The Royal New Zealand
College of General Practitioners
Te Whare Tohu Rata o Aotearoa

14 April 2016 Our Ref: HMB45-16

Professor Des Gorman
Executive Chairman
Health Workforce New Zealand
PO Box 5013
WELLINGTON 6145

Dear Professor Gorman

Thank you for asking the Royal New Zealand College of General Practitioners (the College) to comment on a new model for the funding of vocational training.

Executive summary

The College's key points on the future of vocational funding are that:

- Continuity and certainty must be supported through multi-year contracts with training providers.
- Greater support should be provided to Registrars in priority specialties.
- A fund should be introduced that will provide for the co-ordination of all health professional training in general practices – with appropriate joint governance –and allow practices to invest in the infrastructure necessary to deliver training.
- Changes to funding for vocational training should be aligned, as far as possible, with changes to the undergraduate and immediate post-graduate training of medical practitioners

Introduction to general practice and the College

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

GPs comprise almost 40 percent of New Zealand's specialist workforce and their professional body, the Royal New Zealand College of General Practitioners (the College), is the largest medical College in the country. The College provides training and ongoing professional development for general GPs and rural hospital generalists, and sets standards for general practice. The College is committed to achieving health equity in New Zealand. To achieve health equity, we advocate for:

- A greater focus on the social determinants of health (including labour, welfare, education and housing).
- A greater focus on measures to reduce smoking and to increase healthy food options for low-income families.
- Health services that are better integrated with other community services.
- A review of the funding model for primary care to ensure that funding is targeted towards the most disadvantaged.
- Free primary health care for low-income families, because health inequities begin early and compound over the life course.

Submission

At the Council of Medical Colleges (CMC) meeting on 10 March you indicated that you were seeking input on:

- The draft principles proposed for a new model.
- What a new funding model should look like.
- Other impediments that stand in the way of uptake of vocational training.

We note that the College has previously provided comment via CMC on the subject of how specialty training programmes should be prioritised, and we refer you to that earlier correspondence for our views on this issue. This submission has been written under the assumption that general practice is one of those specialties identified as being "vulnerable", as per the consultation paper you circulated via CMC in April 2015.

Draft principles

The paper presented at CMC included a number of principles. Our comment on each of those suggested principles is as follows:

- *Priority specialties to be determined through engagement and consultation with the Council of Medical Colleges*

  There is likely to be disagreement from those Colleges that benefit from the status quo, and who are likely to be disadvantaged by change. However, our preference would be that, if possible, the methodology for prioritising specialties be agreed on by CMC members.

- *Close engagement with key stakeholders required to inform identification of risks and challenges, and support implementation of appropriate mitigation and management strategies*

  The College agrees with this principle.

- *Investment to be conditional upon retention of College training site accreditation*

  Training in general practice is conducted by educators who are accredited by the College in facilities that are also accredited by the College. Information about these accreditation processes, and the standards that apply, can be found here.

- *Investment to be focused on priority specialities*

  The College agrees with this principle.

- *An increased level of investment to be directed to priority specialties*

  This principle is very similar to, and could be incorporated into, the principle above.

- *Innovative and efficient approaches to recruitment, retention and training to be supported*

  The College agrees with this principle.

- *The viability of non-prioritised vocational training specialties to be assured*

  The College agrees with this principle.

- *Current training registrars are to be supported for the duration of their vocational training*

  The College agrees with, and welcomes, this principle.

- *Investment must support College training site accreditation, as relevant*

  The accreditation processes for GP educators and facilities are described above. We are aware that there are some appropriately qualified GPs who are keen to become GP educators, but a lack of infrastructure means that their practices do not meet accreditation standards. In particular, their practices lack the rooms and facilities to accommodate trainees. In addition, there are practices that do provide medical education, but could accommodate more trainees if they had the facilities to do so. Funding that would support practices to invest in training infrastructure could enable more practices to become teaching practices.

- *Increased primary and community-based care must be supported*

  The College strongly supports this principle.

- *Support must be provided to addressing service maldistribution*

  The College agrees with this principle. We suggest that extra funding be targeted to regions where the undersupply of specialists is most significant. Training within a region allows trainees, including undergraduates, to develop connections with that region, and they are more likely to remain there in the longer term.

