

A review of how the training of the New Zealand health workforce is planned and funded: a proposal for a reconfiguration of the Clinical Training Agency

Report of the Minister of Health's Taskforce 17 April 2009

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Abbreviations and acronyms

	<u>Abbreviation/acronym</u>
Australian Medical Council	AMC
Clinical Training Agency	CTA
District Health Board	DHB
District Health Boards New Zealand	DHBNZ
Equivalent Full Time Student	EFTS
Health and Disability Commission	HDC
Health Workforce Advisory Commission	HWAC
Health Workforce Implementation Program	HWIP
Industry Training Organisation	ITO
Ministry of Health	MoH
New Zealand Medical Council	NZMC
Non Government Organisation	NGO
Nurses Advisory Group	NAG
Physician's Assistant	PA
Primary Health Organisation	PHO
Resident Medical Officer (junior doctor)	RMO
Senior Medical Officer	SMO
Tertiary Education Commission	TEC
Tertiary Education Institutions	TEI

Executive Summary

New Zealand has significant problems in recruiting, training and retaining adequate numbers of appropriate health and disability services workers. This is most likely to worsen.

The planning and funding of the training of the New Zealand health and disability services workforce is iterative, ad hoc and poorly coordinated.

A single agency, which has a whole of health and disability services workforce and a whole of educational continuum responsibility, is needed if New Zealand is to have an affordable and fit-for-purpose health and disability services workforce.

It is recommended that the Clinical Training Agency be substantially reconfigured so that the Agency can plan and either fund or direct the funding of the training of the New Zealand health and disability services workforce.

Terms of Reference for the Ministerial Taskforce on the Funding of Health Workforce Training

The taskforce was directed to investigate and provide options to the Minister of Health on:

- ways to improve links across the education continuum for all health disciplines, including education and training, service design/planning and workforce planning/configuration;
- the planning (data collection, forecasting and modelling) and intelligence systems required to inform the purchase of health workforce education and training;
- the governance arrangements necessary to ensure that the purchase of health workforce training and education is flexible and responsive to the needs of the health sector;
- ways to support innovation in health care, including new ways of working and training.

The Case for a Reconfiguration of the Clinical Training Agency (CTA)

Introduction. The ability of the New Zealand Government to fund and deliver health and disability services that are fit-for-purpose and that can adequately meet need is variously and increasingly challenged by the following interactive factors:

The term health services will be used throughout this report. However, it is our intent that this refer to health and disability services (see page 10).

- the relative ageing of the population (1), and of the health workforce (2, 3);
- the increasing cost of health technology and services (4);
- a decline in the number of overseas trained doctors, nurses and other health professionals who want to come to New Zealand to work, and by barriers to employment for many of those that do (5);
- a longstanding under-supply of New Zealand trained doctors, and many other categories of health professional, relative to need (6);

Funding problems for health services are compounded by the current global recession such that the anticipated tipping point for the affordability of health services will have been brought forward.

There is little actually known about the overseas trained health professional community. Most international medical graduates have left New Zealand within two years of arrival. Appropriately, the New Zealand Medical Council (NZMC) has proposed eight relevant research projects, which deserve support.

- confused planning and funding responsibilities in respect of the health workforce, and, Tertiary Education Commission (TEC)-imposed limits on the training of health workers in New Zealand;
 - a health workforce that is not well distributed, by way of discipline, demography and culture, in regard to the needs of New Zealand communities (7-12); and, by
 - a largely untrained and unregulated workforce serving the disability sector.
- There is confusion about the relative roles of TEC, the CTA, the District Health Boards (DHBs) and Tertiary Education Institutions (TEIs). However the major constraint on undergraduate enrolments is the recently introduced TEC cap on domestic student numbers. With some exceptions (e.g. medical laboratory science and health protection), student applications well exceed available places – up to a rate of 10 applicants for every place. This governing of supply exists in the context of significant DHB workforce shortages across the major clinical staff groupings of allied health, nursing and midwifery, and medicine.

Ageing and the baby boomer generation. The ageing of the population alone, if nothing else changes, will “require” between 40 and 70% more health workers if current standards of care and of access to care are to be maintained over the next 10 or so years (1). Members of the “baby boomer” generation are predicted to largely leave the relevant workforces during that same period (2, 3).

The Primary Health Care Strategy. Other factors also aggravate this situation. The Primary Health Care Strategy (13) has resulted in a per capita loss of doctor productivity and has not resulted in any substantial diversification of health professional roles. The function of allied health professionals remains limited. Based on NZMC data, individual “full time” medical general practitioner

productivity (working hours) have decreased by 12.5% (equivalent to 250 retirements). Although nursing roles have reportedly increased and changed, there are still only 15 nurse practitioners in primary care and only eight of the latter can prescribe. In retrospect, the Strategy has two major flaws. First, the nature of the capitation does not create an incentive for nurse practitioners (as compared to the UK model – see page 9)(14). Second, the Strategy is essentially devoid of implementation planning in the context of innovative health workforce roles. This perspective is not unique to our review. The 2008 Health Workforce Taskforce report includes a recommendation for a major reform of primary care in respect to both structure and funding (15).

Feminisation and generational effects.

The effects of feminisation of the traditionally male dominated guilds (16-18), and of generational effects

Feminisation is used here in the now commonplace meaning that the majority of new entrants to a worker group are female.

and student debt (19), on productivity are unknown, but, are most likely to be quantitatively negative. An opportunity does nevertheless arise in respect of feminisation in terms of increasing the relative commitment to the recognisably high utility general scopes of (medical) practice (17), and in the context of both sociological phenomena in terms of increasing health workforce flexibility and re-deployability (7, 9, 11, 20).

Innovative health service provision (7, 12, 21-23). Although experience exists internationally for physician assistants (23, 24), technician and nurse anaesthetists, nurse endoscopists, nurse practitioners in chronic care programs (e.g. diabetes) and prescribing pharmacists (apothecaries) (25), New Zealand has not meaningfully trialled any of these innovations and the likely utility is consequently not proven. New Zealand also has a poor record in

recognising novel health practitioner groups and innovative practice (5, 26).

