

Senior Doctors in New Zealand

Securing the future

Report of the Director-General of Health's
Commission on Competitive and Sustainable Terms and Conditions of Employment
for Senior Medical and Dental Officers Employed by District Health Boards

25 June 2009

Citation: Commission on Competitive and Sustainable Terms and Conditions of Employment for Senior Medical and Dental Officers Employed by District Health Boards. 2009. *Senior Doctors in New Zealand: Securing the future*. Wellington: Ministry of Health.

Published in 2009 by the Ministry of Health
Po Box 5013, Wellington, New Zealand

ISBN 978-0-478-31950-7

HP 4893

This document is available on the Ministry of Health website:

<http://www.moh.govt.nz>

Contents

List of Tables	v
List of Figures	v
Executive Summary	vii
1 Introduction	1
1.1 Background to the commission	1
1.2 Purpose and timeframe	1
1.3 Information sources and data quality	2
1.4 Glossary	2
2 Senior Medical Officer Workforce	3
2.1 Role of senior medical officers	3
2.2 Statistical sources	4
2.3 Senior medical officer workforce profile	4
2.4 Hours worked	9
2.5 Senior medical officer shortages	10
3 Senior Medical Officer Supply Constraints	13
3.1 Financial sustainability	13
3.2 Recruiting senior medical officers in the international market	15
3.3 Increasing local production of senior medical officers – training more medical students	16
4 Drivers of Demand for Senior Medical Officers	17
4.1 Demographic change and changing health needs	18
4.2 Models of service delivery	18
4.3 Workforce attrition	19
4.4 Increased workloads	23
4.5 International demand	24
5 Balancing Supply and Demand	27
5.1 Improved information collection and analysis	27
5.2 Focusing on New Zealand’s doctors in training	28
5.3 Improved international recruitment and retention	29
5.4 Improved local recruitment	34
5.5 Improved senior medical officer retention	35
5.6 Making better use of the workforce	41
5.7 Competitive remuneration	43
5.8 Senior dental officers	45
5.9 Conclusion	46
6 Accelerating Progress	49
6.1 Introduction	49
6.2 National strategy	49
6.3 Recruitment	57
6.4 Retention	59

6.5	Sustainable pathway	62
6.6	Competitive terms and conditions of employment	63
Appendix 1: Terms of Reference and Members of the SMO Commission		67
Appendix 2: Glossary		69
Appendix 3: Senior Medical Officer Workforce Data		71
Appendix 4: Medical Officer Workforce Data.....		77
Appendix 5: Resident Medical Officer Workforce Retention Data		81
Appendix 6: Senior Medical Officer Workforce Shortages.....		83
Appendix 7: Senior Medical Officers' Roles as Teachers and Researchers.....		86
Appendix 8: Cross-Tasman Comparison of Agreements		98
Appendix 9: Key Agencies in Medical Training and Education.....		103
Appendix 10: Overview of Non-Clinical Training		116
Appendix 11: Excerpt from <i>In Good Hands</i>		119

List of Tables

Table 1: Number of senior medical officers, by gender, 1998–2008	5
Table 2: Place of primary employment for senior medical officers, 1998–2008	5
Table 3: Specialty practised by senior medical officers	6
Table 4: Share of international medical graduates in the senior medical officer workforce	7
Table 5: DHB use of international medical graduates (IMGs), senior medical officers and medical officers by DHB, year to 31 March 2008	8
Table 6: Concentration of international medical graduates in selected medical specialties, year to 31 March 2008	9
Table 7: Country of primary qualification of international medical graduates, year to 30 June 2007	9
Table 8: Hours worked per week by DHB-employed senior medical officers	10
Table 9: On call hours per week by DHB-employed senior medical officers	10
Table 10: Senior medical officer vacancies by DHB, as at 30 September 2008	11
Table 11: Retention of vocationally trained graduates, 2000–2008	19
Table 12: Retention of international medical graduates by type of registration, 2000–2007	21
Table 13: Retention of international medical graduate cohorts from first year of vocational registration, 2000–2007	22
Table 14: Senior medical officer and medical officer workforce by gender and specialty, 2008	72
Table 15: Female senior medical officer and medical officer workforce where more than 50 percent of specialty workforce, 2008	72
Table 16: Average hours worked per week by senior medical officers and medical officers, year to 31 March 2008	73
Table 17: Average on-call hours per week senior medical officers and medical officers, year to 31 March 2008	74
Table 18: Typical hours worked per week by DHB employed senior medical officers by specialty	75
Table 19: Number and proportion of medical officers to senior medical officers, 1998–2008	77
Table 20: Proportion of international medical graduates (IMGs) among senior medical officers and medical officers, year to 31 March 2008	78
Table 21: DHB use of international medical graduate senior medical officers and medical officers by DHB, year to 31 March 2008	79
Table 22: Retention of New Zealand graduate doctors, 1995–2007	81
Table 23: Comparison of New Zealand and Australian senior medical officer collective agreements	99

List of Figures

Figure 1: Health expenditure as a share of gross domestic product in selected OECD countries, 2006	14
Figure 2: Total health expenditure per capita in selected OECD countries, 2006	15
Figure 3: Age composition of the New Zealand–trained SMO workforce, 1998–2008	20
Figure 4: Retention of international medical graduates (IMGs) cohorts from first year of vocational registration, 2000–2007	23
Figure 5: Age distribution of the total senior medical officer workforce, 1998–2008	71
Figure 6: Age distribution as a proportion of the senior medical officer workforce, 1998–2008	71
Figure 7: Age distribution of the medical officer workforce, 1998–2008	78
Figure 8: Retention of New Zealand graduate doctors, 1995–2007	82

Executive Summary

Background

The Commission on Competitive and Sustainable Terms and Conditions of Employment for Senior Medical and Dental Officers Employed by District Health Boards (SMO Commission) was established in October 2008 to recommend a national recruitment and retention strategy that will provide a sustainable pathway to competitive terms and conditions of employment for senior medical officers and dental officers (SMOs). The SMO Commission reviewed relevant reports and literature, examined available data, and consulted widely.

We found that the SMO workforce has grown 46 percent over the last 10 years, and in September 2008 comprised 3713 medical specialists working across the public and private sectors. As at 30 September 2008, 3105 full-time equivalent SMOs were employed across the 21 district health boards (DHBs) at a total annual cost of approximately \$718 million. At the same time, there were 331 outstanding vacancies for SMOs, representing an overall vacancy rate of around 10 percent.

Overall, international medical graduates (IMGs) comprise 40 percent of the SMO workforce. In smaller rural DHBs, the proportion of IMGs in the SMO workforce tends to be significantly higher – up to 87 percent in the most extreme case. Once IMGs are vocationally registered, their retention rates are good, but indications are that retention is significantly lower among SMOs who have not achieved vocational registration.

Population growth and changes in the population's age structure are key drivers of increasing demand for health services. An increased proportion of older people who are also living longer is expected to dramatically increase the proportion of the population needing treatment and care for complex and/or chronic conditions.

Prevailing models of care will also influence workforce requirements. For example, the consolidation of some service delivery at national and regional levels may reduce the total number of SMOs required in the related subspecialty.

New Zealand is relatively disadvantaged in the international market for senior doctors in that it is geographically distant from many potential sources of doctors and remuneration is lower than in some other places. The smaller scale of hospitals and communities in New Zealand may also present professional challenges for some doctors and their families. Despite this, New Zealand has been reasonably successful in recruiting IMGs. We should not be complacent though, as our ability to recruit internationally and retain New Zealand-trained SMOs may be dramatically altered as a result of changes in supply, recruitment and retention in other countries.

An important response to this risk, and to current shortages, is to increase domestic supply by training more doctors. The number of funded medical student places is to increase by 200 over five years, commencing with 60 places in 2010. The full benefit of these increases will not be realised before 2029 because it takes 12–15 years to qualify as an SMO.

There are anecdotal reports that increasing numbers of SMOs are leaving New Zealand to work offshore. Retention among newly qualified SMOs appears to be deteriorating – dropping from 95 percent in 2000 to 89 percent in 2007. SMO numbers drop off from age 50, but it is difficult to interpret what this means. It seems likely to reflect a loss of SMOs to the system through early retirement and emigration.

Not surprisingly, Australia is the primary competitor for New Zealand's workforce as a result of geographical proximity, cultural similarity, shared professional colleges and training programmes, and superior pay and pay-related conditions. Our heavily qualified conclusion is that there is roughly a difference of 30–35 percent between the remuneration of New Zealand SMOs and Australian SMOs.

Findings and conclusions

SMOs report being undervalued within their organisations and the health system in general. Lack of involvement and influence in the strategic direction of services was a source of immense frustration to SMOs we met with. Some senior DHB managers seemed to have a limited appreciation of SMO perspectives. In our view, this is largely a product of the health reforms of the 1990s, which introduced a culture to the public health system that has devalued clinicians and proved detrimental to effective working relationships and service delivery.

To extract the best possible value out of New Zealand's investment in the public health system it is essential to draw on the knowledge and expertise of health professionals. We strongly support current efforts to strengthen the contribution of SMOs and have made recommendations to facilitate this objective through strong clinical–management partnerships and DHB board-led leadership development programmes. (*See recommendations 1 and 8.*)

In addition to having limited participation and influence, many SMOs in the public health system are dissatisfied with their working environment. They say 'push factors' are more important than the 'pull factors' of more attractive pay and conditions in the private sector or overseas in contributing to the loss of SMOs from the public health system. Some of their concerns were about having the appropriate space, tools and support to provide quality services and use their time well. It is easy to underestimate the impact of what can appear to be relatively trivial matters. We urge DHBs to review current arrangements and take necessary action. (*See recommendation 12.*)

Increased medical student intake is a positive initiative although somewhat overdue. Both the undersupply and oversupply of New Zealand-trained doctors is to be avoided as far as possible. Given that many complex and often external variables influence New Zealand's training requirements, and the lag between commencing training and qualifying as an SMO, it is important for student intakes to be adjusted regularly to align student intake to future service need. (*See recommendation 4.*)

To maximise the benefit of increased student intake, attention needs to be paid to improving the training and employment experience of doctors in training to realise their full productive capacity as soon as possible and retain them within New Zealand's public health system. We are aware several reviews have been initiated in this area, including the Medical Training Board Review, the Clinical Training Agency Review and the Commission on the Resident Medical Officer Workforce, and encourage the Government to agree to rapid implementation of co-ordinated initiatives that will significantly strengthen medical training. (*See recommendation 5.*)

Attention also needs to be paid to addressing current SMO concerns, so that doctors in training are motivated to maintain and build their connection to New Zealand's health system throughout their careers.

IMGs make a major contribution to the SMO workforce. Their contribution is particularly important at present given the relatively low production of New Zealand-trained SMOs, but will continue to be important in the face of expected increases in service need. There is scope for vocational registration and related processes to:

- be more user-friendly, so IMGs are not deterred from applying
- take less time
- support appropriate SMO deployment across the New Zealand health system.

We suggest that the Medical Council of New Zealand and professional colleges work together to achieve this. If necessary, the Minister of Health may need to review the mandate of the Medical Council of New Zealand to enable this to be achieved. (See *recommendation 10.*)

From a systems perspective, fragmentation is a major impediment to the effective management of the SMO workforce as a critical health system resource. A variety of organisations play important and interdependent roles but their mandates are not always aligned with each other or with the wider interests of the health system as a whole.

The need for clear processes for regional and national service planning is well recognised, and we understand that work on this has commenced. We recommend that this work be accelerated to strengthen the alignment across SMO workforce planning and deployment, and determination of the appropriate number, mix and geographical distribution of vocational training positions. (See *recommendations 3 and 9.*)

The way that organisations work together to achieve system objectives is equally critical. It is extremely difficult to design and implement system-wide initiatives in the absence of the authority and accountability to do so. Accordingly, we recommend that DHB mandates be amended to introduce shared accountability for workforce planning to enable a co-ordinated approach. (See *recommendation 2.*) We also recommend the establishment of regionally co-ordinated recruitment functions. (See *recommendation 11.*)

System-wide considerations, such as fiscal and service sustainability and productivity, need to be part of the ongoing dialogue at all levels of the system, and we consider that existing bipartite and tripartite processes need to be strengthened to nurture this dialogue. (See *recommendation 13.*)

Over the past few years, the negotiations for renewal of the SMO multi-employer collective agreement have been difficult and protracted, giving rise to the proposal to establish this commission so future negotiations might proceed more smoothly. From the information provided to us it seems clear several factors contributed to the difficulties experienced by the primary parties (the DHBs collectively and the Association of Salaried Medical Specialists on behalf of SMOs) in reaching a mutually acceptable settlement.

The negotiations should not be seen as a periodic opportunity to address accumulated claims and frustrations; rather they should be a joint problem-solving exercise that, as far as possible, reflects the mutual interests of the parties.

Accordingly, we advise the establishment of an interest-based bargaining model that uses collaborative problem-solving and innovation to reach an integrative solution of mutual benefit rather than distributing rewards in a win/loss manner. We also recommend that the bargaining process be supported by reliable and accurate base information and analysis, and led by experienced and senior representatives with delegated authority to reach agreement. This will ensure negotiation is underpinned by expertise that is commensurate

with the significant cost and contribution of SMOs to the health system. (See *recommendation 7.*)

Summary of recommendations

Recommendation 1: DHBs and the Ministry of Health value the SMO contribution, and jointly develop effective clinical leadership and participation through strong clinician–management partnerships. This will get the best value out of public health spending.

Recommendation 2: The Government amend DHB mandates to drive critical health system goals, such as workforce and clinical services planning, through shared accountability.

Recommendation 3: The Ministry of Health accelerate the development of a clear process for regional and national service planning, to enable aligned SMO workforce planning.

Recommendation 4: The Ministry of Health require the Medical Training Board (or any successor) to review and recommend medical student intakes at three-yearly intervals to align intakes with future service needs.

Recommendation 5: The Government consider the recommendations of the Medical Training Board report and Commission on the Resident Medical Officer Workforce, and agree to the rapid implementation of co-ordinated initiatives that will significantly strengthen medical training.

Recommendation 6: The Ministry of Health lead a sector-wide process to identify core SMO workforce management information and establish systematic ways of collecting, analysing and reporting that information to provide a common understanding of SMO workforce issues.

Recommendation 7: DHBs and the Association of Salaried Medical Specialists develop an interest-based bargaining model that is:

- supported by reliable and accurate base information and analysis
- led by experienced and senior representatives with delegated authority to reach agreement (subject to ratification).

This will ensure negotiation is underpinned by expertise that is commensurate with the significance of SMOs to the health system.

Recommendation 8: DHB boards initiate and monitor an ongoing programme of SMO leadership development and report progress through their accountability documents. This will enable them to realise the contribution of potential SMO leaders.

Recommendation 9: DHBs, the Ministry of Health and professional colleges work collectively to use emerging national and regional service planning processes to determine the numbers and mix of general specialty and subspecialty training positions needed to match future service needs.

Recommendation 10: The Medical Council of New Zealand and professional colleges adapt their processes to provide the necessary support, responsiveness and facilitation to IMGs seeking vocational registration. This will ensure the wider public interest of appropriate SMO deployment across the New Zealand health system is met.

If necessary, the Minister of Health may need to review the mandate of the Medical Council of New Zealand to enable this to be achieved.

Recommendation 11: DHBs establish regionally co-ordinated recruitment functions that complement regional and national service planning, retaining the benefits of local strategies. This is a critical component of a national recruitment strategy.

Recommendation 12: DHBs review current arrangements and take necessary actions to improve space, tools and support for SMOs, recognising the importance of these factors to SMO retention.

Recommendation 13: DHBs, the Association of Salaried Medical Specialists and the Ministry of Health strengthen existing bipartite and tripartite processes to nurture an informed dialogue at all levels. This will contribute to a sustainable level of SMO staffing that is aligned to service needs.

1 Introduction

1.1 Background to the commission

Senior medical and dental officers (SMOs) play a critical role in the medical workforce, especially in the delivery and leadership of hospital services. As at 30 September 2008, 3105 full-time equivalent SMOs were employed across the 21 district health boards (DHBs) at a total annual cost of approximately \$718 million. At the same time, there were 331 outstanding vacancies for SMO positions.¹

Sustained vacancies signal problems with recruitment and retention. These problems have been debated in the context of industrial negotiations, prolonging the negotiation process. To expedite settlement of the most recent collective agreement between DHBs and the Association of Salaried Medical Specialists (ASMS) the parties proposed that the Director-General of Health establish a commission on SMO recruitment and retention. This was agreed and the terms of reference for the Commission on Competitive and Sustainable Terms and Conditions of Employment for Senior Medical and Dental Officers Employed by District Health Boards (the SMO Commission) became part of the 1 July 2007 collective agreement.²

The current collective agreement expires on 30 April 2010. The DHBs and ASMS have agreed to meet at the earliest possible opportunity to discuss the SMO Commission's recommendations so debate around recruitment and retention issues does not impede future negotiations.

1.2 Purpose and timeframe

The SMO Commission was established in October 2008.³

The SMO Commission's terms of reference require it to recommend a recruitment and retention strategy that will provide a sustainable pathway to competitive terms and conditions of employment for SMOs.⁴

The SMO Commission was initially expected to report by 31 March 2009. Following discussion with the DHBs and ASMS, the Director-General of Health agreed that, in light of the complexity of the issues involved and the need to consult widely, the reporting deadline would be extended to 30 June 2009.

¹ Data collated by District Health Boards New Zealand and appended to its 6 March 2009 written submission to the SMO Commission.

² See clause 56 on page 42 and Appendix 1 on page 48 of the 2007 collective agreement.

³ Membership of the SMO Commission is outlined in Appendix 1. At the same time, the Director-General of Health's established the Commission on the Resident Medical Officer Workforce, recognising that issues concerning SMOs and resident medical officers (RMOs) would be distinct, but with important points of intersection. In the interests of efficiency and to facilitate communication between the commissions, they shared a secretariat.

⁴ The terms of reference are in Appendix 1.

1.3 Information sources and data quality

Throughout the course of its work, the SMO Commission met with a wide variety of individuals, groups and organisations. The SMO Commission also invited interested parties to make written submissions to it. A summary of the submissions was published on the SMO Commission's website in April 2009.⁵

In carrying out its task, the SMO Commission reviewed a range of reports about New Zealand's medical workforce. It has been mindful of related work in train across a variety of groups and organisations. The SMO Commission has endeavoured to be well informed about this work in order to ensure that its investigations and advice take full consideration of these initiatives.

The SMO Commission gathered data from a variety of sources in an attempt to quantify and understand current recruitment and retention issues and how they might be changing.

Not unexpectedly, the SMO Commission discovered significant data gaps. It is also aware that the nature of much of the available data requires a cautious approach to its interpretation. For example, high-level analyses do not reveal the dramatic variance in recruitment and retention that occurs in particular locations or within individual specialities. The SMO Commission has taken pains to document its data sources fully and articulate clearly any data limitations.

The SMO Commission also looked more widely at local and international literature for a better understanding of the issues and new ideas for moving forward. Source documents are identified in the footnotes to this report.

1.4 Glossary

Key terms and abbreviations used in this report are explained in the glossary in Appendix 2.

⁵ Ministry of Health. 2009. *Summary of Submissions: Director-General of Health's Commission on Competitive and Sustainable Terms and Conditions of Employment for Senior Medical and Dental Officers Employed by DHBs*. Wellington: Ministry of Health, available from <http://www.moh.govt.nz/moh.nsf/indexmh/summary-of-smo-submissions-apr09>.

2 Senior Medical Officer Workforce

In this chapter, we describe the SMO workforce including the role of SMOs, the composition of the SMO workforce, and changes in the composition of the SMO workforce that may have a bearing on the SMO capacity available to the health system in future. The chapter also outlines SMO shortages.

Highlights

- In 2008, 3713 SMOs had an annual practising certificate and worked in a vocational scope of practice.
- SMO numbers increased 46 percent between 1998 and 2008.
- Seventy-one percent of SMOs work in a public hospital at least some of the time, with 33 percent working exclusively in a public hospital.
- More than half of the specialties had 50 or fewer SMOs, and 10 specialties had fewer than 20 SMOs nationwide.
- Women account for a growing proportion of SMOs, increasing from 18 percent in 1998 to 26 percent in 2008.
- IMGs comprise a significant proportion of the overall SMO workforce, increasing from 35 percent in 1998 to 40 percent in 2008.
- Smaller DHBs tend to be more reliant on IMGs with up to 87 percent of their SMO workforce in 2008.
- New Zealand receives most of its IMG SMOs from the United Kingdom, North America and South Africa
- SMOs working in public hospitals work an average 48 hours a week, although a few report working in excess of 90 hours a week.
- As at 30 September 2008, DHBs reported 331 full-time equivalent SMO vacancies – an overall vacancy rate of 9.5 percent.
- Vacancy rates tend to be higher in smaller DHBs than in larger DHBs.

2.1 Role of senior medical officers

SMOs are senior doctors, often referred to as specialists or consultants.⁶ The term SMO is used to distinguish these doctors from doctors who are still in training and are collectively referred to as resident medical officers (RMOs) or doctors in training. SMOs complete a vocational training programme, after which the Medical Council of New Zealand (Medical Council) may register them to practise within a defined scope of practice in a particular branch of medicine.⁷

⁶ This includes a small but growing number of SMOs who are vocationally registered general practitioners employed by DHBs.

⁷ Medical officers (MOs) are senior doctors who have undertaken registrar training but are not vocationally qualified. MOs may have completed their Part One, but not their Part Two, examinations, and have discontinued their vocational training temporarily (eg, to meet family commitments) or permanently. They are regarded as senior doctors and are paid on a special scale that reflects their experience and a wider scope of practice. They also come under the SMO multi-employer collective agreement. Further information on MOs is in Appendix 4.

As senior clinicians, SMOs may carry out a variety of functions, including:

- diagnosis and treatment
- clinical leadership
- supervision
- training
- management
- research.

2.2 Statistical sources

The statistics presented in this section and chapters 3 and 4 are drawn from the Medical Council's annual practising certificate process, unless stated otherwise. In addition to the information obtained in the obligatory annual registration process, the council includes a voluntary survey for those who have worked in New Zealand during the previous year. The survey is the source of information on:

- SMO ethnicity
- primary employment type
- area of specialty
- typical hours worked per week and hours on-call but not worked
- whether the applicant is an SMO, a medical officer (MO) or a general practitioner.

In 2008, only 85 percent of doctors completed the voluntary survey, but the Medical Council reports that it believes younger doctors are less likely to complete the survey than older doctors, so the response rate among SMOs is likely to be higher than 85 percent (as SMOs tend to be older).

We have reported three key groups of SMO data from the Medical Council .

- Overall SMO workforce data, which includes all SMOs in all public and private employment settings (3713 in total).
- SMOs who work at least some of the time in a public hospital (3060 in total).
- SMOs whose main employment is in a public hospital (2626 in total).

When analysing information by specialty we have excluded those identifying as general practitioners and those working in some other capacity in primary care. While a small minority of these will be DHB employees, we were unable to distinguish them with any accuracy.

The other key source of statistics is the information the 21 DHBs use in the employment of medical staff. District Health Boards New Zealand regularly aggregates the information from each of the DHBs.

2.3 Senior medical officer workforce profile

2.3.1 Senior medical officer workforce numbers

This report is based on information the Medical Council provided to the SMO Commission.

In 2008, 3713 SMOs had an annual practising certificate to work in a vocational scope of practice. Between 1998 and 2003, the number of SMOs grew 13 percent, and between 2003 and 2008 the number grew 29 percent – an overall increase of 46 percent over the last 10 years. (See Table 1.)

Table 1: Number of senior medical officers, by gender, 1998–2008

Gender	1998	2003	2008
Male	2088	2269	2731
Female	448	604	982
Total	2536	2873	3713

Source: Medical Council of New Zealand.

2.3.2 Senior medical officers by main employment

SMOs work across a wide variety of public and private settings, as shown in Table 2. Many SMOs work in more than one setting. The majority (71 percent) of SMOs are mainly employed in public hospitals. Twenty-one percent identified solo or group private practice or a private hospital as their main place of employment.

Table 2: Place of primary employment for senior medical officers, 1998–2008

Place of primary employment	Number			Percentage of total (%)		
	1998	2003	2008	1998	2003	2008
Commercial company	94	52	63	4	2	2
Government department/agency	48	48	75	2	2	2
Professional body	1	5	2	0	0	0
Group private practice	214	241	356	8	8	10
Private hospital ^a	-	46	106	0	2	3
Public hospital	1706	1995	2626	67	69	71
Solo private practice	363	339	319	14	12	9
University	94	83	114	4	3	3
Other	14	51	50	1	2	1
Not reported	2	13	2	0	0	0
Total	2536	2873	3713	100	100	100

Note

a This category was not included as an option in the 1998 annual practising certificate survey.

Source: Medical Council of New Zealand.

In 2008, 1212 SMOs (33 percent) reported working *exclusively* in a public hospital, and 291 (8 percent) *exclusively* in solo or group private practice or a private hospital. The majority of the remainder work across a variety of settings.⁸

2.3.3 Senior medical officers by specialty

SMOs work in many specialty and subspecialty branches of medicine, as shown in Table 3, and are employed across the 21 DHBs and other employers. More than half of the specialties have 50 or less SMOs, and 10 specialties have less than 20.

⁸ For more details, see Appendix 3.

