schools and the training and continuing professional development (CPD) programmes of the Australasian medical colleges. The [Medical] Council also accredits the training and CPD programmes of New Zealand-only vocational branches. Regulations and standards may also be set or may evolve externally or internally by other bodies, for example through the Health and Disability Commissioner.

The Medical Council is funded by registration and annual practising fees paid by all practising doctors.

**Dental Council**

Like the Medical Council, the Dental Council is the statutory body under the HPCAA responsible for promoting and protecting the public interest by ensuring that oral health practitioners are safe and competent to practise.

The Dental Council protects the public and promotes good dental practice by carrying out its statutory responsibilities in relation to the registration, competence, conduct, health and education of registered oral health practitioners. These include:

- ensuring that undergraduate and postgraduate programmes leading to dental registration meet acceptable national and international standards
- setting the clinical, cultural and ethical standards for oral health practitioners
- authorising the registration of practitioners and considering applications for annual practising certificates
- establishing systems and processes to ensure that practitioners maintain competence throughout their practising lives
- promoting the health of practitioners and developing programmes for health-impaired practitioners to ensure a speedy return to practice while assuring public safety
- dealing with practitioners whose competence or fitness to practise has been called into question.

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56 Ibid.
57 Ibid.
The professions regulated by the Dental Council are dentists, dental specialists, dental therapists, dental technicians, clinical dental technicians, dental hygienists, dental auxiliaries and orthodontic auxiliaries.

The Dental Council is funded by the registration and practising fees paid by practitioners.

**Funding**

**Tertiary Education Commission**

The Tertiary Education Commission (TEC) is a Crown entity established under section 159C of the Education Act 1989. It is governed by a board of commissioners, appointed by, and responsible to, the Minister for Tertiary Education. The TEC is a Crown agent under the Crown Entities Act 2004, and must therefore give effect to government policy.

In addition, the TEC also has statutorily independent powers in respect of the planning and approval of funding for individual tertiary education organisations, and monitoring financial performance and governance of tertiary institutions. These powers are exercised within the strategic and policy frameworks set by the Government under the Education Act 1989. Notably, the Education Act 1989 gives the Minister for Tertiary Education responsibility for determining the design of the funding mechanisms the TEC must use to fund tertiary education organisations. This includes the purpose of a fund, general eligibility requirements, policy parameters, and conditions on funding. The Minister for Tertiary Education issues funding determinations to the TEC by letter under section 159L of the Education Act 1989.

The funding mechanisms of interest with respect to medical undergraduate training are the:

- Student Achievement Component (SAC) and Tertiary Education Organisation Component (TEOC)
- Performance-Based Research Fund (PBRF)
- Special Supplementary Grants (SSGs).

**Student Achievement Component and Tertiary Education Organisation Component (TEOC)**

The SAC and TEOC are two separate funds. Money from the two components is allocated through the TEC’s approval for funding of investments plans submitted by tertiary education institutions. SAC funding per full-time equivalent medicine undergraduate student in 2009 is $30,477 for each year of years two and three; and $35,945 for each of year of year’s four to six. This compares with dentistry at $43,592; veterinary science at $23,209; engineering at $9,512; nursing at $8,892; science $8,892 and arts at $5,171.

The PBRF is part of TEOC, but allocated under a separate funding mechanism, outlined below.

**Performance-Based Research Fund**

The PBRF aims to:

- improve the quality of research
• ensure research continues to support degree and postgraduate teaching
• ensure funding is available for postgraduate students and new researchers.

PBRF allocations, including any proposed portion for medical or health-related research, are made annually subject to TEC approval of investment plans submitted by the universities. The overall amount of funding received varies according to cost weightings for subject areas and a performance assessment process.

**Special Supplementary Grants**

SSGs provide an additional funding contribution to tertiary education institutions to meet the needs of specific groups of students. The two SSGs are the:

- SSG for Special Education
- Medical Trainee Intern SSG.

The purpose of the Medical Trainee Intern SSG is to provide a stipend for medical students working as interns as part of their sixth year of study. Tertiary education institutions applying for this funding must apply annually and are required to identify proposed initiatives and set performance targets and indicators for these initiatives. At the conclusion of each academic year, institutions are required to report back to the TEC on how funding has been used and on whether objectives were met.

**Clinical Training Agency**

The Clinical Training Agency (CTA) is a business unit of the Ministry of Health. It is part of the Health and Disability National Services Directorate, which brings together the Ministry’s national contracts for clinical training, disability support, population screening, personal health and public health.

The CTA's role is to purchase post-entry clinical training (PECT) for New Zealand health professionals. This means training that is substantially clinical, vocational and nationally recognised. To attract funding, training must be equivalent to a minimum of six months’ full-time training and occur after entry into a health profession so that a person is eligible to practise as a health practitioner under the Health Practitioners Competence Assurance Act 2003.

The CTA is also involved in workforce analysis and development. This includes joint projects with the Population Health, Health & Disability National Services, Māori Health, and Health & Disability Systems Strategy Directorates, as well as utilising sector reference groups. The CTA also has responsibility for the Overseas Trained Doctors Programme and for funds managed on behalf of the Mental Health Directorate.

Key projects for 2008/09 include the development of a new funding model for the training purchases, and the implementation of the outcomes of the surgery review and of the new funding model for Māori health training.

The CTA baseline budget has increased to approximately $120.2 million in 2008/09. This includes increased funding of more than $10 million for ongoing provision of the Nursing Entry to Practice (NETP) and Midwifery First Year of Practice Programmes and general practice training places.
The Industrial Framework

RMO multi-employer collective agreement

The RMO MECA contains two sections directly referring to training and education. Section 7, 'Protection of Training Programmes', explicitly acknowledges that RMOs 'are training under the supervision of district health board employees and in the case of training programmes, the appropriate professional College or vocational registration training body'.

Section 26, 'Medical (Dental) Education', recognises the importance of ongoing medical education and describes provisions to support this including:

- the number of hours of rostered duty per week in each DHB that will be set aside for the purpose of medical learning
- employees in their second and subsequent years of service being entitled to five days' medical education leave each year
- medical education leave entitlements (six weeks) for college or university study
- medical education leave of up to 12 weeks per annum for vocational training
- additional medical education leave allowed and determined on a case-by-case basis
- registrar entitlement to conference leave (six days plus expenses of up to $6,000 in total with a maximum of three days plus $3,000 in any one year)
- away-training expenses, for employees who are required to spend part of their training away from their base hospital, including travel expenses.

The MECA also sets out run requirements closely link to training and learning opportunities.

Senior medical officer MECA

Part 5 of the senior medical officer (SMO) MECA addresses professional matters, including quality improvement, credentialing, professional development and education provisions. Professional development and educational provisions include:

- continuing medical education – leave for 10 working days, plus agreed travelling time
- expenses of up to $16,000
- employees enrolled in two or more maintenance of professional standards (MOPS) programmes reimbursed up to an additional $500 per annum
- secondment of two weeks every three years to a recognised unit for the purpose of professional development
- sabbatical of three months (or other agreed period) on full pay after every six years of service.