A barrier to reform is the Health Practitioners Competence Assurance Act 2003 and the consequently silo-regulatory practice. It is noteworthy that the Act (Sections 115 and 116) does empower the Minister of Health to recognise and regulate other health professions (including novel worker groups) and to increase scopes of practice. To date, only one new profession (psychotherapy) has been so recognised. Noteworthy and to date unsuccessful applicants include anaesthesia technicians. Whereas Australia has only nine registration boards, New Zealand already has 16 registration authorities, which cover 21 health professions.

The large uptake of primary care nurse practitioners in the UK versus the less than modest relative response to the New Zealand Primary Health Care Strategy is such that it is not reasonable to extrapolate from one funding and service model to another and local data are essential (14).

The cost of health care. The cost of health care in all developed nations is increasing at a rate that is generally recognised as being unaffordable. The Nobel Laureate, Robert Fogel, reasonably predicts that such nations will spend 20% of GDP on health by 2020 (4).

The global shortage of health workers. The health workforce situation in New Zealand is also reasonably considered to be that of a crisis. In the context of a current global shortage of health workers of greater than 4.3 million (27), New Zealand is the most reliant country in the OECD group on overseas trained doctors and nurses (>40% for doctors) (6). The problem is compounded by New Zealand also being a high exporter of health workers; however, even if every expatriated New Zealand trained doctor was recovered to work in New Zealand, the country's health services

would still need half the current number of overseas trained doctors to maintain service levels (>20% of the workforce)(6).

The Waiting List Policy. The New Zealand Government has recognised outstanding shortfalls in some clinical services and is consequently committed to strategies to increase access to elective surgery (Surgical Super Centres). The intent to establish an additional 20 operating theatres will require 800 additional health workers.

This target of 800 additional workers is unobtainable unless the funding of health worker training is substantially revised to deliberately trial innovative roles for the traditional guilds and novel types of health worker. It is probable that any additional need for health workers will not be met by either the recruitment of international medical and nursing graduates (the available pool in this context is anecdotally decreasing quickly – four fold in the year to date according to one Auckland regional DHB) or by the training of more doctors and nurses (given the training lead times). As such, an innovative approach is essential. This would involve anaesthesia technicians, theatre aides and physician assistants (PAs), non-doctor proceduralists, and so on.

The disability services workforce. A relative (to health) and absolute lack of information on the requirements of the

Organisations such as CareerForce (ITO), and the Ministry of Education, along with some educational institutions and the many providers (NGOs), have a role in this particular area of health and disability workforce education and training.

workforce needed for the various disability services is such that it is very difficult to plan for the training of these particular workers. What is clear is that the demand for disability-related services is increasing. The size of this workforce is probably larger than the health workforce *per sae* and it is widely accepted that the majority of these workers are inadequately trained for the support services they deliver. Many workers frequently carry out tasks beyond their scope of practice or training and in a milieu of increasingly complex care needs. Finally, many work in isolation. Consequently,

workforce planning for and coordination of disability services is an urgent priority.

In part, the increased need for disability services is due to improvements in the diagnosis of conditions such as Autism Spectrum Disorder and Foetal Alcohol Syndrome; in addition, there are increased survivors of very premature births, which results in a greater number of young people requiring disability support. Intellectually disabled people now live long enough to grow old and have an earlier onset and a greater incidence of a number of chronic health conditions. For example, 40% of people with Down's Syndrome have symptoms of Alzheimer's Disease by the age of 50 years. People with intellectual disabilities also have a higher incidence of other age related problems such as heart disease and diabetes.

The training for health professionals in the area of disability, assessment, diagnosis and triage is poorly coordinated; the number of health professionals who have a good working knowledge of the range of disabilities is diminishing as the disability population diversity and numbers increase. Unfortunately, there is no relevant DHB or MoH demographic data as neither accepts responsibility for disability population analysis.

The lack of disability sector capability exaggerates demand on current health services and this trend will continue as the disability population ages.

The drivers of the need for reform. Not surprisingly, it is widely accepted that the status quo is untenable. In addition to the drivers of the need for reform cited above, the following should be considered. The health workforce, and especially the medical element, is subject to a career-choice distortion that arises because of remuneration anomalies within New Zealand and between New Zealand and Australia, and to student debt (7, 9, 11, 19, 20, 28).

Health workforce planning in New Zealand. The process of health workforce planning in New Zealand is confused and, over the last 20 years, iterative. The last report of the Health Workforce Advisory Commission (HWAC) identified the need for a health workforce planning group to match demand and supply. Consequent to Ministry and medical profession feedback, the response was limited to the establishment of a Medical Training Board (MTB)(29). This

limitation occurred despite a widespread recognition that such a Board could not exist in a vacuum and that a whole-of-health perspective was needed.

The situation as it applies to medicine will be used here as an illustration. Currently, there are at least ten "groups" - NZMC, MTB, the junior (RMO) and senior (SMO) doctors' Commissions, CTA, DHBNZ's Health Workforce Implementation Program (HWIP) and Workforce Taskforce, and the Starfish Consultancy Group, and two other groups in the Ministry of Health (MoH) - opining on the training and continuing education of doctors. The MTB and the RMO Commission have identified at least 20 recent reports on medical education and workforce – none of the recommendations of which appear to have been substantially employed.

Although the CTA states a determination to closely align with the MTB, and acknowledging that a nursing advisory group (NAG) does exist for the Agency, our understanding is that the CTA is essentially divorced from these intelligence processes.

It is worth noting that the composition of the NAG is not comprehensive (e.g. there are no university nursing leaders) and that there is no CTA representation for the over 30 other health professional groups. With a few notable exceptions (e.g. midwifery), CTA programs have not addressed the post-entry training needs of these other health professions.

The NZMC has a mandate for patient safety and doctor regulation (5). This does require the Council to have a role in setting standards and competencies. Despite the presence on the Council of members who have considerable medical educational experience, the Council has neither the mandate nor establishment expertise to be involved in curricula and pedagogical debates. Similarly, the Council cannot have a leadership role in the planning of the (wider) health workforce, and for that matter cannot be involved in the identification of health service demand and supply, and or find innovative ways of reducing demand for and increasing supply of health services. Finally, the Council has no role in the purchasing of

training of any health worker group. The Australian Medical Council (AMC) role is constrained in New Zealand to accreditation of universities and colleges. The colleges themselves are standard-setters and have some role in providing education, but are secular and cannot have a role in overall planning and funding.