Table 3: Specialty practised by senior medical officers

Specialty	Number	Percent (%)
Internal medicine	689	16.4
Anaesthesia	515	12.3
Psychological medicine & psychiatry	502	12.0
Diagnostic and interventional radiology	274	6.5
Paediatrics	229	5.5
Surgery: orthopaedic	210	5.0
Obstetrics & gynaecology	201	4.8
Emergency medicine	190	4.5
Surgery: general	173	4.1
Pathology	169	4.0
Public health medicine & management	142	3.4
Ophthalmology	111	2.6
Accident and medical practice	88	2.1
Surgery: otolaryngology	85	2.0
Occupational medicine	59	1.4
Dermatology	50	1.2
Surgery: urology	50	1.2
Surgery: plastic	48	1.1
Intensive care medicine	46	1.1
Palliative medicine	46	1.1
Surgery: other	40	1.0
Radiation oncology	34	0.8
Sexual health medicine	27	0.6
Medical administration	22	0.5
Surgery: cardiothoracic	21	0.5
Musculo-skeletal medicine	18	0.4
Sports Medicine	17	0.4
Surgery: neurosurgery	17	0.4
Surgery: vascular	17	0.4
Surgery: paediatric	14	0.3
Rehabilitation medicine	12	0.3
Basic medical science	11	0.3
Family planning	10	0.2
Breast medicine	7	0.2
Clinical genetics	4	0.1
Other	11	0.3
Not recorded	36	0.9
Total	4195	100.0

Note: Some specialists will be registered in more than one vocational scope of practice. Therefore, there will be some double counting, which accounts for the total of 4195 DHB-employed SMOs exceeding the total SMO workforce of 3713.

Source: Medical Council of New Zealand.

Although qualified in one or more vocational scopes of practice, some SMOs practise as generalists, working across a range of specialty areas. This is most common outside the

main centres where SMOs have to work in smaller teams to cover the needs of the local population, so need to be quite versatile.

2.3.4 International flows of senior medical officers

New Zealand stands out among OECD countries in that it experiences both high emigration and high immigration among medical professionals.

The OECD reports that immigration and emigration among New Zealand’s medical workforce is significantly more marked than for tertiary-educated people in general. On average 5.8 percent of medical graduates leave New Zealand after a year, and over that time on average the number of short- and long-term arrivals of overseas-trained doctors will be 14.5 percent of all doctors in the workforce.

The number of New Zealand-trained doctors overseas is about half the number of overseas-trained doctors in New Zealand. One study reports that in 2000, roughly 1900 New Zealand-born doctors were living in another OECD country, accounting for an estimated 29 percent of all New Zealand doctors.⁹

2.3.5 International medical graduates in the senior medical officer workforce

International medical graduates (IMGs) comprise an increasing proportion of the total SMO workforce, increasing from 35 percent in 1998 to 40 percent in 2008, as shown in Table 4.

Table 4: Share of international medical graduates in the senior medical officer workforce

Year	New Zealand graduates(%)	International medical graduates(%)
1998	65	35
2003	64	36
2008	60	40

Source: Medical Council of New Zealand.

Based on Medical Council registrations for 2008, 43 percent of SMOs whose main employment was in public hospitals are IMGs – slightly higher than the proportion among all SMOs (40 percent). An even higher proportion of MOs (61 percent) are IMGs, which may reflect the difficulties some IMGs report experiencing in having their overseas experience and/or qualifications recognised in New Zealand.¹⁰

There is considerable variation among DHBs in the share of the SMO workforce that IMGs make up. Table 5 shows that these differences range from 27 percent in Nelson Marlborough DHB to 87 percent in Tairāwhiti DHB. Smaller DHBs are particularly reliant on IMGs, reflecting their relative difficulty in being able to attract and/or retain New Zealand-trained SMOs. Nelson-Marlborough DHB stands out as an exception to this.

⁹ P Zurn and J-C Dumont, *Health Workforce and International Migration: Can New Zealand compete?* Health Working Paper No. 33, Organisation for Economic Co-operation and Development, Paris, 2008. For information on the retention of New Zealand-trained doctors, see Appendix 5.

¹⁰ For further information on MOs, see Appendix 4.

Table 5: DHB use of international medical graduates (IMGs), senior medical officers and medical officers by DHB, year to 31 March 2008

DHB	Medical officers			Senior medical officers		
	Number of IMGs	Percentage of IMGs (%)	Total medical officers	Number of IMGs	Percentage of IMGs (%)	Total senior medical officers
Tairāwhiti	6	75	8	27	87	31
Wairarapa	4	57	7	15	75	20
Whanganui	10	91	11	29	74	39
Northland	18	64	28	53	62	85
Lakes	9	75	12	33	59	56
South Canterbury	4	57	7	17	59	29
Taranaki	15	75	20	36	59	61
West Coast	4	44	9	7	58	12
Southland	8	42	19	30	56	54
Bay of Plenty	22	76	29	57	52	110
MidCentral	11	65	17	50	49	103
Waikato	23	72	32	131	49	267
Waitemata	22	47	47	109	46	238
Counties-Manukau	15	68	22	101	40	253
Hutt Valley	7	78	9	32	39	82
Otago	9	50	18	61	38	161
Hawke's Bay	10	50	20	28	37	75
Auckland	23	46	50	223	34	659
Capital & Coast	4	25	16	89	34	263
Canterbury	25	51	49	120	31	385
Nelson Marlborough	12	41	29	21	27	77
Total	261	57	459	1269	41	3060

Source: Medical Council of New Zealand.

Among SMOs whose primary employment is in public hospitals, IMGs are more strongly represented in some specialties than others. Table 6 shows those specialties where IMGs account for more than half of the SMO workforce primarily working in DHBs.

Table 6: Concentration of international medical graduates in selected medical specialties, year to 31 March 2008

Specialty	New Zealand graduates		International medical graduates		Total senior medical officers
	Number	Percent (%)	Number	Percent (%)	
Palliative medicine	1	8	11	92	12
Rehabilitation medicine	2	29	5	71	7
Surgery: neurosurgery	6	40	9	60	15
Psychological medicine & psychiatry	144	41	207	59	351
Radiation oncology	14	42	19	58	33
Obstetrics & gynaecology	58	44	73	56	131

Source: Medical Council of New Zealand.

IMGs who come to New Zealand for SMO positions are mainly from the United Kingdom, North America and South Africa, as shown in Table 7.¹¹

Table 7: Country of primary qualification of international medical graduates, year to 30 June 2007

Country of primary qualification	Number
England	25
United States	12
South Africa	9
Scotland	5
Netherlands	4
Sri Lanka	4
Germany	3
India	3
Canada	2
Egypt	2
Ireland	2
Poland	2
Wales	2
Croatia	1
Italy	1
Zambia	1

Source: Medical Council of New Zealand.

2.4 Hours worked

SMOs working in public hospitals¹² worked an average of 47.7 hours a week including on-call hours that were actually worked. There was a wide distribution of hours, as shown in Table 8.

¹¹ Medical Council of New Zealand, *Medical Council of New Zealand Annual Report 2007*, Medical Council of New Zealand, Wellington, 2008, pp 24–27.

Table 8: Hours worked per week by DHB-employed senior medical officers

Hours worked	4–9	10–19	20–29	30–39	40–49	50–59	60–69	70–79	80–89	90+	Total
Number	13	33	151	248	1097	1040	390	66	19	3	3060
Percent (%)	0.4	1.1	4.9	8.1	35.8	34.0	12.7	2.2	0.6	0.6	100

Source: Medical Council of New Zealand.

Nearly 60 percent of SMOs who work at least some of the time in a public hospital do some rostered on-call hours, as shown in Table 9.

Table 9: On call hours per week by DHB-employed senior medical officers

Hours on-call	0	1–9	10–19	20–29	30–39	40–49	50+	Total
SMOs with on call as specified	1251	450	615	354	141	114	135	3060
Percent of SMOs on call as specified (%)	41	15	20	12	5	4	4	100

Source: Medical Council of New Zealand.

2.5 Senior medical officer shortages

Approaches to measuring SMO shortages include:

- current vacancies compared against established positions
- an optimised vacancy measure to compare existing numbers of active medical specialists with the number that would be required to meet specialist-to-population ratios
- demand-driven projections based on demographic and health status projections
- a supply-side response looking at the numbers of doctors being trained and service delivery models.

All of these approaches have a degree of relevance and validity and they interact. In this section, we focus on the current vacancy measure, as the most direct and available measure of current SMO workforce shortages. The other measures are estimates based on assumptions about which we do not have information. Their measurement and application are outlined in Appendix 6. Current vacancies will be affected by the capacity to replace staff who are needed, the ability to find short-term cover from within the DHB, and the extent to which established positions are a good reflection of current demand. In practice, there is considerable variability in how establishment numbers are determined.

¹² This includes SMOs whose primary employment was not in a public hospital. For data on hours worked by those whose main employment is in a public hospital, see in Appendix 3.

2.5.1 Senior medical officer workforce and vacancies by DHB vacancies

Table 10 shows the number of individual SMOs in each DHB, but includes some double counting as SMOs may simultaneously hold positions at more than one DHB. Conversely, the use of full-time equivalents under-represents the number of individuals involved as it includes many part-time positions. The table identifies 331.3 full-time equivalent vacancies, giving an overall vacancy rate of 9.5 percent.

Table 10: Senior medical officer vacancies by DHB, as at 30 September 2008

DHB	Number of individual senior medical officers	Number of filled full-time equivalent positions	Number of full-time equivalent vacancies	DHB vacancy rate (%)
Auckland	862	663.1	54.5	7.6
Bay of Plenty	157	122.8	9.2	7.0
Canterbury	449	350.2	27.0	7.2
Capital & Coast	319	224.5	20.1	8.2
Counties Manukau	346	262.6	29.8	10.2
Hawke's Bay	111	92.4	2.0	2.1
Hutt Valley	155	105.3	14.2	11.9
Lakes	64	55.7	5.0	8.2
MidCentral	143	115.6	17.2	13.0
Nelson Marlborough	143	110.5	1.3	1.2
Northland	128	120.1	7.0	5.5
Otago	165	117.9	12.9	9.9
South Canterbury	33	26.8	8.2	23.4
Southland	73	52.4	9.0	14.7
Tairāwhiti	53	47.2	6.0	11.3
Taranaki	76	60.5	9.0	12.9
Waikato	311	267.3	28.9	9.8
Wairarapa	30	26.4	5.0	15.9
Waitemata	354	287.5	38.5	11.8
West Coast	35	27.8	14.5	34.3
Whanganui	56	33.4	12.0	26.4
Total	4063	3169.9	331.3	9.5

Note: The number of individual SMOs in each DHB includes some double counting as SMOs can simultaneously hold positions at more than one DHB. The use of full-time equivalents under-represents the number of individuals involved, as it includes many part time positions.

Source: Data collated by District Health Boards New Zealand and appended to its 6 March 2009 written submission to the SMO Commission.

Vacancy rates varied markedly between DHBs. In the main, the pattern is consistent with international experiences, which indicate it is more difficult to attract and retain specialists in smaller and more remote communities. Vacancy rates that were substantially higher than

the national average were found in West Coast, Whanganui, South Canterbury, Wairarapa and Southland DHBs. However, substantially lower than average vacancy rates were recorded in Nelson Marlborough, Hawke's Bay and Lakes DHBs. This suggests lifestyle factors could be offsetting some scale disadvantages.

3 Senior Medical Officer Supply Constraints

Our terms of reference direct us to consider the national and international supply of SMOs, including changes and trends in factors that affect the supply of SMOs to the New Zealand public health system. Accordingly, in this chapter we explore the factors that constrain New Zealand's ability to increase its supply of SMOs, including:

- financial sustainability
- the ability to recruit and retain SMOs from the international labour market
- the ability to increase local production through additional student intake.

3.1 Financial sustainability

The OECD reports that the New Zealand health care system performs quite well, expending somewhat fewer resources on health care in absolute dollars per capita than the OECD average, while achieving some good population-level health outcomes along with universal public coverage.¹³

To address workforce shortages New Zealand needs to spend more to train additional doctors to become future specialists and to attract and retain specialists to work within New Zealand's public health system. To some extent this is happening. For example, the Government has announced additional funded medical student places, and most DHBs pay a premium to recruit into hard-to-fill positions. Overall, however, New Zealand is not well placed to increase health expenditure, especially without a commensurate increase in productivity.

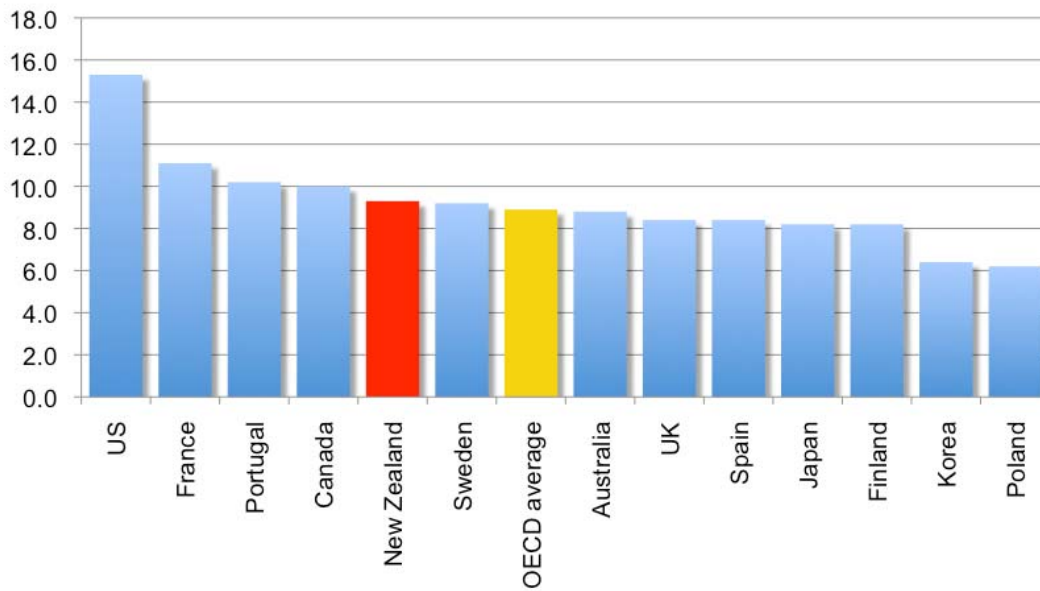
Most OECD countries strive to ensure that expenditure on health provides a good level of health service delivery while being affordable and sustainable. A comparison with other OECD countries indicates how well New Zealand is doing in this respect.¹⁴

New Zealand's per capita spending on health is below the OECD average, which is consistent with New Zealand's relatively low per capita income. Most OECD countries (the United States is an exception) spend a similar proportion of their national income on health. As a percentage of gross domestic product, New Zealand's health expenditure is above the OECD average and above the comparable level in Australia, as shown in Figure 1.

¹³ OECD, *OECD Economic Surveys: New Zealand*, Vol 2009/4, Organisation for Economic Co-operation and Development, Paris, 2009.

¹⁴ For detailed comparison data, see OECD, *The Looming Crisis in the Health Workforce: How can OECD countries respond?* Health Policy Studies, Organisation for Economic Co-operation and Development, Paris, 2008.

Figure 1: Health expenditure as a percentage of gross domestic product in selected OECD countries, 2006



Source: OECD.

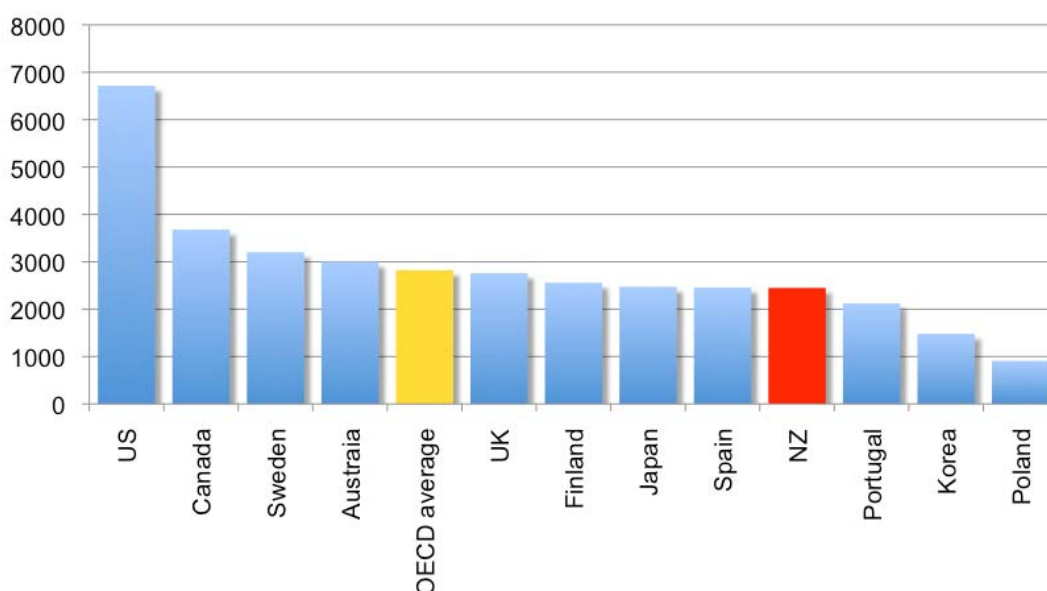
New Zealand's expenditure on health comes from:

- Vote: Health (67 percent)
- other government sources, such as Accident Compensation Corporation (10 percent)
- insurance payments (5 percent)
- out-of-pocket expenses such as general practitioner fees and prescription charges (17 percent)
- charities (1 percent).

Payments for SMOs are predominantly from public funds, and spending on health as a proportion of total government spending is above the OECD average.

New Zealand's expenditure on health is in line with (or fractionally above) comparable international levels when adjusted for differences in levels of national income, as shown in Figure 2.

Figure 2: Total per capita health expenditure \$(US) in selected OECD countries, 2006



Source: OECD.

In light of the current global recession, New Zealand's capacity to increase health expenditure in the immediate future is constrained. Increases in health spending, historically and internationally, have been funded through improved economic performance, and this is likely to be the source of any significant growth in health expenditure in the future.

3.2 Recruiting senior medical officers in the international market

Medical workforce shortages exist worldwide. Many OECD countries recruit a significant proportion of their SMO workforces internationally to make up for shortfalls in the local production of SMOs.

New Zealand is relatively disadvantaged in the international market for SMOs in that it is geographically distant from many other potential sources of doctors, remuneration is lower than in some other places, and the smaller scale of hospitals means access to cutting-edge technology and professional development pathways may be limited. Nevertheless, IMGs comprise 40 percent of the overall SMO workforce, and close to 90 percent in some DHBs.

New Zealand is vulnerable to changes in supply, recruitment and retention in other countries. These changes could have a particular impact on countries such as New Zealand that are highly reliant on IMGs. This may be mitigated, however, by the relatively low absolute number of IMGs who work in New Zealand.

[T]aking into account the fact that the annual numbers of health professional immigrants to New Zealand are relatively small compared [with] the scale of worldwide flows, it is most likely that New Zealand will be able to recruit the doctors and nurses it needs but at an increasing cost with increasing difficulties to attract the best skills.¹⁵

¹⁵ P Zurn and J-C Dumont, *Health Workforce and International Migration: Can New Zealand compete?* Health Working Paper No. 33, Organisation for Economic Co-operation and Development, Paris, 2008, p 44.

Population and workforce ageing will heighten the demand for SMOs in the global market. This could make New Zealand-trained health professionals harder to retain and the potential pool of foreign recruits more difficult to attract.¹⁶

There is also an ethical dimension to the importation of medical professionals, which depletes the resources available to countries that may have significantly higher health needs. Optimal utilisation of available workforce and responsible local workforce production are important responses to this issue.

3.3 Increasing local production of senior medical officers – training more medical students

In New Zealand, the Government sets the number of funded places for medical students. Given the number of variables that will determine future demand for SMOs, there is no way to accurately predict the ideal student intake. In 1982, the number of medical school places was reduced by over 50 to 285 per year. This was unchanged until 2004 when the number of places was raised from 285 to 325 a year. The number of places was raised again to 365 in 2007 for the 2008 intake.¹⁷

The Government has announced it will boost the number of funded medical student places by 200 over five years, commencing with 60 places in 2010. This will increase the total number of funded medical student places from 365 students a year to 565 – a boost of over 50 percent.¹⁸

The full benefit of these increases will not begin to be fully realised until 2029 because it takes 12–15 years to qualify as an SMO. Between 2009 and 2029 there will be up to 2850 additional New Zealand-trained doctors in the health workforce. They will be spread across the medical workforce and, given the demand for increased capacity in primary care together with enhanced incentives,¹⁹ it is assumed that most will choose primary care as a career option.

The potential to keep increasing student intake is not unconstrained. The capacity of the current SMO workforce to train and supervise doctors is limited. The number of vocational training places that can be offered to doctors in particular specialties is also limited. SMOs are critical to the development of succeeding generations of doctors, and this will be no less critical in the coming two decades as we seek to significantly change the number of New Zealand-trained doctors.²⁰

¹⁶ Ibid.

¹⁷ Each year a small number of full fee-paying students are also admitted to medical degree courses. They are usually overseas students and, as expected, tend to return to their country of origin on completion of their training.

Fluctuations in numbers of medical students trained tend to be mirrored across other comparable jurisdictions.

¹⁸ The Government estimates this will cost \$3 million in 2010 – the earliest that universities are likely to be able to start boosting student places – \$7 million in 2011 and \$13 million in 2012. This funding includes an allocation for extra infrastructure and staffing costs for universities, and comes from within the indicative education spending allocations outlined in the 2008 Budget.

¹⁹ Such as improved earning potential as a result of population-based funding introduced as part of the Primary Health Care Strategy implementation.

²⁰ For more information on SMOs' roles as teachers and researchers, see Appendix 7.

4 Drivers of Demand for Senior Medical Officers

In chapter 3, we identified a variety of constraints on increasing the supply of SMOs. Our terms of reference also direct us to consider the drivers of demand for the SMO workforce, including population health need and models of service delivery; opportunities for employment; the terms and conditions of employment for SMOs in Australia and other countries; and employment opportunities available for SMOs in both the private and public health sectors. Given our brief to recommend a national recruitment and retention strategy, we also examine SMO attrition.

Highlights

- New Zealand's population is projected to increase an average 0.7 percent a year between 2006 and 2036.
- New Zealanders are living longer, which will increase the proportion of the population needing treatment and care for complex and/or chronic conditions.
- Considerable health differences exist among the ethnic communities of New Zealand, and morbidity differences have a huge impact on the demand for health care, the benefits of population health initiatives, and the prevalence of acute and chronic conditions.
- The number of doctors in some subspecialties is low with 10 out of 35 specialty fields having less than 20 specialists across New Zealand. This has implications for the number of specialists required given the critical mass of expertise needed in safe and effective teams.
- On average 247 New Zealand doctors graduate each year from vocational training programmes.
- Retention rates for New Zealand-trained SMOs are lowest in the second year following vocational registration.
- The attrition of New Zealand doctors through emigration (and after returns) stabilises after about eight years, with a retention rate after that of around 67 percent.
- In 1990, about 35 percent of New Zealand's doctors were aged under 35 but by 2003 this percentage had fallen to 23 percent.
- By the second year following registration roughly 90 percent of IMG SMOs are retained, with the exception of 2007 when only 80 percent were retained the following year. It is too soon to say whether this figure marks a change in retention patterns or is an anomaly.
- The workloads of individual SMOs are increasing due to a wide variety of factors.
- Increased medical student intake will further increase demands on SMOs.
- Australia employs some 1640 doctors who obtained their first qualification in New Zealand. This represents about one-sixth of the number of doctors in New Zealand, but only 2.6 percent of all doctors in Australia.
- There is roughly a difference of 30–35 percent between the remuneration of New Zealand and Australian SMOs.
- Empirical and anecdotal evidence suggests push factors are more important than pull factors in SMOs' decisions to leave New Zealand.

4.1 Demographic change and changing health needs

Detailed analysis of demographic demand pressures are well documented in Ministry of Health papers related to the development of a long-term system framework and several other documents.²¹

Changes in population are a key driver of demand for health services. New Zealand's population is projected to increase by an average 0.7 percent a year between 2006 and 2036.²² People are also living longer, which will increase the proportion of the population needing treatment and care for complex and/or chronic conditions. Nationally, 40 percent of public health resources currently relate to the needs of people aged over 65.

Lifestyle trends such as physical inactivity and poor diet will also contribute to the increased prevalence of diabetes, heart disease and other related illnesses thereby increasing demand for SMOs.

Increased emphasis on population health and preventative health care are already part of New Zealand's response to these challenges.

4.2 Models of service delivery

4.2.1 Changes to models of care

New Zealand's health sector is constantly changing in response to new knowledge and technology. It will continually evolve in order to strike an appropriate balance between expectations and available resources. The health sector comprises a wide variety of interdependent processes and professional commitments, which makes it difficult to accurately predict the impacts of any particular change across the system.

One recent initiative with widespread and many unpredicted consequences was the increased investment in primary health care, including a strengthened population health approach accompanied by a strong focus on preventative health care.

4.2.2 Geographically dispersed services

New Zealand has relatively fewer doctors per head of population compared with the OECD average (2.2 per 100,000 population compared with the OECD average of 3.1). However, the OECD average is affected by high population densities in most European countries. New Zealand's overall doctor-patient ratio is higher than ratios in countries such as the United Kingdom, Canada and Ireland, and not far behind Australia (2.4 per 100,000 population).

With New Zealand's population of 4.3 million, the number of doctors in some subspecialties is low – with 10 out of 35 specialty fields comprising fewer than 20 specialists.²³ Moreover, they can be spread across up to 21 DHBs and an even larger number of hospitals. This means that one or two departures or recruitments can have a comparatively large impact on flows and vacancy rates. Smaller hospitals may not be able to provide the volumes of work

²¹ P Zurn and J-C Dumont, *Health Workforce and International Migration: Can New Zealand compete?* OECD Health Working Paper No. 33, Organisation for Economic Co-operation and Development, Paris, 2008; Medical Training Board, *The Future of the Medical Workforce: First Annual Report November 2007 – December 2008*. Ministry of Health, Wellington, 2009.

