



ASSOCIATION OF SALARIED MEDICAL SPECIALISTS  
TOI MATA HAUORA

# Submission to Health Workforce New Zealand on the discussion document 'Investing in New Zealand's Future Health Workforce'

19 May 2017



## **Introduction**

The Association (ASMS) represents senior doctors and dentists (predominantly specialists) employed by District Health Boards (DHBs) and other employers of health care professionals, including the New Zealand Family Planning Association, ACC, hospices, community trusts, Iwi health authorities, union health centres and the New Zealand Blood Service. Our membership of over 4,400 members of whom over 4,300 are employed by DHBs (representing over 90% of permanently senior doctors and dentists employed by DHBs).

We appreciate the opportunity to comment on the consultation paper outlining a Health Workforce New Zealand (HWNZ) proposal on a new approach to funding postgraduate training. Given that the process for developing the proposal has not been open to broad public discussion until now (we note that submissions will be published on the Ministry of Health website) our comments are written in part to assist readers, including our members, who are new to the issue.

First, we would like to have noted that we have found the ‘consultation process’ to date – two national workshops for selected sector representatives, with lightly detailed background papers – disappointing on several counts. The medical and dental professions, in particular, and the health professions covered by the Health Practitioners Competence Assurance Act (HPCA Act), in general, were under-represented at the workshops and had only limited input into discussions. At some point in the process between the two workshops, without consultation or agreement with the medical profession, HWNZ unilaterally determined a shift from the funding formula for medical workforce vocational training to all the occupations covered by the HPCA Act.

The proposal raises more questions than answers and these were not resolved during the workshop discussions. The workshops were poorly managed. The subsequent consultation paper which describes the proposal as a ‘co-design’ is untrue (according to the other claimed ‘co-designer’, the DHBs). It is unclear why the decision was made by HWNZ to put forward its investment/disinvestment proposal for consultation above other models discussed in the workshops. Perhaps most concerning, we understand HWNZ plans to have their proposal confirmed in order to start implementation in July 2017, raising further questions about the validity of this consultation.

## **The proposal**

In essence, the proposal argues that the current health workforce is not well aligned to current and projected future health needs (with which we agree), and that this is because the current funding model for training passively subsidises DHBs for providing (mostly medical) training which is focused on areas of current service needs rather than areas where there is a need to “strategically invest in training to meet future needs”. HWNZ’s proposed solution is to better manage post-entry training by redistributing current training resources to areas deemed as having greatest need through a process of competitive tendering (with which we strongly disagree).

From our assessment, the proposal would be unlikely to achieve the stated aim of a future health workforce that is ‘fit for purpose’ and it presents a high risk of damaging unintended consequences as discussed below.

## **The perceived problem**

Government priorities have been identified as Maori health, older people, children, mental health and addictions, primary care, disability support, long-term conditions (obesity and diabetes), and bowel cancer. Under current post-entry training regimes, there are not enough trainees to produce the future workforce that is needed in these priority areas. It is argued that this is due in large part

to the way training is funded – that is, “[subsidising] employers for a portion of the training costs ... based largely on historic and current hospital-based service needs” (p 4).

### **The proposed solution**

Priority areas for post-entry workforce training would be identified in a ‘PHARMAC-like’ process model where training investment decisions are based on a range of factors including government health priorities, workforce trends and measures of unmet need. A ‘rolling proportion’ of HWNZ training funding would be contestable each year – open to bidders from both public and private sectors. Contestability for training funding is seen as a means of addressing the current tendency for providers (usually DHBs) to use the funding for the trainee workforce needed to meet extant service needs rather than in the identified priority areas.

Current funding, which is described as biased towards postgraduate medical training, would shift towards more postgraduate education for nurses, midwives and allied health professionals and unregulated health workforces. Because the proposal is based on a fixed budget, areas for funding ‘disinvestment’ would need to be identified by HWNZ.