Advocacy

Council of Medical Colleges

The Council of Medical Colleges (CMC) has been established to allow the colleges to discuss issues of common interest and to enable them to share knowledge, objectives and policies. Such discussions enable CMC to then inform and advise Ministers, government agencies and other relevant bodies on relevant health issues.
The CMC exists as a forum of educational bodies, established to allow the colleges to discuss issues of common interest and to enable them to share knowledge, objectives and policies, and to interact with government and government agencies on relevant health matters.

[The] CMC seeks to ensure – through the voluntary, co-operative and co-ordinated action of its member medical colleges – that individual medical specialties have a broad base of intercollegiate knowledge. This enables them, both collectively as CMC and individually as medical colleges, to provide for the community the highest quality of medical care delivered in accordance with accepted clinical principles and to improve, protect, and promote the public health.

The following are member colleges:

- Australian and New Zealand College of Anaesthetists
- Australasian College for Emergency Medicine
- The Royal New Zealand College of General Practitioners
- Royal Australasian College of Medical Administrators
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists
- The Royal Australian and New Zealand College of Ophthalmologists
- The Royal College of Pathologists of Australasia
- The Royal Australasian College of Physicians and the Board of Paediatrics and Child Health
- The Royal Australian and New Zealand College of Psychiatrists
- Australasian Faculty of Public Health Medicine
- Joint Faculty of Intensive Care Medicine
- The Royal Australian and New Zealand College of Radiologists
- Royal Australasian College of Surgeons.

New Zealand Medical Association and the Doctors in Training Council

The New Zealand Medical Association (NZMA) is a pan-professional medical organisation with a membership encompassing all disciplines within the medical profession, doctors-in-training, and medical students.

The key roles of the NZMA are to:

- provide advocacy on behalf of doctors and their patients
- provide support and services to members and their practices
- publish and maintain the code of ethics for the profession
- publish the *New Zealand Medical Journal*.

The NZMA has several standing committees including the Doctors-in-Training Council (DITC). The DITC represents the interests of NZMA trainee intern, RMO and medical student members.

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58 There is now also a New Zealand College of Public Health Medicine. The New Zealand College is not currently a member of the Council. Almost all New Zealand registered public health physicians are members of the College, but many currently retain dual membership with the Australasian Faculty (which is a Faculty of the Royal Australasian College of Physicians).
The DITC was established in 2002 to provide support and representation to NZMA members who are the future of the medical profession. The DITC advises the NZMA board of issues of relevance to doctors-in-training (DIT), contributes to NZMA responses to government policy proposals and develops its own policy proposals. It participates in advocacy and representation on DIT issues. The DITC also provides a forum for collaboration with non-RMO doctor groups.

The DITC meets four times a year, plus is represented at the twice-yearly NZMA Council. The Chair of the DITC sits on the NZMA board. The DITC chair is ex officio on the New Zealand Medical Students Association (NZSMA) executive and is also an invited observer to the Australian Medical Association Council of Doctors-in-Training.

**New Zealand Medical Students Association**

The New Zealand Medical Students Association (NZMSA) was established in 1972 and is affiliated to the NZMA. NZMSA is governed by an executive board made up of 10 elected representatives and the four regional presidents. Their role is primarily one of advocating for and representing medical students on issues of interest; including researching medical education and educating for educational best practice.

**New Zealand Dental Association**

The New Zealand Dental Association (NZDA) is the professional association for New Zealand dentists. As well as providing services for its members, the NZDA sees itself as the one body able to speak on behalf of NZ dentistry as a whole.

The key roles of NZDA are:
- publish and maintain codes of practice, including the NZDA Code of Ethics
- publish the New Zealand Dental Journal
- provide support for research
- provide support and services to members and their practices
- provide advocacy and support for dentists and their patients.

**References**


Medical Reference Group, Health Workforce Advisory Committee. 2006. *Fit for Purpose and for Practice: Advice to the Minister of Health on the issues concerning medical workforce in New Zealand*. Wellington: Health Workforce Advisory Committee.
Appendix 11: Locum Issues

This appendix contains a paper prepared by the secretariat to the Commission on the Resident Medical Officer Workforce (RMO Commission) as background to the RMO Commission’s deliberations.

1 Background

While locums have been a feature of the medical landscape for a long time, anecdotal evidence suggests that the practice has been increasing rapidly in New Zealand over the past 10 years with momentum still building.

The recent widespread use of locums is believed to have started in a one hospital that had difficulty attracting resident medical officers (RMOs). The apparent solution was to offer fixed-term contracts with payment above the multi-employer collective agreement (MECA) to fill the vacancies. With district health boards (DHBs) competing with one another for a limited RMO resource, competition led to the practice of filling vacancies in this way spreading among DHBs and creating an inflationary spiral. Using locums for filing vacancies as well as for short-term cover for illness and leave quickly became common practice.

2 Increasing use of locums

DHBs have told the Commission that use of locums is increasing (see section 5 below). The main reasons for this increase appear to be:

- regulation of working hours and the introduction of safe-staffing formulae have increased (arguably overly so) the number of doctors required to provide adequate cover
- RMO shortage in the face increasing health service demand from an ageing population and a primary care sector also under pressure
- locuming offers higher remuneration and more flexibility (particularly valued by RMOs who are parents) than full-time hospital positions.

3 Locum workforce

The locum workforce is made up of:

- career locums – medics who do choose not to hold a permanent job to but locum often as a way of providing flexibility to accommodate child-rearing or other interests
- moonlighters – permanently employed full-time or part-time employees who supplement earnings by additional locum work when rostered off
- permanent employees on zero hours (Christchurch region) – effectively a relief pool, these doctors have permanent jobs and are deployed where needed.

Under the RMO MECA ‘a locum is a casual employee employed to cover an absent RMO for periods of up to one month’ to be paid as a minimum at the additional duties rate.
4 Challenges posed by the use of locums

Cost
The locum ‘problem’ is a cost issue for DHBs, arising from the mismatch between supply and demand of RMOs. Being in short supply, and with DHBs committed to maintaining service, RMOs are in a position to command significantly higher payment for locum work than rates paid under the MECA to those in a full-time position. An industry of agencies has sprung up to supply RMOs, and the fees charged by these agencies further inflate the cost to DHBs. Locum rates are known to affect the satisfaction of permanent employees who perceive them as inequitable and have been the catalyst for permanent employees negotiating locum rates for additional duties.

Quality
It is thought that as many as 90 percent of those providing locum cover are current DHB employees who are on leave or who have completed their regular shift. There is currently no mechanism for recording how many hours a locum covering a shift has already completed that day or that week in another position. Locums often lack familiarity with the workplace, local processes and protocols, and with other clinical team members.

Training
Locums, although they can technically be in training, are generally regarded as being poorly supported and supervised with tenuous ties to any training they may nominally be involved in.

Legal and administrative ambiguities
Roles and responsibilities of hospitals, locum agencies and individual doctors in locum employment arrangements are undefined. Responsibility for indemnity, occupational health and safety, supervision and professional development are rarely explicit when a locum doctor is employed.

