16th May, 2017

Dr Paul Watson
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Health Workforce New Zealand

By email info@healthworkforce.govt.nz

Dear Dr Watson

RE. Health Workforce New Zealand consultation on funding for postgraduate medical training.

Introductory

Thank you for the opportunity to comment on your consultation paper, *Investing in New Zealand's future health workforce: proposed investment approach.*

By way of introduction, general practice is the medical specialty that treats patients: with the widest variety of conditions; with the greatest range of severity (from minor to terminal); from the earliest presentation to the end; and with the most inseparable intertwining of the biomedical and the psychosocial. General practitioners (GPs) treat patients of all ages, from neonates to elderly, across the course of their lives.

GPs comprise almost 40 percent of New Zealand's specialist workforce and their professional body, the Royal New Zealand College of General Practitioners (the College), is the largest medical college in the country. The College provides training and ongoing professional development for GPs and rural hospital generalists, and sets standards for general practice. The College has a commitment to embed the three principles (participation, partnership and protection) of Te Tiriti o Waitangi (Treaty of Waitangi) across its work, and to achieving health equity in New Zealand.

Health equity is the absence of avoidable or remediable differences in health outcomes and access to health services among groups of people, whether those groups are defined socially, economically, demographically, or geographically. To achieve health equity, we advocate for

- a greater focus on the social determinants of health (including labour, welfare, education, housing, and the environment);
- funding and support to sustain the development of a GP workforce of sufficient capacity to meet population need for access to quality primary medical care, particularly in rural and high need areas;
- sustained focus on measures to reduce smoking and to increase healthy food options for low-income families;
- improved integration of primary, community, and secondary care health and social services which ensures the provision of high quality services;

- universally accessible free primary health care for children and low-income families, because health inequities begin early and compound over the life course;
- a review of the funding model for primary care to ensure that resourcing is allocated equitably across diverse populations with differing needs.

College Position

Overall, the College welcomes the prospect of changes to the funding model as broadly proposed over the last several months and as summarised in the HWNZ paper issued on 20 March 2017.

The College supports this development. This is on the basis that establishing a system to re-prioritise funding for postgraduate medical training is an opportunity to substantively re-balance allocations to better recognise all the elements of service-based provision AND to better support longer term workforce development. This will help to shape the medical workforce to better meet the future healthcare needs of the population. A change to the status quo also has the potential to address the long term disparity in allocation of funding to support training of GPs and, pending a successful future bid, enable both expansion in provision of training for GP Registrars and innovation in how they are trained.

Simply put, the College supports the work being done by HWNZ, and believes it is an important and timely initiative, with the potential to deliver a more responsive and fit for purpose funding model.

Logic

As stated, the establishment of a system to prioritise funding for postgraduate medical training is a welcome development. We particularly welcome the prospect of improved alignment across vocational training amongst the service provision element and in respect to long term workforce development. In so far as general practice is identified as a priority area for investment, it is timely opportunity to address historic under-resourcing of general practice education, to expand provision of training for GP Registrars, and to drive innovation in how GP Registrars are trained.

We judge these changes as vital for both general practice workforce development AND for the ongoing development and provision of health care in New Zealand. That is across individuals and families, communities and iwi, as well as the population as a whole. This is especially so given the broader environment within which general practice functions and which serves to inform the College's view.

There are a range of environmental and contextual factors which serve to define and amplify the critical importance of general practice in overall health care provision, and which inform the College's support for changing the funding model. These include

- implications on the demand for primary care of a rapidly growing and ageing population;
- consequent increases in the incidence of age-related and chronic conditions which together will result in a greater share of medical services needing to be provided in the community;
- current, and expected unmet need, and deteriorating rates of patient access;
- implications for the organisation and delivery of clinical practice given emergent new models of care, and evolving general practice business models;
- as a greater share of services are community-based, ensuring that capacity constraints in secondary care are addressed and alleviated;

- projected future shortage of GPs and other primary care professionals[1], taking appropriate action to address long term workforce development;
- addressing the lack of co-ordination in in-practice training and vocational placements;
- improving numbers of trainees placed in rural and high needs areas;
- ensuring for better accountability for training providers, and providing greater transparency for funding decisions.

Awareness of these imperatives serves to inform the College's approach, and underlies its support for a change to the existing funding model.

Concerns about the proposed model

Notwithstanding the preceding comments, the College does have concerns with elements of HWNZ proposal. These include, *inter alia …*