²² Information provided on request from the Medical Training Board by Statistics New Zealand, 2009.

²³ For more details, see Table 3 in chapter 2.

that are required to make optimal use of specialists' expertise, and the departures of a small group of specialists at the same time can seriously compromise the ability of a department or even a hospital to maintain continuity of service.

Some specialties are already provided from regional or national centres, but changes to concentrate the delivery of services to a regional or national basis occur only on an ad hoc basis. An agreed system-wide service framework has yet to be developed.

4.3 Workforce attrition

4.3.1 Retention of New Zealand trained graduates

As shown in Table 11, an average of 247 New Zealand doctors each year from 2000 to 2007 have completed vocational training programmes and practise in their particular vocation, as senior medical officers, many as general practitioners, but most as SMOs. Retention is lowest in the second year following vocational registration, and retention rates appear to be declining – dropping from 95 percent in 2000 to 89 percent in 2007. In the out-years however, some SMOs return to New Zealand, as reflected in retention rates frequently in excess of 100 percent three and four years following completion of vocational training.

Table 11: Retention of vocationally trained graduates, 2000–2008

Year	Number of vocational graduates	Percentage retained in each subsequent year (%)		
		Year 2	Year 3	Year 4
2000	218	95	102	100
2001	360	97	98	101
2002	273	93	102	99
2003	246	96	96	105
2004	210	93	105	93
2005	231	93	97	108
2006	224	89	108	–
2007	215	89	-	–

Source: Medical Council of New Zealand.

4.3.2 Long-term retention of New Zealand-trained senior medical officers

More doctors come to work in New Zealand than depart for work elsewhere. For every one New Zealand doctor working abroad there are two overseas-born doctors working in New Zealand.²⁴ This confirms that regardless of the rate of attrition, there has been a shortfall in supply coming out of New Zealand medical schools.

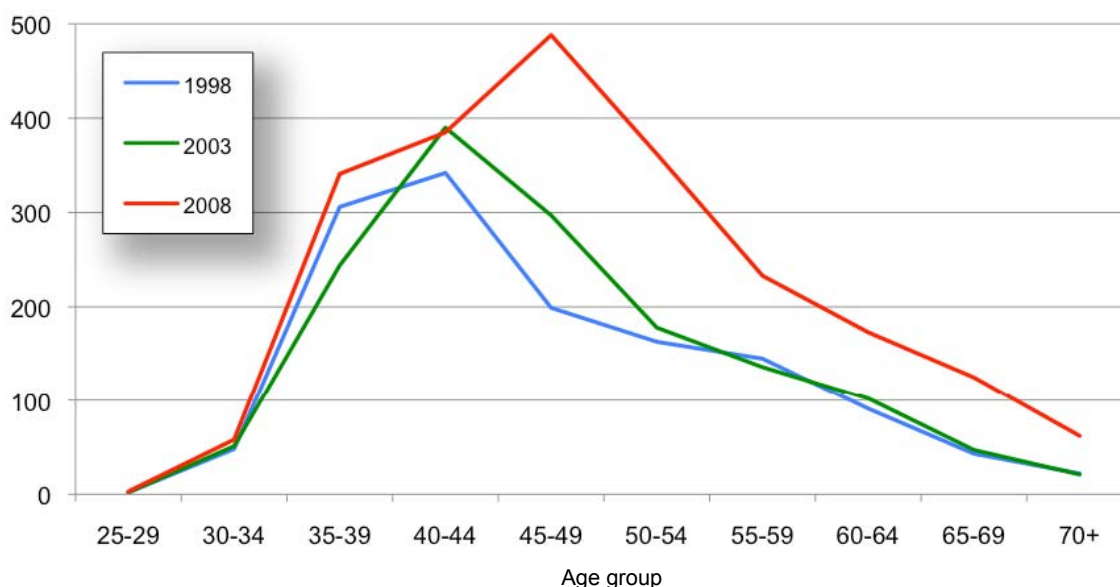
Retention of IMGs varies radically depending on their country of origin. Two-thirds of those trained in the United States and Canada have left within a year and only 5 percent are still here after seven years. For those from the United Kingdom, 46 percent leave after one year, and less than one-fifth are still here after seven years. By contrast, attrition of Asian and

²⁴ P Zurn and J-C Dumont, *Health Workforce and International Migration: Can New Zealand compete?* OECD Health Working Paper No. 33, Organisation for Economic Co-operation and Development, Paris, 2008.

South African graduates in the first year is similar to that of graduates from the United Kingdom, then their attrition slows markedly, with 44 percent still here after seven years.

We were unable to access specific data on the retention of New Zealand trained SMOs.²⁵ However, comparisons of the SMO workforce in 1998, 2003 and 2008 provide some indication of retention, as illustrated in Figure 3.

Figure 3: Number of SMOs per age band in the New Zealand-trained SMO workforce, 1998–2008



Source: Medical Council of New Zealand.

Despite the increase in SMO numbers over the past 10 years, the number of SMOs drops off from age 50, but it is difficult to interpret what this means. To some extent it reflects lower numbers of medical students 30 years ago, but it may also reflect a loss of SMOs to the system through early retirement or a career change, or they may be leaving New Zealand to practise medicine overseas – a widely held belief across the health sector.

Rates of retirement are of concern as the medical workforce is also ageing. In 1990, about 35 percent of medical practitioners were aged under 35, but by 2003 this percentage had fallen to 23 percent.²⁶ Australia’s MABEL survey found that:

*13 percent of specialists are very likely to quit medical work entirely within the next five years. Intentions to quit are largely driven by those over 55 years old who expect to retire, and thus reflects the loss to the workforce of the baby boomer generation.*²⁷

Anecdotal reports suggest retention rates have deteriorated. This may be occurring but not showing up in our high-level data analysis because it affects only certain specialities or

²⁵ For data on the retention of all New Zealand-trained doctors, see Appendix 5.

²⁶ P Zurn and J-C Dumont, *Health Workforce and International Migration: Can New Zealand compete?* Health Working Paper No. 33, Organisation for Economic Co-operation and Development, Paris, 2008.

²⁷ *Medicine in Australia: Balancing Employment and Life, MABEL Matters*, No. 1, May 2009. MABEL is a longitudinal survey of Australian doctors. For further information, go to the MABEL website (<https://mabel.org.au>).

locations or it is a very recent phenomenon not yet evident in the data. More recent information suggests a more complex picture.

Factors reported to be contributing to lower retention include:

- SMOs' feeling undervalued and overworked
- a lack of flexible working arrangements
- an increasing trend for doctors to settle overseas, where historically they would have returned to New Zealand²⁸
- better remuneration packages and working conditions perceived to be available in the private sector, including for casual locums, and overseas.

4.3.3 International medical graduate senior medical officer retention

Retention rates vary by the level of registration obtained, as shown in Table 12. By the sixth year following registration less than a third of IMGs remain in New Zealand compared with two-thirds of those with a general scope of registration²⁹ and four-fifths of those with a vocational scope of registration.³⁰

Table 12: Retention of international medical graduates by type of registration, 2000–2007

Type of registration	Retention rate after initial registration (%)					
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Any scope	100	50	35	31	29	28
General scope	100	83	76	72	70	67
Vocational scope	100	90	86	85	83	81

Source: Medical Council of New Zealand.

To some extent, this is to be expected, as some younger doctors in training come to New Zealand never intending to settle here. However, the order of magnitude of the difference suggests a lower level of retention is likely among older IMGs who are vocationally registered in their country of origin, but who have not achieved vocational registration in New Zealand. This phenomenon needs further exploration to establish the true rate of attrition for this specific group of doctors. The causes behind their lack of vocational registration and departure should also be examined to explore the extent to which New Zealand's regulatory framework is contributing to attrition.³¹

²⁸ This phenomenon was also observed in a sample of 33 expatriate doctors who completed a survey Kaye Thorn (Massey University) conducted as part of a study of the factors influencing the emigration of professional New Zealanders living overseas for her 2008 doctoral thesis, *Flight of the Kiwi*.

²⁹ To register to work in New Zealand within a *general scope* of practice, doctors must first register within a *provisional general scope* of practice and work under supervision in approved positions for one to two years. The exception is for New Zealand or Australian university medical school graduates who have completed their internships in New Zealand or Australia. They are granted registration in a general scope and a vocational scope, if appropriate.

³⁰ A *vocational scope* is for doctors who have appropriate qualifications, training and specialist experience, and are competent to practise independently. Doctors must actively participate in accredited recertification activities to maintain their registration in their vocational scope(s).

³¹ Zurn and Dumont also recommended further analysis to disentangle the extent to which a preference for short-term stays, the re-migration of IMGs to other OECD countries, or difficulties in getting qualifications fully recognised contribute to poor IMG retention figures: P Zurn and J-C Dumont, *Health Workforce and International Migration: Can New Zealand compete?* Health Working Paper No. 33, Organisation for Economic Co-operation and Development, Paris, 2008.

Table 13 shows the number of IMGs who achieved vocational registration in a given year for each year from 2000 to 2007, and the share that continued to be registered as a proportion of the previous year's number. By the second year following registration, roughly 90 percent are retained, with the exception of 2007 when only 80 percent were retained by 2008. It is too soon to say whether this figure marks a change in retention patterns or is an aberration.

Table 13: Retention of international medical graduate cohorts from first year of vocational registration, 2000–2007

Registration Year Cohort	Percentage retained at beginning of each subsequent year ^a								
	1 ^b	2	3	4	5	6	7	8	9
2000	162	91	99	94	96	98	93	103	93
2001	275	92	93	102	93	100	97	98	
2002	201	93	99	96	101	95	98		
2003	220	95	94	97	94	100			
2004	223	89	92	99	96				
2005	205	92	93	93					
2006	204	89	97						
2007	223	80							
Average percent of original cohort (%)	100	90	86	85	83	81	–	–	–

Notes

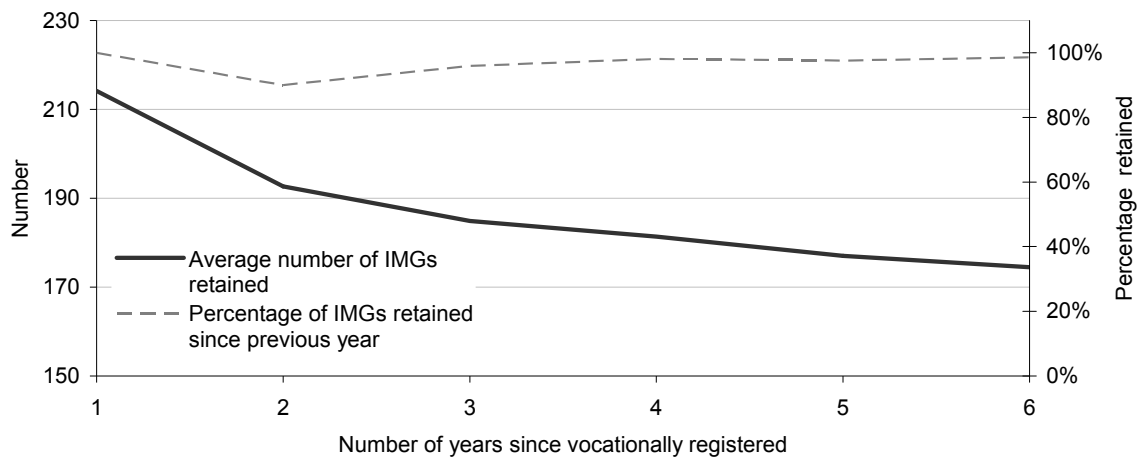
a Percentages in excess of 100 percent represent the return of IMGs who may not have registered in one or more previous years.

b Initial size of cohort at commencement of first year.

Source: Medical Council of New Zealand.

Figure 4 shows that while 10 percent of vocationally registered IMG SMOs are lost within a year, retention rates beyond that are very high. The initial drop-off in retention will reflect in part the departure of IMGs employed in fixed-contract locum positions.

Figure 4: Retention of international medical graduates (IMGs) cohorts from first year of vocational registration, 2000–2007



Note: Retention data more than six years out has not been included because it is available only for 2000 and 2001.

Source: Medical Council of New Zealand.

4.4 Increased workloads

Beyond a certain point, increases in overall workloads cannot be absorbed within existing SMO capacity. Workloads are increasing in response to changes in population size and composition and changes in health needs. Other pressures include:

- increased training and supervision of RMOs (ie, the oversight of short-term appointments and of those awaiting recognition of their qualifications as overseas graduates) and other clinical staff
- reduction in previous ability to delegate work to junior colleagues due to reduced scopes of practice and hours of work
- increased administrative workload
- increased need to provide cover for SMO vacancies
- increased need to provide cover for planned and unplanned leave as a result of changes to industrial agreement entitlements (eg, increased time for continuing medical education).

Increased student numbers will increase demand for training and supervision from SMOs. This is likely to be compounded by the introduction of improved house officer training, including reinvigoration of the training model. In Australia, for example, where there has been a lot of activity to strengthen medical training in recent years, it is generally accepted that training of RMOs takes 20–30 percent of an SMO's time.

In addition, it is likely that a certain number of new SMO positions, such as the directors of clinical training that are a mandatory requirement in Australia to achieve accreditation to train doctors in training, will be created if the recommendations of the Medical Training Board are implemented in New Zealand.³²

³² Medical Training Board, Foundations of Excellence: Building infrastructure for medical education and training, draft report to the Minister of Health, Wellington, April 2009.

4.5 International demand

Just as New Zealand recruits a high proportion of its SMOs internationally, New Zealand-trained SMOs are recruited to work in other countries.

4.5.1 Flows to Australia

Australia is the primary competitor for New Zealand's medical workforce for several reasons, including that:

- it is geographically close, so it is relatively easy for New Zealanders to maintain contact with family and friends remaining in New Zealand
- it is culturally similar, making settling into Australian society relatively easy
- most professional colleges in New Zealand and Australia are Australasian, making qualifications immediately transferable
- Australia generally offers superior pay and pay-related conditions than New Zealand offers to comparable roles.

Australia employs around 1640 doctors³³ who obtained their first qualification in New Zealand. This represents about one-sixth of the number of doctors in New Zealand, but only 2.6 percent of all doctors in Australia. Being a small part of the total means New Zealand graduates can find positions without disrupting the Australian workforce. On the other hand, a relatively small increase in the flow of new Australia graduates can reduce employment opportunities for New Zealanders.

Changes in conditions of access have a significant impact on the numbers of New Zealanders going to Australia. For example the number of doctors migrating from New Zealand to Australia nearly trebled from 231 in 1998/99 to 604 in 2000/01 and then fell back to 248 in 2001/02, largely because of access conditions, in this case particularly for general practitioners who did not practice in rural areas.³⁴ The medical school graduates over this period were the first to experience the higher level of university fees and associated student loan obligations.

4.5.2 Cross-Tasman comparison of pay and conditions

It is difficult to make direct comparisons between rates in collective employment agreements between New Zealand and Australia because:

- the terms are often merely a starting point (or base) for subsequent negotiation of individual variations
- there is scope for augmentation of income through private practice, which will vary across subspecialisations
- several special payments have been negotiated at the point of recruitment, but in some cases are difficult to identify
- in Australia, payments for work in remote localities can result in substantial salary packages that are nevertheless earned by a very small proportion of the workforce.

We took these reservations into account in our economic analysis. Given the uncertainties to be managed we circulated our findings for comment to ensure our assumptions were sound and nothing material had been overlooked.³⁵ Respondents concurred with our

³³ This includes all doctors (, including RMOs, general practitioners and SMOs.

³⁴ P Zurn and J-C Dumont, *Health Workforce and International Migration: Can New Zealand compete?* Health Working Paper No. 33, Organisation for Economic Co-operation and Development, Paris, 2008..

³⁵ The ASMS, District Health Boards New Zealand and Treasury were consulted for this purpose.

general analysis. Our overall conclusion is that there is roughly a difference (albeit with very wide individual, geographical and subspeciality variations) of 30–35 percent between the remuneration of New Zealand SMOs and Australian SMOs.³⁶

The trans-Tasman SMO wage gap largely reflects the different per capita incomes in the two countries (around 28 percent), rather than something particular to SMO comparisons, although there is roughly a 5 percent difference between per capita income differentials and SMO differentials. This suggests there is a greater differential between SMOs and the rest of the population in Australia than there is in New Zealand.

While the differences in pay and conditions may seem to be strong pull factors, some empirical evidence suggests push factors may be more important considerations, as illustrated in the following section. The importance of push factors on retention was also stressed by SMOs during our consultation process.

4.5.3 Canada as a comparative case study

Canada is similar to New Zealand in that it has a high dependency on IMGs of around 22 percent of the total medial workforce. However, it has a relatively low outflow of doctors compared with New Zealand,³⁷ despite there being an absolute and a relative improvement in living standards for SMOs associated with a move from Canada to the United States.³⁸

Furthermore, Canadian studies³⁹ suggest that:

- a higher percentage of overseas-trained, as opposed to Canadian-trained, doctors leave for the United States
- Canadian doctors tend to return after a period of education and training in the United States (in 2006, 80 percent of returning doctors were trained in Canada)
- over 2004–2006 there was a net gain of doctors to Canada.

One study concludes that United States–Canada income differentials have been increasing, but outward migration has been decreasing. This suggests the push factors (use of doctors in the system) have been more important than the pull factors (higher incomes in the United States).

³⁶ For detailed comparisons, see Appendix 8.

³⁷ The Canadian Institute for Health Information identifies two peaks over the last 35 years when doctors left the country: 500–600 in the late 1970s and 600–700 in the late 1990s. However, numbers returning held steady from 1980 at 250–300 per year. The net loss has never been more than 1 percent and has averaged one-quarter of a percent.

³⁸ According to the OECD, the remuneration of specialists in Canada was 4.9 times gross domestic product per capita, but it was 6.5 times that in the United States, which has a higher per capita gross domestic product: OECD, *OECD Health Data 2007*, Organisation for Economic Co-operation and Development, Paris, 2007.

³⁹ K Grepin, *Brain Drain or Brain Train: A longitudinal analysis of Canadian physician migration*, working paper, Harvard University Programme in Health Policy, 2008; Canadian Health Services Research Foundation, *Myth: Canadian doctors are leaving for the United States in droves*, staff paper, Canadian Health Services Research Foundation, 2008.

5 Balancing Supply and Demand

Under any scenario the demand for SMOs will increase steeply in future. New Zealand's ability to respond to increased demand by producing New Zealand-trained SMOs is highly constrained over the next 10–15 years as medical school intakes are only beginning to increase significantly over the next few years. The alternative approach of importing overseas-trained SMOs will be difficult in a highly competitive global market.

In this chapter, we identify a variety of strategies, including recruitment and retention strategies, that can be undertaken to close the gap between the demand for and supply of SMOs in New Zealand.

5.1 Improved information collection and analysis

Our ability to make decisions based on good evidence has been compromised by an extraordinary lack of reliable and objective workforce management information. This is symptomatic of the lack of accountability and priority for workforce planning and management, which is even more remarkable given that the health system is a particularly labour-dependent industry.

For example, it is frequently suggested that SMOs are leaving New Zealand in increasing numbers to take up more attractive work opportunities overseas. It is impossible to substantiate or refute this assertion based on available workforce data. We do see a dramatic fall-off in numbers of SMOs from age 50 but have no information about rates of departure or what those departing have left to do. One can speculate that early retirement from medicine and a degree of international relocation will be among the contributing factors, but without better information it is difficult to determine whether a crisis exists, what the nature of that crisis is, and how best to address it.

This is not an isolated example of serious data inadequacy. Other critical information is lacking, including:

- changes to vacancy rates over time – this data is collated nationally only before wage bargaining, and is not collected in the same way each time so is not comparable
- rates of turnover in the system – with what frequency do SMOs move from one job to another?
- exit interview data that is systematically collected and nationally collated – covering both reasons for departure and intentions
- comprehensive information on the use of locums that captures all SMO locum activity, reasons for using a locum, duration of employment and cost – at present only aggregate cost information is available from each DHB, but because of inconsistent ways of counting locum activity and no complementary information the cost data is incomplete and of limited value.

The Health Workforce Information Project initiated by DHBs has been a helpful start to gathering consistent national workforce data. This project has allowed for some timely workforce projections. However, until this work is developed further, information is insufficient to easily prioritise SMO workforce development across specialities or develop targeted recruitment and retention strategies.

5.2 Focusing on New Zealand's doctors in training

New Zealand is committed to increasing its medical student intake but the full benefit of additional SMOs from the increased intake will not be realised before 2025 due to the training period lag. In the meantime, it is essential to improve the quality of RMO training and employment and retain more of these doctors in the New Zealand health system.⁴⁰

We have kept our comments in this important area brief, in acknowledgment of the other streams of work that have closely examined these issues and recommended solutions, including the:

- Commission on the Resident Medical Officer Workforce⁴¹
- Medical Training Board review⁴²

Each of these pieces of work includes recommendations that have the potential to address the concerns we have identified. We have focused our comments on the issue from the perspective of an SMO.

5.2.1 Improved training for doctors in training

SMOs generally believe that reinvigoration of the apprenticeship model is vital. SMOs commonly reported to us that the work undertaken by house officers and registrars has changed, with less exposure to clinical practice, a reduced scope of practice, and a large increase in administration. The impact on SMOs is that much more often they are carrying out clinical work that they regard as registrar work (when they were undergoing vocational training to be specialists). This is not a good use of the skills and experience of the medical workforce overall, and may well influence retention rates for doctors at all levels of training. It also makes the doctors in training roles a lot less clinically satisfying especially at the house surgeon level.

We need to find a way to reverse the trend.

5.2.2 Impact of increased vocational training

Vocational training is the final gateway to becoming an SMO and a potential bottleneck in growing our own medical workforce. In the future, as a larger cohort of doctors progresses along the training pathway, there will need to be a commensurate increase in vocational training positions and this will require considerable input from SMOs to provide that training.

SMOs need to play a much stronger role in the training, supervision, management and mentoring of doctors to support RMOs to stay engaged in training and to accelerate their professional development. For this to be successful a much stronger sense of team is needed, so SMOs can develop closer working relationships and determine appropriate levels of delegation with confidence.

5.2.3 Impact of vocational training choices

The Clinical Training Agency works alongside the DHBs and professional colleges to determine how many vocational training positions will be offered and funded in each medical

⁴⁰ For a detailed discussion of RMO training and retention issues, see chapter 3.

⁴¹ Commission on the Resident Medical Officer Workforce, *Treating People Well: The Report of the Director-General of Health's Commission on the Resident Medical Officer Workforce*, Ministry of Health, Wellington, 2009.

⁴² Medical Training Board, *The Future of the Medical Workforce: First Annual Report November 2007 – December 2008*. Ministry of Health, Wellington, 2009.

speciality. The professional colleges set the criteria that determine whether a DHB will be accredited to provide vocational training. Individual doctors then choose their training programme.⁴³

However, there is no mechanism to look at these issues regionally or nationally from the perspective of the public health system's interests. (The Clinical Training Agency does this function mainly from a contractual perspective.)

For example, several DHBs and SMOs have observed an increasing trend for specialist training to be provided in main centres, and a commensurate trend toward subspecialisation. They note that in smaller and rural hospitals, of which there are many, the need is greater for generalist SMOs than subspecialists. However, this need does not appear to be reflected in SMO training programmes or registrar choices.

Thus, opportunities are limited for vocational registrars to train in provincial centres, and there are fears that in future, fewer provincial DHBs will be accredited to provide vocational training. This affects the ability of provincial centres to recruit future SMOs early in their careers with a view to longer-term retention. It also diminishes the attractiveness of provincial positions for those SMOs with a strong interest in registrar training.⁴⁴

Both of these issues would benefit from a national process to push the training programmes towards New Zealand's service needs.

5.3 Improved international recruitment and retention

While New Zealand aspires to become more self-sufficient in its production of SMOs, IMGs will always comprise a significant proportion of the SMO workforce. New Zealand will be particularly dependent on IMGs over the next 15–20 years, during the lead-in time for increased student intake to flow through to the SMO workforce.

The SMO Commission believes that overall, New Zealand is not realising the full potential of the global SMO workforce as a source of recruitment. Our analysis shows that when we recruit an overseas-trained IMG at a specialist level, then around 90 percent of these doctors remain permanently in New Zealand. This is extremely beneficial and good value, as these doctors often plug harder to fill gaps in provincial New Zealand.

Much can be done to improve our performance in international recruitment, both of IMGs and expatriate New Zealand graduates, and in supporting these doctors through the gauntlet of being allowed to practise as specialists in New Zealand. There is also a perception by IMGs that they are not valued as highly as their contribution to our health system warrants.

⁴³ For more information on key agencies in medical training and education, see Appendix 9.

⁴⁴ For further information, see Ministry of Health. 2009. *Summary of Submissions: Director-General of Health's Commission on Competitive and Sustainable Terms and Conditions of Employment for Senior Medical and Dental Officers Employed by DHBs*. Wellington: Ministry of Health, available from <http://www.moh.govt.nz/moh.nsf/indexmh/summary-of-smo-submissions-apr09>.

5.3.1 Streamlined recruitment efforts

All 21 DHBs carry out efforts to recruit internationally. Variability in the activities each DHB undertakes with regard to recruitment is huge. Most DHBs have advised that they are generally active in overseas recruitment.⁴⁵ The variety of activity includes:

- print advertising, primarily in medical journals and publications rather than the general print media
- website advertising, on their own website, college websites and specialist medical recruitment websites
- use of specialist medical recruitment agencies (New Zealand and overseas based) for permanent and locum positions
- use of personal networks of existing and former RMOs and SMOs (New Zealand and overseas trained) for 'word of mouth' referrals
- participation in medical job fairs and expos (eg, the BMJ job fair, Opportunities New Zealand expo, and the Working Down Under expo)
- arranging for SMOs attending overseas conferences to hand out brochures and information to colleagues
- participation in collaborative generic recruitment campaigns with other DHBs.