Medical workforce sustainability
A serious potential threat to long-term medical workforce sustainability is posed by the diversion of medical graduates into the locum market. In a time of workforce shortages locum work, which offers better remuneration and flexibility, appeals to an increasing number of junior doctors diverting them away from vocational training programmes and thereby reducing the number of specialists in the system in the longer term.

5 New Zealand data
The Ministry of Health collects some data from DHBs on their expenditure on temporary medical personnel.

District Health Boards New Zealand (DHBNZ) collects some locum data for its own purposes and this was supplied to assist the RMO Commission.

A request for data was submitted to all DHBs. Essentially, DHBs were asked for RMO and SMO locum costs, including fees and other costs, and to provide an indication of how many full-time equivalent (FTE) locums had been purchased in the period. The data request is attached as Appendix 1.
Thirteen of 21 DHBs responded to the request at the time of writing. However, the data was not easily comparable, as among the 13 DHBs, data was reported across five different 12-month periods, and one DHB reported data for only nine months. While most were able to supply cost data, only two DHBs were able to provide FTE figures.

The three Auckland DHBs provided comprehensive data beyond the data request.

**Costs**

The Auckland DHB data shows that in January 2009 the average hours worked by each RMO locum that month was 39, at an average cost of $3,900 per locum.

Most other DHBs provided total RMO locum costs and some provided a headcount of how many locums had been used, however there was no information about the number of hours purchased.

**Trend data**

Ministry of Health data shows that total outsourced medical personnel expenditure – RMOs, SMOs and medical officers special scale (MOSS) – across the 21 DHBs increased by 13 percent from 2006/07 to 2007/08, and based on eight months’ data was projected to increase by a further 13 percent from 2007/08 to 2008/09.

The Auckland DHB data in Table App 11.1 shows the number of RMO locums used each month by the Auckland DHBs increased by 48 percent, from 125 in January 2006 to 185 in January 2009. The hours worked by each locum RMO also showed a 30 percent increase over the same period, from 30 hours a month in January 2006 to 39 hours a month in January 2009. However, the average costs of each temporary RMO increased by 188 percent in that time, from $1,350 in January 2006 to $3,900 in January 2009.

### Table App 11.1: Monthly resident medical officer locum numbers, hours worked and costs

<table>
<thead>
<tr>
<th>Auckland region DHBs – Average numbers, hours and cost of RMOs</th>
<th>January 2006</th>
<th>January 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of resident medical officer (RMO) locums</td>
<td>125</td>
<td>185</td>
</tr>
<tr>
<td>Hours worked per resident medical officer (RMO) locum</td>
<td>30</td>
<td>39</td>
</tr>
<tr>
<td>Cost per resident medical officer (RMO) locum</td>
<td>1350</td>
<td>3900</td>
</tr>
</tbody>
</table>

Source: Figures derived from data supplied by Auckland DHBs.

The following trend information in Table App 11.2 has been taken from the 13 DHB responses to the RMO Commission’s data request.

### Table App 11.2: Comparison of DHB RMO and SMO locum costs between 2008/09 and 2007/08

<table>
<thead>
<tr>
<th>Resident medical officer (RMO) locum costs</th>
<th>Senior medical officer (SMO) locum costs</th>
<th>Where locum costs combined</th>
</tr>
</thead>
</table>

59 Figures derived from data supplied by Auckland DHBs.
<table>
<thead>
<tr>
<th>Costs increased over previous year</th>
<th>7</th>
<th>6</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Costs remained the same</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Costs decreased over previous year</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Source: Information is from the 13 DHB responses to the RMO Commission’s data request.

Table App 11.2 shows that RMO locum expenditure in seven of the 13 DHBs was higher than in the previous year and two DHBs reported RMO locum costs lower than the previous year.

SMO locum expenditure in six of 13 DHBs was higher than in the previous year, two reported SMO locum costs similar to the previous year and one reported SMO locum costs lower than the previous year.

Four DHBs did not distinguish between RMO and SMO locum costs. Of these four, two reported locum costs up, one reported locum costs similar to the previous year, and one reported locum costs down slightly on the previous year.

Other data

Some locum data is gathered by DHBNZ for its own purposes and has been supplied to the RMO Commission. The data is incomplete, but is sufficient to provide an indication that:

- the use of recruitment agencies to supply locums is widespread – DHBs report agency fees ranging from 10 percent to 20 percent of what is paid to the locum
- individuals are usually offered the MECA first, agencies are not interested in terms and conditions based on the MECA
- the most common range for locum rates for RMOs is $75–100 per hour, accommodation and travel allowances may also be paid
- locums commonly have no sick or annual leave entitlement and are not paid for training costs
- it is common for locums to be offered more than one contract.

6 Addressing the ‘locum problem’

The use of locums is inextricably linked with other RMO workforce issues the RMO Commission is considering – medical workforce supply, training pathways, and the industrial relations environment – and as such is unlikely to be able to be addressed in isolation from those issues.

New South Wales

The New South Wales Greater Metropolitan Clinical Taskforce was asked to examine locum employment arrangements in NSW on behalf of the Australian Minister of Health in 2004. The Taskforce found a very similar situation to that in New Zealand today – increasing use of locums, increasing cost of locums, and concerns about quality and safety. The Taskforce recommended action on four fronts.60

• **Prevocational and vocational trainees.** Improve hospital-based prevocational and vocational training experiences for junior doctors (postgraduate years (PGY) 1–PGY8). Emphasis to be placed on maximising involvement of junior doctors in higher-order clinical work by increasing clinical, clerical and technological support and by fostering development of clinical skills through active supervision, hospital-based training schemes and timely delivery of critical care courses.

• **Career medical officers and unstreamed doctors.** Provide greater professional and educational support for non-specialist hospital doctors including career medical officers and doctors in PGY3–PGY8 who are not engaged in vocational training programmes, including regular accreditation of positions, performance review, credentialing and maintenance of training and service records. Alternative, competency-based pathways for non-specialist hospital doctors need to be developed.

• **Locums.** Develop and maintain standards for locum employment arrangements. Centralised information about shift vacancies, employment of locums, individual locum credentials and performance history will reduce competition between hospitals for staff and allow hospitals to find a suitable locum more effectively. A standard employment contract should explicitly define the roles and responsibilities of the locum doctor, locum agency and the hospital.

• **Public hospital clinicians.** Revitalise the commitment and engagement of the public hospital workforce. Improving satisfaction and morale of clinicians by implementing key performance indicators that value social capital and wellbeing should become a priority for hospital administrators. Non-financial aspects of hospital work need attention. Accommodation, meals, parking, work environment and child care, if inadequate, communicate to clinicians that they are not valued in their workplace. Clinical leadership needs encouragement and reward, and clinical leaders of the future need to be developed by providing policy and management training for junior clinicians (Greater Metropolitan Clinical Taskforce, Metropolitan Hospitals Locum Issues Group 2005).