### **The problem with the ‘problem’**

In making its case for change, HWNZ fails to take account of a number of critical issues. They include:

#### **Long-term specialist shortages across the board**

There is no doubt that some specialties are facing more severe shortages than others, and therefore there is a case for giving some priority to investing more in those specialties, including increasing training positions. But when the ‘investment’ is dependent on training funding being taken from another part of the workforce, understanding that specialist shortages exist across the spectrum of specialties is fundamental to the discussion.

The evidence for this has been provided by ASMS in a series of studies analysing qualitative and quantitative data on workforce and workplace dynamics. ASMS surveys of its membership, for example, have indicated a workforce under significant stress. One study found many senior medical officers (SMOs) routinely go to work when they are sick because there is insufficient staffing cover for them to take sick leave. Another study assessing the extent of fatigue found 50% of respondents reporting symptoms of burnout. A further national study found a quarter of respondents intended to leave either medicine or DHB employment within the next five years. While age was a major factor, other factors including work pressures and work satisfaction were also frequently cited as reasons for their intentions to leave.

Other recent studies of DHB heads of department indicate clinical workload pressures mean many SMOs cannot find adequate time for non-clinical work, including time for their own continuing medical education and professional development, as well as time for training and supervising other medical staff. Summaries of the finding of all these studies are provided in Appendix 1, with links to the study reports.

These studies consistently show the SMO workforce as a whole is inadequate; workforce shortages are not confined to a few relatively small specialties, as is suggested in the document. While the numbers have been increasing, it is from a low base by international standards and the growth rate of the New Zealand population of aged 65 and over (24% since 2009/10), who it is estimated account for about 40% of government health spending, is just one indicator of the extent of growing health need.

The effects of SMO shortages are many and varied but they include increasing clinical workloads squeezing out SMOs non-clinical time, such as time for training and supervision. This was recognised in the Resident Medical Officer (RMO) Commission report of 2009<sup>1</sup>. As noted earlier, SMOs are still struggling to find time for training and mentoring, as well as time for activities such as continuing professional development, which for some SMOs may include a need for developing teaching and communication skills in often high-pressure environments. The flow-on effect of these time restrictions impedes good-quality teaching and mentoring. This in turn can influence the decisions RMOs make in deciding on the specialty in which they wish to train.

A literature review of medical career decision-making found role models and mentors have been consistently identified in overseas research as an important influence on trainees' choice of specialty. An Australian survey of doctors already in specialty training, found 55% (2331 out of 4222) of respondents citing 'influence of consultants/mentors' as a factor influencing specialty choice.<sup>2</sup> Another large Australian survey of specialty choices of doctors undertaking vocational training found the most important extrinsic factors were the 'atmosphere/work culture typical of the specialty' (72% of respondents), 'work experience since graduation' (64% of respondents) and 'opportunity to work flexible hours' (55% of respondents).<sup>3</sup>

Similar results have been found from more recent surveys of medical students and those in PGY1 using the Medical School Outcomes Database.<sup>4</sup>

What the evidence tells us is that while the reasons why medical graduates choose a particular specialty are complex, the workplace environment and the quality of training and mentoring are key factors.

As the RMO Commission points out: "Senior medical staff need to be recognised for their roles as supervisors and educators. Moreover, government and health service providers need to recognise that quality education and supervision take time, and the allocation of appropriate funding.

### **RMO workforce capacity**

Despite increases in medical school intakes, OECD data show New Zealand has one of the lowest numbers of medical graduates per head of population (27th lowest of 34 countries in 2014), and much of that investment is lost by the time medical graduates become specialists.<sup>5</sup> Within seven years of graduating, a quarter are lost to New Zealand; a third are lost by year 10 post-graduation.<sup>6</sup>

### **The effects of immediate health need on services**

Increasing health needs are acknowledged by HWNZ. However, it does not adequately consider the immediate effects of this on our health services, including increasing acute admissions which have contributed to increasing rates of hospitalisations per 1000 people (an increase of 13% between 2004/05 to 2013/14)<sup>7</sup>. This is reflected in increasing emergency department admissions across the country, with many DHBs recently reporting record attendances and signs that attendance rates will continue to increase.<sup>8 9</sup>

