New Zealand Medical Association
Te Hauora mō ngā Iwi Katoa

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Health Workforce New Zealand
Ministry of Health
PO Box 5013
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By email: info@healthworkforce.govt.nz

Post-Entry Training of New Zealand's future health workforce: proposed investment approach

Dear Sir/Madam

The New Zealand Medical Association (NZMA) wishes to provide feedback on the above consultation. The NZMA is New Zealand's largest medical organisation, with more than 5,500 members from all areas of medicine. The NZMA aims to provide leadership of the medical profession, and to promote professional unity and values, and the health of all New Zealanders. Our submission has been informed by feedback from our Advisory Councils and Board.

1. The NZMA accepts that the current approach to funding post-entry medical workforce training needs to change. For nearly all doctors in training, the status quo entails Health Workforce New Zealand (HWNZ) subsidising employers for a portion of the training costs associated with current service delivery models. This approach does not enable HWNZ to influence training positions in a way that is responsive to future health needs. However, we do not support the specific model being proposed as a solution. While several objectives are laudable, we have grave concerns that the model is potentially unworkable and may lead to disastrous consequences for the health sector (and for the health of New Zealanders). We are also very disappointed with the consultation process and consultation document. We elaborate on our concerns in the following paragraphs, and seek answers to specific questions. We conclude by providing some aspects we consider could form the basis for a more viable approach to post-entry medical training.

Consultation process and document

2. The NZMA welcomed the opportunity to participate in previous stakeholder workshops convened by HWNZ relating to this area. We are perplexed that, while several different models for post-entry workforce training were discussed at the workshop in December 2016, only one model has been selected for the current consultation. We seek clarification on how this decision

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was reached and what happened to the other models that were under consideration. We also do not agree with the statement that the current proposal arose from co-design. This is patently false. While HWNZ refers to "further co-design work with a working group comprising members of the DHB's Workforce Strategy Group", to our knowledge key stakeholders (eg, Colleges, professional associations, DHB CEOs and CMOs) have not had the opportunity to co-design the model being proposed.

3. We are concerned that the consultation provides no information about timeframes. Given the proposed paradigm shift and the fact that the changes may have decades-long impacts on the health workforce, we would be concerned if there is a rush to progress the proposed approach without meaningful analysis of submissions. We ask HWNZ to provide the sector, including us, with timeframes, including for the analysis of submissions. We also ask to be provided with the results of the analysis of submissions.

4. The consultation document lacks any referencing, and the proposed investment approach model is very light on details. It also lacks any situation analysis that lists all the other models that were discussed, as a full list of potential options (of which the current proposed investment approach is but one), systematically analysing the advantages, disadvantages and costs of each. This would help inform the sector as to why the proposed investment approach option was chosen, and provide the sector with the chance to discuss that analysis, and possibly persuade HWNZ otherwise. We submit that references to workforce data, as well as more details about the proposed investment approach, are needed to enable a more meaningful evaluation of the proposal.

Flawed logic and expectations

5. Underlying the proposal is an assumption that 'the sector' has workforce intelligence—that HWNZ does not have—that will enable *investment* decisions. Yet HWNZ suggests it *does* have the information to be able to make decisions about *disinvestment*. This seems to be flawed logic. How can HWNZ have adequate information to *disinvest* when it requires intelligence from the sector on which to base its decisions to *invest*? Such beliefs about what the sector is capable of also appear to be at odds with previous statements by HWNZ that acknowledge the 'intrinsic uncertainty' of workforce planning.[1] Such uncertainty is not conducive to calculating return on investment or cost-benefit analyses, both of which are required for the proposed approach to succeed.

Assumption the market will deliver the national workforce needed

6. A fundamental problem with the proposed investment approach is the assumption that the market will deliver the national health workforce that is needed. We are not convinced that this will be the case. It is difficult to envisage how the model will incentivise training bids for the areas where there is most need. We return to the example of palliative care, which was the prime example used to stimulate the review in the first place, and ask HWNZ to specifically demonstrate how the current proposal will encourage sufficient bids to meet demand in this area. Māori health is but another example.

7. We contend that there is also an inherent contradiction between the intention for post-entry training to be "more flexible, more re-deployable and more transferable" and the need for the model "allow new investments to become long-term (5-15 year) sustainable investments".