**DHBNZ Locum Project**

The DHBNZ Locum Project is in its early stages. A national steering group of DHB representatives has agreed a number of goals. These are:

• to convene a locum project workgroup within each DHB
• for each DHB to revisit its establishment of RMOs to attempt to reduce demand and to prepare a projected vacancy list
• to develop a national profile of potential shortages
• to develop a template contract for services, including a range of pay rates
• to develop strategies to restrict the use of a contract for services to day-to-day and short-term locums
• to seek national collaboration on control of locum rates
• to foster national collaboration on RMO recruitment and retention.\(^{61}\)

These goals are being updated and will be sent to DHB chief executives in early May 2009.\(^{62}\)

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\(^{61}\) Email from DHBNZ to RMO Commission secretariat, 23 February 2009.

\(^{62}\) Email from DHBNZ to RMO Commission secretariat, 23 April 2009.
Appendix: Summary of district health board resident and senior medical officer locum expenditure – questionnaire

<table>
<thead>
<tr>
<th>Summary of DHB RMO and SMO locum expenditure</th>
<th>Year starting: ..................................</th>
<th>Year ending: ..................................</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Quarter</td>
<td>Quarter</td>
</tr>
<tr>
<td>RMO locums:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Locum FTEs purchased</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Locum fees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travel</td>
<td></td>
<td></td>
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<tr>
<td>Accommodation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agency fees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other locum expenditure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SMO locums:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Locum FTEs purchased</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Locum fees</td>
<td></td>
<td></td>
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<tr>
<td>Travel</td>
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<tr>
<td>Accommodation</td>
<td></td>
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<tr>
<td>Agency fees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other locum expenditure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MOSS/medical officer total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Name of DHB
How does this expenditure compare with previous years?

Is there anything the Commission needs to be aware of in interpreting the information you have supplied?

Notes
- For the purposes of this exercise a locum is any doctor providing services who is not permanently employed as an RMO or SMO by your DHB.
- If quarterly data is not available then annual numbers (per financial year) would suffice.
- If you are unable to break out locum costs please indicate what is included the costs you report.

Thank you for your assistance.

References


*Treating People Well: Report of the RMO Commission* 87
Appendix 12: Senior Medical Officer Roles as Teachers and Researchers

This appendix contains a paper prepared by the secretariat to the Commission on Competitive and Sustainable Terms and Conditions of Employment for Senior Medical and Dental Officers Employed by District Health Boards as background to the SMO Commission’s deliberations, and considered by the RMO Commission in its deliberations.

Purpose

This paper provides information about:
- senior medical officers (SMOs) providing training roles in the clinical setting
- the academic medical workforce.

The key issues identified in this paper are the:
- difficulties in balancing teaching (and research) with clinical service provision
- lack of funding to support research.

Background

Doctors are clinical scientists applying the principles and procedures of medicine to prevent, diagnose, care for and treat patients with illness, disease and injury and to maintain physical and mental health. They supervise the implementation of care and treatment plans by others in the health care team and conduct medical education and research.63

The concept of doctors as teachers and scientists is common to most definitions of the role of a doctor. Senior Medical Officers (SMOs) roles as teachers and researchers sits within, and is influenced by, a complex environment where responsibility for medical education and research is spread across government, universities, specialist colleges, professional associations, accreditation agencies and district health boards. While there are generally sound reasons for the delineation of responsibility across organisations, it has also created a degree of fragmentation leaving SMOs to manage frequently competing service and teaching demands and a challenging research environment.

Clinical teaching role

Describing the teaching role

The SMO multi employer collective agreement (MECA) provides guidance on the content of job descriptions for senior doctors including ‘non-clinical and other professional activities’ which “should make up at least 30 percent of the total job size”.64 Included in the MECA list of non-clinical activities are:

63 International Labour Organization.
64 New Zealand District Health Boards, Senior Medical and Dental Officers Collective Agreement, 1 July 2007 Until 30 April 2010, section 48.1.
- research
- teaching, including preparation time
- supervision and oversight of others.\(^{65}\)

Actual SMO job descriptions tend to vary across DHBs and generally do not specify the amount of time that should be allocated to providing training overall, nor do they contain detailed descriptions of teaching and/or supervisory responsibilities. That said, some, particularly where this includes taking on an additional role such as intern supervisor, do make time provision for these duties, though this may not necessarily reflect the amount of time taken on this work.

By contrast, the resident medical officer (RMO) MECA specifies the expected amount of weekly teaching time for doctors in training in each DHB.

Appendix A provides you with an example of the array of teaching and supervision roles that SMOs may undertake.

**The apprenticeship model**

New Zealand postgraduate medical training is based on the apprenticeship model of learning. The apprenticeship model is based on the trainee practitioner observing, practising and gradually acquiring ‘the competencies of the senior practitioner through graded supervision and experience. The senior practitioner delegates increasing responsibility and independence to the apprentice, according to the individual’s progress and abilities’.\(^{66}\) There are many benefits, but implicit in the apprenticeship model is a significant time investment by SMOs to provide doctors in training with quality training and learning experiences.

The apprenticeship model relies ‘on senior clinicians to supervise the day-to-day practice ... and ensure quality health care ... However, the changing health care environment is putting the apprenticeship model under threat’.\(^{67}\) There is now a significant difference between the senior clinicians’ own experiences as trainees and the experiences of current trainees, in particular in relation to the industrial environment, changing workforce expectations, and the make-up of clinical service demands.

**Challenges to providing teaching**

Several factors impact adversely on the availability of senior doctors to teach junior doctors, including:

- an increasing clinical workload which reduces the time available to teach
- changes to RMO working hours, which reduce contact (and therefore teaching opportunities) between SMOs and RMOs

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\(^{65}\) Ibid, section 48(1)(d).


• increasing numbers of medical students, interns and registrars and the associated additional teaching and training workload

• a lack of clearly defined teaching responsibilities and duties in their employment contract.

**Time for training**

Feedback from the consultation meetings with SMOs (and RMOs) indicates that a strong commitment to education and training by a DHB can be a significant pull factor for medical recruitment and retention. In practice, however, SMOs often carry heavy clinical and non-clinical workloads associated with meeting hospital’s service requirements. SMOs are generally not allocated dedicated time for teaching, supervising and mentoring junior clinical staff. This is borne out by the Clinical Training Agency: Summary of Responses to 2006 Training Programme Questionnaire, which found that the most common issue for supervisors was having insufficient time to provide clinical supervision. Both doctors in training and supervisors found that their workloads limited their ability to effectively participate in the training.

**The growing training workload**

The Canterbury District Health Board RMO Advisory Committee and Stephen Child explored the impact of the 1985 M10 determination in reducing RMO working hours and the subsequent increase in the number of RMOs required to meet service needs. As a result of the changes:

- junior doctors had come to constitute 24 percent of the medical workforce, when the optimum for a balanced staff mix was considered to be 8–12 percent. The SMO/RMO ratio has become inverted. Whilst the Medical Council and the Clinical Training Agency place increasing emphasis on the responsibility of SMOs for the supervision and training of junior staff, there are proportionally fewer of them to undertake these tasks.

In addition, SMOs have experienced ‘an “upward shift” of workload ... as continuity of care becomes increasingly provided at the consultant level’.

The Medical Training Board has recommended the number of medical student placements in New Zealand increase by 100. The Minister of Health has signalled an increase of 200. As medical student graduate and the number of doctors in training increase, the demand on SMOs to provide supervision and training will grow, as will the need to protect time for this purpose.