This level of fragmentation makes poor use of available resources from a whole-of-system perspective and is not without risks. For example, DHBs have described situations where they have been poised to recruit after many months of work, which might include paid visits to New Zealand for interviews and service orientation, only to find that the potential candidate has taken a job with another DHB, so the effort has been wasted, precious time has been lost and the whole process must begin again.

We consider that there is scope to promote New Zealand more aggressively as a potential job-market to SMOs. Several people suggested a single agency be established to co-ordinate international recruitment, but we are not persuaded that this would be workable in a system where 21 DHBs operate autonomously and individually have service accountability. We understand, for example, that District Health Boards New Zealand has endeavoured to facilitate a nationally co-ordinated approach across the DHBs but that several DHBs have opted to remain outside of such an arrangement.

The SMO Commission believes a regional approach is much more likely to succeed. This would be simpler because there are fewer relationships to manage but more importantly it would be better aligned to the greater level of regional service planning that clearly needs to happen in New Zealand. This is discussed further in section 5.4.3.

5.3.2 Streamlined immigration processes

Doctors and dentists appear on Immigration New Zealand's Immediate Skill Shortage List, which is region-specific, and Long Term Skill Shortage List, which relates to ongoing national shortages.⁴⁶ Applications under the Immediate Skill Shortage List are only for temporary work permits while the Long Term Skill Shortage List can be used as the basis for both temporary work permit and permanent residence applications. A job that appears on either

⁴⁵ Information obtained by the SMO Commission directly from DHBs via a purpose-specific survey carried out during April 2009.

⁴⁶ New Zealand also has a number of working holiday schemes with other countries whereby young people aged 18–30 years can obtain a temporary work permit for up to 12 months to work in non-permanent positions. This facilitates the entry of short-term working tourists across a wide variety of industries, including the health sector, but has little impact on the SMO workforce, which tends to encompass an older cohort.

list means Immigration New Zealand has established there is a shortage and that the employer is not required to produce evidence that there are no suitably qualified New Zealand residents or citizens available.

DHBs reported few issues with the immigration process or their relationship with Immigration New Zealand. The information provided to employers and individuals is clear and the process well explained. Individuals are able to complete preliminary checklists and apply online on the Immigration New Zealand website. Additionally, those individuals recruited through recruitment agencies generally receive help from the agencies with their immigration application process.

At least one DHB has established a close working relationship with Immigration New Zealand in which the DHB has become an agent for Immigration New Zealand and may process work permits for SMOs (and their partners). Through this relationship, SMOs can get work permits within 60–80 hours.

One simple suggestion made to us is the removal of the requirement for DHBs to re-establish their credentials as viable businesses each time they seek to recruit internationally.⁴⁷ Given that DHBs are Crown entities with an implicit government guarantee, this requirement does seem a particular example of bureaucratic madness.

Overall, immigration processes appear to be working well. We do not consider there is much upside in further improving immigration processes as a priority at this time.

5.3.3 Streamlined registration processes

The Medical Council is responsible for the registration of doctors and issuing of annual practising certificates. Its empowering legislation, the Health Practitioners Competency Assurance Act 2003, gives it considerable autonomy as to how it carries out these functions.

The SMO Commission received consistent and uniform feedback from SMOs that IMG registration processes are complex, unclear and cumbersome to the extent that people:

- were put off from considering New Zealand as a potential destination because it is much less user friendly than other registration processes
- became frustrated with the initial registration process, lack of courtesy, and long delays and withdrew their applications and/or accepted other positions
- left positions in frustration at not being able to achieve full registration within an appropriate scope of practice (ie, aligned with their previous qualifications and experience).

Concerns with delays in processing applications together with insufficient communication about the progress of applications were frequently raised, especially around the acceptability of referees. Some also complained of inconsistent advice on correct procedure being provided by Medical Council staff.

We recognise that professional colleges contribute to some delays. The Medical Council typically consults the appropriate college about a specialist application. The college process then relies on an assessment usually by its members on a voluntary basis, which understandably takes time. Some commentators expressed the view that some assessments may be influenced by self-interest, especially when there is a small but lucrative private sector market in that particular area of specialisation.

⁴⁷ The requirement is on Immigration New Zealand form NZIS 1113 (employer supplementary form – work permit/visa application).

Onerous supervision requirements were also frequently raised. These were of particular concern to more provincial locations where supervision can be difficult to arrange. While most affected, provincial locations have less influence on the professional colleges than do the main urban hospitals where most SMOs work. There is considerable fear that gradual changes to supervision requirements are increasingly reducing the ability of provincial DHBs, many of which are dependent on IMGs, to recruit. It was suggested that this would ultimately compromise the viability of some local services.

Examples were given of supervision requirements that at face value appear to be unreasonable. We were told, for example, that the West Coast DHB employs some specialists from South Africa for five-week blocks of work on a rotational basis at a very high cost. At the beginning of each rotation, however, they must undergo two weeks' direct on-site supervision from a registered specialist in the same scope of practice, which is only through an alternative DHB. This means the locums are available to the West Coast for only three of the five weeks of their contract, which, repeated for several positions and over the course of a year, represents a significant waste of resource.

Depending on the pathway through which registration is being sought, supervision is required for a minimum of one year, but often two years, before vocational registration can be achieved. Some IMGs may also have to study for and sit local vocational examinations as a condition of attaining vocational registration. This introduces a degree of uncertainty for both the SMO and their family that can be very unsettling.

We also heard that, because it is easier to obtain registration for temporary positions, some SMOs and DHBs have opted to sacrifice their preference for permanent employment in favour of speed and certainty. Some SMOs coming in under temporary arrangements decide they would like to stay in New Zealand, but there is no simple way for them to upgrade their registration status and they must commence the application process from scratch. This was criticised as illogical given that someone working under a temporary arrangement needs to be just as competent as someone working in a permanent position. From a whole-of-system perspective it contributes to workforce instability, which is not desirable.

The other approach that could be used to give some degree of certainty is to determine equivalence with the specialist training programmes of other countries. This kind of pre-approval coupled with sensible supervision requirements would help to provide more certainty while addressing public safety requirements.

The Medical Council is addressing specific issues (such as the West Coast example described above) directly, and says that it has measures in place to check the quality of its work. It contracts an independent professional review of its written communications to identify scope for improving tone and clarity. It has also introduced Comparable Health System and Competent Authority Programme pathways to expedite the registration of candidates from jurisdictions with similar training standards and/or health systems. The Medical Council is also aware of supervision issues, and has a discussion document proposing improvements to supervision processes out for comment. It may be that these improvements have yet to bed in, as we received little positive feedback from the SMOs who talked to us.

There is no formal requirement for the Medical Council to take into account the wider medical workforce needs of New Zealand or pressure to operate an efficient and effective SMO-friendly registration process. Augmenting the current roles of the Medical Council in this way would align its interests more with those of the rest of the public health system and serve to balance the current 'individual doctor' focus with a system-oriented perspective.

We believe, given the ongoing importance of IMGs to New Zealand's medical workforce, that every opportunity to streamline the registration process needs to be exploited to the full. Notwithstanding the Medical Council's efforts, the strong and consistent concerns of the sector cannot be overlooked. Most tellingly, by the Medical Council's own admission, almost every application ends up having to be re-submitted because the initial documentation does not meet the Medical Council's exact expectations. Given that we have a highly intelligent workforce applying, those expectations are obviously not clear and transparent enough. The current approach is piecemeal and achieving only incremental benefits. New Zealand's processes need to be welcoming, easy to navigate, fair and transparent, with applications processed speedily. Other countries are doing this, if we do not, we will lose out.

DHBs appear to be just managing their way through by helping people to negotiate the hurdles. A collective approach is needed that provides a more assertive approach to identifying and implementing improvements.

We believe, given the current and ongoing importance of IMGs as an integral and valued part of New Zealand's SMO workforce, that a customer-focused review of the registration processes is necessary to maximise our ability to attract, recruit and retain IMGs.

To achieve this we need:

- national leadership – key messages about the importance of the IMG workforce, and a coherent policy framework and system oversight to ensure fair and transparent processes for IMGs
- collaboration between the Ministry of Health, DHBs, professional colleges and the Medical Council to establish processes that align the interests, roles and responsibilities of each party
- adequate resourcing so that user-friendly, responsive and efficient services can be provided to expedite registration
- accountability processes that hold each party responsible for its performance in ensuring that the integrity of the medical workforce is maintained, given the variety of places where doctors who practise here are trained.

5.3.4 Encouraging the return of New Zealand-trained senior medical officers

About one-sixth of New Zealand's medical graduates live and work overseas. We have been told that historically doctors tended to work overseas for a few years before returning to New Zealand. However, there is an increasing trend for these doctors to settle offshore permanently.

There is some scope to improve the rate of return of New Zealand medical graduates. A good strategy for achieving this is by making an explicit commitment to re-employ them on their return and maintaining ongoing and frequent contact with them while away to sustain their connection to their New Zealand workplace.

In some places, there are strong clinical relationships on the ground, and robust networks with New Zealand's medical diaspora, but this is not consistent across New Zealand. At times too, clinical relationships are not supported by management, who may be reluctant to commit funds prospectively. Closer engagement between managers and clinical leaders in decision-making is clearly desirable. Such commitments might also be undertaken with greater confidence at a regional level, where funding and a suitable position may be easier to find within the region's cluster of services.

5.4 Improved local recruitment

Many factors affect the local recruitment of SMOs, including:

- career opportunities for SMOs and their family members
- scopes of practice and insufficient work volumes for subspecialists
- opportunities to be involved in the training of RMOs and in research
- DHB resources to fund professional development opportunities
- access to the latest clinical technology
- the quality of collegial relationships and support with the DHB
- the workload from on-call rosters because of working in small teams
- opportunities to supplement income through work in private practice
- DHB resources for recruitment initiatives
- social and cultural support networks within the local community
- DHBs' need for full-time SMO positions
- remuneration.

Many DHBs are competing aggressively to recruit SMOs using a variety of recruitment strategies.

5.4.1 Local links are important

The SMO Commission heard throughout the consultation process that having a positive work experience was a major determinant in both the selection of a vocational training programme and choosing to work in a particular DHB or department. Personal relationships, with both senior colleagues and teams, were at the heart of this. Maintaining those relationships over time was the key to recruiting SMOs at the conclusion of their vocational training, particularly in attracting doctors back from overseas.

In the past clinical directors often offered promising young doctors positions that could be taken up in the future. We were told though, that an increasing focus on managing financial risk, issues around human resource processes, and a separation of management and clinical leadership have made this much more difficult in most DHBs.

This situation highlights the need for managers and clinical leaders to work closely together to meet the needs of the organisation and take a longer-term view of service delivery.

5.4.2 Managing growth in the senior medical officer casual locum workforce

As mentioned above we have little information about current SMO participation in the locum market. There is no standardised way of recording locum activity, nor any requirement to do so. What information we have suggests it is relatively modest compared with RMO locums. We have been told, however, that the SMO locum market in New Zealand is growing, possibly as a continuation of the locum phenomenon among RMOs.

An increase in the number of locum SMOs is not inherently bad, but we are concerned about the potential for SMO locum patterns to follow those of RMOs where a significant number are working in a largely unregulated casual labour market. Casual locums provide poor continuity of care for the patient, interfere with effective teamwork, and increase the risk of safety concerns because there is no effective oversight of the doctor's clinical performance or the hours they work.

Concern was expressed that some SMOs are using their leave entitlement to locum elsewhere in New Zealand and Australia, and that the resulting fatigue raises clinical safety issues and is likely to produce burnout.

There is a risk that if significant numbers of SMOs take up casual locum work, permanent staff will resent working harder but being paid less than locums, and that locum rates will drive up the remuneration expectations of permanent staff as it has among RMOs. The remuneration available to SMO locums may disincentivise their uptake of permanent full-time SMO positions, thereby eroding SMO capacity within the permanent workforce and reducing workforce stability.

The increasing use of locums is also a more costly option. This risk needs to be managed proactively.

We believe a national policy on managing the risk of a casualised SMO locum workforce would be helpful, and that locum expenditure and utilisation need to be monitored more closely, both within DHBs and at a national level.

5.4.3 Regional approach to senior medical officer recruitment

Written submissions and comments made through the SMO Commission's consultation process frequently raised recruitment difficulties experienced by smaller provincial DHBs and services with poorer socioeconomic indicators. This is reflected in the SMO workforce data, which shows a much higher dependence on IMGs and/or higher vacancy rates among the provincial and rural DHBs.

We believe a more regionalised approach to local recruitment makes more sense for most services and should be developed in the context of mandated regional workforce planning, development and management.

This approach would:

- strengthen the overall attractiveness of positions offered in that they would all have the potential to access available technology within the region, serve larger population bases, and be part of a regional training and research network
- enable the workforce to be deployed to best effect across a region and improve job satisfaction for more SMOs.

In this way, we would strongly promote a much closer alignment between service planning and the requisite capital and workforce planning and management that is necessary to deliver the required services.

5.5 Improved senior medical officer retention

Many SMOs told us they did not feel valued by their managers, their employers, the health system or the New Zealand public. **Many were dissatisfied with their current situation, and said this factor drove them to leave rather than better pay and conditions attracting them.** Indeed, this was one of the most powerful and compelling themes individual SMOs raised through the consultation process. The SMO Commission was struck by the gap between the commonly held view (among others) of the high status of SMOs in the health hierarchy and the actual expressions and feelings of disempowerment and lack of value articulated by SMOs in meetings.

Another commonly raised issue was that of onerous clinical workloads. This factor affected the availability of non-clinical time (eg, for training, supervision, research and professional development) as well as the opportunity to take leave entitlements.

A further gripe was the small or absent remuneration gap relative to senior RMOs who had less expertise and responsibility. This was felt to be different to what their peers experience in some other jurisdictions.

We now discuss the opportunities for addressing these push factors.

5.5.1 Improving senior medical officer participation and influence

SMO participation and influence is widely recognised as a key factor in high-performing health systems. During our consultation, we saw little evidence of this. Many SMOs identified the lack of participation and influence in decision-making as the area in which they experienced most professional frustration. More experienced SMOs identified a dramatic change in SMO engagement from the 1990s. This parallels a strong managerial focus being introduced into hospital administration, and the increasing separation of clinical and managerial roles. As a result, SMOs perceive their ability to contribute fully and influence the system or services in which they work to have diminished dramatically.

Reported manifestations of this diminished ability included:

- lack of participation and/or influence in decision-making that affects SMOs directly or service delivery
- systems that impinge on clinical judgement and/or increase administrative requirements without consideration of the impact on SMOs and service delivery
- token consultation of SMOs' views at the last minute
- business case inertia where it is impossible to get decisions made
- being treated as 'widgets' in a managerially oriented system that fails to recognise the extent to which the health system depends on professional altruism and goodwill
- a lack of opportunity for SMOs to manage doctors in training despite SMOs being held responsible for their training and clinical supervision
- a weakening of the traditional senior staff network through mechanisms such as the combined senior medical staff meeting.

The manner in which this has played out is also important. Many SMOs told us that they were not always consulted on major issues. When SMOs were consulted, they often received little or no feedback on the outcome of that consultation, or their input appeared to be ignored, leading them to believe the consultation process was a token gesture.

Most DHBs have established one or more SMO leadership positions but arrangements across DHBs are diverse and, judging by the widespread level of discontent among SMOs, their effectiveness is often limited. Many of the positions are part time and some of the roles are confined to clinical matters with SMO input on wider matters such as the strategic direction of the organisation neither valued nor sought. Given this, it is hardly surprising that those taking up leadership positions do not always appear to be highly regarded or valued by SMOs.⁴⁸

We observed a considerable disjunction between management and SMOs in several DHBs on the issues we have discussed above. On the whole, senior DHB managers appeared to

⁴⁸ For further information on non-clinical training opportunities, see Appendix 10.

have limited awareness of the level of discontent among SMOs regarding their participation and influence. Some DHBs believed they had strong clinical leadership and partnership arrangements, a view not often shared by their own SMOs in the consultation meetings. A small minority seemed not to appreciate the potential value their SMOs could add to the organisation or the adverse consequences of alienating this workforce by not treating them respectfully. Some of the issues SMOs raised, such as the need to bring some contracted-out procedures back within the DHB provider arm, were being addressed by management unbeknown to SMOs. In such cases, poor communication is a key driver of discontent – one that ought to be simple to address.

Under the current arrangements, we are seeing low morale and loss of goodwill among an increasingly disenfranchised workforce. This adversely affects productivity, retention and service improvement. In this time of workforce shortages and steep growth in service demand, productivity needs to be maximised. People are already working hard, so the greatest gains will come from working smarter. Innovation is needed, and the most creative ideas are usually generated closest to the service delivery level. SMOs and other health professionals need to have the opportunity to generate and test new ideas, the enthusiasm to want to do so, and managerial colleagues who will support them in this.

The importance of clinician participation and influence, for the most part, is becoming better recognised. Several recent initiatives have the ability to address this.

The current collective agreement contains reference to the Time for Quality agreement. The reference provides an opportunity for both individual SMO activities (such as continuing medical education) and organisational activities (such as audit, service planning and quality improvement initiatives that could improve service effectiveness and delivery).

At the end of 2008, the Minister of Health set up the Ministerial Task Group on Clinical Leadership. The task group noted that:

A lot of effort has gone into corporate governance, and reporting corporate outcomes, and processes are being established for community governance. However, clinical governance, and reporting on clinical outcomes, has not been the prime focus of many DHBs, especially in their hospitals.⁴⁹

Accordingly, the task group concluded that the following adjustments are imperative for the successful transformation of healthcare and effective clinical governance.⁵⁰

- DHB boards must establish governance structures that ensure effective partnership of clinical and corporate management.
- The chief executive must enable strong clinical leadership and decision-making throughout the organisation and the chief executive's performance must be assessed against the achievement of these outcomes.
- DHB governance: DHBs will report on clinical leadership and clinical governance through their district annual plans, statement of intent, and scorecard reports to the Ministry of Health, including, but not limited to, the functions of their clinical board.
- Clinical governance: Tangible examples of clinical governance, on which DHBs must report, include:
 - clinicians on the executive management team as full active participants in all decision-making

⁴⁹ Ministerial Task Group on Clinical Leadership, *In Good Hands: Transforming clinical governance in New Zealand*, Ministerial Task Group on Clinical Leadership, Wellington 2009, p 2.

⁵⁰ For a more detailed excerpt from the task group report (ibid), see Appendix 11.

- effective partnership between clinicians and management at all levels of the organisation with shared decision-making, responsibility and accountability
- decisions and trust devolved to the most appropriate clinical units or teams, which are many and varied, including clinics, offices and practices, wards and departments, hospitals and networks, regional and national bodies.
- Clinical leadership must include the whole spectrum – inherent, peer-elected to clinician–management appointment, and DHBs must report on the establishment and effectiveness of clinical leadership across the spectrum of their activities, aligning management to clinical activities.
- DHBs and the health system must identify actual and potential clinical leaders, and foster and support the development of clinical leadership at all levels. To this end, DHBs must together establish strategies to provide on-the-job training, measure the achievement of leadership competencies, and link with universities, colleges and professional associations to co-ordinate funding, access to internal and external training, and support for coaching and mentoring of leadership at all levels.
- SMOs must be prepared to develop the non-medical skills and competencies that are necessary for bringing about valued contributions to the wider leadership of the health system. There will need to be regular leadership development programmes, and the doctors who succeed in these will have to meet fewer obligations in continuing clinical practice, as they contribute to wider roles in the health system. Senior doctors as a group do not yet seem to genuinely value this critical form of contribution to the health service by those senior doctors who have already made this shift, despite their vital significance to achieving the wider goals of the clinical leadership initiatives.

The Minister of Health, In a February 2009 letter of expectation to DHBs, identified the need for DHBs to foster a culture of clinical leadership. Consistent with this, the Ministry of Health has asked DHBs to consider the recommendations of the Ministerial Task Force on Clinical Leadership and to transfer these into measurable outputs when preparing their district annual plans.

The Ministerial Task Group on Clinical Leadership also recommended the establishment of a small group to develop an initial national framework for reporting on clinical outcomes, clinical effectiveness and clinical leadership within DHBs.

5.5.2 Providing necessary space, tools and support

During the consultation, it was not uncommon for SMOs to raise concerns about their working environments. In general, they felt their needs were largely overlooked or the significance of their requests under-rated. We think this happens because at face value some concerns can appear trivial, compared with larger organisational concerns such as increasing budget deficits, but their cumulative impact on SMOs in an environment in which they do not feel valued can be dramatic. One SMO described the impact of such things as ‘death by a thousand cuts’.

Examples of inadequate space, tools and support that were mentioned to us included:

- lack of essential equipment such as a refrigerator for drug storage
- lack of private interview rooms in some services, meaning personal and highly sensitive information needed to be disclosed by patients in a public space
- lack of access to computers or even desk space for completing administrative tasks
- no provision for personal effects to be stored securely
- lack of staff rooms and café facilities
- lack of car parking when on call or working nights

- lack of administrative support with a clear line of accountability to provide required support and sufficient capacity to do so
- major capital purchases that were not fit for purpose and hospital redevelopment that failed to incorporate essential and basic service delivery requirements in the new design through a lack of participation during the design phase.

5.5.3 Reducing the perception of medico-legal risk

Reputation is very important to SMOs as a mark of professional standing, and it is also central to the relationship of trust between doctor and patient and other health professionals. Several SMOs reported feeling that their reputations were extremely vulnerable in what they perceived as a hostile medico-legal environment. They believed there to be an increasing range of onerous and lengthy complaints review processes. In reality, however, New Zealand's system is more benign than systems in jurisdictions such as the United States, where 'medical misadventure' is not covered by an accident compensation system and aggressive litigation is rife.

The perception of increased risk stems from highly public and controversial events such the Cartwright Inquiry and Gisborne Inquiry. These inquiries led to the development of clinical guidelines and much greater public accountability for performance, such as the establishment of the Code of Patient Rights and the Office of the Health and Disability Commissioner. Similar developments have occurred worldwide where the consumer voice and protection of consumer interests have gained increased attention.

SMOs are very concerned, legitimately in our view, about the extent to which they are often working in less than ideal conditions over which they have limited control. However, they are held personally accountable for adverse outcomes brought about by their actions or the actions of anyone for whom they are responsible. Overwork, for example, is reported to be discounted as a mitigating factor when errors are made, as SMOs are deemed to have a personal duty of care to manage such threats to their performance.

Again, this is a relatively common experience, which to some extent might be ameliorated if SMO influence was stronger, as reflected in the observation on the United Kingdom health system by Lord Darzi.

If clinicians are to be held to account for the quality outcomes of the care that they deliver, then they can reasonably expect that they will have the powers to affect those outcomes. This means they must be empowered to set the direction for the services they deliver, to make decisions on resources, and to make decisions on people.⁵¹

We also consider that our health system's focus on outputs and outcomes, to the exclusion of inputs and processes, is a major factor in placing clinicians in personal jeopardy where the organisation or system should be held to account for providing an environment in which health professionals can function safely and effectively. The focus on outputs and outcomes is current management orthodoxy but it has resulted in little cohesion in the development of the future health workforce, regional or national planning of services and practices, or in patient, diagnostic or employee information exchange.

Complaints processes are of high public interest and draw close media scrutiny, often with a strong negative emphasis and a mission to 'name, shame and blame' individuals. Many

⁵¹ Lord Darzi, *High Quality Care for All: NHS Next Stage Review Final Report*, Department of Health, United Kingdom, 2008.

SMOs consider that in the current environment there is a failure to contextualise adverse events in a system that has relatively few such events (given the volumes of patient referrals and treatments and the level of clinical uncertainty inherent in the practice of medicine). The length of time of complaints and their adversarial nature probably cause as much harm to SMOs as anything else – sadly, a resolution-based approach occurs in a minority of cases.

With leadership and support from the Quality Improvement Committee initiative, DHBs have moved some way toward addressing this issue.

5.5.4 Reducing onerous workloads

SMOs working in DHBs tend to work longer hours than their peers in private practice and general practice. However, there has been little appreciable change in the average hours worked by SMOs in the past 10 years. This suggests the change in workloads affects some specialties and locations more than others and that the nature of the work has changed.

In submissions and throughout our consultation, SMOs frequently referred to onerous workloads. The main causes were said to be:

- persistent and significant staff shortages
- providing cover for other SMOs during planned and unplanned leave
- less ability to delegate work to registrars and house surgeons because of less developed competencies than in the past and limitations on practice.

As clinical work takes precedence for most SMOs, high workloads have a major impact on non-clinical activities such as supervision and mentoring, education and training, and their own ongoing professional development and continuing medical education.

Onerous rosters affect smaller and rural hospitals in particular. In smaller centres with persistent vacancies SMOs reported not being able to take annual leave because no one could cover their clinical responsibilities. Larger hospitals are also affected. It was observed that some specialists are required to participate in more than one roster (eg, surgical and maternity rosters) exposing them to more onerous on-call expectations.

Ensuring that SMO workloads are not too onerous is the responsibility of DHBs. Many, for example, incur considerable expense in employing SMO locums to provide cover. The availability of SMOs to provide cover, even on a locum basis, is problematic in many areas.

A very small number of SMOs stated that their main objection to doing on-call rosters was that they were not sufficiently well paid. Pay and conditions are matters to be negotiated between DHBs and the ASMS. However, it is our impression that at least some of the discontent with on-call rosters and on-call remuneration reflects the breakdown in relationship between SMOs and DHB management. The sense of being undervalued has eroded the goodwill SMOs feel toward the organisation and given rise to a more industrialised perspective on work and remuneration. This underscores the need to undertake measures to improve the relationship between SMOs and managers.