By contrast, the Nursing Council is heavily involved in assessing curricula and pedagogical approaches to educating nurses, as is true for the respective regulators of other professions including pharmacy, psychology, physiotherapy, occupational therapy, optometry and medical laboratory science (5). All of these groups are, by definition, secular.

The education sector and the DHBs have a fiscal interest in providing education, but, currently do not have a whole of workforce or whole of continuum view. The DHBNZ taskforce on the health workforce is problematic as there is no singular DHB view; indeed, analysis of DHB status in respect to junior doctors shows that there is great disparity within the sector. The RMO and SOM commissions are time limited.

The MTB is generally well configured to represent the whole of continuum training needs of doctors. It is, by definition and nature, secular and it has to be acknowledged that any change in doctor roles or training has “knock-on” effects throughout the health (workforce) sector. The MTB is also divorced from the funding agency (CTA); that is, it is yet another non-executive advocacy and advisory group.

The relationship between the Ministry elements that are involved in health workforce planning (the Sector Capabilities and Innovation Directorate and the Strategic Workforce Development Group, and,

indirectly, the DHBNZ HWIP), the CTA itself, CTA's NAG, and the Minister is variously duplicative and is not explicit.

The CTA. The CTA is a group of eleven MoH employees based in Christchurch (a group manager, four managers, an administrator, an accountant and an executive assistant, and three analysts). The operating budget for this group is less than \$1 million p.a. and the funding to be purchased or part-purchased in 2009 will exceed \$120 million. At one stage, the CTA was a Crown Entity. The reason for the subsequent absorption into the Ministry is not clear. A possible reason proposed to us was that there were problems in linking the external Crown Entity to policy processes within the Ministry.

Regardless of its roots, the CTA is in need of a significant reform in respect to

governance, and to intelligence; the purchasing and monitoring functions are variable and variously perceived.

In respect of nursing, elements of the CTA funding process are inflexible and the related monitoring is both punitive and overly bureaucratic. The arrangements for postgraduate nursing training are also complex and diverse. Since 2007, the CTA has devolved a budget for postgraduate nursing to the DHBs (on a proportional basis). The DHBs (in consultation with Primary Health Organisations – PHOs) make decisions with the educational institutions as to what type of programs they wish to see provided. Such programs must be approved by the Nursing Council, and, to qualify for CTA funding, the program must be postgraduate and lead to a qualification. The TEIs (universities and some polytechnics) are funded by TEC and CTA/DHB money is used to pay the student fee portion, to provide for staff replacement or to release staff from other duties, and to provide clinical support or preceptors, as well as some student travel costs. For nursing, this has increased the uptake of some clinically relevant programs and, where well managed and rationalised, has been responsive to clinical need. In 2009, the CTA has indicated intent to consult on the mix of programs available for nurses.

The overall reporting lines of the CTA are not clear and neither is the responsibility of the Agency to either the Minister or the Sector. Review of the 2008/9 purchasing intentions shows the schedule to be historically based and somewhat ad hoc. There is little history of innovative funding or funding of innovations.

The primary care role of the pharmacist. The preoccupation of planners with the medical workforce in trying to manage the health workforce crisis also overlooks the reality that the health provider that people most commonly contact first with a health concern is a pharmacist (25); these practitioners are not currently trained for such a diagnostic and triage role. This role will inevitably increase in response to direct to consumer health disease industry marketing (30-32). Already, there is an acknowledged increase in the prevalence of medically unexplained symptoms and, perhaps, a consequent increase in the number of irregular health providers (33).

The ACC, the recession, unemployment and ill-health. There are other community markers of concern, which warrant a whole of health workforce planning and funding approach. In the context of injuries and work related disease, the ACC has unfunded liabilities in two accounts in excess of a billion dollars each. Doctors and other health professionals are the “gateway” to this scheme; much of the variance in the underpinning clinical decision making is not Bayesian (34). The ACC liability is likely to worsen given the relationship of unemployment to ill health in the context of the current global recession.

The responsibility for health worker education. Finally, responsibility for the health worker educational continuum is fragmented. The Health and Disability Commissioner also has a

variable role across this continuum and different students' and workers' unions are involved at different stages.

The situation for medicine well illustrates this commentary. Medical students, junior and senior doctors are variously subject to universities, the AMC and NZMC, TEC, CTA, the DHBs, the professional colleges, and the private health sector and NGOs.

The reform of health workforce training. The need for reform then, by way of simplification and unification, is reasonably self-evident. The necessary reform can be seen to need the following elements.

The formation of a health workforce training agency. First, a whole of health workforce and whole of career (continuum) oversight role is needed for a singular health workforce training agency. The agency requires effective governance and intelligence functions. There is a strong argument for a health workforce innovations unit.

The demand-side measures. Second, a series of demand-side measures should be introduced. These need to include small-scale trials of innovative chronic disease management models (e.g. diabetes)(7, 22).

Most commentators would include a portfolio of preventive health measures; these are highly valuable in maintaining community productivity and welfare, but, will not affect the demand for health services in the short or intermediate term (28). By contrast, hospital admission rates would most likely be reduced by targeted expenditure on housing.

The supply-side measures. Third, there are a plethora of necessary supply-side measures. These include, but, are not limited to the following:

- restore junior doctors to an apprenticeship model (35, 36), which should include management of their overseas training experiences, the creation of a national “apprenticeship board” and CTA driven incentives for national and or regional employers to provide a broad apprenticeship;

A comprehensive review of junior doctor employment and the rationale for such an apprenticeship system will be presented in the RMO Commission Report; which is due later in 2009. There are many models of apprenticeship and the term is variously understood. Common to all models is a central relationship between a “master” and an “apprentice” that is interdependent and mutually beneficial. The model of apprenticeship being considered here is based on the triad of a broad view of mentoring, career navigation and “on the job training”, and, is likely to be applicable to other health professions.