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70 Ibid.

71 Ibid.
The Review of Victorian Public Medical Health Staff\textsuperscript{72} found that there was:

considerable concern among senior medical staff regarding the availability of resources ... for the additional teaching load that increased undergraduate (and postgraduate) students will create.\textsuperscript{73}

It seems likely that similar concerns will arise in New Zealand as a result of increasing numbers of doctors in training. While non-clinical time provisions may offset these additional requirements to some degree (assuming this time is protected and available), it may result in demands for increases in the amount of non-clinical time or additional payment for postgraduate teaching responsibilities. For DHBs, increased training demands will likely impact on productivity both as a result of potentially reduced clinical hours (relative to non-clinical hours) to meet the additional teaching demands, and due to slower service provision as a result of the additional required to teach while providing clinical care, for example teaching while on ward rounds.

Support for senior medical officers undertaking a training role

‘Senior medical staff need to be recognised for their roles as supervisors and educators.’\textsuperscript{74} Moreover, government and health service providers need to recognise that quality education and supervision take time, and the allocation of appropriate funding.\textsuperscript{75}

Training the trainers

Peter Garling argues that training delivered by SMOs can be ad hoc and unstructured.

Without interested and engaged consultants who are interested in teaching and who have had training in how to deliver training, the registrars’ experience is not optimal, nor can it be expected to be.\textsuperscript{76}

By and large, fellows of the Colleges train junior medical officers, including registrars, according to their own somewhat idiosyncratic personal standards.\textsuperscript{77}

Good clinical teaching and supervision are central to building a competent medical workforce. SMOs have usually not been trained in how to teach, but are expected to carry out teaching tasks. Historically, there has been little support provided for teaching, but increasingly universities and medical colleges are designing programmes to enhance SMO teaching activities. The College of Physicians has a programme and the University of Otago, Wellington Clinical School, for example, is also setting up a programme to support doctors as teachers.

Colleges also run supervision workshops, and DHBs generally run ‘train the trainer’ workshops.


\textsuperscript{73} Ibid, p. 88.


\textsuperscript{77} Ibid.
Payment for training

In New Zealand, clinical training is viewed as part of the SMO role in the public sector. Payment is through SMO salaries, which recognise that a portion of SMOs’ time will be spent on training.

Though payment for clinical training did not emerge as a high profile issue through the SMO Commission consultation process, it is pertinent in as far as it has arisen in other documents, for example, the Medical Training Board’s *The Curriculum Framework*, and also appears to arise regularly in the Australian literature. In 2005, the Australian Productivity Commission in its report on the health workforce argued that the lack of payment for clinical training services ‘makes such training vulnerable to competing service delivery needs’. Its view was that:

greater use of explicit payment to those providing infrastructure support for clinical training and for the training services themselves, is likely to be necessary if the system is to remain sustainable over the longer term ... Explicitly funding could also be particularly helpful in encouraging the private sector to take on a larger clinical training role.

The 2008 Garling Report also noted calls for payment for trainers, but shied away from recommending explicit payments, instead arguing for a uniform approach to recognising and remunerating all teaching and mentoring roles, and focusing on protected time for training and formal teaching duties as part of SMO terms of employment.

To date however, the shared New Zealand and Australian medical colleges have expressed little enthusiasm for greater reliance on explicit payment models within colleges. The Victorian Government also noted its concern that an explicit payment model could lead to higher charges for doctors in training.

Any move toward instituting a system of payment for training will require careful thought and the development of a methodology to cost teaching and training activities.

One quarter of all clinical activity undertaken in public hospitals was of a ‘multiple product nature’, involving clinical care undertaken in conjunction with teaching, training and research, and that ‘attempts to disaggregate multiple product activities into proportions of time spent on teaching, research and clinical care is not feasible and should not be undertaken.’

Alternative approaches to teaching and mentoring roles

SMOs will always play a critical role in the training and supervision of trainee doctors. There are, however, opportunities to share some of the teaching workload. Options that may be considered include:

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82 Ibid.
• a more multi-disciplinary approach to training roles with, for example, with nurse specialists providing teaching in their specialist area

• increasing the role of advanced trainees in providing training – this also has the benefit of preparing them for their future role as SMOs

• devolving examination processes to expert nurses

• encouraging retiring or recently retired doctors to take up teaching and mentoring roles

• developing a career stream (particularly towards the end of an SMO’s career) focusing on education and training.

Research and clinical academic career pathways

In its submission to the SMO Commission, the Medical Council of New Zealand argued that the current workforce shortage goes beyond SMOs employed solely by DHBs, and extends into the universities. It notes that research and teaching are fundamental to quality training and education of medical practitioners.

DHBs actively supporting clinicians engaging in teaching and research are generally considered to be a powerful recruitment and retention tool, ‘providing a culture of innovation and reflective thinking’. Feedback to the SMO Commission suggests that the presence of the medical school made a huge difference to the culture of the DHB, and that academic appointments attracted quality specialists to DHBs.

Feedback from the SMO Commission submissions process suggests that there are two key areas of concern in this area:

• role conflict issues for clinical academics trying to balance clinical practice and teaching and research commitments

• a lack of funding to support research.

Balancing clinical practice and academic roles

There are two roles available for doctors who wish to retain a clinical component to their academic career rather than focusing on pure research:

• joint clinical academics

• clinical (senior) lecturers.

As the name suggests, joint clinical academics have both academic and research, and clinical components to their role. This is an academic career pathway where doctors are required to meet the requirements of academia to achieve academic career progression.

A real difficulty for clinical academics is that they are frequently balancing roles and often have accountabilities both within the university and the DHB. Often they will be undertaking undergraduate and postgraduate teaching, research, administrative and management tasks, alongside maintaining active engagement in clinical practice. The balance between research, teaching and clinical service can be especially challenging, particularly as clinical academics are employed by the university, but the DHB pays half of their salary.
The role of clinical lecturer is evolving, but is generally something of an honorary role, where doctors may be paid little or nothing for providing clinical teaching opportunities for medical students. In return clinicians are linked to the university and as ‘members of staff’ have access to the university library. Some clinical lecturers do have a more substantive role and will be employed up to 0.3 full-time equivalent. While this role clearly provides important learning opportunities for medical students, it does raise the important question of the role of DHBs in training the future medical workforce and highlights some of the challenges across the academic–clinical interface.

**Growing the medical academic workforce**

A survey undertaken by Zarkovic and colleagues suggests that rotation in a specialty was the strongest factor influencing career decisions.\(^\text{84}\) While there are some opportunities for undertaking research during student years,\(^\text{85}\) feedback suggests the loss of links with research is a particular problem during the postgraduate years, before vocational training, resulting in fewer clinical academics coming through.

Examples of career pathways for research and clinical academics in other jurisdictions are in Appendix B.

**Access to research funding**

**Sources of research funding**

The Health Research Council (HRC) is the main public funder of health and disability research in New Zealand. The HRC administers government funding through Vote: Research, Science and Technology funds and through the Ministry of Health and DHBs (through Vote: Health funds). There is also a range of other funding sources, including:

- other government sources, such as the Foundation for Research, Science and Technology and the Tertiary Education Commission
- non-government organisation funders, such as the Cancer Society
- private sector businesses
- international funders (both public and private), such as the National Institutes of Health and the Gates Foundation.\(^\text{86}\)

Health features strongly in overall research in New Zealand.