At the same time, there is growing evidence of substantial unmet need, not confined to a small number of specialties deemed priority areas for HWNZ's proposed 'investment' but across a wide range of specialties. General surgery, for example was given as a hypothetical case for disinvestment in an earlier HWNZ paper (not released publicly). Yet recent first specialist assessment (FSA) data indicate general surgery is consistently among the group of specialties with relatively high numbers of patients being returned to the care of their GP because they do not meet the DHB treatment threshold.<sup>10</sup> Recently published research indicates nearly one in 10 adult patients are not able to access the hospital treatment they need, while one in four are not accessing primary care.<sup>11</sup>

### **The effects of government policies**

Government policies require DHBs to give priority to immediate health care needs in specific areas, such as elective surgery and emergency departments (which have implications for specialties throughout the hospital), and provide care and treatment sooner and closer to home, but at the same time require DHBs to operate within tight budgets. The effects of these fiscal policies are indicated in a recent Treasury report which gives a green light on financial performance to only half the country's DHBs and comments that, "Some DHBs look to be sweating their assets and under-funding repairs and maintenance to help balance their books."<sup>12</sup>

As an example of how funding constraints have impeded attempts to address specialist shortages in one of HWNZ's recognised vulnerable specialties (palliative care), as at the beginning of this year there were just nine fully funded palliative care training rotations in the country. However, maximum training capacity, were funding available, is 14 posts. This could be increased even further to 19, were it not for the lack of specialists available in the regions to be supervisors.<sup>13</sup>

No consideration appears to have been given by HWNZ to working with government to ensure vocational training funding increased as the number of medical graduates have increased.

In summary, the tendency for DHBs to focus their training around immediate service needs rather than areas where services are especially vulnerable is a downstream effect of a range of factors such as those outlined above.

### **The problem with the 'solution'**

Notwithstanding that the proposed solution does not address the issues discussed above, meaning any attempt to "ensure that the workforce will meet the future needs of the healthcare system" (p 4) will face the same obstacles, our assessment of HWNZ's proposal is that it is unworkable. More concerning, it involves a high risk of damaging unintended consequences.

First, the often-used term 'investment approach' is a misnomer. The approach being proposed is as much a 'disinvestment' approach.

To assess accurately how much investment is needed in a particular specialty in the competitive 'return on investment' model being proposed, requires much more data and information than HWNZ possesses, or indeed any bidder for the contracts would possess. While there is much evidence that investment in the specialist workforce in general would achieve health and financial benefits,<sup>14</sup> a precise cost-benefit analysis, specialty by specialty, across different providers, including the costs of training, the impacts on service delivery and the costs to wider society, as well as other factors such as unmet need, as is being proposed, would require sophisticated intelligence and sophisticated monitoring of contracts, both of which – even if they could be achieved, which is highly unlikely – would be enormously costly. The administration cost of this proposal is not considered.

HWNZ's idea of a PHARMAC-like agency to determine where workforce investment is to be made does not bear scrutiny. Making decisions based on the known costs and efficacy of medicine is vastly different to making decisions on the range of factors discussed above.

While HWNZ claims this unworkable idea would involve a 'transparent' process, the 'disinvestment' process would be undertaken by HWNZ, which the document says 'needs to be' transparent but makes no attempt as to how that might happen. Disinvestment decisions would "take into account government health priorities, improved workforce supply and demand models, sector intelligence of emerging technologies, changing models of care and areas of unmet need". Specialties considered for disinvestment would be assessed for their impact on service users, the health system and wider society.

The consultation paper demonstrates ignorance on ‘models of care’, a term which has validity but is increasingly used as a throwaway line or slogan to describe something that has little or no bearing on or likeness to what it means. Among real models of care there are enormous differences between their scopes, including those that are service specific, those that are hospital-wide, those that are between community and hospital care, and those that are between DHBs. In this context of high variability there is no natural commonality in time spans of a model of care and no connection with the time span for medical and dental training. In fact, many models of care are about how the specific workforce is utilised rather than how many should there be in that workforce.