- expand the student debt forgiveness scheme that was recently introduced for some health professional groups, and undertake a relative values study and realignment of health professional remuneration, to

While not an issue for medicine, physiotherapy and some other highly desired undergraduate programs, insufficient student interest is important. In some cases (e.g. health protection), special incentives may be needed. It is also highly desirable to have a health workforce that resembles the population it serves. More needs to be done to increase Māori and Pasifika entry and completion. This requires attention from at least the early high school years, if not before.

- generate incentives for both career choice and practice behaviour of high utility (9, 11, 12, 17, 19, 20, 28);
- introduce genuine clinical governance and increase health provider involvement in health-related corporate governance (37, 38);

- facilitate New Zealand health workers returning to the workforce (e.g. after having a family)(5);
- reduce barriers to overseas trained health workers being registered to work in New Zealand (5); and,
- undertake small-scale field trials of innovations such as “prescribing apothecaries” (25), PAs and operating theatre aides, technician and nurse anaesthetists, different scopes of practice for oral health workers, nurse endoscopists, and nurse practitioners in chronic care (e.g. diabetes and COPD), as a preface to wider training and implementation (21-24).

In the absence of both a reform of the funding of health worker training and the adoption of innovations, the Government target of 20 Surgical Super Centres (800 additional health workers) would seem unobtainable (see Page 10).

Key recommendations. The key recommendation then is for a singular health and disability services workforce training agency. Other more specific, but key, recommendations include the following.

- The Government should set the priorities and plans for health workforce training (in discussion with the agency) and the Minister of Health should approve all purchase intentions.
- The Government (publicly funded) units and groups committed to health workforce planning, and especially those that have a role in the funding of training, need to be aggregated, if not combined, to avoid duplication and to concentrate expertise. For example, the HWIP was established by funding from the MoH and it would facilitate

both the intelligence processes, and, importantly, the access of any singular health workforce training funding agency to the respective data and personnel, if HWIP was united with MoH elements such as the Strategic Workforce Development Group and the Sector Capabilities and Innovation Directorate.

The Governance, Management and Operations of a Reconfigured Clinical Training Agency

Underlying principles for a reconfigured CTA. The following operational principles have been used to guide this proposal for a singular agency to plan and fund the training of the New Zealand health and disability services workforce.

- Any health workforce training (planning and funding) agency should be a Crown Entity and the governance of the agency should be outside of the Ministry of Health.

Two options were considered possible. The first is to either reconfigure the CTA in place in the MoH or to form a new agency in the MoH; this could be augmented by amalgamation of the Ministry's Sector Capabilities and Innovation Directorate, the Strategic Workforce Development Group, the CTA itself and perhaps by an assumption of the DHB HWIP. The rationale in part for such a solution is the basis for the wind up of the original Crown Entity – see page 14. However, this option is neither favoured by us nor by key opinion leaders outside the MoH for three reasons. First, a singular health workforce training agency should be independent of any Ministry or Government organisation as it must interact without favour with *Te Puni Kokiri* and the Ministries of Health, of Education, of Social Development, and of Research, Science and Technology, as well as the ACC, TEC, various Industry Training Organisations (ITOs) and the DHBs, NGOs, and the private and voluntary health and disability sector. Second, an independent organisation is probably necessary if the key stakeholders of training (the employers) are to fully accept responsibility for the roles of health workers, which will determine recruitment and training needs. This is the key underlying principle of "sector ownership". Third, as indicated by the plethora of "failed reports", the track record of such ministry groups is poor. The second option is for a Crown Entity and that is what we recommend. Some economy might be lost in such a formation. The other problem to be overcome is that of a dislocation from MoH and related resources.

- The Minister of Health should be responsible for the purchasing of health worker training on the advice of a singular health workforce training (planning and funding) agency.

- The health workforce training (planning and funding) agency should be governed by a board that is strongly representative of employers in the broader health service.
- The operations of the health workforce training (planning and funding) agency must be such that it is able to be reactive and adaptable.
- Any health workforce training (planning and funding) agency should not replicate resources that already exist and that are accessible in the Government and Non-Government sectors.

One viewpoint is that a governance board is needed, whereas the other is that the health workforce training funding agency needs an executive director and that all that is needed is a stakeholder advisory board. The director (Training Csar) option is not favoured as the Csar can be “captured”, there is a need to find consistently high quality Csars, and the various stakeholders are likely to be alienated by being relegated to an advisory board such that they will not take ownership of the various employment models.

MoH elements that have considerable and relevant data collection, analytical and planning capacity are the CTA itself, the Sector Capabilities and Innovation Directorate and the Strategic Workforce Development Group, and, indirectly, the DHBNZ HWIP. There are three options here. The first is to replicate the databases and the analytical capabilities of these MoH units in the CTA. This is contrary to the sensible principle cited above and would be expensive; to some degree, such triplication is current and, in part, is due to the geographical dislocation of the CTA and the separation of the MoH innovations and workforce planning groups. The second is to aggregate all relevant capabilities in the CTA. This is the economically rational option. The third option is to direct/require unfettered access for the CTA to all MoH data and personnel.

The option of a *de novo* agency or a reconfiguration of the CTA.

There are two options for the formation of a singular health workforce training (planning and funding) agency. The first is for a reconfiguration of the CTA. The other is for a *de novo* agency or

commission that will assume the roles of the CTA, but, be employed in a much broader scope of practice than that currently undertaken by the CTA.

The CTA is perhaps the only currently suitable proto-agency in this context, although it now exists as a group within the MoH and not as a standalone agency. As such, any conversion (reconfiguration) of the CTA would be more than a re-branding exercise. The upside is the CTA is well known and, in many domains, is seen as being much improved. The downside is a common pejorative perspective and a title that is unlikely to encourage a broad view of the health and disability sector; indeed, a title that is likely to alienate many disability services and workers.

Our recommendation is for a two phase conversion of the CTA. The first phase should maintain the agency's name and be a process of reconfiguration. The focus of this phase is on the health workforce; our consequent recommendation is that the CTA be substantially reconfigured in respect of governance and intelligence processes and be employed as the singular health workforce training (planning and funding) agency. The second phase would be for a change in name to a more generic and broadly applicable one, and for a widening of scope to include the disability services. The balance of this report is dedicated to the first phase of a reconfiguration of the CTA.