In 2006, research expenditure across government, business and university sectors on health was $268.7 million, 15 percent of total research expenditure ($1,825.6 million) and the largest individual research expenditure category. Within the total of health-related research expenditure, the ... higher education sector [undertook research to the value of] $124.2 million (46 percent).\(^\text{87}\)

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\(^\text{85}\) The Universities of Otago and Auckland support summer studentship programmes for undergraduates, and the Medical Council of New Zealand offers research awards to undergraduates.


\(^\text{87}\) Ibid, p. 13.
Health delivery research comparisons with other countries are difficult as there is no standard or routine categorisation of health delivery research and different countries have different funding models. We can, however, note research funding data from the United Kingdom, where the government is supporting budget increases to £1 billion for the National Institute for Health Research (health sector focused research) and £0.7 billion for the Medical Research Council (mostly early stage and discovery research) by 2010/11. Notably, National Institute for Health Research (NIHR) research centres have £459 million over five years to enable leading National Health Service (NHS) and university partnerships to drive progress on innovation and translational research in Biomedicines and NHS Patient Safety and Service Quality.

In Australia, where in 2007, government funding through the National Health and Medical Research Council, their primary funder of health research, was AU$342 million for basic science and AU$296 million for other research areas including ‘clinical medicine and science’, ‘public health’ and ‘health services research’.88

The main concern of the academic community is that “HRC funding is diminishing in real terms because of increasing research cost, particularly academic and medical salaries. Thus volumes of research are falling”.89 This view is reiterated in comments from Professor Ian Reid and Professor Peter Joyce in their discussion paper on health research.90 They argue:

“staff within our hospitals and universities have been willing, for many years, to accept lower pay rates than in comparator countries. However, they are much less accepting of the lack of opportunity to carry out research, since they regard this as a defining part of their professional lives. .... This is of particular concern in light of the recent expansion of the number and size of Australian medical schools, which is already making the Australasian market for health academic staff very competitive. With this loss of staff, there will be a progressive inability for our tertiary institutions to train the New Zealand health workforce.”91

District health board funding

Though there is considerable research undertaken within DHBs, research is specifically excluded from DHBs operating funds. As a result, DHB management is seen by some researchers to be indifferent to research or discouraging staff involvement because of the effect on outputs.92 This notwithstanding, the DHB Research Fund (DHBRF) was established in 2005 to fund small to medium sized research projects of direct relevance to DHBs. The DHBRF has $6.2 million available over four years,93 and has been taken up by a variety of university and non-university research groups.

88 Ibid, p. 16.
90 Ibid.
91 Ibid.
93 Ibid.
**Academic workforce**

The majority of publicly funded health research, and health delivery research, is carried out through universities, principally through the schools of medicine and health sciences at both the University of Otago and Auckland, and often in conjunction with DHBs.\(^{94}\)

Clinical academics (with joint DHB and university appointments) working on HRC funded projects have increased from 21 to 36 full-time equivalents (151 to 273 individuals) between 2003 and 2007. Clinical academics are now the second largest HRC workforce category (after academics), making up 21 percent of the workforce. Data suggests, however, that they are very much ‘part-time’ researchers, most with only a ‘few-tenths’ of their time allocated for research.\(^{95}\)

The Universities of Otago, Auckland and Victoria have expressed concerns about their ability to retain and recruit promising researchers ... because of the relatively low levels of funding here and the difficulty in obtaining funding, compared with elsewhere. These difficulties are compounded by the fact that many people working in health services research are not in academic teaching positions and are on fixed term contracts.\(^{96}\)

Most health researchers rely on research grants to support some or all of their salary and hence experience a degree of job insecurity.

**Appendix A: Senior medical officer teaching and training roles**

**Director of clinical training**

Directors of clinical training are usually only found in larger the DHBs. Their role is to have an overview of clinical training across the DHB. They are often the key liaison person with the hospital, colleges, the intern supervisors, the Medical Council of New Zealand and the Ministry of Health. There are directors of clinical training at Counties Manukau DHB and Capital & Coast DHB.

**Intern supervision and training**

Intern supervisors are the Medical Council’s agents and are responsible for ensuring that the standards of clinical experience and education are maintained at their hospital. Their focus is on postgraduate year (PGY) 1 doctors in training, and they have a statutory role in signing off assessments as part of the requirements for registration. Run reports are completed at the beginning, middle and end of runs, along with a three-monthly report completed by the supervisor. Generally any one supervisor should be responsible for up to 10 doctors in training. Intern supervisors are also responsible for organising teaching activities, including tutorials.

Some hospitals are now putting into place a similar structure for PGY2 graduates.

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\(^{94}\) Ibid, p 29.

\(^{95}\) Ibid, p 41.

\(^{96}\) Ibid, p 42.
On a day-to-day basis, the supervising specialist also undertakes a critical role in supervision and training. They are expected to act as role models, provide regular feedback, incorporate interns into the ward team, ensure the Registrar is actively engaged with the intern, support formal teaching programmes, make specific time for clinical teaching about issues for a particular patient and meet with the interns three or four times during the run outside of formal teaching time to provide feedback and performance evaluation.

**Registrar supervision and training**

This description of supervision and training comes from the College of Physicians, though the requirements for other colleges are similar. Support is provided through a four-tier structure within each training institute. Key elements of this support centre around planning and facilitating the trainee's learning path, the facilitation of effective teaching and learning opportunities and the provision of comprehensive and feedback on the trainee's progress and achievement of the curricula learning objectives.

The four tiers are:

- director of physician education
- educational supervisor (basic / advanced training)
- rotational supervisor (ward consultant)
- professional development advisor (PDA).

There is one director of physician education per geographic network or large hospital. Their focus is on strategic and macro level educative leadership links between college and hospital(s). Their role is to:

- provide leadership within their workplace or geographic area
- provide oversight basic and advanced training programmes and support within the network or hospital
- drive training and support of educational/rotational supervisors in conjunction with regional committees
- present two three-hour physician educator core training modules for educational/rotational supervisors within their network or hospitals
- establish and facilitate local support networks
- provide advice to the College Education Committee through the expert advisory group
- complete programme administrative work as required.

There is at least one educational supervisor for basic and advanced training within each hospital: one per 10–15 trainees (dependant on location). The focus of the educational supervisor is on the operational level educative leadership and management link between the college and hospital, and they provide a direct link between the college and the trainee. Their role is to provide:

- oversight training programmes for a small group (maximum 10–15) of basic or advanced trainees within their hospital
- meet with each trainee a minimum of four times per year to develop and implement an appropriate plan of training
- conduct regular formative assessments and monitoring of trainees’ progress (in conjunction with the rotational/run supervisor)
• provide regular and timely feedback to trainees within their group
• ensures specific training programme requirements are satisfied
• provide direct guidance and support for rotational/run supervisors working with trainees in their group
• facilitate/assist with teaching and learning
• facilitate/assist with formative assessments
• facilitate penultimate year review (advanced trainees)
• assist with presentation of two three-hour physician educator core training modules for rotational supervisors within their hospital
• complete programme administrative work.