Again, all this would require an extraordinary level of sector intelligence – and ongoing high costs – which HWNZ does not have. Technological change, for example, could potentially reduce demand for health services and lower costs or, just as easily, generate increased demand on the health sector and raise costs. But there is no standardised measure of technological change by which it can be factored into health service projections.<sup>15</sup> Health workforce planning is notoriously difficult to undertake with any degree of certainty, and HWNZ’s knowledge of the prevalence of unmet need falls well short of what is needed, let alone understanding and measuring its effects. FSA data, for example, do not consider factors such as unmet need for primary care.

The risks of disinvesting in specialty areas that are deemed, through a vaguely outlined process, to require fewer resources, are obvious. Given the current state of the specialist workforce described above, any disinvestment is likely to create further service gaps than already exist, affecting access to timely treatment, which in turn has health, social, financial and wider economic costs. The resulting additional stress in the workplace is likely to impact on the quality and efficiency of the service and on staff retention.

The unavailability of disinvested specialties as a career choice for medical graduates will likely result in an increase of graduates leaving New Zealand, thereby wasting the considerable investment made in their education and training.

The proposal to extend current funding for post-entry medical training to a range of other disciplines will logically see more disinvestment than investment in medical training. HWNZ explains the ‘investment pool’ will depend on the ability to disinvest in some areas ‘or justify and obtain new funding’. However, HWNZ’s record to date in doing the latter, despite there being strong cases to be made for increased funding, does not give us any confidence in the likelihood of new funding being obtained.

In the event of a specialty becoming more vulnerable and under increased stress due to disinvestment, remedial measures are likely to require recruitment of international medical graduates (IMGs) from overseas, contrary to HWNZ’s aims of reducing New Zealand’s heavy reliance on IMGs. Stabilising the specialty would be far from straightforward given that many IMGs do not remain in New Zealand for very long.

The proposal to introduce competitive tendering for contracts will create fragmentation in the system and is contrary to the aims of the New Zealand Health Strategy, which calls for greater collaboration and a ‘One Team’ approach to service delivery. The likely high administration costs of assessing and monitoring contracts is not considered in HWNZ’s proposal, let alone the costs of supporting bidders, as described in the proposal, and the costs of developing much deeper and wider levels of sector intelligence than exists currently.

Furthermore, the effect of making part of the training funding contestable each year would introduce a great deal of uncertainty into service planning and would require increased demands on senior doctors in continually having to justify training positions.

As a general comment, the quality of the consultation document falls well short of what should be expected from an agency such as HWNZ, especially given the proposal's potentially profound effects on the delivery of our public health services.

Many assertions are made but with no evidence to support them. The proposal contains no references. It is often vague, often referring to amorphous 'changing models of care', for example, and in parts is incomprehensible and confused. Among the examples is the assertion that, on the one hand, investment decisions would be based on comprehensive data on such things as unmet need, emerging technologies and changing models of care; on the other hand, the document suggests that in order to have a better understanding of all these factors, an investment approach is needed.

The document also states that, "an essential prerequisite to inform investment decisions" is the development of a national health workforce strategy "that clearly sets out a vision, principles, and key themes and identifies national strategic priorities. Work on the national strategy should begin as soon as possible, incorporate co-design, and build on work such as service forecasts, measures of met and unmet need, and dynamic workforce forecast models."

In other words, in an Escher-like depiction of endless stairs, an investment approach requires a national strategy which requires the sector intelligence produced from an investment approach.

We do, however, support the proposal for such a strategy. It is well overdue. And we recommend:

- That it takes into account the underlying workforce issues outlined in this submission.
- That it is used to make a 'business case' for better investment in the health workforce overall.
- That it recognises the considerable benefit to the quality of training for doctors and dentists that the current apprenticeship model provides where training is highly integrated with service provision.
- That it recognises that the exigency arising out of service provision, reinforced by the safer hours' requirements of the multi-employer collective agreement covering resident medical and dental officers, by itself significantly determines the numbers and types of registrar positions.
- That it recognises that the current funding model has not restricted numbers trained in the larger vocational scopes of practice, noting for example the encouraging increase in general practitioner registrar posts.
- That it recognises that the main difficulties in respect of medical training are around smaller specialties where the current funding model focusing on service provision is too blunt an instrument to address such needs.
- That it recognises the high quality of training and output which should be built on, not undermined, including refinement to address particular needs (eg, palliative care and dermatology where the system needs to be more directional because registrar positions in these small specialties are less likely to be considered a priority for service provision), rebalancing between generalism and sub-specialism, and with the engagement to be led by those who do the training.
- That, in respect of medical vocational training, HWNZ engage with the Council of Medical Colleges over how best to refine the current model, including being more directional where training needs do not sufficiently match up with DHB service needs. The Council's approach is considered, pragmatic, practical and born out of much more experience than those who have designed this proposal.
- That it recognises the importance of the funding model having low rather than high transaction cost, avoiding 'bureaucratic capture'.

We note that many of the concerns we raise here with regards to HWNZ's proposed solution to the misalignment between the post-entry training model and future workforce needs are shared by other submitters such as the Medical Council, the Council of Medical Colleges and the New Zealand Medical Association.

Finally, the central aim of a workforce strategy should be to foster the kind of workplace environment reflected in the following comment in the RMO Commission report. While there are no single solutions to addressing health training needs, or health workforce needs as a whole, working towards such a goal would take us a long way to achieving HWNZ's stated intention of ensuring New Zealand's health workforce is fit for purpose.

*"... the junior [sic] 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, fueling 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."*

---

<sup>1</sup> Commission on the Resident Medical Officer Workforce. 2009. *Treating People Well: Report of the Director-General of Health's Commission on the Resident Medical Officer Workforce*. Wellington: Ministry of Health.

<sup>2</sup> Scott A, Joyce CI, Cheng T, Wang W. Medical career path decision making: an Evidence Check rapid review brokered by the Sax Institute (<http://www.saxinstitute.org.au>) for the NSW Ministry of Health, 2013.

<sup>3</sup> Harris MG, Gavel PH, Young JR. Factors influencing the choice of specialty of Australian medical graduates. *Med J Aust* 2005;183(6):295–300.

<sup>4</sup> Scott et al (2013).

<sup>5</sup> OECD. Health Care Resources Dataset. 2016 ed: OECD, 2014.

<sup>6</sup> MCNZ. *The New Zealand Medical Workforce in 2013 and 2014*. MCNZ, 2016.

<sup>7</sup> Ministry of Health. Publicly funded hospital discharges, 1 July 2013 to 30 June 2014, published July 2016.

<sup>8</sup> Heather B. Emergency departments around New Zealand under enormous strain as sickness rises, *Stuff*, 4 March 2016.

<sup>9</sup> Lee B. Record number of hospital admissions in Hawke's Bay on ongoing trends, *NZ Dr*, 9 March 2016.

<sup>10</sup> Ministry of Health. Number and percentage of referrals received between July 2015 and September 2016 for publicly funded First Specialist Assessments, by health specialty and prioritisation outcome (developmental), 2017.

<sup>11</sup> Bagshaw P, Bagshaw S, Frampton C, et al. Pilot study of methods for assessing unmet secondary health care need in New Zealand, *NZMJ*, Vol 130 NO 1452, 24 March 2017.

<sup>12</sup> NZ Treasury. *District Health Board Financial Performance to 2016 and 2017 Plans*, February 2017.

<sup>13</sup> ASMS. *Despatches from the front line: Senior doctors talk about specialist workforce shortages in New Zealand's public hospitals*, January 2017.

<sup>14</sup> ASMS, DHBs. *Securing a Sustainable Senior Medical and Dental Officer Workforce in New Zealand*, November 2010. Available <https://www.asms.org.nz/wp-content/uploads/2014/07/The-Business-Case-Nov-2010.pdf>

<sup>15</sup> ASMS. *The Public Hospital Specialist Workforce: Entrenched shortages or workforce investment?* (pp 36/37), February 2013. Available: <https://www.asms.org.nz/wp-content/uploads/2014/07/The-Public-Hospital-Specialist-Workforce-web.pdf>