[1] Gorman DF. Towards a sustainable and fit-for-purpose health workforce--lessons from New Zealand. Med J Aust. 2013 Sep 2;199(5 Suppl):S32-6.

Furthermore, the proposed model requires a built-in profit margin for providers to stimulate bids; this is arguably an inefficient use of funding.

Disinvest to invest approach

8. Several aspects of this approach are problematic. Disinvestment is a threat to existing training programmes and providers, and to current and future service delivery. We believe that HWNZ does not have enough information to make robust disinvestment decisions. There is an effort to make the investment decision process transparent, but the lack of process around disinvestment decisions is ironic and concerning. While HWNZ proposes identifying candidates for disinvestment, there is no indication that its decisions can be independently reviewed or appealed. We are also concerned by the apparent ease by which HWNZ thinks it can cut funding to certain existing Colleges.

Evolution of funding

9. While we appreciate the need for post-entry training of the entire health workforce, we have strong reservations about the idea that funds previously earmarked for training the RMO workforce could be used for training other sections of the health workforce. This is likely to lead to a reduction in services in some important areas of healthcare. Rather than redistribute existing funding away from the training of doctors, we believe additional funding is required to train other sectors in the health workforce.

10. Since 2008, the number of domestic medical student intake places has risen by over 50%. Has HWNZ funding for vocational training increased to match the increase in numbers of graduating doctors? As the increase in medical student places would be expected to lead to an increase in the number of vocationally training doctors, we ask HWNZ, in the spirit of openness, transparency and good process, to provide the sector (us included) with data on the baseline funding for medical vocational training in 2008, as well as annual increases to date, and forecast increases.

Unintended consequences of a contestable approach

11. The NZMA believes that introducing a contestable approach to post-entry health workforce training will have several unintended, but inevitable, negative consequences for the health sector, and, therefore, for the health of New Zealanders.

12. Firstly, a contestable approach is likely to fracture the sector, setting training organisations and groups against each other. This is directly contrary to the goal of ‘fostering greater trust and collaboration’ in the sector that underpins the ‘One Team’ theme in the New Zealand Health Strategy. Indeed, this extends to the multidisciplinary teamwork in clinical and public health settings necessary for best health outcomes—where, on the ground, individual clinical specialties and disciplines are necessary but in themselves insufficient, and working together is essential. We would be very concerned if the proposal led to a split between vocational training Colleges, for example. There is a strong view that the superficial appeal of competition will soon be replaced by inter-organisational discord and dysfunction. The impacts of aberrant competition and specialty/disciplinary attrition will not necessarily be fully felt for many years, with definite reductions in services in some important areas of health care—by which time it will be very difficult to undo. This is similar to the major problems and limitations with the competitive model of health that failed New Zealand in the 1990s.[2]

[2] Devlin N, Maynard A, Mays N. New Zealand's new health sector reforms: back to the future? BMJ. 2001 May 12;322(7295):1171-4. Available from http://www.bmj.com/content/322/7295/1171

13. Secondly, the process is likely to favour some types of organisations, and some Colleges, over others. We are not starting on a level playing field. Many smaller Colleges already struggle to meet extensive and onerous administrative requirements, and may find it difficult to meet evidence requirements for proposals, especially in those fields that are complex and where epidemiological need and service effects are harder to establish because of multiple confounders (regardless of the resources they might potentially have available). While HWNZ claims it will "develop ways to support potential bidders, including those with limited resources of analytical capabilities", and will make evidence requirements lower for smaller investments, we seek clarification on whether differing standards will be permitted by the Ministry for Business, Innovation and Employment (MBIE), particularly if the Government Electronic Tenders Service (GETS) is the selected platform for proposals.

14. Thirdly, it would be particularly concerning if the proposed market approach favoured large corporate entities with global aspirations but without local expertise or sensitivities. It is important that the New Zealand health workforce is trained to be culturally competent and sensitive to the specific needs of Māori.