The next layer is the rotational supervisor, of which there is one per basic or advanced trainee. Their focus is on actively supervising and supporting the training of individual trainee(s) and providing direct teaching and learning support to their trainee(s). The role of the rotational supervisor is to:
• as ward consultant, be actively involved in the direct teaching of their trainee(s)
• guide and facilitate development of knowledge and skills outlined in basic or advanced training curricula as applicable
• role model exemplar clinical practice and procedures
• conduct formative assessments and provide direct feedback to the trainee
• assist with conduct of penultimate year review (advanced trainees)
• monitor trainee progress and provide advice to educational supervisor as appropriate
• complete supervisor’s reports.

The professional development advisor (PDA) will, ideally, follow the trainee through both basic and advanced training. Their focus is on facilitating personal and professional development support. They do this by:
• guiding and facilitating development of knowledge and skills as detailed in the professional qualities curriculum
• meeting with the trainee a minimum of two times per year
• facilitating critical reviews and reflection on the trainee’s practice through discussion and use of e-portfolios / reflective journals
• using multi-source feedback assessments to conduct formative assessment of professional qualities curriculum domains or learning objectives (per year)
• providing comprehensive feedback to the trainee
• assisting with the penultimate year review (advanced trainees).

**Mentoring and peer supervision roles**

SMOs may also provide medical student training. This requirement varies as trainee interns are the primary responsibility of the university. That notwithstanding, SMOs commonly undertake training for students while they are attached to a consultants team. SMOs also provide teaching for other health professional groups.
In addition to teaching, SMOs also undertake general mentoring roles. This may happen with trainees across the spectrum and often for more than one doctor in training. There can be additional demands on female consultants where female trainees particularly seek out a female senior doctor as a mentor.

SMOs may also provide mentoring and supervision for their international medical graduate colleagues.

Appendix B: Formal career pathways for research and clinical academics in other jurisdictions

United Kingdom

The United Kingdom Clinical Research Collaboration (UKCRC) was established in 2004 with the aim of re-engineering the clinical research environment in the UK. The Partnership brings together the major stakeholders that influence clinical research in the UK, and includes the main UK research funding bodies; academia; the National Health Service (NHS); regulatory bodies; the bioscience, healthcare and pharmaceutical industries; and patients.

The partnership model arose out of the Walport report, published in 2005 by a subcommittee of the UK Clinical Research Collaboration (UKCRC) and the NHS Modernising Medical Careers (MMC), which made recommendations for initiatives to integrate the development of academic skills with each of the key stages of a clinician’s career. As a result, integrated academic training pathways have now been established through partnerships between universities, local NHS trusts and postgraduate deaneries. The integrated academic training pathway consists of three phases:

- academic clinical fellowships
- clinical lectureships
- clinical senior lectureships.

The scheme is available in England and Wales.

Australia

The Australian Clinical Research Fellowship provides full-time training in the area of clinical research, including the social and behavioural sciences. Eligibility is not restricted to doctors, but applicants must hold a doctorate in a health-related field.

The National Health and Medical Research Council also runs Training (Postdoctoral) Fellowships, the purpose of which is to provide opportunities for Australian researchers to undertake research that is both of major importance in its field and of benefit to Australian health. Training (Postdoctoral) Fellowships provide a vehicle for training in basic research either in Australia or overseas (where appropriate), to enable Fellows to work on research projects with nominated advisors.

The Training (Postdoctoral) Fellowship funding includes Health Professional Research Training Fellowships, which aim to provide part-time (50–70 percent) training for awardees who wish to combine their professional career development with a research Training Fellowship in Australia.

In addition there are state initiatives. For example, the Queensland Government has launched a $20 million clinical research fellowship scheme, commencing in 2010. Six fellowships will be awarded each year, each worth up to $850,000 a year over five
years. Fellowship recipients will be required to deliver clinical care as well as undertake research.

References


Appendix 13: Public–Private Interface

This appendix contains a paper prepared by the secretariat to the Commission on the Resident Medical Officer Workforce (RMO Commission) and Commission on Competitive and Sustainable Terms and Conditions of Employment for Senior Medical and Dental Officers Employed by District Health Boards as background to the SMO and RMO Commissions’ deliberations.

Purpose

This paper provides information about:

- the interface between public and private health care in New Zealand
- the impact of the private sector on the recruitment and retention of senior medical officers (SMOs)
- the impact of the private sector on the training and numbers of resident medical officers (RMOs)
- public–private partnerships.

The key issues identified in this paper are:

- SMOs working across the public and private sectors brings both benefits and tensions
- the most commonly cited benefit is that increased remuneration from the private sector offsets lower salaries in the public sector, and therefore supports district health boards (DHBs) to attract and retain senior medical staff
- benefits must be balanced against the risks of access to necessary services being determined by income, potential conflicts of interest, and private sector–generated costs being borne by the public sector.

Background

The New Zealand health care system is predominantly a publicly financed system, with the government funding 78 percent of national health care expenditures. Private health insurance payments account for only 6 percent of national health expenditures, with the remaining 16 percent paid out-of-pocket by individuals. Although the private health insurance share of national health expenditures is modest, about 40 percent of New Zealand adults have private health coverage, so incentives created by the coverage can have a widespread impact.97

Regardless of the predominance of publicly funded health care, the public and private health care systems are closely intertwined. There are numerous interdependencies, the most critical of which is the medical workforce. Many specialists work in both sectors and there is competition between public and private providers for this workforce.

Overview of the current public–private mix

Around half of public funds for health services go to private providers. Figure App 13.1 depicts the flow of funding from public and private sources through to various types of providers including public, private (for-profit and not-for-profit). Private work opportunities for SMOs arise in quadrants B and D, that is, as a result of DHB and Accident Compensation Corporation purchase of services or through purely privately funded purchase (insurance or self-funded).

<table>
<thead>
<tr>
<th>Funding</th>
<th>Service provision</th>
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<tbody>
<tr>
<td>Public</td>
<td>Private (includes for profit/not for profit organisations)</td>
</tr>
<tr>
<td>Public</td>
<td>A In patient acute and elective hospital services Most outpatient services Community nursing services • Emergency department services</td>
</tr>
<tr>
<td>Private</td>
<td>C Some DHBs contract theatre space to private practice Contracts with Pacific governments for the provision of complex treatments to their citizens • In general this is not a common feature of the New Zealand system</td>
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Public and private: benefits and tensions

The New Zealand public health system makes explicit provision for public sector specialists to undertake private work. Allowing a critical workforce to be engaged in private activity alongside their public sector work is unusual. The state sector more generally does not allow employees to work for other organisations. This is similarly true for other organisations, for example Telecom, who do not allow their employees to work for competing organisations, or in any capacity that may lead to conflicts of interest.

Feedback during the consultation meetings suggest the following factors come into play in specialists deciding how to allocate their time.