5.5.5 More flexible working arrangements for senior medical officers

Working as an SMO in the public health system is extremely demanding. There is a strong, desire (but by no means exclusively) among the younger generation of SMOs to seek a better work–life balance. One Australian study reported that 17.4 percent of specialists are very or moderately dissatisfied with their hours of work, and that among specialists and general practitioners ‘men were more likely to be dissatisfied with their hours of work than

women. This could reflect that male doctors generally work longer hours relative to female doctors.⁵²

The health system needs to find a way to accommodate the desire for shorter working hours to retain part-time participation in the SMO workforce rather than have people withdraw from the workforce altogether. There is a tension here, however, with the desire for continuity of care.

At the same time, it is important for SMOs toward the end of their careers to be able to reduce their acute on-call responsibilities and find ways to use their experience more flexibly. At present, there may be a tendency to retire or take up part-time private work rather than partially stepping down from duties in public hospitals. Such a loss of experience is likely to be even more significant as the baby boomers reach their mid-60s during the next decade.

5.6 Making better use of the workforce

Sustained SMO shortages can threaten the viability of hospitals or services.

We could respond in various ways, including by:

- employing more SMOs (and complementary staff and other required resources)
- making better use of the available workforce
- looking at other ways of providing access to services by leveraging the skills and experience of SMOs.

5.6.1 Innovative workforce measures

In the current environment of worldwide medical shortages, employing more SMOs is often not an option, so other ways of providing services need to be found. These may include:

- reducing need through outreach into the community through visits or using technology such as videoconferencing to do distance consultations and provide remote specialist support to local generalists
- making greater use of information technology to expedite diagnostic testing, sharing results across community and hospital service providers, and using collaborative approaches to diagnosis, treatment and review
- using locums and other workforces to augment SMO capacity, and efficient teamwork approaches.

While there are some examples of innovation in this area such as the 'hospital at night' approach, implementation of such innovations across the whole DHB system has been rare. For example, although experience exists internationally for physician assistants, nurse anaesthetists, nurse endoscopists, and nurse practitioners in chronic health care programmes (eg, diabetes), New Zealand has not meaningfully trialled most of these innovations and where it has there are relatively few practitioners on the ground.

In part, this is because many DHBs have limited capacity to innovate, there are few incentives in the system to do so and often the regulatory scope of practice issues is daunting. There is also a need to obtain buy-in across a range of unionised workforces, which can be challenging to achieve. Health system leadership lacks the authority to deliver

⁵² Medicine in Australia: Balancing Employment and Life, *MABEL Matters*, No. 1 May, 2009. MABEL is a longitudinal survey of Australian doctors. For further information, go to <https://mabel.org.au>.

system wide change across 21 autonomously managed DHBs, when innovation at a local level is well proven. Realistically, workforce innovation needs to be funded and supported as national demonstration projects.

5.6.2 Ensuring appropriate service configuration

Even when employing SMOs is an option or work-arounds can be devised to keep a service afloat, this may not be the best option from a national perspective.

The provision of paediatric oncology at Wellington Hospital is a case in point. In the late 1990s paediatricians recognised that New Zealand should plan for two paediatric oncology units as a realistic approach to maintaining service viability.⁵³ More than a decade later, New Zealand is still struggling to implement this rather pragmatic suggestion to planning services.

It may be better where specialist expertise is scarce to concentrate that expertise in fewer locations, providing required access:

- through outreach from regional or national or even international services
- by transporting patients to other locations for their consultations.

The rationalisation of services, however, is difficult to implement, given local and political sensitivities.

At the risk of repeating ourselves, the SMO Commission believes there is an urgent need to agree on a co-ordinated system for making clinical service decisions at national and regional levels. New Zealand is far too small a country to plan services only at a local DHB level. The creation of a national and regional service planning framework would make it a lot easier to align capital investment and workforce planning and management decisions that really need to be made at a national or regional level.

5.6.3 Public–private partnerships

In New Zealand, the public sector is responsible for delivering secondary care services that cover emergency, acute and some elective care, while the private sector delivers mostly elective procedures and ambulatory care. The two sectors provide complementary services but the boundary is dynamic and they are inextricably linked through a shared SMO workforce.

Some SMOs need to work in both the public and private systems to meet the continuing requirements of their scope of practice. Some supplement the income they earn in the public sector through private practice. Others, however, work primarily in private practice but continue to work in the public sector part time because of the clinical cases that present and collegiality.

Many people we spoke to in the course of our work, identified opportunities for mutually beneficial public–private arrangements, including:

- private sector contribution to the training of RMOs
- joint public–private recruitment and appointments
- joint acute on-call coverage

⁵³ Community Consultation on Paediatric Specialty Services, *Through the Eyes of a Child: A report of the Community Consultation on Paediatric Specialty Services in New Zealand*, Health Funding Authority, Dunedin, 1998.

- the effective use of marginal excess elective capacity in the private system
- public–private co-location of services.

Regardless of one’s ideological views on publicly and privately funded health services, the reality is that both are here to stay. The SMO Commission believes the public–private interface needs to be an integral consideration in workforce planning, and that innovative public–private partnerships should be encouraged when they will add to the country’s collective SMO capacity.

Somewhat ironically, the creation of the accident compensation system has had one of the most prolific impacts on the development of private SMO practice in New Zealand.

A recent Australian review has similarly identified the value of mutually beneficial public–private arrangements.

The panel understands that many full-time specialists now complete their nominal required weekly hours over a four-day period (or less), and while this may be satisfactory for specialists in disciplines without ongoing responsibility for in-patient care such as anaesthetists and emergency physicians, it is less satisfactory for those who do have such responsibilities. In a number of situations, this problem is addressed by the ability to be ‘geographically full-time’, through the availability of both public and private facilities on the same or adjacent locations, thus allowing the distribution of work between the two sectors to be spread across the working week.

Promotion of options that support and encourage specialists to be ‘geographically full-time’ provides considerable benefits to a hospital, including increased access to medical staff and possibilities such as providing office accommodation integrated with consulting rooms and procedure rooms at shared cost.⁵⁴

In New Zealand, the private health sector is often perceived as a threat to the public provision of services, so there has been a tendency to ignore the private sector in public sector planning. This appears nonsensical as the private sector is still very much present. The challenge for the public system is to ensure its own interests are optimised where possible and to find ways to achieve a win–win outcome, such as through the public–private co-location of services.

5.7 Competitive remuneration

In this section, we take account of the terms and conditions of employment for SMOs in Australia and other countries and consider the equity issues raised during the consultation about the current remuneration practice.

The SMO Commission was impressed during our consultation process by the extent to which pay and conditions were *not* at the centre of SMO concerns as they were expressed to us. At most meetings with SMOs they spoke of their commitment as professionals to achieving excellence within the public health system. While acknowledging that good pay

⁵⁴ S Morey, B Barraclough, A Hughes (Review Panel), *Ministerial Review of Victorian Public Health Medical Staff: Report of the Review Panel*, 2007, pp 47–48.

and conditions are important, the primary focus of their concern was frustration with an environment that does not appear to value and adequately support their key role.

It was suggested by some that this underlying dissatisfaction with conditions of employment in the broadest sense has manifested itself in a situation where higher monetary rewards appeared to be the only means of retaining SMOs in an environment from which many had become increasingly detached.

The SMO Commission agrees with this view. Our belief is that the loss of SMO goodwill, the reduction in feeling valued, and the drop in SMO job satisfaction will all tend to raise the focus on the remuneration component of the employment relationship. To the extent that the public health system fails to address the broader issues identified in this report with SMO recruitment and retention over the next few years, then there will be a direct and costlier impact on wage settlements.

5.7.1 Internationally competitive remuneration rates

DHB managers and clinical leaders identified that the pay and conditions offered in other jurisdictions, Australia in particular, have reduced their ability to recruit in a competitive global market. In agreement with this position, the ASMS has argued for significant improvements to achieve parity with the pay and conditions offered in Australia. Indeed, one could say that this idea is the major thrust of the ASMS submission to the SMO Commission.

As discussed in section 4.5.2 above, making comparisons is extremely difficult given the huge variability in a diverse range of salary and non-salary components, as well as differences in things such as the cost of living and tax rates. There are differences between the Australian states and (unknown) differences between jurisdictions – and even individuals – about what amounts are earned in private practice and what recruitment and retention payments are built into salary packages.

Given the proximity of Australia within the same labour market, the SMO remuneration disparity is clearly a relevant factor for consideration. Whether closing the gap is likely to be a strategy that ensures the retention of SMOs in New Zealand is, on the evidence available, unclear.

DHBs will need to consider redistributing funds if necessary within the current spend on medical and other labour costs. We believe that money is better spent to retain a committed permanent workforce. While it is understandable that in the short run managers respond to gaps by paying high rates to attract locums, this is not generally a winning long-term strategy.

Similarly, there has been a large increase in RMO roles over the last decade. We believe the balance has swung too far and that the system would benefit from a greater balance of SMO roles than currently exists. Reducing RMO roles may help to fund an increased investment in SMO roles and provide a better incentive for those in vocational training.

5.7.2 Relativity and transparency

Relativity and transparency around remuneration was raised as an issue by many SMOs.

In order of priority, our impression of the relativity issues for SMO is:

- RMOs
- peers in the same specialties
- SMOs at other DHBs and in other specialities

- SMOs in Australia and other jurisdictions.

Some specialities have more market power, so can negotiate rates above those in the multi-employer collective agreement. Indeed, there appeared to be significant variations in pay across some specialties. However, it appears that RMOs at the top of the scale getting paid more than new SMOs and peers in the same specialties getting paid different rates are the inequities most criticised by SMOs. These two issues are certainly within the realm of DHBs to solve in their collective negotiations and day-to-day remuneration practice.

Some respondents also expressed a view that full-time work in the public sector was important and needed to be supported, possibly through some form of additional incentive. This is especially so when one considers that the opportunities for private practice differ considerably as well. The surgical and procedural specialties can attract substantial extra income in private practice.

One other relativity issue the SMO Commission noted was the significantly lower academic medical salaries. This affects not only full-time academic staff but also those who hold joint DHB and academic appointments but who are employed by a medical school. There appears to be no compelling reason for a significant differential and there is a noticeable impact on recruitment and retention of academic appointments and consequently on the training of doctors in the system. The plans being put in place for a much-needed increase in medical student numbers will stretch these resources further at a time when our capacity to recruit medical academics has diminished.⁵⁵

While discussion around pay and conditions is properly the role of the parties (ie, DHBs and the ASMS), it is important that the parties consider the complexity of establishing relativities in their discussions and **the minimal impact it is likely to have on long-term SMO retention relative to other measures that can be taken** to address the push factors identified in this report.

5.8 Senior dental officers

No formal submissions were made from representative dental organisations, although we did receive comments from senior dental officers (SDOs).

The issues SDOs highlighted related almost exclusively to support for the training path to becoming an SDO.

Where SDOs choose to specialise in the maxillo-facial or related specialist areas there are funded registrar positions and a training pathway. The big gap is the absence of registrar positions for dentists who wish to become general SDOs who can provide general specialist services to DHBs. Typically, this is in pain relief and the treatment of children, young people and other high -risk groups with poor dental hygiene requiring extraction and/or intensive management. Currently, a dentist wishing to pursue that career has to work unfunded and without any certainty about a future SDO position.

There is also no specific pathway to train to become a dental officer in community dental areas such as the school dental programme. Typically, dentists come from a private practice background and may or may not complete a postgraduate qualification in public health or related areas.

⁵⁵ For more information on SMOs' roles as teachers and researchers, see Appendix 11.

If New Zealand wishes to have SDOs working in the public health system in these two areas, then a more supportive training pathway is needed to bring prospective candidates into the system.

5.9 Conclusion

Around 10 percent of the SMO roles in the public health system are vacant. The impact of ageing predominantly, and population growth and immigration to a lesser extent, will continue to push up the demand for health services and SMOs into the foreseeable future.

In the SMO Commission's view, the current level of progress and achievement by DHBs and the Ministry of Health collectively will not adequately meet the future recruitment and retention needs for SMOs over the next 10–15 years. We believe that this is mostly due to the lack of priority and focus given to strategic workforce issues in general. The clearest illustration of this lack of focus is that, despite the health system's major spend being on staff, it is almost impossible to find major business cases being written about workforce issues. Business cases are almost entirely focused on buildings, information technology and capital equipment.

In this chapter we have identified many opportunities for better balancing supply and demand. No opportunity stands out as a 'silver bullet'. Therefore, it is imperative to work on delivering on a variety of opportunities.

Balancing the supply of SMOs to the expected demand is a challenging problem. At a very simple level, the four strategies are:

- train more
- recruit more
- retain more
- make better use of the SMO workforce (eg, by substitution, leverage or changing the work to be done).

Increased student intake will have a considerable lead-in time before its impact is felt, some 10–15 years. We have touched briefly on some of the changes required to improve the training of RMOs, which we believe is the key to improving retention of this medical workforce and realising the full potential of the increased student intake. Attention also needs to be paid to addressing current SMO concerns, so that doctors in training are motivated to maintain and build their connection to New Zealand's health system throughout their careers as outlined by the Medical Training Board and Commission on the Resident Medical Officer Workforce reviews.

IMGs make an important contribution to New Zealand's medical workforce, and will continue to do so. We have identified considerable scope for becoming more effective at valuing, recruiting and retaining IMGs, and consider this a high priority for action.

Local recruitment processes across each of the 21 DHBs struggle to meet the existing challenges. We consider greater national leadership and regional collaboration are needed, if New Zealand is to make worthwhile progress.

One of the key retention factors the SMO Commission identified is that SMOs do not feel valued. This is manifest by a relative lack of participation and/or influence in decision-making that affects them and the services they provide directly. Often this is expressed as being a cog in a system dominated by management jargon and a focus on throughputs

rather than quality inputs, good process and good care. We strongly support current efforts to strengthen the contribution of SMOs within the public health system.

A lack of basic facilities and support services is a concern, as are onerous clinical workloads. We have identified opportunities that were suggested to us as ways to better manage workloads, such as regional service models and regional cover arrangements.

We are of the view that, by itself, increasing remuneration will only partially improve recruitment. It will have even less impact on retention, because it will not address the underlying push factors identified. We accept that New Zealand SMOs receive about 35 percent less remuneration than their Australian counterparts. In our view, this gap is too big but we have not been persuaded that a major reduction of the gap is sustainable at present.

We repeat our previous comments — to the extent that the public health system fails to address the broader issues with SMO recruitment and retention over the next few years that this report has identified, then there will be a direct and costly impact on wage settlements.

The presence of 21 DHBs to cover the service planning and delivery needs of 4.3 million people leads to a situation where it is relatively difficult to deal with the regional and national service issues that arise as there are so many players to co-ordinate and integrate. It is not necessary for there to be fewer DHBs to achieve a lot more cohesiveness. Indeed the difficulties in achieving any momentum or cohesive DHB-wide action on workforce matters reflect more on the very nature of our public sector management system and the limited capacity for governance of the DHBs as a system.

Any discussion about the need for an SMO workforce ultimately comes back to the requirements for local, regional and national service delivery. It is clear to the SMO Commission that New Zealand needs a much clearer regional and national process for planning and delivering clinical services. This will require clusters of individual DHBs to work together with a shared view of how services should be delivered and to have some form of shared accountability for delivery. The current system is not making these decisions as well as it needs to, and the costs of fragmentation are significant. That is not to say that the choices about what will and will not be delivered to a particular community will ever be easy, but hopefully they will be more informed, equitable and consistent.

Once a regional and national framework is in place, then appropriate workforce, capital, information technology and other critical parts of the delivery system can be aligned to the proposed service delivery models. In a time of economic constraint, this is even more compelling as a sustainable approach for New Zealand.

Everything the SMO Commission has said can be dealt with as part of a pathway going forward. It will take time and money but the emphasis now has to be on decisions, innovation and cohesive action. We believe that grasping the opportunities that are available is achievable, affordable and sustainable.

6 Accelerating Progress

6.1 Introduction

The essential elements of the SMO Commission's terms of reference are to recommend a national strategy for recruitment and retention of SMOs that is sustainable along a pathway to competitive terms and conditions of employment.

In this chapter, we draw together the key issues and make recommendations within the general framework of our terms of reference.

6.2 National strategy

6.2.1 Context

Delivering the long-standing commitment of successive New Zealand governments to a high-quality, publicly funded health service accessible to all, keeps the performance of the health service in the public eye, and underpins public expectations of accessibility and quality. The SMO Commission has been told that in many places services are maintained with great difficulty and high cost, and in other places services exist but their long-term sustainability seems unlikely and impractical. The health system in New Zealand is struggling in many places to maintain the level of staffing of SMOs necessary to deliver a sustainable level of service.

We note from international comparisons that we are pushing the boundaries of fiscal sustainability in the resources we put into health, given the national income of New Zealanders. Despite this, our lower national income per capita means New Zealand must rely on other strengths in order to recruit doctors into New Zealand's health services at less than international salary levels. We do this in many scientific and professional fields. We have to compete extensively in the international medical labour market in order to both retain New Zealand trained doctors in New Zealand and attract graduates from other countries to stay in New Zealand.

Health services are extraordinarily complex, and involve myriads of decisions where doctors, nurses, allied health professionals, managers and planners are balancing demands against resources. The delineation of leadership into separate clinical professions as well as the separation of other services seems extraordinarily exaggerated in the New Zealand health system, particularly as we understand that elsewhere more recent trends have been to recognise the collective contribution and mutuality of accountability for achieving desired patient outcomes. We see the need to build a strong common basis for resource allocation decisions at all levels – across the whole health system, within institutions, in clinical services, and in patient treatment and care.

Present performance has been significantly determined by past decisions, for example on the training of health professionals, investments in medical infrastructures, as well as standards, accreditation, regulation and the form of institutional structures and linkages, industrial agreements and governance processes. Similarly, for the future, the longer-term benefits and costs of the most recent decisions may prove to be far in excess of their immediate impact. There is often only a muted voice from medical leaders when public debate occurs about health services, and where an authoritative mix of medical opinion would add immensely to public confidence in difficult decisions.

The consequences of the attempts to separately delineate the roles of clinicians from managers in the early 1990s linger, as SMOs have been reluctant to take on roles where clinical activity of necessity is limited or has to cease. There are few established means for clinicians who have the aptitude for managerial or other system-wide leadership roles to engage in the leadership development activities typical of high-level performers in many other professional fields. We see the long-term success of a focus on clinical leadership being dependent on the way that all health professionals are embraced in the initiatives, and in how a partnership model with health system managers is crafted across the whole health service.

New Zealand's health system has long accepted quite significant losses of New Zealand medical graduates, and the tolerance of these losses has left New Zealand unprepared for the large unheralded shifts that have recently been occurring in the countries that have usually employed New Zealand doctors. Pressures in those countries have often led to intensifying efforts to recruit New Zealand doctors and to retain more effectively those they employ. Our proposals will assist in countering this.

Action now to increase the supply of potential recruits through the training and professional development systems will, over time, increase the numbers of SMOs who elect to remain working here. It will be some 15 years before the very recent initiatives to increase medical school graduates have a significant effect on the number who complete vocational training for specialist practice in New Zealand. Ensuring that the training programmes doctors select meet the needs of the New Zealand population will necessitate action soon to ensure incentives and resources are appropriate.

The vocational training that medical graduates receive in the course of working in the New Zealand health service is dependent on the contribution of SMOs. Several recent reports have highlighted the fragility of the traditional apprenticeship model, and the SMO Commission has found considerable frustration among senior doctors at the way that employer accountabilities, employment arrangements, fragmentation in health services and limited cohesive national leadership have diminished the place of training across the health service. Solutions to this will most likely require new models of training that will need considerable collaboration and trust to develop.

A large minority of New Zealand doctors will always be overseas trained. We have seen considerable scope to reduce the turnover of overseas-trained SMOs and facilitate their placement in positions that reflect their competence and capacity to contribute. We see an opportunity to improve processes for the scrutiny and assessment of the professional competency of IMGs. Improvements gained here will, in the near future, be an important means of alleviating pressure in the supply of senior doctors in New Zealand. SMOs can be assisted by regulatory and process reforms to avoid delay and ensure the scrutiny and assessment of the professional competency of IMGs is no more than is required to meet service standards.

Perhaps most significantly, we see very poor accountability for decisions that have significant consequence for the place, direction and performance of New Zealand's health services. Those bodies that have accountability for the performance of the health services as a whole have little information to advance their understanding, nor is there any legal recognition or financial capacity underpinning their authority. No performance expectations are based on the systems that are so often recognised as central to adverse events, high costs and fragmentation. The SMO Commission found that many critical decisions about the health system as a whole were made by default or involved much delay

6.2.2 Fiscal sustainability

New Zealand's national income per head is near to the average that all OECD countries achieved in 1990. Among OECD and other countries, we observe a fairly tight linkage between the level of gross domestic product per capita and health spending per capita, which reflects a near universal tendency for countries to spend more of their income on health, as their national income per head rises. In 2007/08, New Zealand was over the level of spending on health that its economic position would imply, which undoubtedly reflects the higher rate of increased spending on health over the last decade compared with growth in national income.

Expert opinion is that New Zealand's economic growth during the next decade will be significantly less than that we have experienced in the previous decade, constraining the amount of annual increases in health spending. Despite this, to meet the health demands of a larger population that is living significantly longer, we need to maintain an even greater capacity to innovate and to adapt to shifts in technology, skills, pharmaceuticals, public expectations and awareness. Much of this dynamism will need to be led and sustained by health professionals in all fields.

The potential range of treatments that doctors can provide to people has increasingly become far in excess of what can be achieved by the resources and systems that doctors have access to. This increases the necessity for effective mechanisms to strengthen the coherence between the annual national level health budget and DHB-specific decisions made about resource allocation on the one hand and the patient-focused clinical context within which doctors, nurses and other health professionals continually make decisions about the resources they can apply to the patient's needs at the time on the other. The weaker this fit, the less that patients will benefit from increases in the national health budget.

While the economic capacity of the New Zealand economy broadly determines the scale of resources in health services, there is a dynamism and cohesion that is much valued in the depth of teamwork in New Zealand among professionals. A country the size of New Zealand can support a culture of evaluation and innovation that could be a profound and significant unique national strength, where catalysts exist to ignite it. When New Zealand does establish sound infrastructures, its capacity to sustain and maintain their relevance can be much greater than larger countries with more complex national political structures.

Unfortunately, the external focus on performance measures is quite narrowly based on outputs and outcomes. Quite limited processes for governance generate few focal points for the external scrutiny of investment decisions or the oversight of key input markets, yet these are usually critical to health professionals in sustaining the integrity of future treatment and care. Through the absence of legislative recognition, policy direction or financial authority, there has been a paucity of obligations on chief executives when acting collectively that relate to maintaining the integrity of nationwide systems or containing the vulnerability that uncertainty about input markets brings to the future capacity to deliver services across the health system in New Zealand. The Pharmaceutical Management Agency Ltd (PHARMAC) has been the main exception to this.

Much of the potential benefit of evaluation and innovation on health system performance will remain unrealised until the mutual accountability for the performance of the health system service as a whole is recognised in accountability measures faced in a common way by chief executives, DHB boards, clinicians, nurses and other service managers. The relationships among health professionals, health service managers and governance bodies need to be consistent with a strong mutuality of accountability. Alongside the more long-standing weakness of system-wide leadership, there remain the residual effects of the now-superseded health management changes introduced in 1993.

It is the SMO Commission's view that New Zealand will be highly dependent on innovation and evaluation by health professionals to provide most of the impetus for the increased added value expected of health services. Implementation will need a strong partnership between managers and clinicians, using the available resources well, responding as needs change, and putting resources in the right place. It is important, therefore, to recognise the potential economic significance of clinical leadership and related input in adding value to the total health system. Including systems and key inputs in the performance expectations in both DHB-wide and DHB leadership will be essential if there is ever to be a relevant common focus for all involved.

SMOs will be the anchor for most of this to be achieved, as health services recognise the potential from medical, technological and organisational advances. Adding value in this way is seen as a central component of developing sustainable terms and conditions of employment for SMOs, both in terms of responding to fiscal constraints and in dealing with the causes of dissatisfaction that we identified as the main push factors contributing to less than ideal rates of SMO retention.

Recommendation 1: DHBs and the Ministry of Health value the SMO contribution, and jointly develop effective clinical leadership and participation through strong clinician–management partnerships. This will get the best value out of public health spending.

Recommendation 2: Government amend DHB mandates to drive critical health system goals, such as workforce and clinical services planning, through shared accountability.

6.2.3 National oversight, co-ordination and responsibility

The health services of New Zealand, including hospitals, primary care settings, private services and public health initiatives will inevitably involve a wide variety of institutions. There seems to be no ideal structural form for New Zealand's publicly funded health services, as seen in the three major institutional transformations over the past two decades (1993, 1997, 2001). New Zealand has consistently shown a failure to recognise that whatever devolved, decentralised or fragmented form is preferred, well co-ordinated, ongoing system-wide leadership in the health system remains a necessity alongside whatever form of community representation is in place. This is particularly pertinent to the optimal recruitment and deployment of highly specialised medical personnel.

There will always be many tensions between the immediacy of local service demands and sound system-wide leadership of the long-term resource base.

There is no focused drive to put in place a national strategy for the combined health services of New Zealand. There is no legislative basis or financial authority for whole-of-system initiatives, except as initiatives explicitly led by the Ministry of Health. This creates a lack of coherence, as no one can give or enforce consistent leadership across the system on matters about standards. Agreement on priorities is needed, as is a much greater focus on implementation.

Workforce planning and implementation that involve balancing the long-term supply and demand of health professionals needs to be done at DHB level, and by DHBs working together, with the Ministry of Health to set the overall context by monitoring the demand for health services. Without a coherent strategic view, the accumulated responses to continual operational pressures may fail to stimulate any relevant fundamental change. This risks a

continuation of the situation that the SMO Commission has found, that opportunities are frequently ignored when they require common approaches across the DHB system, which seems to lack mechanisms to achieve integration on even the most fundamental matters.