1. The process for implementation, and important details about how the programme will operate remain unclear. The College readily acknowledges that the model is subject to sector wide consultation, but nevertheless, seeks clarity on both counts.
2. The size of the pool for new funding is dependent on disinvestment, and there appears to be is no rational nor transparent process for this. This concern arises on the basis of our understanding that the New Zealand College of Public Health Medicine (NZCPHM) received a letter notifying it that there will be no money available for training of new entrants to the Public Health training programme in 2018. There is no indication how HWNZ came to the decision that funding for the training should be cut, and NZCPHM only received notice of this decision after it had begun accepting applications to the 2018 training programme. Inappropriate disinvestment decisions, at short notice, could do significant damage to the continued viability of training programmes that might be judged critical to the long term health of individuals, communities and iwi, and the population more generally. It is also important to note that once a training programme ceases, it becomes very hard to restart it as teachers move on to different roles and educational expertise is lost[2].
3. Our view is that the process for decision-making around disinvestment must be transparent, principles-based, takes account of the long term consequences in service provision and workforce development, and requires timely notification.
4. In contrast, the process for new investment appears overly narrow and complicated. As noted above, new investment will be limited only to areas that HWNZ has identified as a priority – there is a danger of a 'short-termist' approach given the many competing priorities that will no doubt arise. As HWNZ makes disinvestment and investment decisions amidst these competing priorities, and subject to the vagaries of electoral politics, the prospect of unintended and deleterious consequences is very real.
5. Once a priority area has been identified, and a proposal worked up and submitted, a series of three gates are proposed wherein individual proposals are assessed with increasing rigour, and with a requirement for further development at each stage as proposals are prioritised and taken forward. Given that we are dealing with a relatively small system with a relatively small number of specialties, the process seems unnecessarily complex and lengthy. A simpler model would rely on HWNZ itself gearing-up to achieve a superior level of knowledge of the sector, long term trends on workforce development across all scopes, and use this intelligence for more immediate means of prioritisation in funding allocation cf. the proposed PHARMAC

[1] As established by HWNZ's data projections and supported by the results of workforce surveys undertaken by MCNZ and RCNZGP

[2] In February 2017, HWNZ sent NZCPHM a letter advising that they would receive no funding for new placements from 2018. In April 2017, HWNZ sent NZCPHM another letter advising that they would receive funding for 3 new placements in 2018.

model. It seems the proposed expert advisory panel might be re-positioned to function in a more proactive manner (than as an adjudicating body across the three-gates).

6. Notwithstanding, the bidding and adjudication process seems to mitigate against collaborative proposals.
7. Proposals are also expected to provide a national-level solutions. While this has some benefits from a College perspective, it may also result in complications. This is particularly true for services where training is provided in District Health Boards (DHBs). For example, it appears likely that Palliative Care will be an early priority area. This College may well wish to participate in an investment bid with the Royal Australasian College of Physicians that would aim to achieve: improved funding for training of Palliative Care Physicians (RACP); and funding to provide training to GPs to allow them to provide a wider range of palliative care services. In order for such a bid to succeed, the College would not only need to collaborate with the RACP but also all with all 20 DHBs. This is because training of Palliative Care Physicians occurs through the DHBs, with RACP input limited to training accreditation. Obtaining consensus across 22 diverse organisations will be complicated and time-consuming. A more efficient and effective alternative would be for HWNZ to take a more proactive role and to be actively involved in not just identifying funding gaps, but also in working with the sector to develop proposals to address those gaps.
8. There remains no indication that new funding allocations – as these are determined and resourced from a contestable pool – would be allocated on a recurrent basis. This mitigates against stable planning in the medium to long term and can be expected to compromise approaches to innovation in training models as these are pursued in the near term. As we seek to innovate, implementation of new approaches can be expected to be rolled out over a period of several years. During that period, there needs to be some certainty in funding allocation.
9. Expectations around performance reporting and in respect of return on investment lacks definition, there is minimal sense of timeframe for assessing return on investment, and militates against development of innovative investment proposals. It is not at all clear how 'benefits' will be measured, and against what criteria. This is in respect of both quantitative and qualitative criteria.
10. The consultation document states that '... the investment approach will strengthen HWNZ's sector intelligence ... (and) will inform our understanding of where to target investments'. In actual fact, it appears as if the burden of workforce intelligence is being passed from HWNZ to sectoral organisations. It is concerning that HWNZ does not already have processes in place to conduct long term trend analyses, and which would inform both dis-investment and investment decisions.
11. It is not clear how the proposed model will interact with Medical Council of New Zealand (MCNZ) requirements and the Health Practitioners Competence Assurance Act 2003 (HPCAA). The Medical Council has developed robust accreditation processes for vocational training programmes, and that to obtain any vocational qualification a New Zealand trained doctor must hold a "prescribed qualification" (for example, to become a vocationally registered GP a New Zealand trained doctor must obtain the FRNZCGP). This system provides an assurance that training programmes are of a high standard, but it also restricts the number of qualifications and training providers. This appears incompatible with HWNZ's desire for a competitive and contestable application process.
12. We are concerned that the model does not go far enough in supporting innovation in service delivery. For example, it does not appear to allow for training solutions outside of medical vocational training. In particular, it would not allow for funding to be allocated to increase the skill base of primary care nurses to allow them to better support GPs, and nor would it allow for, recognise and support the development of "advanced competencies" in general practice that would help address workforce needs in areas such as palliative care.

Getting the model right

Our view is that the ideal model would include:

- a HWNZ that has a superior level of knowledge of the sector, and is able to identify long term trends on workforce development across all scopes;
- an expert panel to identify areas for increased investment and areas for disinvestment, supported by clear and transparent criteria and utilising HWNZ's intelligence;
- a partnership approach to developing solutions, with HWNZ taking a lead role in discussions with relevant training organisations;
- clear accountability, with any spending subject to transparency and monitoring against expected performance standards;
- funding arrangements that extend into the medium term (3-5 years) and which provide training providers with room to innovate and invest in infrastructure that will support efficiencies in the longer term;
- recognition of the multidisciplinary nature of general practice (and indeed, of primary care), and therein, prioritisation for new approaches to specific and advanced competency training, as well as the collaborative development and delivery of new models of post-graduate vocational training.

We trust these comments are useful, and look forward to hearing from you in due course.

Yours sincerely

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Chief Executive

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