The mission of a reconfigured CTA. The mission of a reconfigured CTA is to be responsible for planning, purchasing and monitoring the training of the health workforce for New Zealand such that the workforce is appropriate and fit-for-purpose, and, both cost- and outcome-effective. To achieve this mission, the CTA must have a whole of health workforce and a whole of education continuum

responsibility. It will also be necessary for the CTA to be reactive and quickly responsive. A CTA Health Workforce Innovations Trials Unit will consequently need to be established.

The governance of a reconfigured CTA (see Figure One and Two).

The CTA should be governed by a board. The Board Chairperson should be appointed by the Minister of Health and the board made up of representatives of the DHBs, NGOs, the private health sector, aggregates of the health professions, consumers, Māori and the education sector. Government (e.g. *Te Puni Kokiri*, the Deputy Director General of Health, who has the responsibility for workforce, and the CEO of the ACC) representation on the board is controversial. On the one hand, it ensures linkages, at the least at the strategic level. On the other hand, it depreciates the necessary board independence and creates conflicts of duties for any such Government board members. Figure Two then represents a board membership that is indicative rather than fully agreed.

Stakeholder input to the CTA should occur at both the board level and to discipline specific reference groups that will be needed for the larger and more diverse health disciplines (e.g. medicine and nursing). Medicine and nursing are the only recommended professional reference groups that will meet regularly because of their nature, complexity, the length of training and their tribalism (especially medicine). The other health professions are far too numerous to account for individually and an interprofessional approach is both preferred and practical – hence the suggested aggregates. In the context of a lean, but, dynamic approach to intelligence gathering, the CTA would be able to call a “speech language therapy” reference group together if the need arose and for as long as the need for such a reference group existed.

Figure One: Governance of the CTA

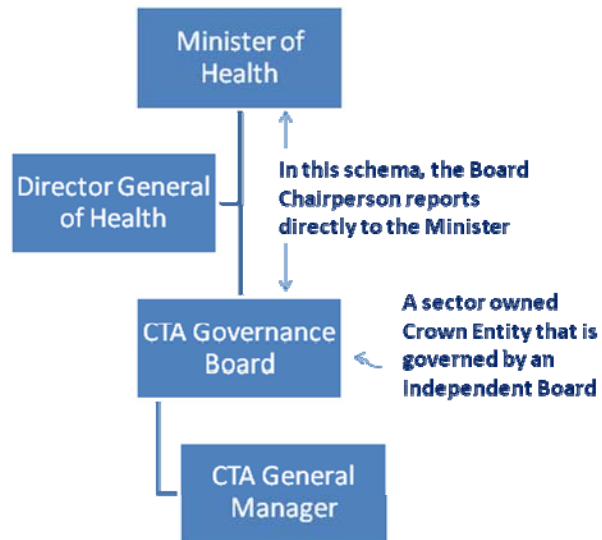


Figure Two: CTA Governance Board



Rationalisation of advocacy and advisory groups is both possible and desirable. For example, a slightly modified MTB should assume the role of the CTA medical reference group and could replace the ten already cited groups committed to medical workforce planning (see Page 12), and, should also provide a basis for ongoing dialogue with universities, colleges and councils.

The management of a reconfigured CTA. (see Figures Three and Four). Management of the CTA should be the responsibility of a General Manager and two subservient managers who will have specific responsibilities for planning, purchasing and monitoring, and for a Health Workforce Innovations Unit.

The operations of a reconfigured CTA.

CTA programs and projects. The planning, funding and monitoring processes should be divided into core programs and programs, and projects, which will require specific program and project leaders. A CTA program and project leader will have a portfolio of such programs and projects.

These program leaders should have secondary responsibility for other programs to ensure continuation in the event of leave, illness and so on.

The following programs and projects are what we would initially recommend: Core Programs (Medicine, Nursing); Programs (Aged care, Disability services, Maternity services, Mental health, Oral health. Pathology and laboratory services, Primary care, community care and integrated care including community pharmacy services); and, Projects (Elective surgical services, Obesity and diabetes community projects).

Consideration could also be given to a program that brings together a range of health professionals to consider interdisciplinary education and practice, new roles and innovations that transcend particular professions and extended scopes of practice. This program could provide advice to the Health Innovations Workforce Unit.

Affirmation for indigenous health workers will be a core element of all programs and projects and not abrogated to a singular and potentially disconnected process.

Figure Three: Management of the CTA

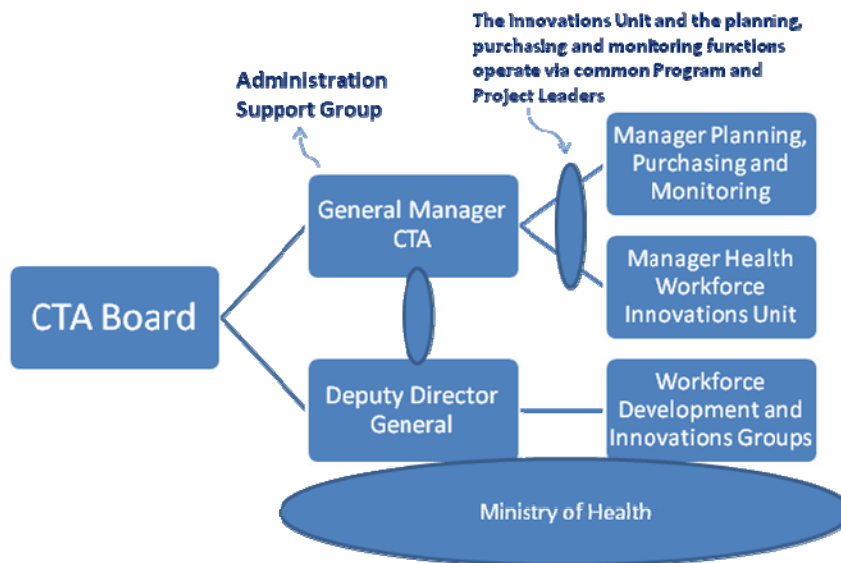
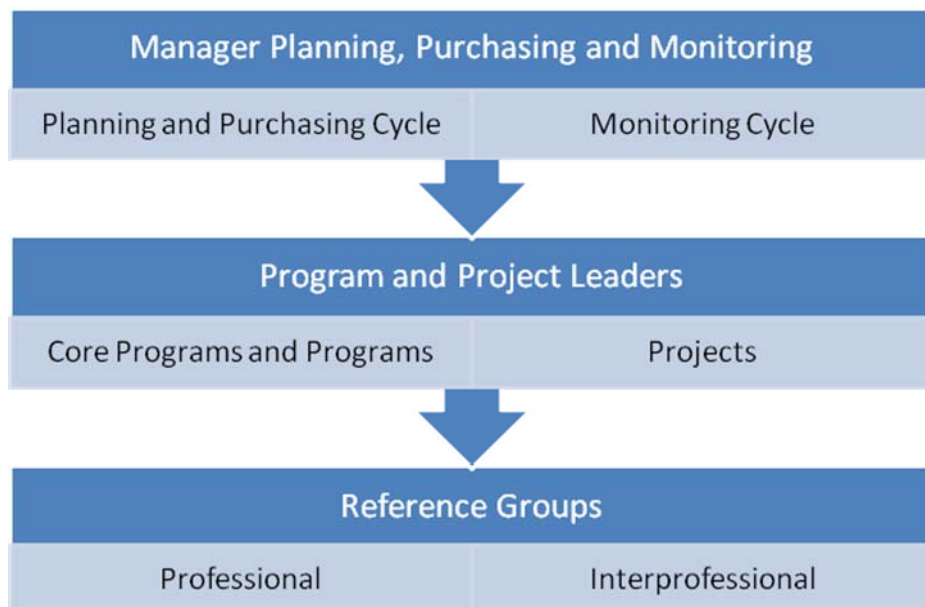