Impact on IMG numbers

15. While reliance on overseas-trained health professionals is identified as a challenge that the proposal is intended to address, we are not convinced that the model will address this. Indeed, we envisage various scenarios whereby the proposed approach may exacerbate reliance on international medical graduates (IMGs). For example, to meet gaps in service that arise because of the proposed disinvest-to-invest approach, DHBs may look to recruit more experienced RMOs from overseas. New Zealand graduate doctors may also be more likely to head overseas for their postgraduate training. Once they do so, they may be less inclined to return. This would represent a major loss of investment, given that medical school and PGY1/2 years are subsidised by the taxpayer. We also seek clarification on who would fill potential surpluses in training programmes if providers offered these. Would IMGs be accepted to fill these positions? We suggest that HWNZ commissions analysis of the potential impacts of the proposed investment approach to postgraduate training on IMG numbers.

PHARMAC-like process model

16. We note HWNZ's preference for "a PHARMAC-like model in which HWNZ bases its investment decisions on a transparent and rigorous process that is consistent with agreed principles and transparent prioritisation criteria". While transparency and rigour are laudable aspirations to guide any investment decisions, we have serious reservations that a PHARMAC-like model could be operationalised to usefully guide decisions on training the health workforce. Cost-benefit analysis and return on investment methods for prioritisation require a high level of evidence and certainty to be in any way useful. Our view is that the proposal to use a PHARMAC-like model is potentially unworkable in the health workforce setting, for the reasons below.

17. The health workforce is fundamentally and qualitatively very different from pharmaceuticals. Unlike pharmaceuticals, workforce supply cannot be switched in and out of the market *ad libitum*. The workforce takes years to train, and multiple diverse factors influence supply and demand in more complex ways than medicines. Furthermore, despite the well-known enormous complexities and biases inherent in evidence from clinical epidemiology and clinical trials, including that evidence's generalisability to new settings, evaluating pharmaceuticals is still in fact relatively straightforward (at least compared with workforces). There are known

models and approaches, and importantly, data (in the form of effect sizes in randomised controlled trials), and relatively discrete counterfactual health needs expressed in terms of types and numbers of patients and communities, extent of premature death and excess morbidity, and health service needs. Crucially, medicines funding decisions have much more (if still insufficient) available and accessible data and literature and well-established methods; systematic workforce funding decisions patently do not. The approach to the health workforce is considerably less evidence-informed and risks being highly subjective and invalid.

18. The PHARMAC model uses Programme Budgeting Marginal Analysis (PBMA), together with a capped budget and tools to generate savings.[3] The information requirements to support this are large. It is our view that these will be significantly larger still (maybe unachievably so, at least in the short to medium term) for the HWNZ exercise (see Appendix 1 for technical details of the information requirements to inform a PHARMAC-like model for decisions about the health workforce, and how these may be unworkable). We ask HWNZ to provide us, and the sector, with an incremental cost analysis for the considerable uplift in capacity and capability needed to pursue the proposed approach effectively.

Questions, conclusion and recommendations

19. We thank HWNZ for consulting with the sector. We reiterate the questions we have raised in our submission and would very much appreciate information from HWNZ that answers the following:

- Why was only one model selected for the current consultation out of the several different models for post-entry workforce training discussed at the December 2016 workshop? On what basis was this decision made and what happened to the other models that were under consideration?

- Could we please see the situation analysis listing all the other models originally considered, with comparative advantages, disadvantages and costs for each?

- Could we please receive timeframes for this proposal, including for the analysis of submissions? Could we also be provided with the results of the analysis of submissions, once available?

- What would be the potential impacts of the proposed investment approach to postgraduate training on IMG numbers? Who would fill potential surpluses in training programmes if providers offered these? Would IMGs be accepted to fill these positions?

- What will be the costs of the considerable uplift in capacity and capability needed to pursue the proposed approach?

- If attempting to use an HWNZ-described PHARMAC-styled approach, then:
    - how will the direction of causality be disimpacted technically?
    - how will it be evaluated technically whether specific investments have had tangible effects/benefits for New Zealand society, and how these benefits compare with those generated by other workforces?