The annual remuneration of SMOs was \$718 million for the year to 30 September 2008, and we can guess that the value of the human capital that is invested in SMOs is well over \$5 billion.⁵⁶ This extraordinary asset needs to get ongoing top-level attention on a scale that reflects its significance. Those responsible for the governance of the system as a whole ought to have access to informed and appropriately focused monitoring of such a key workforce. The SMO Commission judges that on workforce issues generally, while operational issues may be well managed, the limited information about the medical workforce as a whole suggests strategic issues are not well considered. Authority needs to be given for some system-wide capacity to implement the recommendations in this report. This responsibility should rest with the chairs of DHBs collectively in their role as strategic leaders of the DHB system as a whole. The District Health Boards New Zealand Medical Workforce Group could provide a specific focus on implementing the SMO Commission's recommendations with strategic input from the Ministry of Health.

The service organisation needed to provide 24/7 cover across New Zealand in particular fields of medicine does not appear to be responding to the growing imbalance between costs and quality of services, different cost structures, and the huge range of experiences in the scale of the demand for services. There is a huge variation in DHBs' capacity to respond to shifts in their base populations through the national and international labour markets. This could be moderated by stronger cross-DHB collaboration and a more intense focus on national and regional services. Long-term initiatives and system-wide leadership need special nurturing and leadership in the face of these continuing immediate pressures, not only because of the nature of many medical services, but also because New Zealand has diluted its leadership resources through the continued fragmentation of the health service. To bring a consistent approach to the remuneration, place and development of professional staff in the health system, in both their responsibilities and the responsibilities of the health service to them, we need to reduce the need for effective management of so many different local labour markets.

In short, there is no single recruitment and retention problem and no standard universal solution.

The number of medical students will be increased from 2010, by an additional 200 places. We can now see quite clearly that New Zealand should have increased the number of medical students it trains at least a decade ago, and that the scale of increase should have been larger than the smaller increases introduced in 2004 and 2007. Service capacity now is set in the shadow of decisions long past about the training and recruitment of doctors. The legacy of this is now a gap of some 10 percent between the number of senior doctors New Zealand needs and the number it can recruit elsewhere. The impact of this gap is compounded by the tendency for doctors trained in New Zealand to prefer to live in larger urban centres. We also have few ways of ensuring that the fields of medicine that are most likely to fit future population needs can influence the preferences that doctors in training have for particular specialities. Up to now, it has not been clear that nationwide preferences are recognised in the training capacity of medical colleges, current training positions in DHBs and elsewhere, or in the rewards that exist in different fields during training. Therefore, the gap is more widespread in emergency medicine, psychiatry, radiology, general practice and oncology. We also have noted that smaller regional DHBs generally face very different and more fraught medical labour markets than other DHBs face, and the large hospitals

⁵⁶ This estimate is based on an approximate medical undergraduate and pre-vocational training cost of \$1.5 million per SMO in 2009 dollars.

associated with medical schools seem to be the least pressured. Many regional DHBs employ just a few New Zealand medical graduates, and have to compete internationally for most medical staff. There are exceptions to these general observations. The SMO Commission judges that the 10 percent deficit in the number of SMOs is more likely to be an underestimate of the current structural gap, as we are aware that the recent provision of a 30 percent non-clinical entitlement cannot yet be taken up in a good many settings. Furthermore, we recognise that this gap will remain a significant element of the health service in New Zealand for perhaps 20 years, until New Zealand has made a sizeable increase in the annual additions to the SMO workforce from New Zealand medical school graduates.

We have seen a high degree of commonality in the nature of the pressures on the medical workforce, not only across the DHBs of New Zealand, but also among OECD countries. While the articulated strategies and vision of the New Zealand health service share many similarities with other OECD countries, what differs among countries is that New Zealand seems unusual in the extent to which there has not been system-wide leadership of responses, and that where these are emerging they have yet to gain the necessary traction. Few countries seem to have as many impediments in the way of the development, adoption and implementation of strategies for the system as a whole.

Recommendation 3: The Ministry of Health accelerate the development of a clear process for regional and national service planning, to enable aligned SMO workforce planning.

Recommendation 4: The Ministry of Health require the Medical Training Board (or any successor) to review and recommend medical student intakes at three-yearly intervals to align intakes with future service needs.

Recommendation 5: Government consider the recommendations of the Medical Training Board review and Commission on the Resident Medical Officer Workforce, and agree to the rapid implementation of co-ordinated initiatives that will significantly strengthen medical training.

6.2.4 Improved information collection and analysis

There is a paucity of good information on SMO workforce issues, as outlined in section 5.1. This impedes workforce planning and management and has contributed to disagreement between the ASMS and DHBs around interpretations of basic wage and workforce information. Important information should be transparent to all parties and each party should have confidence in the robustness and reliability of the information.

We believe work needs to commence urgently to identify core information requirements, and establish systematic, routine, regular, simple, robust and appropriate ways of collecting, analysing and reporting that information. The need for purpose-specific research also needs to be explored, together with the placement of data in the public domain to enable independent research and analysis, while still protecting the privacy of individual SMOs.

Recommendation 6: The Ministry of Health lead a sector-wide process to identify core SMO workforce management information and establish systematic ways of collecting, analysing and reporting to provide a common understanding of SMO workforce issues.

6.2.5 Relationships and bargaining processes

We have already commented on the apparently lower priority given to long-term human capital issues compared with other capital items in the DHB sector. This ranking of human resource management as a second or third order matter appears to have been reflected in the approach taken to the collective bargaining processes between the DHBs collectively and the ASMS in the past few years.

Given that the collective bargaining forum can provide an opportunity for a myriad of underlying issues of dissatisfaction or concern to manifest, it should perhaps be no surprise that over the past few years the negotiations for the renewal of the SMO multi-employer collective agreement have been very difficult and protracted.

From the information provided to us it seems clear that several factors contributed to difficulties experienced by the primary parties (the DHBs collectively and the ASMS on behalf of SMOs) in reaching a mutually acceptable settlement. These factors included the positional nature of the bargaining process; the lack of reliable data that both parties could have confidence in; an apparent lack of ownership of the negotiations by the DHBs at a senior management level; a significant divergence of expectation on the key issues; and a failure to bring to bear all of the resources, skills and experience, and advance strategic thinking, necessary for such an important process.

Clearly, neither party welcomed the tense and difficult situation it eventually found itself in. It was not in the interests of the DHBs to be engaged in a sometimes bitter dispute with their most senior clinical staff, and such a dispute had the potential to be damaging to key management–clinical relationships and to the ability of DHBs to retain SMO staff.

It is, therefore, very important that both parties take steps to minimise the likelihood of such a situation developing in future negotiations. We note that, under current government policy settings collective bargaining within the framework of the Employment Relations Act 2000 will remain the primary means of setting remuneration and conditions of employment for SMOs. The challenge is to develop processes that reflect the good faith intentions of the Act.

Given the recent positive developments, such as the Time for Quality agreement, the SMO Commission is of the view that the next logical step would be the development of an interest-based bargaining model that could ensure a more effective structure and process of bargaining that is more likely to produce sustainable results.

A key objective should be to build good faith relationships and mutual respect. The negotiations should not be seen as a periodic opportunity to address accumulated claims and frustrations; rather it should be a joint problem-solving exercise that, as far as possible, reflects the parties' mutual interests. Such a model for collective bargaining sits comfortably with the more collaborative and participative management model we have discussed elsewhere in the report. The SMO Commission sees a strong need to invest the necessary resources to develop an interest-based bargaining model that focuses on the commonality of interest rather than positioning on differences. Interest-based bargaining is well recognised in human resources literature and uses collaborative problem-solving and innovation to reach an integrative solution of mutual benefit rather than distributing rewards in a win/loss manner.

Recommendation 7: DHBs and the ASMS develop an interest-based bargaining model that is:

- **supported by reliable and accurate base information and analysis**

- **led by experienced and senior representation with delegated authority to reach agreement (subject to ratification).**

This will ensure negotiation is underpinned by expertise that is commensurate with the significance of SMOs to the health system.

6.2.6 Developing and supporting medical leaders

Two decades of continual and contradictory change in the managerial underpinnings of health services have left New Zealand with a variable quality of professional management, with much of the variation resulting in lost opportunities to bring in approaches that encourage professional staff. The regular negotiation process, whatever the outcome, should be conducted in a manner that reinforces the leadership commitment to change the status quo. Senior doctors expect engagement on a great variety of concerns, and the regular bargaining process needs to be complemented by other forums and practices that also discuss such concerns. Perhaps one thing that distinguishes those DHBs with less fraught industrial relations is the nature of these practices.

The fragmentation of health leadership may also be reflected in a seemingly unresponsive human resource leadership, as the plethora of industrial agreements, with their many versions and exceptions, get managed on a day-to-day basis. Despite the extraordinarily complex mix of arrangements, the number of human resource and personnel staff is significantly less than that of the wider public service. Despite the high investment that is lost by departures of SMOs overseas, there is a marked lack of exit interviews carried out by employers.

It is not for this commission to have addressed the challenge of whether the current service model is relevant now or whether we have ways of making it better. What we can conclude is that the service model will periodically evolve and a capacity for continual change is a vital characteristic inherent in health systems worldwide. The medical leadership of change in health services is a vital ingredient in this. Volatility in personnel in many clinical services places at risk the capacity for system-wide leadership at a time when the demands on New Zealand's health services place great reliance on the capacity to adapt, not only in practices and enabling technologies and treatments, but also in the mix and complexity of patient needs. The organisational change needed for this necessitates strong relationships across health professions. This will need a strong partnership between clinicians and managers, and will need a good number of medical professionals to seek to advance in roles in the leadership of health services. It will be necessary to face up to the need for training and development usually associated with effective performance in leadership roles to be systematically planned for in each cohort of doctors among the sample that demonstrates the aptitude for this.

The role of chief medical officer varies among DHBs, in its reporting links, responsibilities to the board of the DHB, and authority in personnel, investment and standard-setting activities that affect the medical capacity and performance of the DHB and the DHB system generally. This looseness in role reflects the predilections of the individual DHB leaders of the times, yet a consistent role across all DHBs would reinforce professional and clinical leadership initiatives in a more effective manner. It would also reinforce the intent that chief medical officers collectively have responsibility for leadership on clinical issues, and build up managerial–professional partnerships across DHBs as a whole.

Senior doctors have a huge impact on health services, not only when they take on managerial roles, but in their investment advice, training and uplifting the quality standards and practices, including accreditation processes, on which the integrity and performance of the health service depends. We found little investment in the non-clinical development of

doctors who do or could have a huge impact on the health service, yet in almost all other fields of endeavour this is well recognised as a serious role of the top level of institutional leadership, to systematically advance the leadership capability of the organisation. We understand that at various times initiatives have been developed, and then waned. We see this as a core responsibility of the top leadership, and a matter in which DHB chairs should collectively demonstrate a strong interest. While no formula can be exact, we suggest that 10–20 senior doctors of each graduation year should have participated in a top-level leadership programme by the time they reach 45 years of age.

Recommendation 8: DHB boards initiate and monitor an ongoing programme of SMO leadership development and report progress through their accountability documents. This will enable them to realise the contribution of potential SMO leaders.

6.3 Recruitment

6.3.1 Linking vocational training to future demand and supply

Estimates of the future demand for health services are prepared regularly by the Ministry of Health in association with the Treasury. Until last year, little had been done to link these estimates of the demand for health services with the supply of doctors or to consider a long-run fiscally sustainable balance among the three main means of supplying doctors. Demand and supply imbalances have long been left to individual DHBs, balancing their short-term operational needs with newly recognised demands, drawing as best they could on the three main medical markets (domestic graduates, international graduates and locums). The lack of nationwide leadership in managing the domestic supply of graduates has led to a strong reliance on international graduates, and the insufficient attention given to their retention has led to an accelerating demand for locums.

In the long run, New Zealand needs to reduce its vulnerability to shifts in policy among the major markets that compete to recruit New Zealand doctors, and key to this is the need to train in New Zealand a majority of the doctors needed to meet future demands. There is a need to ensure an alignment between the output of the medical schools and the capacity of the system to create opportunities for supervised specialist training.

The SMO Commission recognises the very significant shift in the number of New Zealand medical graduates that is now being planned for, but sees that over the next 15 years many of the current pressures on the medical labour market will remain, until there is a significant increase in the flow of doctors completing vocational training programmes. The recent large increase in the number of medical graduates was preceded by initiatives to retain doctors in particular fields of medicine, and related initiatives will need to follow, if difficulties in the retention of New Zealand graduates are not to dilute this major impetus. For those who start vocational training in the future, there needs to be stronger incentives to train in the fields of medicine where New Zealand has a high vulnerability, in particular, general practice, general surgery, psychiatry, radiology, geriatric and palliative care. The voluntary bonding scheme and rural practice schemes provide some incentive for this. Nationwide leadership is needed to ensure judgements of future priorities are robust, and that not only training programmes, but funding, availability of training positions and industrial agreements provide consistent incentives on doctors in training. We strongly endorse the Medical Training Board's view that there is a window of opportunity in which to develop an alternative approach to the present, as we have not allocated funding for additional capacity coming through increased student intake

The best time to recruit SMOs is not necessarily at the point a vacancy becomes formally available. In some fields of medicine, there will be few ideal candidates, and the opportunity to establish a commitment to employ an ideal candidate is often not supported by formal administrative practices. As financial constraints on DHBs increase in the next decade, it will be essential that the little flexibility that DHBs already allow senior clinicians in this personalised commitment is not removed. This is just one reason why we conclude that prescribing a national approach to recruitment immediately may risk undermining the capacity of DHBs to recruit in ways that best fit their circumstances. We see considerable value in supporting collaboration, not only among the DHBs from the same regions, but among the smaller DHBs, which tend to have a far greater dependence on IMGs. We expect that when a strong nationwide commitment to national and regional medical services exists, this will provide the necessary underpinning and a far stronger driver for collaboration in recruitment than approaches now that encourage collaboration in recruitment in the context of the current highly individualised performance obligations. The bilateral collaboration that has recently developed between Southland and Otago DHBs and between West Coast and Nelson Marlborough DHBs show the way, as does the regional services planning of the North Island's central regions, and the Auckland Regional Registered Medical Officer Services scheme of the three Auckland urban DHBs.

Recommendation 9: DHBs, the Ministry of Health and professional colleges work collectively to use emerging national and regional service planning processes to determine the numbers and mix of general specialty and subspecialty training positions needed to match future service needs.

6.3.2 Accreditation of international medical graduates

We believe complex, lengthy and uncertain assessment processes are discouraging some IMGs from applying for registration and causing others to withdraw before completing the process. This represents a significant impediment to recruiting IMGs.

We heard from a good number of applicants for registration from many countries whose medical services have very high standards and population health levels greater than New Zealand that they had waited over two years, some without feedback on their applications. They noted that registration with a vocational scope appeared to be a particular barrier.

We appreciated the opportunity to discuss this issue with the chair and chief executive of the Medical Council, and we came to appreciate the load on existing SMOs, often in their roles within medical colleges, placed by the demands of the assessment processes necessary for accreditation.

We recognised that across DHBs, many operational imperatives may have a higher short-term priority, but we consider that the breadth of concern across the whole DHB system was quite substantial and justified greater attention. The protection of the public is an issue of great import, and we considered that it ought to have had the weight and resources of DHBs collectively working with the Medical Council and medical colleges to find more effective ways to support their evaluation of overseas doctors' credentials. The Health and Disability Commissioner might be another participant in this rethink of accreditation processes.

We ask the Minister of Health to be fully supportive of any work that the Medical Council and medical colleges can do to develop a clearer time path and a more systematic approach to the processing of applications for registration. This might even necessitate a different payment model from the individual fee for service and perhaps legislative change. We do not know how far delays in recruiting IMGs have consequences also for patient safety. We recognise that the flow of IMG applications to the Medical Council, which now number some

four times those from domestic graduates, would seriously challenge any well-established and well-run process, as it strives to be responsive to the service and safety needs of the community. In the same way as the Medical Training Board has judged that it can no longer manage medical training with informally managed processes based on the goodwill of SMOs, so we may need to challenge the way in which we have established commitments for expert medical resources to be applied to assessments for accreditation.

There needs to be stronger support for the Medical Council in improving the way senior doctors through the medical colleges now contribute to processes to ensure all overseas-trained doctors have been properly assessed to meet required service standards. This may require regulatory reform and perhaps a different model of funding assessment processes.

Recommendation 10: The Medical Council of New Zealand and professional colleges adapt their processes to provide the necessary support, responsiveness and facilitation to IMGs seeking vocational registration. This will ensure the wider public interest of appropriate SMO deployment across the New Zealand health system is met.

If necessary, the Minister of Health may need to review the mandate of the Medical Council to enable this to be achieved.

6.3.3 Regional approach to senior medical officer recruitment

In sections 5.3.4 and 5.4, we discussed the need to improve recruitment processes and concluded that a more regionalised approach to local recruitment should be developed in the context of mandated regional workforce planning, development and management. In the SMO Commission's view such an approach would build on the existing local links (see section 5.4.1) while at the same time gaining the benefits, for both SMOs and DHBs, of a co-operative regional approach.

Such an approach may also minimise the current fragmentation and unnecessary duplication of processes, often including the use of agencies.

Recommendation 11: DHBs establish regionally co-ordinated recruitment functions that complement regional and national service planning, retaining the benefits of local strategies. This is a critical component of a national recruitment strategy.

6.4 Retention

We have noted that any loss of SMO capacity to the health system is of concern given the level of public investment in educating and training, the high demand for SMOs, the shortages and difficulties in filling some vacancies, and the high financial and training costs of replacements.

In chapter 5, we observed that SMOs' dissatisfaction with their work environment and conditions, as a factor influencing them to leave the New Zealand health system, was one of the most powerful and compelling themes SMOs raised during our consultation process. We have also discussed ways of addressing a variety of important issues relating to retention. In this section, we look at those issues within the framework of our terms of reference and make recommendations where appropriate.

The SMO Commission is of the view that increased remuneration will not in itself reduce concerns that affect the recruitment and retention of doctors in the New Zealand health service, whatever reasonable salary level is paid.

The way the health service is organised has been determined by many influences other than the implications for the recruitment, retention and remuneration of doctors. Notwithstanding this, our judgement is that there needs to be a very strong recognition of the significant detrimental influence of the health services organisational forms we have had since 1990. The extraordinary experiences faced by all health professionals once the now-displaced Crown Health Enterprise model was introduced were totally contrary to decades of managerial thinking. The recent clinical leadership debates may not fully encapsulate the extent to which managerial and professional relationships need more scrutiny, and this report should add impetus and a sense of immediacy to initiatives here. The careful advancement of managerial–professional partnerships, and the variety of roles that senior doctors play in them, needs an appropriate mutuality of accountability. Initiatives need to be developed health service–wide and remuneration strategies should reinforce these.

The relationship between SMOs and doctors in training is strongly based on an apprenticeship model of training, as advanced through some 30 medical colleges or faculties. The employment arrangements of doctors in training have, like those for senior doctors, increasingly defined the employment setting in which training takes place. The industrial agreements that both doctors in training and SMOs have with DHB employers have almost no reference to the mutual engagement they have in giving and receiving training. In recent years, a very large increase in doctors in training posts has resulted from a higher workload and changes in the conditions of employment of doctors in training. Now, a large minority of doctors in training are young, overseas university graduates who come to work in New Zealand for up to one year. Employment schedules now make it difficult for senior doctors to develop a working relationship with individual house surgeons, and the frequent handover of work has led to house surgeons being trained at a slower rate. In general, DHBs have given little attention to this, and it is a source of considerable frustration to senior doctors. Training receives no particular recognition in the accountability of DHBs although it is critical for the future of New Zealand's health services.

The quality of managerial–professional relationships has become a more significant element in industrial negotiations among all health professionals as a consequence of the introduction of the Crown Health Enterprise model, and its subsequent replacement by the Health Funding Authority, then the DHB model. We have seen this reinforced following each new industrial agreement. This approach will require extraordinarily focused leadership across the New Zealand health service, if it is to change.

6.4.1 Improving senior medical officer participation and influence

The SMO Commission is broadly in agreement with the findings and recommendations of the Ministerial Task Force on Clinical Leadership.⁵⁷ However, we do not think that the focus on clinical leadership encapsulates the full extent of professional tensions. The health services are complex managerially, involving large specialised investments as well as needing skills common to many other resource-intensive sectors focused on a large professional staff. The variety and depth of managerial skills needed to be fully effective are extensive and are best provided by strong partnerships between clinicians from the health professions and those trained in health services management, including some who are uniquely experienced to bring all these capabilities. High turnover in service managers was often identified as an issue by SMOs. Managers may have limited understanding of their

⁵⁷ Ministerial Task Group on Clinical Leadership, *In Good Hands: Transforming clinical governance in New Zealand*, Ministerial Task Group on Clinical Leadership, Wellington, 2009.

particular service and are often focused on short-run performance targets at the expense of broader strategic or service considerations.

Managers and clinicians clearly need to work as a team, and mutual respect and trust is an essential prerequisite. It was suggested to us that to re-build confidence in hospital leadership, clinical leaders and managers needed to be seen as 'joined at the hip'. More than once, SMOs spoke favourably of the benefits of joint training where they had developed closer relationships with their managers. This helped SMOs to realise that they did not want to be managers and to understand more constructive ways to the outcomes sought by the organisation. They reported that following this kind of training, they were more likely to seek one another out to discuss issues and possible solutions more openly. This mutuality of accountability needs to be recognised in the performance goals of the health service as a whole and in DHB expectations. It also needs to embrace other health professionals, particularly nurses. Many health services are delivered in organisations that are effectively working communities, with informal peer support and collegiality developed in myriads of intangible ways. How far this intangible value is recognised, may influence how some risks are reduced.

6.4.2 Space, tools and support

A general view SMOs expressed to the SMO Commission during the consultation process was that their material needs were largely overlooked or the significance of their requests were under-rated. This was said to be a major factor influencing their decisions to leave New Zealand. While budgetary constraints will limit the extent to which SMO needs can always be accommodated, it is clear that unreasonable constraint can be counterproductive and ultimately lead to higher costs to the system through adverse impacts on productivity. This situation varied across the DHB sector, but, to a significant extent, could be seen as a measure of the state of the relationship between SMOs and management in individual DHBs. A good many of the individual stories told to the SMO Commission suggested that there was a strong emphasis on reducing quite minor costs through convoluted and frustrating processes, without recognition that the consequent frustrations probably reduced effectiveness on a much larger scale. While we were surprised at the number of quite minor matters that were drawn to our attention, perhaps because no one else would listen, we learned of many issues that ought to have been well sorted long ago.

Recommendation 12: DHBs review current arrangements and take any necessary action to improve space, tools and support for SMOs, recognising the importance of these factors to SMO retention.

6.4.3 Medico-legal environment

Alongside the fragmentation of the health service, the focus on outputs places accountability for service failure with respect to individual patients on individual health professionals, particularly doctors, but also nurses and midwives, and dilutes the accountability for performance in managing input markets or ensuring the integrity of system-wide processes. Partly as a consequence of the Health and Disability Commissioner Act 1994, this much stronger focus on patient treatment failures overshadows accountability for the operation of systems that can be fundamental to the capacity of health professionals to function effectively.

An organisational culture should be established across New Zealand's health services that emphasises system accountability, and is supportive and works collaboratively to identify ways to manage the risks all clinical staff face when systems perform poorly. Moreover, if they are to be held accountable for clinical outcomes, clinical leadership needs to be

strengthened so they can influence the direction of the services they deliver and decisions on resources.

6.5 Sustainable pathway

6.5.1 Interpretation of 'sustainable pathway'

In recommending a recruitment and retention strategy that 'will provide a sustainable pathway to competitive terms and conditions of employment' for SMOs, as required by our terms of reference, it is necessary for us to interpret 'sustainable pathway'.

The ASMS, in its submission to the SMO Commission, urges us to adopt an interpretation in relation to terms and conditions of employment consistent with its 'reasonable' interpretation of 'sustainability', namely:

ensuring that sufficient resources, as determined by New Zealanders, are available to provide timely access to quality services that address New Zealanders' evolving health needs, and that those resources are efficiently managed.

Our view is that the term 'sustainable pathway' requires us to have regard to a range of matters. Sustainability of services is certainly one such matter and 'a sustainable pathway' is one that ensures terms and conditions of employment that are sufficiently competitive to ensure that SMO services are available. However, it also implies financial sustainability, and any pathway must also take account of fiscal limitations, most notably in the current economic climate.

New Zealand's spending on health is at about the level that would be expected of a country of its size and level of national income, compared with similar developed countries. During the last decade at least, increases in spending have been at more than twice the rate of national income growth, putting New Zealand among a small number of high-spending OECD countries, in comparison with its national income per head. New Zealand is, therefore, pushing the boundaries of fiscal sustainability.

Within the context of fiscal constraint, it is important to address whether New Zealand is getting the best value from the amounts it has available to spend (in particular, whether the system is too fragmented to capture scale or scope efficiencies and whether health professionals are allocated the correct roles and duties as opposed to functions being carried out by people who are at times over-qualified in relation to the task at hand).

On the other hand, along with most similar countries, our health system is facing workforce pressures as it responds to the challenges posed by an ageing population, the opportunities from increasingly sophisticated medical technology, a deterioration in the health status of the population seeking treatment (eg, for diabetes and obesity), and rising public expectations of service (eg, waiting times). It is facing those challenges from a current position of a worrying, but not yet crisis, level of medical specialist vacancies. The system, as currently configured, is struggling to maintain a level of staffing that delivers a sustainable level of service.