Figure Four: Management of the CTA



The CTA, TEC and the DHB's. Funding of and support for health worker training at all levels must be revised and or improved.

The health sector (MoH, DHBs, PHOs and community providers) presents significant challenges to any reform of health worker training. Until recently, there was no cap on student places other than for medicine and dentistry. While there was growth in some health groups, it was modest relative to need. The major restraint was an inability to secure sufficient practicum/clinical placements. While DHBs are now somewhat more user-friendly to educators and students, this remains a significant issue despite the rhetoric at board and senior management levels. Although it was once a legal requirement for health services to provide education and training for student health professionals, some now regard it as burdensome or as a source of income. Primary care is a particular challenge. Education and student support has to be clearly stated as a requirement of publicly funded or subsidised health services. For example, AUT University would be unable to provide some programs (e.g. oral health, podiatry and child psychotherapy) if it did not operate relevant health services. If the TEC cap on domestic students was removed, in a number of disciplines, growth would be modest unless there was a significant change in DHB/PHO attitudes and practice. While it may be less of an issue for medicine, health education providers and DHBs need to be more closely linked. There should be someone in each DHB, at a senior level, who has oversight of student placements and related matters.

There are three possible categorical responses to the funding of TEC-related health worker education.

The first is an acceptance of the status quo. This is not seen by us as reasonable, although a lifting or partial (e.g. health professions) lifting of the TEC overall tertiary sector funding cap (TEC cap) would bring significant relief. This would restore the situation to one in which

The status quo *per sae* is dysfunctional. Increases in numbers of TEI health professional students can generally only occur by way of a disinvestment in other TEC funded students (e.g. commerce, arts, science and law students). Increases in health worker training at TEIs then is opposed and in an environment in which the needs of the health sector are not paramount. The debate also alienates the health training elements of the tertiary sector.

health professional training at TEIs is essentially governed by health provider student access and support capacity (39).

Second, responsibility for the funding of health worker education at the TEIs could be left procedurally with TEC, but, the CTA would set funding targets for all health professional groups. These targets would need to be both national and regional, to be based on ranges rather than explicit numbers, and would need to be both reactive and modifiable, but, would not be left to the discretion of TEC; this process would also need to be independent of the process of the Government setting of the ceiling for tertiary education spending. It should not preclude TEIs from moving student fees (EFTS) from other program categories to health and responding to local or highly specific needs not recognised at the national level.

Third, the TEC funding for health professional groups could be unbundled and shifted to the CTA, such that the Agency would purchase undergraduate as well as postgraduate (post-entry) health worker training. This is a preferred option for health, but has two drawbacks. First, if the TEC cap was lifted (a phenomenon that is being witnessed elsewhere in the context of the global recession), then, perversely, the funding of health workers might be selectively disadvantaged by still being capped. Second, the relocation of those TEC funds currently employed for health worker education to the CTA would create a divided system of tertiary education sector funding and would certainly be opposed by the universities.

The consequent recommendation here then is for either a lifting of the TEC cap on health worker educational programs and the use of “market forces” to regulate training numbers (39), or probably simpler, a system in which the CTA sets the funding targets for TEC in the context of the health workforce.

A similar requirement exists to rationalise DHB expenditure on health worker training and that of the CTA. Again, the options are the status quo, or for either an unbundling of funds and transfer to the CTA or for the CTA to regulate training by way of both standards setting (e.g. access to funds to employ a junior doctor would be contingent on standards of apprenticeship being in place) and directive target setting.

CTA reference groups (see Figure Five A and B). Each program and project leader will have access to a reference group or groups, which, in turn, will either be amalgamated with or that will have unfettered access to the relevant MoH data and personnel.

Some, such as the medical reference group (MTB) and a comprehensive NAG, will underpin core programs and will meet regularly as part of the CTA annual planning cycle. The medical reference group should also serve as the junior doctor apprenticeship board.

As an example, the medical group should include a representative of the doctors in training, the tertiary education providers (the University of Otago and of Auckland), the professional colleges, the Māori health provider communities, and the employers (the DHBs, the private sector and primary care providers. See Pages 17 (apprenticeship model) and 25 (rationalisation of the current situation of multiple opining and reporting groups).