- *Monitoring and evaluation to be ongoing*

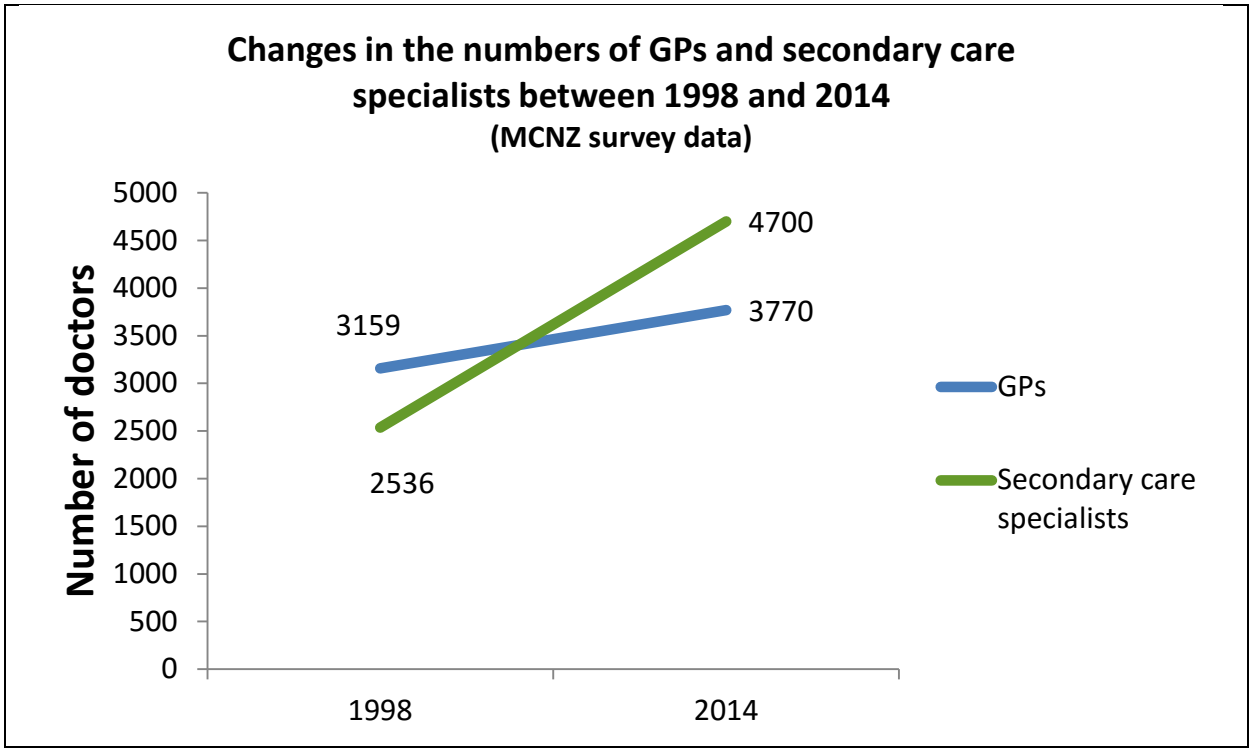
  The College agrees with this principle. The funding model must be subject to regular review and adjustment to reflect changes in priority and supply.

- *Decision-making to be transparent*

  The College agrees with this principle.

- *Implementation to be transitioned over a period of three to five years, to ensure manageability of change impact*

  The College notes that discussion around changes to vocational funding has been dragging on for a number of years now. As the graph below demonstrates, during that period the maldistribution of the specialist workforce has continued to worsen:



While the College agrees that a transition period is necessary to both scale-up and scale-down existing training programmes, it is also likely that HWNZ already has a strong indication of which training programmes should be prioritised and which should not. Notifying those training programmes provisionally identified as being a "red flag" in terms of both high vulnerability and chronic over-supply should therefore occur as soon as possible to allow Colleges to start planning, recruitment and to begin to make necessary adjustments. Similarly, finalising and implementing the new funding model should be prioritised.

The College also suggests that HWNZ include three additional principles to those already identified.

The first additional principle looks at continuity and sustainability of training programmes in the long-term. Making any major change to a vocational training programme, particularly one such as general practice that is delivered in a diverse range of settings, requires certainty of funding.

The first year of GPEP (GPEP1) training is conducted in primary care practices, with training provided by vocationally registered GP medical educators. The nature of this training environment makes implementation challenging. That challenge is exacerbated when funding decisions are made on a yearly basis, with the College advised of those funding decisions only a few short months before each training year begins.

The current year-by-year funding arrangement leaves doctors applying for the training programme, medical educators, practices and the College uncertain and unable to plan appropriately.

Providing certainty around future funding arrangements, ideally in the form of a multi-year contract, would provide doctors, medical educators, practices and training providers with certainty, and allow appropriate forward planning to occur.

We therefore suggest that continuity and certainty be incorporated into your principles as follows:

Continuity and certainty to be supported through multi-year contracts with training providers.

The second additional principle looks at providing support directly to Registrars. While recent changes have greatly increased the level of support provided to Registrars in the first year of the College programme (GPEP1), those Registrars in later years (GPEP2) receive little support. Unlike their Colleagues in GPEP1 and secondary care specialist training programmes, this cohort must currently pay costs out of their own pockets, including:

- To sit College examinations
- To take the full study time they are entitled to as part of their training
- For direct costs, such as books, software, electronic access to journals, and other learning materials
- To complete academic papers in order to meet the training programme's academic paper requirement
- To prepare for and attend other educational activities, such as small group meetings.