This inevitably raises the issue that the ASMS has referred to: the efficient management and use of existing resources. In turn, this raises the role that SMOs, and other health professionals, can play in helping to identify new and innovative ways of configuring and delivering services that can ensure there are productivity gains that can be diverted to

enhancing conditions of employment. We have referred to the recognised value in international literature of a more collaborative working relationship between clinicians and management. The ASMS and DHBs have taken steps in this direction with the establishment of the National Consultative Committee, which has as its objective improving ongoing engagement between the ASMS and DHBs on matters relating to SMOs, and the signing of the bipartite Time for Quality agreement. In addition DHBs, the Government and the Council of Trade Union–affiliated health sector unions have a collective commitment to work together to improve the quality of healthcare delivery as documented in the Health Sector Relationship Agreement. The Health Sector Relationship Agreement is a tripartite agreement that complements and runs in parallel to the Time for Quality agreement.

6.5.2 Developing a sustainable pathway

Having regard to our definition of ‘sustainable pathway’, the challenge is to identify a pathway or process that ensures a level of SMO staffing is maintained to deliver a sustainable level of service within the limits of fiscal sustainability.

In our view, a great deal can be achieved by developing the current processes, such as the Time for Quality. Several of these initiatives will be best established as tripartite and bipartite arrangements in which an ongoing dialogue, based on a good faith relationship and accurate and comprehensive data, can identify, on an ongoing basis, the steps along the pathway to competitive terms and conditions of employment. In doing so, it is reasonable to expect that, as the economy grows, amounts available to spend on health will also grow. It may also involve dialogue on the priorities and allocation of resources within the health system. Such an approach is consistent with, and was foreshadowed by, the Ministerial Task Force on Clinical Leadership.⁵⁸

Recommendation 13: DHBs, ASMS and Ministry of Health strengthen existing bipartite and tripartite processes to nurture an informed dialogue at all levels. This will contribute to a sustainable level of SMO staffing that is aligned to service needs.

6.6 Competitive terms and conditions of employment

We were surprised during our consultation process by the extent to which pay and conditions were not at the centre of SMO concerns as they were expressed to us. At most meetings with SMOs they spoke of their commitment as professionals to achieving excellence within the public health system. While acknowledging that good pay and conditions are important, the primary focus of their concern was frustration with an environment that does not appear to value and adequately support their key role. It was suggested by some that this underlying dissatisfaction with conditions of employment in the broadest sense had manifested itself in a situation where higher monetary rewards appeared to be the only means of retaining SMOs in an environment from which many have become increasingly detached.

The medical labour market is increasingly international, and for New Zealand doctors there are many unique factors that make it more so here. The first is the long-standing nature of New Zealand as both a migrant-receiving and -sending country. Throughout much of the last century, New Zealand doctors have succeeded in holding significant posts in medicine in Australia, Canada, the United Kingdom and the United States. Medical competence is

⁵⁸ Ministerial Task Group on Clinical Leadership, *In Good Hands: Transforming clinical governance in New Zealand*, Ministerial Task Group on Clinical Leadership, Wellington, 2009.

recognised in the same way as in Australia and in similar ways as in the other countries. The international linkages vary by speciality, and even now the different impact of scattered local efforts to respond to international salary differentials is at risk of bringing into New Zealand potentially large differences in remuneration, depending on the field of medicine. Such differences are in part obscured by the share of specialists in any field that work in the private sector, and the increase in the share of SMOs who work in the private sector as an alternative to emigrating in response to knowledge about international pay differentials.

Our terms of reference direct us, in addressing our core term of reference to recommend 'a national recruitment and retention strategy that will provide a sustainable pathway to competitive terms and conditions of employment', to take account of the terms and conditions of employment for SMOs in Australia and other countries. DHB managers and clinical leaders identified that the pay and conditions offered in other jurisdictions, and in Australia in particular, have reduced their ability to recruit in a competitive global market. In agreement with this position, the ASMS has argued for significant improvements to achieve parity with the pay and conditions offered in Australia.

Making comparisons is extremely difficult given the huge variability in a diverse range of salary and non-salary components, as well as differences in things such as the cost of living and tax rates. We have identified differences between the Australian states and (unknown) differences between jurisdictions – and even individuals – about what amounts are earned in private practice and what recruitment and retention payments are built into salary packages.

As reported in section 4.5.2, we undertook an economic analysis that took the above factors into account. Our heavily qualified conclusion is that there is roughly a difference of 30–35 percent between the remuneration of New Zealand SMOs and Australian SMOs.⁵⁹

This remuneration gap is also apparent in many other professions and occupations between the two markets. The gap largely reflects the different per capita incomes in the two countries (30 percent), rather than something particular to SMO comparisons, although there is roughly a 5 percent difference between per capita income differentials and SMO differentials. This suggests that there is a greater differential between SMOs and the rest of the population in Australia than there is in New Zealand.

Given the proximity of Australia within, effectively, the same labour market as New Zealand, the difference in SMO remuneration disparity is clearly a relevant factor for consideration. Whether closing the gap is likely to be a strategy that ensures competitive retention of SMOs in New Zealand is, on the evidence available, unclear. This is an issue that is properly addressed in a collective bargaining context. The SMO Commission is not a party to collective bargaining and is not affected by its outcomes, so it is important that it avoids making recommendations that might be interpreted as predetermining the results of proper processes. However, it does appear that in addition to the absolute gap in salaries between Australia and New Zealand (which reflect inter-country income differences and which cannot be closed immediately or seamlessly within sustainable fiscal boundaries), **Australian SMOs earn relatively more (approximately 5 percent) than do their New Zealand counterparts in comparison to their fellow citizens.** Intuitively, it seems that this may be a consequence of Australian states competing with each other for scarce skills, with New Zealand caught in the slipstream.

There is no 'bright line' figure that can be placed on this relative gap, because of all of the data inadequacies that exist about actual earnings in both countries. A primary requirement would be a full codification of existing terms and conditions to establish the extent to which individual specific recruitment allowances or other special payments have been built onto

⁵⁹ For detailed comparisons, see Appendix 8.

basic multi-employer collective agreement entitlements, the extent of private practice earnings, and variances between subspecialties. Without this core starting data, it is not possible to ascertain where, how and whether terms and conditions are competitive, let alone trace out a pathway to attain them.

We also note other tentative conclusions we have been able to reach on the limited evidence available to us.

- There is no data we have seen that shows large numbers of New Zealand SMOs relocating to Australia.
- Australia has limited capacity to absorb large numbers of New Zealand SMOs, especially given that it has greatly increased its internal production of SMOs.
- There are significant variations in the remuneration New Zealand consultants receive between different fields of medicine that are comparable to the variations seen in international comparisons. For this reason there is no basis for an exacting and continuing direct linkage between the remuneration of SMOs in New Zealand with Australia or elsewhere.
- SMOs have told us that frustration with their current work environment and conditions of employment is a much stronger determinant of decisions to leave New Zealand than the lure of better employment packages elsewhere.
- Closing the gap raises financial sustainability issues in the current economic climate, which will affect the gradient of the 'sustainable pathway' to competitive terms and conditions of employment.

With all of the caveats, it must be observed that the current average 10 percent vacancy rate for SMOs puts the system in a vulnerable situation and some adjustment of SMO remuneration is likely to be necessary to address this.

We do not consider it appropriate to make a specific recommendation on remuneration. The SMO Commission was not established as a remuneration authority and we interpret the terms of reference to require us to focus on strategy and processes rather than a point-in-time determination on current remuneration.

Strategic oversight of the medical workforce needs regular information about the turnover and retention rates of doctors, the differences between prevailing remuneration and industrial agreement obligations, exit interviews, attitudes and expectations, including regular 360 degree assessments. Core information requirements need to be identified. This information should be regularly summarised and made available.

Appendix 1: Terms of Reference and Members

Terms of reference

The Director General of Health has established a commission to recommend to the Minister of Health (through the Ministry of Health), district health boards and the Association of Salaried Medical Specialists, a national recruitment and retention strategy that will provide a sustainable pathway to competitive terms and conditions of employment for senior medical and dental officers (SMO).

This establishment of the Commission recognises New Zealand's potential vulnerability as a small, relatively geographically isolated country in:

- retaining current senior medical and dental officer employees,
- recruiting and retaining medical and dental officers trained in New Zealand, and
- recruiting and retaining international medical graduates.

In reaching its recommendations, the Commission will have regard to, but not necessarily be bound by, other national conversations and work programmes, including tripartite initiatives and the work of the Medical Training Board. In its deliberations the Commission will take into account:

- drivers of demand for the SMO workforce, including population health need and models of service delivery
- national and international supply of SMOs, including opportunities for employment, and the terms and conditions of employment for SMOs in Australia and other countries
- employment opportunities available for SMOs in both the private and public health sectors
- margins between specialist salary scales and the relative remuneration resident house officers (in particular senior registrars) and SMOs
- changes and trends in factors that affect the supply of SMOs to the New Zealand public health system
- the Government's priorities and health targets
- any other factors it considers relevant.

The Commission's recommendations will be forwarded to the Minister of Health, district health boards and the Association of Salaried Medical Specialists by 31 March 2009.

Membership

Members of the SMO Commission were:

- Len Cook (chair) – former government statistician and current chair of the Medical Training Board
- Dr Dwayne Crombie – former chief executive of Waitemata DHB and current CEO of Guardian Health Care
- Ross Wilson – former chair of the Accident Compensation Corporation and former president of the New Zealand Council of Trade Unions

Appendix 2: Glossary

Words and abbreviations in *italics* are defined elsewhere in the Glossary.

advanced trainee – a registrar who has passed their Part One examinations and is in the final stage of their training.

apprenticeship model – the traditional model for training *RMOs* whereby they work under the supervision and guidance of *SMOs* to increase their knowledge and acquire the experience necessary to work independently to a satisfactory standard.

ASMS – Association of Salaried Medical Specialists – the union representing *SMOs* and *MOs*.

consultant – a senior specialist.

District Health Boards New Zealand – the organisation that has a co-ordinating function of behalf of the 21 independent district health boards.

doctor in training – often referred to as a junior doctor or *RMO*.

general scope of practice – a doctor who has completed the requirements of a provisional general scope will be registered within a general scope of practice. Examples are *RMOs* who have completed their first postgraduate year and may be in vocational training, doctors who have not started, or have chosen not to do, vocational training, or doctors nearing retirement who are no longer meeting the requirements for registration within a vocational scope of practice. The doctor must establish a professional collegial relationship with another doctor who is registered within the same or related vocational scope, and must participate in appropriate continuing professional development to maintain and improve competence and to be recertified each year.

generalist – a specialist who maintains skills that enable them to work across a broad range of areas of medicine.

house officer – a doctor in training who is a recent medical school graduate. Also referred to as a house surgeon. A senior house officer is usually in their third year since graduating from medical school.

house surgeon – also referred to as a *house officer*.

IMG – international medical graduate – anyone who has completed their bachelor of medicine degree or equivalent university qualification in a country other than New Zealand, irrespective of their nationality (ie, will include some New Zealanders).

junior doctor – the term commonly used to describe collectively all doctors working in hospitals who are not *SMOs*. The term junior doctor is synonymous with resident medical officer. See also **RMO**.

medical student – someone undertaking a course of university study in medicine.

MO – medical officer – includes senior doctors who have commenced but suspended or terminated their vocational training, so are not vocationally qualified. *MOs* are regarded as senior doctors and paid on a special scale that reflects their experience and wider scope of practice. Also includes some *IMGs* who have been unable to obtain registration to work as a specialist in New Zealand. Were previously known as *MOSS's* and the term is still used in some places.

MOSS – medical officer special scale – now referred to as an *MO*.

multi-employer collective agreement – the employment agreement negotiated every three years between the *ASMS* and district health boards.

PGY1 – postgraduate year 1 – the number of years since completion of the six-year New Zealand bachelor of medicine degree.

provisional general scope of practice – all new registrants, regardless of seniority, must work under supervision for at least their first 12 months in New Zealand to become familiar with the culture. During this time they are registered within a provisional general scope of practice and their performance is assessed by senior colleagues. They are required to complete certain requirements to be registered within a general scope. The only exception to this supervised period is for New Zealand and Australian graduates who have completed their internship in Australia.

provisional vocational scope of practice – doctors who have completed their vocational training and who are not already registered in New Zealand must work under supervision for at least 12 months. They are registered within a provisional vocational scope of practice. During this time, they must complete Medical Council of New Zealand's requirements for registration in a vocational scope. Those requirements may include working in a formal assessment position and/or passing an examination.

RMO – resident medical officer – collectively all doctors working in hospitals who are not SMOs. Also referred to as a *junior doctor*.

registrar – an RMO who has started a vocational training programme to become an SMO.

SMO – a senior medical or dental officer who has completed a vocational training programme and is registered to practice within a particular vocational scope of practice.

special purpose scope of practice – a doctor who satisfies the registration criteria to visit New Zealand for one of the following defined and specific reasons will be registered within a special purpose scope of practice:

- a visiting expert
- as a sponsored trainee
- for postgraduate training and/or experience
- as a medical researcher
- a locum specialist working in New Zealand for less than six months
- to help in an emergency or for any other reason approved by the Medical Council of New Zealand.

These doctors must work under supervision for the duration of their employment or appointment. This 'special purpose' scope of practice is not a pathway to permanent registration.

specialist – another term for an SMO.

temporary registration – gained by a doctor who is working in New Zealand for up to three years. This applies mainly to doctors who trained in the United Kingdom, the Republic of Ireland, Canada, the United States or South Africa.

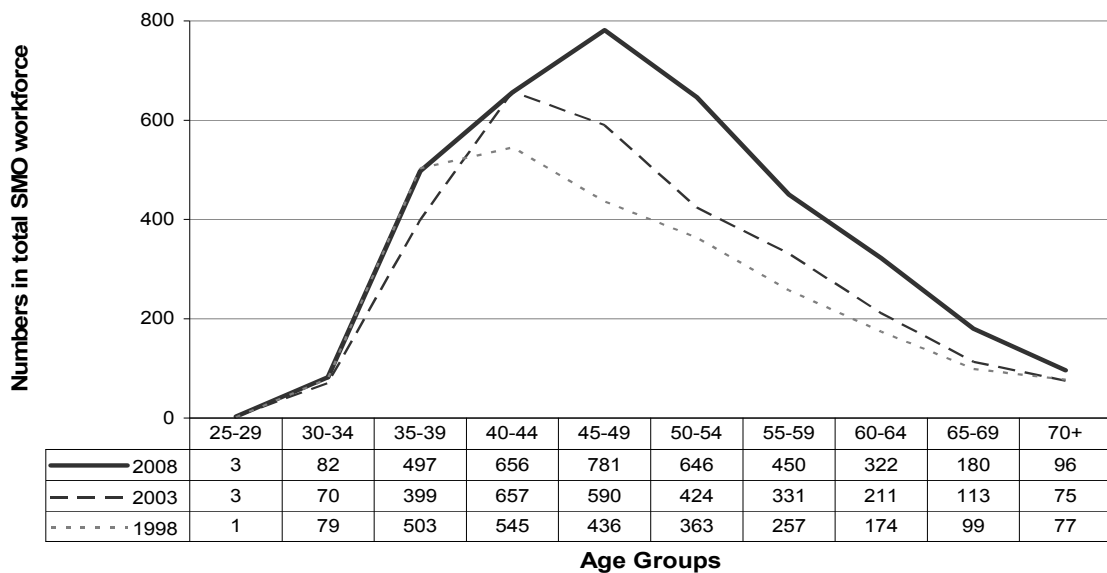
vocational scope of practice – a doctor who has completed their vocational training as a consultant and has appropriate qualifications and experience can be registered within a vocational scope of practice. These vocational scopes are recognised by the Medical Council of New Zealand. A doctor registered in a vocational scope must participate in an approved continuing professional development programme to maintain competence and be recertified each year.

Appendix 3: SMO Workforce Data

Age distribution of the SMO workforce

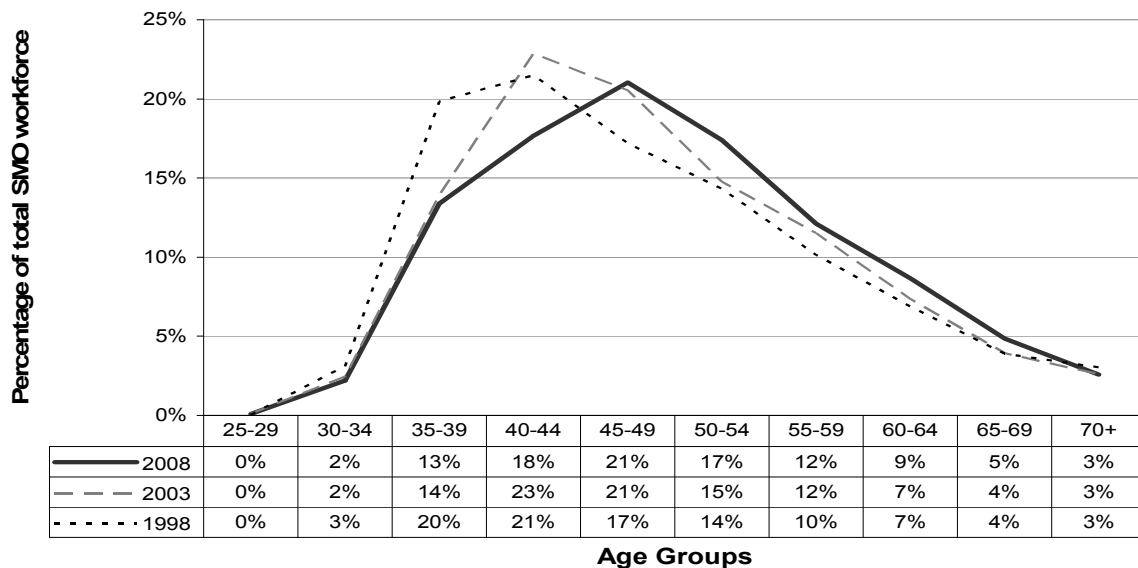
Figure 5 and Figure 6 below show that the proportion of the overall SMO workforce, including IMGs and SMOs working for any health sector employer that is older is increasing.

Figure 5: Age distribution of the total SMO Workforce, 1998–2008



Source: Medical Council of New Zealand

Figure 6: Age distribution as a proportion of the SMO Workforce, 1998–2008



Source: Medical Council of New Zealand

The proportion of younger SMOs is decreasing, while the proportion of older SMOs is increasing slightly. From about 50 years of age on there is as steep tapering off in workforce participation.

Women in the SMO workforce

Ten specialties account for eighty-four percent of the female SMO workforce.

Table 14: SMO and MO workforce by gender and specialty, 2008

Specialty	Male	Female	Total	Percentage of all female SMOs
Psychological medicine & psychiatry	292	210	502	18
Internal medicine	522	167	689	14
Anaesthesia	380	135	515	12
Paediatrics	137	92	229	8
Diagnostic and interventional radiology	192	82	274	7
Obstetrics & gynaecology	119	82	201	7
Public health medicine & mgmt	77	65	142	6
Emergency medicine	129	61	190	5
Pathology	114	55	169	5
Palliative medicine	15	31	46	3
Total	–	–	–	84

Source: Medical Council of New Zealand

Women comprise more than half of the SMO workforce in only four specialties (including MOs).

Table 15: Female SMO and MO workforce where more than 50 percent of specialty workforce

Specialty	Male	Female	Total	% Female
Breast medicine	0	7	7	100
Sexual health medicine	3	24	27	89
Family planning	2	8	10	80
Palliative medicine	15	31	46	67

Source: Medical Council of New Zealand

Women tend to be under-represented in the so-called procedural specialties.

Hours worked

SMOs primarily employed in public hospitals worked and average of 47.6 hours a week including on-call hours that were actually worked. There was a wide distribution of hours though as shown in Table 16 below, with some SMOs claiming to work 90 hours in a typical week.

Table 16: Average hours worked per week by SMOs and MOs for the year to 31 March 2008⁶⁰

Average hours worked per week	SMOs		MOs	
	Number	Percent	Number	Percent
4-9	11	0.4	6	1.8
10-19	27	1.0	13	3.8
20-29	135	5.1	35	10.3
30-39	203	7.7	47	13.9
40-49	941	35.8	166	49.0
50-59	910	34.7	48	14.2
60-69	323	12.3	17	5.0
70-79	57	2.2	4	1.2
80-99	16	0.6	2	0.6
90+	3	0.1	1	0.3
Total	2626	100.00	339	100.0

Source: Medical Council of New Zealand

Based on this data, the majority of SMOs (70 percent) work 40–59 hours a week, with similar proportions working less than 40 hours a week (14 percent) and 60 hours or more (15 percent).

On the same basis MOs worked an average of 40.5 hours a week. While the majority of MOs (63 percent) work 40–59 hours a week, a relatively large proportion (30 percent) work less than 40 hours a week with few (7.1 percent) working 60 hours or more. This may reflect what we have heard regarding MOs suspending or stopping their training because of their need for greater work life balance.

Almost 60 percent of SMOs primarily employed in a public hospital do some rostered on-call as shown in Table 17 below. Of these, roughly a third do 10–19 hours and week, and a further third do 20 to 50 hours a week. MOs are less likely to be rostered on-call, with only 20 percent doing on-call.

⁶⁰ This excludes SMOs listing a different employment type as their primary employment, but working some of the time in a public hospital, so is only a partial picture.

Table 17: Average on-call hours per week SMOs and MOs for the year to 31 March 2008⁶¹

Average on-call hours per week	SMOs		MOs	
	Number	Percent	Number	Percent
0	1052	40.1	268	79.1
1-4	113	4.3	5	1.5
5-9	272	10.4	7	2.1
10-19	548	20.9	23	6.8
20-49	527	20.1	32	9.4
50 and over	114	4.3	4	1.2
Total	2626	100.0	339	100.0

Source: Medical Council of New Zealand

SMOs in some specialities tend to work longer hours than others as shown in Table 18 below, which is organised from highest average hours to lowest. Again there is a wide distribution of hours. Neurosurgeons, for example, report that typically work between 40 to 90 hours a week.

⁶¹ In the APC survey on-call hours are defined as on-call but not actually worked. On-call hours that entail actual work (eg a call-out) are reported as hours worked.

Table 18: Typical hours worked per week by DHB employed SMOs by specialty

Specialty	Average hours worked
Surgery: neurosurgery	62
Surgery: cardiothoracic	62
Surgery: vascular	59
Surgery: paediatric	57
Intensive care medicine	55
Surgery: general	54
Surgery: orthopaedic	53
Surgery: plastic	53
Surgery: other	52
Radiation oncology	52
Surgery: urology	52
Internal medicine	49
Rehabilitation medicine	48
Obstetrics & gynaecology	48
Anaesthesia	48
Surgery: otolaryngology	48
Occupational medicine	48
Paediatrics	47
Ophthalmology	46
Medical Administration	45
Emergency medicine	45
Diagnostic and interventional radiology	45
Dermatology	44
Pathology	44
Palliative medicine	42
Psychological medicine & psychiatry	42
Musculo-skeletal medicine	41
Sports Medicine	40
Public health medicine & mgmt	40
Breast medicine	38
Clinical genetics	37
Sexual health medicine	34
Accident and medical practice	31
Basic medical science	30
Not recorded	47
Other	30
Grand Total	48

Source: Medical Council of New Zealand

We would have liked to do further analysis of part-time work patterns but information for this analysis was not available.

Appendix 4: MO Workforce Data

Relationship between the MO and SMO workforces

Medical officers (MOs) are senior doctors who have undertaken registrar training but are not vocationally qualified. MOs may have completed their Part One, but not their Part Two examinations, and have discontinued their vocational training either temporarily (eg, to meet family commitments) or permanently. They are regarded as senior doctors and paid on a special scale that reflects their experience and a wider scope of practice. They also come under the SMO multi-employer collective agreement.

As can be seen from Table 19 below, the medical officer workforce has grown in parallel to the SMO workforce, comprising approximately ten percent of the combined MO/SMO workforce.

Table 19: Number and proportion of MOs to SMOs, 1998–2008

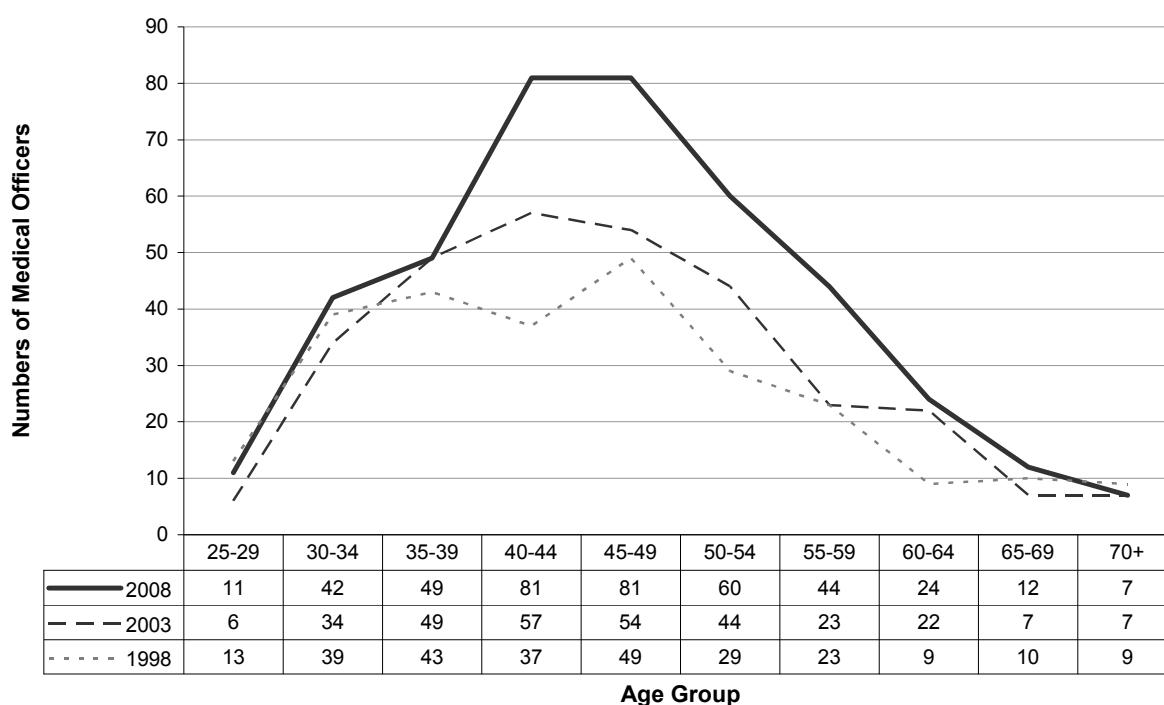
Numbers	1998	2003	2008
Medical officers	261	303	411
Specialists	2536	2873	3713
Total	2797	3176	4124

Percentages	1998	2003	2008
Medical officers	9	10	10
Specialists	91	90	90
Total	100	100	100

Source: Medical Council of New Zealand

Growth in the MO workforce is most evident in the middle to older age groups, reflecting the significant contribution made by IMGs, as shown in Figure 7 below. These IMGs are likely to have been working in a vocational scope of practice before coming to New Zealand, but be unable to obtain registration to practice within a vocational scope of practice without supervision and/or further training/retraining.