Figure Five A: Illustrative CTA Reference Groups

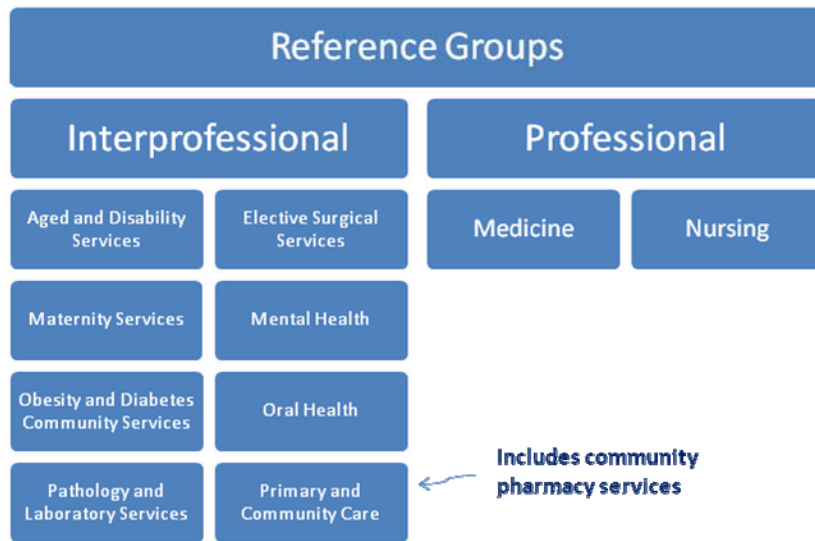
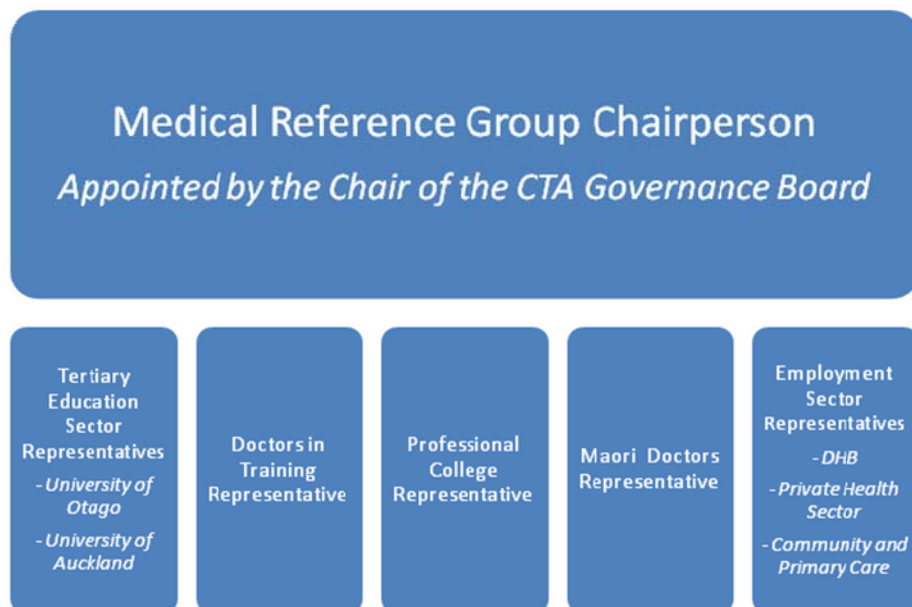


Figure Five B: The CTA Medical Reference Group



Although the medicine and nursing reference groups are guild based, other reference groups will be formed and used as required and will be interprofessional (e.g. aged care, disability services, elective surgical services, maternity services, mental health, oral health, pathology and laboratory services, primary care, community care and integrated care, and, obesity and diabetes).

To illustrate the complexity and plethora of stakeholders, the College of Nurses, the New Zealand Nurses Organisation, the Nursing Council, the respective Medical Colleges and the New Zealand Society for the Study of Diabetes are all involved in determining for nurses and employers what the role of a nurse could and should be in diabetes care.

The CTA planning, purchasing and monitoring process (see Figures Six A, B and C). An annual CTA planning, funding and monitoring cycle, which conforms to standard public sector practices, is recommended; the proposed process here is that this be based on an initial analysis (by way of the respective reference group and any relevant MoH groups) of health demand and supply and consequently that 1, 5, 10 and 20 year forecasts be derived.

If a shortage of supply relative to demand is predicted, the standard operating procedure would be to refer the plan to the CTA Health Workforce Innovations Unit. The first obligation of the Unit will be to identify potential innovations to reduce demand and or to increase supply.

The CTA Health Workforce Innovations Unit should either be amalgamated with or should engage directly with and use the resources of the MoH Sector Capabilities and Innovation Directorate.