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98 Clause 46 of the SMO MECA.
Push factors:
- Limited input in management
- Capped salaries
- Lack of control of environment
- Perceived lack of value

Pull factors
- Predictable caseload with no acute work
- Control of environment
- Uncapped income

Retention factors
- Loyalty to the public system
- Interesting cases, research opportunities
- Collegiality and referral networks

Advantages of dual practice
Allowing specialists to undertake private work alongside their public commitments brings a number of advantages, including:

- remuneration – this is the main argument supporting dual practice, ie, by allowing specialists to increase their total remuneration package through private employment, DHBs do not have to pay as much to attract and retain SMOs.

- the value of publicly funded continuing medical education (CME) flows through to the private sector benefiting both private as well as public patients and supporting quality care in both sectors

- attracting specialists to smaller centres – in some parts of the country, the volume of public sector work is insufficient to attract a specialist. The ability to undertake dual practice may attract them to the public sector role and/or provide sufficient volumes of procedures to ensure their ongoing competence

- employing greater numbers of part-time specialists can spread the demands of on-call rosters.

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99 Specialists in the public health system are generally employed on a salary (total remuneration averaging $223,581), while private sector remuneration tends to be based on rates for particular procedures. Information on private sector remuneration for specialists is difficult to obtain, however, some now rather dated, figures provide an insight into the disparity between public and private sectors. It was estimated that in 1999, private sector remuneration rates were between $100–$200 per hour (net of practices costs) compared with $50–$75 per hour in the public sector.

Tensions

SMOs play a key role in determining New Zealanders access to public health services:

- patients must undergo specialist assessment before they can access the next level of care
- specialists assess the level of need for care (priority assessment)

These are critical steps to accessing specialist health care services in the public health system and raise three areas of concern when SMOs are engaged in providing both public and private health services:  

- a two-tiered system (ie, access to health services based on ability to pay rather than need)
- interdependencies (eg, demand in one sector affecting capacity to deliver in the other)
- potential conflicts of interest.

Two-tiered system

The two-tiered system operates where waiting lists exist for services. Paying specialists for their services in the private sector provides patients quicker access, at a lower level of assessed need. The most obvious example of the operation of the two-tiered system is in the area of elective surgery. While differential access to services based on ability to pay appears to be a broadly accepted feature of New Zealand’s health system, it is less acceptable when ability to pay affects access to necessary services such as specialist assessments and surgical procedures offering significant health benefits.

Interdependencies

The private sector can assist the public sector to deliver care in some circumstances, for example many DHBs have increased their contracting out of electives to the private sector, in response to capacity constraints. It can provide products and services that complement the public sector.

However, there are a number of areas where costs associated with private activity are met from public funding. This includes:

- the training costs of professionals working privately
- laboratory tests and prescriptions following private consultations with specialists
- patients sometimes move back and forth between the two sectors. For example, a person might pay for a specialist assessment privately, then be referred for public treatment, thus reducing waiting times and ‘jumping the queue’. In some other cases, patients treated privately may be transferred into the public sector if the case proves too complex, or something goes wrong.

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Potential for conflicts of interest

Somewhere around half of all New Zealand specialists are engaged in dual practice, often spending around half of their time in each role. The potential conflict arises because, for the most part, the same specialists who are seeing private patients are also assessing the clinical priority (need and speed of access to care) and treating publicly funded patients. If the wait in the public sector ‘becomes too long, or the clinical threshold is set too high, then some patients – those with enough income or private medical insurance – will opt to have their treatment in the private sector’, often by the same specialist. These specialists are able to offer some patients treatment on a different set of criteria than that offered by the public sector. This gives rise to the most significant area of tension in dual practice – waiting times versus remuneration.

A 2005 Ministry of Health discussion paper notes:

when specialists are able to work in both sectors, there is a potential for them to manipulate waiting time and/or clinical criteria for public treatment, to maximise remuneration from private work – treating less urgent and more routine cases in private, while still having access to more difficult and more interesting cases in the public hospital system.  

It goes on to say that:

even without the potential for medical specialists as employees to undermine the goals of public hospitals, having part-time employees makes it much more difficult to co-ordinate the actions of various individual employees to achieve the goals of the organisation and to motivate employees to act in accordance with those goals.

Waiting time goals are further compromised because the greater financial rewards of the private sector act as incentive for specialists to focus a greater percentage of their available time on private patients where possible. ‘This dynamic will tend to lengthen waiting times in the public sector, potentially increasing demand for private insurance and thus access to private services.’

Further work

The Centre for Health Services Research and Policy at the University of Auckland is currently undertaking a study, funded by the Health Research Council, examining the relationship between the public and private sectors. The first part of the study is near completion and has been looking at patients’ perceptions of the public and private sectors and factors determining their choice of where to receive health care. The second part of the study comprises a survey examining the factors determining where an SMO chooses to work.

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103 Ibid, p. 12.
104 Ibid.
105 Ibid.
Training and teaching

Teaching and training are, and have always been, key functions of the public health sector. The opportunity to be involved in teaching has traditionally been regarded as one of the main attractions of work in the public sector for medical specialists.

The worldwide demand for doctors is seeing significant growth in the numbers of medical students. In the near future, this growth will flow through to increasing training demands on hospitals and medical specialists. Australia has already begun grappling with this issue. The Ministerial Review of Victorian Public Health Medical Staff in 2007 noted that in order to manage the load on hospitals as a result of the planned increases in the number of medical school students, new training opportunities will need to be developed for both undergraduates and post graduates in the private sector and in general practice. It also noted:

the major limiting factor in creating capacity is the availability of clinicians who are prepared to take on the task of teaching and supervision, ...
However,] encouragement of clinicians to teach in private hospitals will reduce their capacity to teach in public hospitals.107

Government policy on public–private partnerships

The focus of the previous government’s policy on public–private partnerships was primarily on increasing capacity within the public sector. In broad terms, the Provider Selection Protocols left it to DHBs to decide how to purchase services. The main guideline is that the choice of provider should be the most effective option to achieve public sector health and independence goals. The protocols do not generally signal a preference for either public or private provision. The main exception being in respect of hospital services where, if all else is equal, public provision is preferred. The protocols also include guidance in relation to looking at the impact on the DHB provider arm as a whole and how to deal with conflicts of interest.

The new government has signalled a change in policy direction for the public–private interface. The Ministry of Health is currently implementing a programme of work to establish a more consistent and planned approach to the private sector that reflects the Government’s expectation that DHBs will make much ‘smarter use’ of the private sector. As part of this new direction the Government is committed to building 20 new dedicated elective surgery theatres with associated bed, facilities and staff over the next five years. This initiative will require the health system to train additional surgeons.

The Ministry of Health is also investigating the role for the private sector in providing at least a portion of this training. The following matters have already been identified for exploration before proceeding further in this direction include:

- the capacity in the public sector to train additional surgeons
- the range and volume of elective procedures that are being undertaken in the private sector assessed against public sector range and volumes to confirm whether clinical capacity in selected procedures is declining in the public sector
- consistency with the overall strategy for purchasing publicly funded elective services in the private sector

- the costs and benefits of private training compared with the costs and benefits of increasing the number of public training opportunities
- the service impact of trainees moving to the private sector.

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