The NZMA has recently conducted a survey of Registrars across the vocational specialties. This survey found that:

- Only 32% of GP Registrars "strongly agree" or "agree" with the statement "I am given protected time to attend educational activities" (compared with 47% of all Registrars).
- Only 52% of GP Registrars "strongly agree" or "agree" with the statement "I am able to access adequate conference and study leave to meet my training needs" (compared with 61% of all Registrars).[1]

[1] 2014 vocational trainee survey. NZMA. 2015.

It is noted that this survey does not differentiate between the answers given by GPEP1 and GPEP2 Registrars, and it is highly likely that GPEP2 Registrars are considerably less satisfied with the protected time and study leave available to them than GPEP1 Registrars.

The College therefore proposes that an additional principle be incorporated as follows:

> *Where appropriate, funding should be directed to Registrars to support their engagement in educational activities.*

Our final additional principle looks at vocational training in the wider context of medical training. Our view is that the entirety of medical training should be rationalised and better coordinated. Currently: universities seek teaching practices for medical students; the Medical Council seeks teaching practices to provide "community placements" for new graduates; and the College seeks practices to provide vocational training. Our view is that it would be highly beneficial for these different processes to be better aligned. With other organisations the College has already taken a lead in this area[2], but much more is needed.

In this context, we believe that work being done by Associate Professor Sue Pullon (Otago University) and Professor Felicity Goodyear-Smith (Auckland University) to conduct a national stocktake to assess the capacity of practices to take students, postgraduate trainees and Registrars will provide valuable information that will ensure better co-ordination of training needs across the different stages of medical education.

From a HWNZ perspective, increasing funding for vocational funding within any particular specialty is likely to have a greater impact on uptake of that specialty if it is also accompanied by an increased focus on training at an undergraduate and immediate-postgraduate level. We therefore propose that an additional principle be added which states that:

> *Changes to funding for vocational training should be aligned, as far as possible, with changes to undergraduate and immediate post-graduate training of medical practitioners.*

A new funding model

Our comments around a new funding model are that:

- Funding should not be looked at in isolation. Funding is only one lever that will influence training decisions and allow more trainees to be trained. Any changes to funding should be accompanied by actions intended to influence other levers (see below).
- The model must recognise that training is also delivered outside of DHB funding streams. We note that all of the "straw men" funding models proposed in the CMC paper look at funding into DHBs only. Vocational training in general practice is not delivered in the DHB environment, but is instead delivered by a combination of College-employed and practice providers.
- The funding model must be subject to regular review and adjustment to reflect changes in priority and supply. The answer to a shortage of some vocational specialties might best be addressed through a short-term boost followed by a return to equilibrium. For example, doubling the supply of one specialty might be necessary to meet looming workforce needs, but continued supply at the increased level over a ten-year period is likely to result in future over-supply.
- Caution would need to be taken in linking funding with either recruitment of a trainees or successful completion of training. This could result in perverse incentives that might encourage recruitment of under-qualified trainees, or an easing of examination standards. Steps should therefore be taken to ensure that appropriate baselines are maintained.
- The funding model should actively address issues of maldistribution and equity. For example, it might target extra funding to regions where the undersupply of specialists is most significant. Training within a region allows trainees to develop connections with that region, and they are more likely to remain there in the longer term.

[2] In particular, via an RNZCGP working group and the HWNZ CBA working group.

Other levers

As discussed above, funding is only one lever that will influence training decisions and allow more trainees to be trained. In order to positively increase the uptake of GP training, the College believes that the following changes will also need to be made:

- A fund should be introduced that will provide for co-ordination of all health professional training in general practices – with appropriate joint governance –and allow practices to invest in the infrastructure necessary to deliver training.
- Funding should also be provided directly to Registrars to meet the costs of their training and, in particular, costs such as:
  - Examinations
  - Study entitlement and leave
  - Direct costs, such as books and other learning materials
  - Completing academic paper requirements
  - Protected time to allow them to engage in educational activities, such as attending small group meetings.
- Changes to funding for vocational training should be aligned, as far as possible, with changes to undergraduate and immediate post-graduate training of medical practitioners. Steps intended to encourage medical students to develop an interest in prioritised specialties, such as the Medical Council's new requirements around community placements, should be supported.
- Academic work in prioritised specialties should also be supported. The lack of support for academic general practice significantly restricts opportunities for general practices trainees and medical students considering general practice as a career, who wish to undertake research alongside their medical practice.

We hope you find our submission helpful. Should you require any further information or clarification please contact the College's policy team at policy@rnzcgp.org.nz.

Yours sincerely,

Helen Morgan-Banda
Chief Executive