[3] Grocott R. Applying Programme Budgeting Marginal Analysis in the health sector: 12 years of experience. Expert Rev Pharmacoecon Outcomes Res. 2009 Apr;9(2):181-7. Available from http://www.tandfonline.com/doi/full/10.1586/erp.09.2

20. In conclusion, the NZMA accepts the need to change the way in which medical vocational training is funded. However, we do not support the model HWNZ proposes to address shortcomings in the status quo across the health workforce. We believe the proposal to use a PHARMAC-like approach is unworkable and naïve. We also believe that a contestable market model would lead to several negative consequences. We submit the following recommendations:

- The other models discussed at previous stakeholder workshops need to be looked at again.

- Rather than focus on the post-entry workforce, instead use the total investment in the health workforce (which is the much more appropriate view). For medicine, this includes the investments made for medical school and for PGY 1 and 2.

- Baseline funding for vocational medical training needs to be commensurate with the increase in medical student places from 2008.

- Rather than redirecting funds away from medical training to other sectors in the health workforce, additional funding is required for training these other sectors.

- Instead of disinvesting to invest, an alternative approach to explore could be the targeted investment of new funding, like the approach to additional funding that PHARMAC receives.

- Rather than delegate responsibility for workforce planning to the sector, HWNZ should increase its internal capabilities, perhaps by way of the establishment of an Expert Advisory Group. Such a group could include experts from Treasury and/or other economists to help inform its planning.

- All recipients of HWNZ funding should be required to provide a minimum standard of reporting to ensure clear accountability.

We hope our feedback is helpful. We look forward to receiving answers to our questions, and to continuing to be involved in the development of solutions to post-entry training of the health workforce.

Yours sincerely

Dr Stephen Child
NZMA Chair

Appendix 1: Information requirements to inform a PHARMAC-like model for decisions about the health workforce, and how these may be unworkable for health workforce planning

If there is an attempt to use a PHARMAC-like approach, using PBMA, the first step required would be to stocktake candidates/proposals—ie, all the different workforces/training programmes, their current numbers and costs, and who those specialities serve. This is far from straightforward. For example, dermatology includes people with skin conditions needing specialist care, including biologic immunosuppression, beyond standard general practice care, but with some grey areas in-between.

For each item of health need, this stocktake needs to navigate across the breadth of medical versus other professions, be stratified by sole sub profession alone versus multidisciplinary teams, sub stratified again by primary care versus secondary versus tertiary versus quaternary, and subsubstratified again by clinical versus clinical support versus population, with many boundary issues. Next, there is a need to somehow define and then estimate the extent of need, both current and future, and then make a highly contestable estimate of the health benefit to individuals and society from having that specific workforce (including savings to health spend). Next, it is necessary to combine costs and benefits (plus or minus weighting for population need), and then rank small increments until expected funds are exhausted.

The relative paucity of detail in the HWNZ document is unhelpful. While we are aware of some overseas material on health workforce planning/prioritisation,[4] this material draws large conclusions despite limitations in the available data. Health workforce planning is very complex. An example is the bimodal age distribution in nursing (and some medical workforces) with staff taking time away to raise families then re-emerging, and the effects this has on stock and flows over time. This is a type of issue that PHARMAC models have never had to contend with.

We seek clarification on how HWNZ will disimpact technically the direction of causality. For example, are health needs high in some spheres because of high or worsening underlying disease/inequities/social determinants, etc, or because current or past services are/have been ineffective? Are health needs in other spheres lower because of lower or improving underlying disease/inequities/social determinants, etc, or because services are effective? If effective services and good workforce training by providers mean that health needs reduce, and if funding is 'needs based', there is a risk of creative perverse incentives for training providers to become less effective.

We also seek clarification as to how HWNZ will evaluate technically whether specific investments have had tangible effects/benefits for New Zealand society, and how these benefits compare with those generated by other workforces. This is epidemiologically fraught in the form of uncontrolled interrupted time series analysis, subject to the usual confounding (with false positive and false negative results), and subject to uncontrollable external influences. As far as we are aware, health workforce reports provide overview data but do not provide the level of detail required to adequately inform the proposed investment approach.

[4] Birch S, Mason T, Sutton M, Whittaker W. Not enough doctors or not enough needs? Refocusing health workforce planning from providers and services to populations and needs. J Health Serv Res Policy. 2013 Apr 24. Available from http://journals.sagepub.com/doi/abs/10.1177/1355819612473592