Figure Six A: CTA Health Workforce Annual Planning Cycle

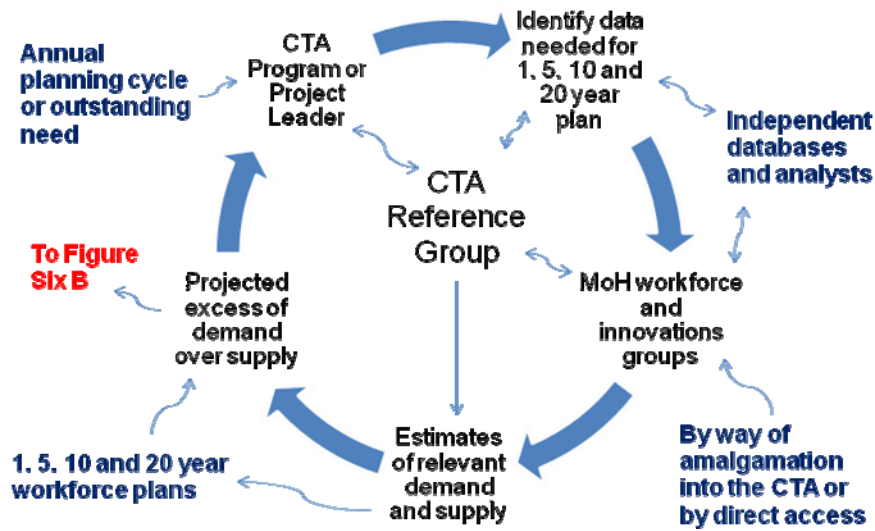


Figure Six B: CTA Health Workforce Annual Planning Cycle

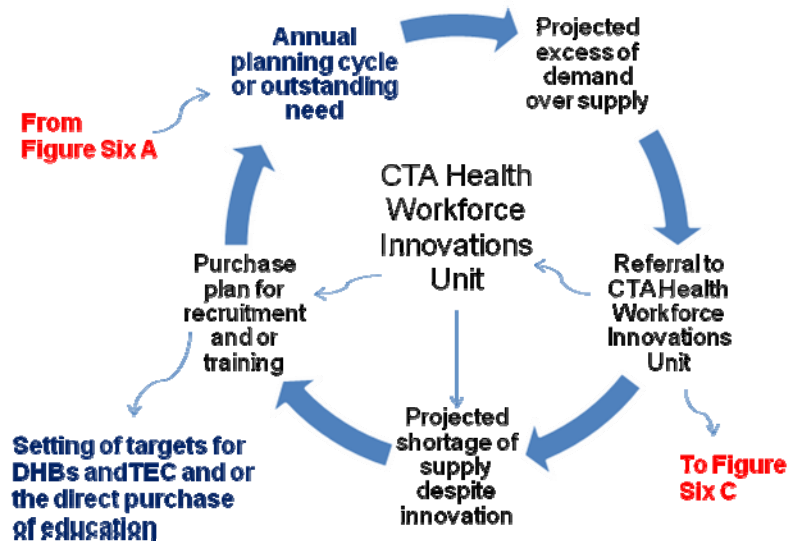
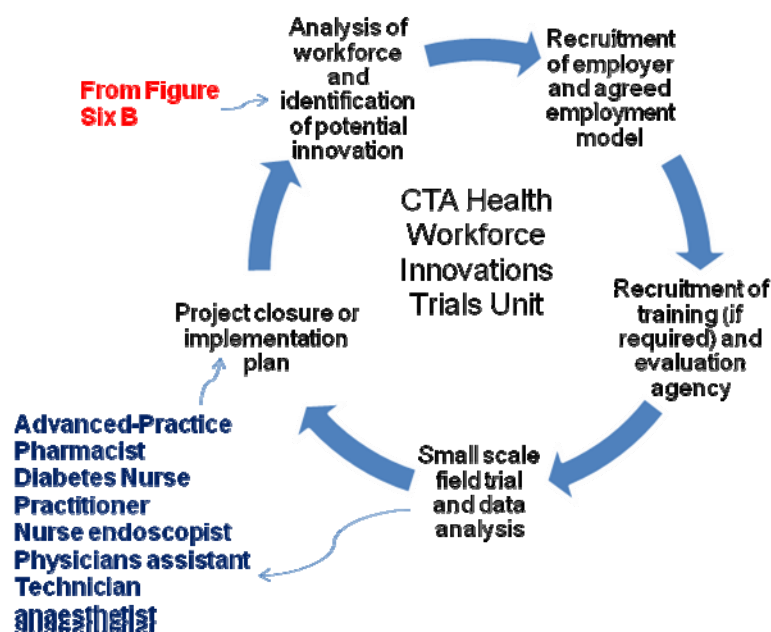


Figure Six C: CTA Health Workforce Annual Planning Cycle



In the event that a potential innovation is found, the next step will be to implement the innovation, or to fund a trial of the innovation or to fund training for the innovation.

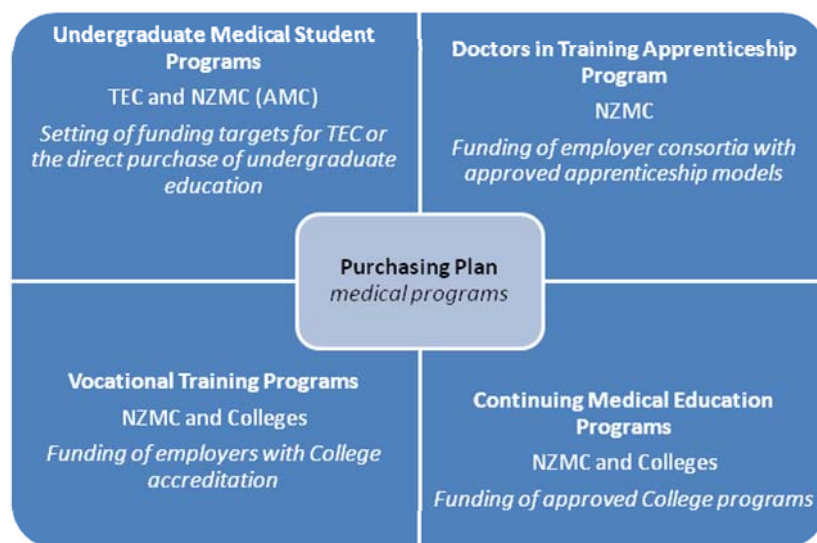
The staffing of the Government’s targeted 20 Surgical Super Centres (800 additional health workers) would be an example of a project for the CTA Health Workforce Innovations Unit and would involve the initial small scale field trials of anaesthesia technicians, theatre aides and PAs, non-doctor proceduralists, and so on.

It will often be the case that there is a projected shortage of supply despite any innovation. In this event, the action taken will be to fund the recruitment of additional traditional workers and or to purchase training for traditional health workers.

A tri-phasic approach is recommended. For example, for PAs, the first phase would be to recruit already trained PAs from the US or UK to both prove the concept and to act as trainers. The second phase would be to send New Zealand students to one of the new PA programs in Australia for training – this would enable a supply of PAs during the period when the third phase, New Zealand based programs, were undergoing the process of development and approval.

It may even arise that there is a projected excess of supply relative to demand. The referral to the CTA Innovations Unit in this context will be to try and find a way in which at least some of these workers can be redeployed into under-supplied areas of need. The final phase of the cycle will be for the CTA to prepare an overall purchasing, monitoring, compliance and planning schema for submission, via the CTA Governance Board, to the Minister of Health for approval (see Figure Seven for an example of how the medical programs purchase plan could be configured).

Figure Seven: CTA Medical Funding Programs



Recommendation for an Implementation Plan. Our recommendations are presented for your consideration and in accord with our Terms of Reference. Our final recommendation then is that once you have decided the extent to which you wish you want to implement these changes, that the Taskforce be directed to provide you with the key elements of an implementation

process.

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