

8 June 2011

Brenda Wraight
Director
Health Workforce New Zealand
National Health Board
Ministry of Health

By email info@healthworkforce.govt.nz

Dear Brenda

Health Workforce New Zealand Draft Investment Plan Prioritisation Criteria

Thank you for the opportunity to comment on this document. Before commenting on the criteria directly however, we advise that the extremely tight timeframe (one week) has impacted seriously on our ability to provide feedback as we have not been able to obtain the full range of views of our membership.

The above caveat being given we advise the following.

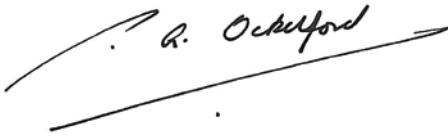
- a) We agree with the objectives and applaud the transparency they demonstrate by attempting to fund with limited resources. In particular it is pleasing to see that you are requesting clinical input into the decision making and are striving to create an equitable process.
- b) We agree with the prioritisation criteria but advise that assumptions should not be made based on financial constraints. We also believe that despite the elements of objectivity imposed the final decision is still likely to be highly subjective.
- c) In the final matrix, HWNZ appears to award equal points for each of the criteria (i.e. there is no ranking order for the prioritisation). This implies that productivity is equal to a commitment to those already in training and capacity when clearly a "relative merit" decision will need to be made: We would favour a relative weighting to the prioritisation criteria.
- d) In terms of the matrix model we are uncertain how this will work given the various differing situations. While the matrix model has its merits it is only as good as the numbers that are inputted and the assumptions made.

- e) We also have some serious concerns about the assumptions made in terms of the real cost and time spent training which should be addressed prior to the application of the matrix. Our concerns are as follows.
- i) We do not agree with the assumption that the total cost of a medical trainee can be estimated as 125% of base salary. This figure does not include a large number of the "extra costs" incurred including meals, reimbursements, APC, additional duty hours, annual leave, etc. It also then underestimates the true overhead costs. In respect to this, we ask that you contact the DHBs to reveal the true costs of RMOs and then consult the literature in order to calculate the overhead. We are aware that some Australian states and the VA hospitals in the United States calculate an overhead figure of 100% above base salary. Similarly, if HWNZ chooses to "peg" training costs against base salary costs, then training cost increases should match future MECA awards.
 - ii) More importantly we are concerned that there is no mention of SMO teaching time in these calculations which is core to actual training. This may be a considerable component particularly if we consider the relative training load drop seen in basic trainees (see point iii).
 - iii) We disagree with the generalisation of the service load calculation of doctors-in-training. While this is probably correct for house officers (RMOs), basic trainees actually drop considerably in relative service load in some specialties (eg Pathology, Radiology, and Surgery) in which the service contribution in the first few years is low as they learn their new vocation. Other specialties, of course, may be closer to the assumed 75% but a sizable proportion of trainees may not. We note that the current CTA/IRP pricing model takes this into account.
 - iv) We are concerned that "overtime" is excluded as per footnote 10 in the calculation. We assume that this refers to "after hours duties" other than Monday – Friday, 8am-4pm. Many educationalists would argue that this is when a large amount of the apprentice type learning occurs. To exclude it from the calculation reinforces the notion that RMOs are only learning in the weekday/daylight hours and does not take heed of the fact that many SMOs are exceeding 55 hours per week as per the MCNZ workforce survey. While we understand that the decision was likely made due to financial restrictions, we would nonetheless consider a more reasonable 50 hour week was used as base salary and then actual payments were calculated from this model.
- f) There is no mention of the contribution provided by the private sector. For example, dermatology is carried out mostly in private practice. Is this college likely to be penalised for this? Is there any prioritisation given to areas working primarily in private practice?
- g) We see no mention of IMGs in the document. As 52% of New Zealand doctors are overseas born and 41% overseas trained, it is important to make a clear statement about this group of doctors and how to efficiently and effectively integrate them into training schemes and vulnerable workforce areas.

- h) While we accept the financial limitations inherent in the system we struggle to support a process that does not appropriately incentivise the employers to improve training.
- i) We do not understand the final box of "Overall training priority". Is this a total score of the boxes above or does it have another meaning? Indeed in the example given in footnote 12 they multiply by 0.25 as an "overall training priority". We do not understand however, how this relates to the table?
- j) Finally we think that these proposed criteria will place increased pressure on some of the smaller colleges to 'prove' their worth. While this is good in some ways, it raises work capacity issues for small colleges with low staff numbers.

We trust our comments are of assistance. Given the complexity of the issues and the extremely tight timeframe given for stakeholders to reply we ask that once HWNZ has absorbed the initial feedback of all stakeholders, a second round of more extensive consultation takes place. We would be happy to meet with you to discuss any of the above matters further.

Yours faithfully

A handwritten signature in black ink, reading "Dr Paul Ockelford". The signature is written in a cursive style and is positioned above a horizontal line that spans the width of the signature.

Dr Paul Ockelford
Chair, NZMA