Figure 7: Age distribution of the MO workforce, 1998–2008



Source: Medical Council of New Zealand

IMGs are more strongly represented among MOs than SMOs whose main employment is in a public hospital, as shown in Table 20 below.

Table 20: Proportion of IMGs among SMOs and MOs for the year to 31 March 2008

Graduate	SMOs		MOs	
	Number	Percent	Number	Percent
New Zealand	1485	57	132	39
IMG	1141	43	207	61
Total	2626	100	339	100

Source: Medical Council of New Zealand

There is considerable variation in the proportion of IMGs in the SMO and MO workforces from one DHB to another, as shown in Table 21 below, which is organised by the proportion of IMG SMOs in descending order.

Table 21: DHB use of IMG SMOs and MOs by DHB for the year to 31 March 2008

SMOs by DHB	MOs			SMOs		
	Number IMGs	Percent IMGs	Total MOs	Number IMGs	Percent IMGs	Total SMOs
Tairāwhiti	5	71	7	26	90	29
Whanganui	5	83	6	27	79	34
Wairarapa	4	57	7	15	75	20
Northland	11	65	17	47	66	71
Taranaki	10	71	14	31	63	49
South Canterbury	3	60	5	15	60	25
Southland	8	44	18	30	59	51
West Coast	2	33	6	7	58	12
Bay of Plenty	18	78	23	53	58	92
Lakes	8	89	9	28	57	49
MidCentral	11	69	16	48	51	94
Waikato	20	80	25	119	51	235
Waitemata	21	51	41	103	48	213
Otago	6	50	12	54	41	133
Hutt Valley	7	88	8	29	40	73
Hawke's Bay	6	55	11	26	39	67
Counties-Manukau	14	78	18	90	39	232
Capital & Coast	3	38	8	77	35	217
Auckland	17	50	34	189	35	533
Canterbury	19	56	34	106	33	321
Nelson Marlborough	9	45	20	21	28	76
Total	207	61	339	1141	43	2626

Source: Medical Council of New Zealand

While not dramatic at an average of 21.5 SMOs in the first year and 6.5 SMOs in subsequent years, the trickle-loss of IMG SMOs from the system over time should be examined further to explore whether measures could be taken to enhance IMG SMO retention.

Appendix 5: RMO Workforce Retention Data

RMO retention

Table 22 shows the retention rates of registered New Zealand graduates for each year from 1995–2007, and the percentage who continue to be registered¹ as proportion of the previous year. Retention patterns appear to be stable over time, which is to say that based on the available data there is no statistical evidence of a worsening trend.

Retention is poorest in PGY3 where there is a loss of 10–20 percent over the previous year. There is an overall loss of 25 percent of New Zealand graduates by PGY4. Numbers are stable during PGY4, PGY5 and PGY6, when many RMOs have become registrars and commenced a programme of vocational training to become a qualified SMO.

Table 22: Retention of New Zealand graduate doctors, 1995–2007²

Cohort (class size) ³	Percentage registered as a proportion of previous year ⁴								
	PGY1	PGY2	PGY3	PGY4	PGY5	PGY6	PGY7	PGY8	PGY9
1995 (275)	258	96	88	88	103	105	93	97	96
1996 (275)	264	97	91	89	103	98	99	97	92
1997 (284)	266	97	89	85	93	106	100	97	97
1998 (288)	251	96	83	86	112	100	95	96	94
1999 (305)	270	99	80	95	103	100	94	97	96
2000 (323)	286	94	87	90	104	101	101	96	
2001 (297)	271	95	83	99	104	99	98		
2002 (308)	285	94	86	94	104	104			
2003 (329)	302	94	86	99	98				
2004 (342)	284	101	86	98					
2005 (318)	297	100	84						
2006 (322)	287	99							
Average numbers	277	268	228	209	210	210	200	192	178
Average percent (%)	–	97	85	91	100	100	95	96	92
Cumulative percent (%)	–	97	82	75	76	76	72	69	64

¹Source: Medical Council of New Zealand

Following this period of stability there is a continued trickle of New Zealand trained SMOs from the system, as illustrated in Figure 8 below. By the end of PGY9 more than a third of New Zealand trained doctors have left the system.

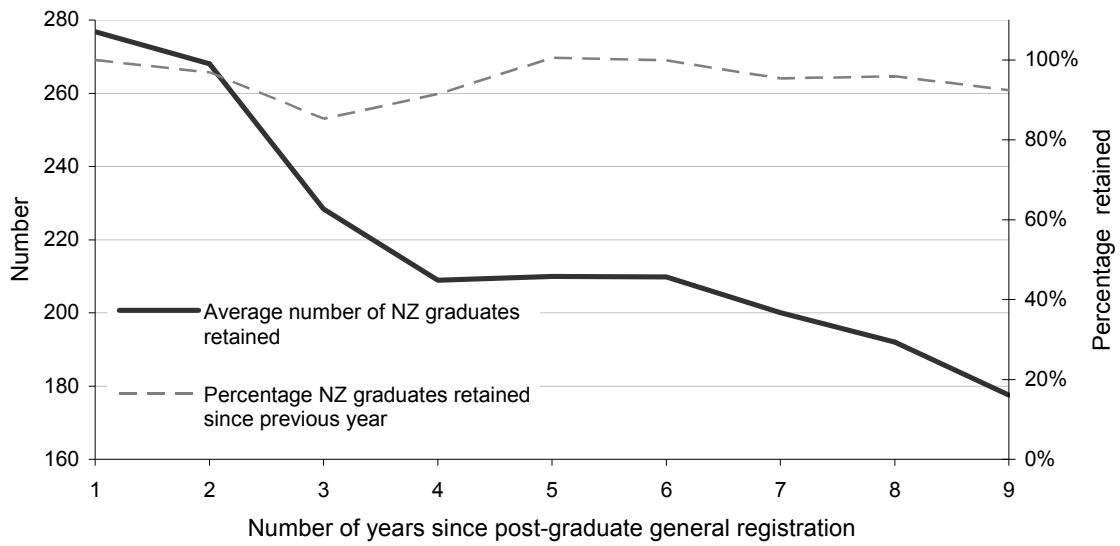
¹ Almost all will have attained general registration the following year, and a small minority will have attained vocational registration among the first two or three cohorts. The point is that they continue to work in the New Zealand health system.

² Data for year 2 of the 2006 cohort relates to 2007.

³ “Size of class” is taken from a list of those in final class years as given by medical schools. Not all will necessarily be eligible to graduate.

⁴ Data is available for out-years and is stable at between

Figure 8: Retention of New Zealand graduate doctors, 1995–2007



Source: Medical Council of New Zealand

Appendix 6: SMO Workforce Shortages

There are several approaches to determining “shortages” of SMOs.

- Shortages can be derived by comparing vacancies with established levels of FTE positions within DHBs (a “current vacancy” measure).
- Vacancy rates can be “benchmarked” by comparing existing numbers of active medical specialists with what would be required to meet specialist-to-population ratios as recommended by various international advisory sources (an “optimised vacancy” measure).
- Future demands can be extrapolated by projecting needs for service in relation to expected changes in the size and composition (especially the age structure) of the population, and the health needs of the future demographic structure (a “demand driven” projection).
- Estimates can be made about future supply of specialists flowing from an increase in the throughput of medical schools, changes to the ability of international graduates to qualify to practice in New Zealand, and changes to the way that medical services are configured (a “supply side” response).

Clearly, all approaches have a degree of relevance and validity and they interact. Current vacancies were discussed in the body of the report. The remaining three measures are discussed here.

Benchmarking

Assessing need against some benchmark specialist-to-population ratio (and comparing that with numbers of active doctors to determine the vacancy rate) has the advantage of aggregating demand and supply across the country, so that vacancy rates are not distorted by difficulties in maintaining sufficient volumes of treatments to sustain special services in a financially viable way.

The difficulty arises in determining whether recommended ratios are over generous by building in some safety margin, (they tend to be generated by provider organisations) and whether ratios developed for higher income jurisdictions are affordable in lower income societies.

An application of the benchmarking method to determine vacancy rates by ASMS more than doubled the vacancy rate as measured against existing established positions (to 802 or 19 percent of the (higher) optimum establishment level).

Demand derived projections

The study done by the NZIER used projections of demand to derive estimated future staffing needs. The basic logic of the study was that older age groups are heavier users of health services (the average cost of health treatments for different age cohorts starts to rise exponentially from age 65) and that the population is ageing. The study concludes that population ageing will increase the demand for health and disability labour by between 2.5 and 4.3 times between 2001 and 2021, with (depending on which projection is used) an excess of labour demand over supply of between 28 and 42 percent by that date. (This “demand derived” vacancy rate is not disaggregated by occupation type.)

A fundamental element of the projection is the assumption that any clinical or technological advances that might otherwise be used to increase labour productivity will instead be used to intensify care or increase its quality. Hence demand for labour grows directly in line with projected service needs, which grow in line with demographic changes.

There is a very small increase in labour supply built into these projections. Again, this is derived from the assumptions used: in this case that health and disability services will (only) maintain their share of the total New Zealand working age population. This assumption gives supply growth projections of only 12 percent in two of the scenarios, and 27 percent in the other, over that twenty year period. [It is worth noting that as the proportion over 65s rises, the proportion under 65 falls, and if the health workforce is a constant fraction of that, by virtue of assumptions used demand must outstrip supply and open up a skills gap!]

While demographic change is largely predictable, trends in productivity, the impacts of improved technologies and growth of supply of skills are less so, so small changes in the dynamics on the supply side will have large impacts on the “gap” between demand and supply, especially over an extended period like twenty years.

Supply side responses

Supply side responses can involve a number of variables, so it is very difficult to project them in any reasonably predictable way. These include increasing the throughput of medical schools, retaining a higher percentage of graduates, recruiting more international medical graduates, retaining a higher percentage of those IMGs, altering the regulatory barriers to registration and residence, and changing the configuration of service delivery to concentrate some services in a smaller number of geographical centres. These changes can be additive, or can negate gains made in some areas.

Existing levels of retention (say of medical graduates or IMGs) are relatively stable, so changing inflows can have reasonably predictable consequences within a largely known time frame. That time frame, however, is somewhat elongated (depending on type of change), and input changes can take ten to twelve years to feed through into changes in the number of SMOs in the system.

Australian data can give insights into orders of magnitude of potential adjustment. As recently as 1996, Australian health authorities were estimating an oversupply of doctors, and places at medical schools were capped. However, changes in demand, but significantly a reduction in average hours worked (to some degree associated with a rapid feminisation of the workforce) absorbed the apparent surplus and by 2004 the Australian government formally committed to a goal of self sufficiency in medical workforce supply.

Australian trained doctors working abroad are only 2.4 percent of the total number of doctors working in Australia, so retention and repatriation have limited potential to boost supply. The immediate response was to increase the number of medical school places, from 1,586 in 2007 to 2,945 in 2012 – an 86 percent increase in only five years. That will flow through to an increase in the numbers of specialists in training. That increased from 5,474 in 2002 to 7,632 by 2006, and (provided the logistics of creating training places are addressed), will increase further as the output of the medical schools expands.

The supply responses of other countries are connected to the likely level of shortage experienced in New Zealand. As self sufficiency initiatives (which are also being undertaken in the UK) increase supply, they reduce opportunities for New Zealand graduates (and those from other countries) to obtain positions, and the net supply of work seekers globally will impact at the margin on all IMG user countries.

In the meantime, IMG supply is needed to cover shortages. IMGs make up 13.4 percent of doctors actively working in Australia, so that creates a potential buffer supply. Streamlining provisions for registration and introducing a temporary entry visa for up to four years are seen as mechanisms to assist a supply increase.

New Zealand has the potential to increase supply on all fronts (returning graduates, new graduates and IMGs).

Appendix 7: 'SMO Roles as Teachers and Researchers

The following is a paper prepared by the RMO & SMO Commission secretariat as background to our deliberations.

Purpose

This paper provides you with information about:

- SMOs providing training roles in the clinical setting
- the academic medical workforce.

The key issues identified in this paper are:

- the difficulties in balancing teaching (and research) with clinical service provision
- the lack of funding to support research.

Background

*Doctors are clinical scientists applying the principles and procedures of medicine to prevent, diagnose, care for and treat patients with illness, disease and injury and to maintain physical and mental health. They supervise the implementation of care and treatment plans by others in the health care team and conduct medical education and research.*⁵

The concept of doctors as teachers and scientists is common to most definitions of the role of a doctor. Senior Medical Officers (SMOs') roles as teachers and researchers sits within, and is influenced by, a complex environment where responsibility for medical education and research is spread across government, universities, specialist colleges, professional associations, accreditation agencies and district health boards. While there are generally sound reasons for the delineation of responsibility across organisations, it has also created a degree of fragmentation leaving SMOs to manage frequently competing service and teaching demands and a challenging research environment.

The clinical teaching role

Describing the teaching role

The SMO multi employer collective agreement (MECA) provides guidance on the content of job descriptions for senior doctors including 'non-clinical and other professional activities' which, "should make up at least 30 percent of the total job size".⁶ Included in the MECA 'list of non clinical activities are:

- research
- teaching, including preparation time
- supervision and oversight of others.⁷

⁵ International Labour Organisation

⁶ New Zealand District Health Boards, Senior Medical and Dental Officers Collective Agreement, 1 July 2007 Until 30 April 2010, section 48.1.

⁷ Ibid, section 48(1) (d).

Actual SMO job descriptions tend to vary across district health boards (DHBs) and generally do not specify the amount of time that should be allocated to providing training overall, nor do they contain detailed descriptions of teaching and/or supervisory responsibilities. That said some, particularly where this includes taking on an additional role such as intern supervisor, do make time provision for these duties, though this may not necessarily reflect the amount of time taken on this work.

By contrast, the resident medical officer (RMO) MECA specifies the expected amount of weekly teaching time for doctors in training in each DHB.

Appendix One provides you with an example of the array of teaching and supervision roles that may be undertaken by SMOs.

The apprentice model

New Zealand post graduate medical training is based on the apprenticeship model of learning. The apprenticeship model is based on the trainee practitioner observing, practising and gradually acquiring “the competencies of the senior practitioner through graded supervision and experience. The senior practitioner delegates increasing responsibility and independence to the apprentice, according to the individual’s progress and abilities’.”⁸ While there are many benefits, implicit in the apprenticeship model is a significant time investment by SMOs to provide doctors in training with quality training and learning experiences.

The apprenticeship model relies “on senior clinicians to supervise the day-to-day practice ... and ensure quality health care... However, the changing health care environment is putting the apprenticeship model under threat.”⁹ There is now a significant difference between the senior clinicians’ own experiences as a trainee and the experiences of current trainees, in particular in relation to the industrial environment, changing workforce expectations and makeup of clinical service demands.

Challenges to providing teaching

Several factors impact adversely on the availability of senior doctors to teach junior doctors, including:

- an increasing clinical workload which reduces the time available to teach;
- changes to RMO working hours which reduce contact (and therefore teaching opportunities) between SMOs and RMOs; and
- increasing numbers of medical students, interns and registrars and the associated additional teaching and training workload;¹⁰
- lack of clearly defined teaching responsibilities and duties in their employment contract.

Time for training

Feedback from the consultation meetings with SMOs (and RMOs) indicates that a strong commitment to education and training by a DHB can be a significant pull factor for medical recruitment and retention. In practice, however, SMOs often carry heavy clinical and non

⁸ Doctors in Training Workforce Roundtable, *Training the Medical Workforce 2006 and Beyond*, Ministry of Health, New Zealand, 2006, p.12.

⁹ Paltridge, Deborah, Prevocational Medical Training in Australia: Where does it need to go?, *Medical Journal of Australia*, Vol 184, No.7, 3 April 2006, p.349.

¹⁰ Garling, Peter SC, *Final Report of the Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals*, Vol. 1, New South Wales Government, 27 November 2008, p.335

clinical workloads associated with meeting hospital's service requirements. SMOs are generally not allocated dedicated time for teaching, supervising and mentoring junior clinical staff. This is borne out by the *Clinical Training Agency: Summary of Responses to 2006 Training Programme Questionnaire* which found that the most common issue for supervisors was having insufficient time to provide clinical supervision. Both doctors in training and supervisors found that their workloads limited their ability to effectively participate in the training.

The growing training workload

Child et al¹¹ explored the impact of the 1985 M10 determination in reducing RMO working hours and the subsequent increase in the number of RMOs required to meet service needs. As a result of the changes, "junior doctors had come to constitute 24% of the medical workforce, when the optimum for a balanced staff mix was considered to be 8-12%.... The SMO/RMO ratio has become inverted. Whilst the Medical Council and the Clinical Training Agency place increasing emphasis on the responsibility of SMOs for the supervision and training of junior staff, there are proportionally fewer of them to undertake these tasks."¹² In addition, SMOs have experienced "an 'upward shift' of workload ... as continuity of care becomes increasingly provided at the consultant level."¹³

The Medical Training Board has recommended the number of medical student placements in New Zealand increase by 100. The Minister of Health has signaled the number increase by 200. As medical student graduate and the number of doctors in training increases, the demand on SMOs to provide supervision and training will grow, as will the need to protect time for this purpose.

The Review of Victorian Public Medical Health Staff¹⁴ found that there was "considerable concern among senior medical staff regarding the availability of resources ...for the additional teaching load that increased undergraduate (and postgraduate) students will create."¹⁵ It seems likely that similar concerns will arise in New Zealand as a result of increasing numbers of doctors in training. While non-clinical time provisions may offset these additional requirements to some degree (assuming this time is protected and available), it may result in demands for increases in the amount of non clinical time or additional payment for post graduate teaching responsibilities. For DHBs, increased training demands will likely impact on productivity both as a result of potentially reduced clinical hours (relative to non-clinical hours) to meet the additional teaching demands, and due to slower service provision as a result of the additional required to teach while providing clinical care, for example teaching while on ward rounds.

Support for SMOs undertaking a training role

"Senior medical staff need to be recognised for their roles as supervisors and educators."¹⁶ Moreover, government and health service providers need to recognise that quality education and supervision take time, and the allocation of appropriate funding.¹⁷

¹¹ Canterbury District Health Board RMO Advisory Committee, and Stephen Child, Time to Revisit Ashburton? Junior hospital doctor employment in New Zealand 1985-2002, *NZMJ*, 22 November 2002, Vol 115, No. 1166.

¹² Ibid

¹³ Ibid.

¹⁴ Morey, Dr Sue, Prof. Bruce Barraclough, Allan Hughes, *Ministerial Review of Victorian Public Health Medical Staff*, Report of the Review Panel, 30 November 2007.

¹⁵ Ibid, p.88.

¹⁶ Paltridge, Deborah, *Prevocational Medical Training in Australia: where does it need to go?*, *Medical Journal of Australia*, Vol 184, No.7, 3 April 2006, p349.

Training the trainers

Peter Garling argues that training delivered by SMOs can be ad hoc and unstructured. “Without interested and engaged consultants who are interested in teaching and who have had training in how to deliver training, the registrars’ experience is not optimal, nor can it be expected to be.”¹⁸ “By and large, fellows of the colleges train junior medical officers, including registrars, according to their own somewhat idiosyncratic personal standards.”¹⁹

Good clinical teaching and supervision is central to building a competent medical workforce. SMOs have usually not been trained in how to teach, but are expected to carry out these tasks. Historically, there has been little support provided for teaching, but increasingly universities and medical colleges are designing programmes to enhance SMO teaching activities. The College of Physicians has a programme and the Otago University, Wellington Clinical School, for example, is also setting up a programme to support doctors as teachers.

Colleges also run supervision workshops, and DHBs generally run ‘train the trainer’ workshops.

Payment for training

In New Zealand, clinical training is viewed as part of the SMO role in the public sector. Payment is through SMO salaries which recognise that a portion of their ‘time will be spent on training.

Though payment for clinical training did not emerge as a high profile issue through the SMO Commission consultation process, it is pertinent in as far as it has arisen in other documents, for example, the Medical Training Board’s, The Curriculum Framework, and also appears to arise regularly in the Australian literature. In 2005, the Australian Productivity Commission Report on the health workforce²⁰ argued that the lack of payment for clinical training services “makes such training vulnerable to competing service delivery needs.” It’s view was that “greater use of explicit payment to those providing infrastructure support for clinical training and for the training services themselves, is likely to be necessary if the system is to remain sustainable over the longer term.... Explicitly funding could also be particularly helpful in encouraging the private sector to take on a larger clinical training role.”²¹

The 2008 Garling Report also noted calls for payment for trainers, but shied away from recommending explicit payments, instead arguing for a uniform approach to recognising and remunerating all teaching and mentoring roles, and focusing on protected time for training and formal teaching duties as part of SMO terms of employment.²²

¹⁷ Australian Productivity Commission, *Australia’s Health Workforce*, Productivity Commission Report, December 2005, p351.

¹⁸ Garling, Peter SC, Final Report of the Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals, Vol. 1, New South Wales Government, 27 November 2008, p.333.

¹⁹ Ibid.

²⁰ Australian Productivity Commission, *Australia’s Health Workforce*, Productivity Commission Report, December 2005, p.98.

²¹ Ibid, p.101

²² Garling, Peter SC, Final Report of the Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals, Vol. 1, New South Wales Government, 27 November 2008, p.338.

To date however, the shared New Zealand and Australian Medical colleges have expressed little enthusiasm for greater reliance on explicit payment models within colleges. The Victorian Government also noted their concern that an explicit payment model could lead to higher charges for doctors in training.²³

Any move toward instituting a system of payment for training will require careful thought and the development of a methodology to cost teaching and training activities. A 1996 KPMG study commissioned by the Australian Commonwealth government suggested that about “one quarter of all clinical activity undertaken in public hospitals was of a ‘multiple product nature’, involving clinical care undertaken in conjunction with teaching, training and research, and that ‘attempts to disaggregate multiple product activities into proportions of time spent on teaching, research and clinical care is not feasible and should not be undertaken.’”²⁴

Alternative approaches to teaching and mentoring roles

SMOs will always play a critical role in the training and supervision of trainee doctors. There are, however, opportunities to share some of the teaching workload. Options that may be considered include:

- a more multi-disciplinary approach to training roles with, for example, nurse specialists providing teaching in their specialist area
- increasing the role of advanced trainees in providing training – this also has the benefit of preparing them for their future role as SMOs
- devolving examination processes to expert nurses
- encouraging retiring or recently retired doctors to take up teaching and mentoring roles
- developing a career stream (particularly towards the end of an SMO’s career) focusing on education and training.

Research and clinical academic career pathways

In their submission to the SMO Commission, the Medical Council of New Zealand argue that “the current workforce shortage goes beyond SMOs employed solely by DHBs, [and] extends into the universities.” They note that research and teaching are fundamental to quality training and education of medical practitioners.

DHBs actively supporting clinicians engaging in teaching and research are generally considered to be a powerful recruitment and retention tool, ‘providing a culture of innovation and reflective thinking’. Feedback to the SMO Commission suggests that the presence of the medical school made a huge difference to the culture of the DHB, and that academic appointments attracted quality specialists to DHBs

Feedback from the SMO Commission submissions process suggests that there are two key areas of concern in this area:

- role conflict issues for clinical academics trying to balance clinical practice and teaching and research commitments

²³ Ibid.

²⁴ Morey, Dr Sue, Prof Bruce Barraclough, Mr Allan Huges, *Ministerial Review of Victorian Public Health Medical Staff: Report of the Review Panel*, Victorian State Government, Australia, 30 November 2007, p.87.

- a lack of funding to support research.

Balancing clinical practice and academic roles

There are two roles available for doctors who wish to retain a clinical component to their academic career rather than focusing on pure research:

- joint clinical academics
- clinical (senior) lecturers.

As the name suggests, joint clinical academics have both academic and research, and clinical components to their role. This is an academic career pathway where doctors are required to meet the requirements of academia to achieve academic career progression.

A real difficulty for clinical academics is that they are frequently balancing roles and often have accountabilities both within the university and the DHB. Often they will be undertaking undergraduate and postgraduate teaching, research, administrative and management tasks, alongside maintaining active engagement in clinical practice. The balance between research, teaching and clinical service can be especially challenging, particularly as clinical academics are employed by the University, but the DHB pays half of their salary.

The role of clinical lecturer is evolving, but is generally something of an honorary role, where doctors may be paid little or nothing for providing clinical teaching opportunities for medical students. In return clinicians are linked to the university and as 'members of staff' have access to the university library. Some clinical lecturers do have a more substantive role and will be employed for anything up to 0.3 FTE. While this role clearly provides important learning opportunities for medical students, it does raise the important question of the role of DHBs in training the future medical workforce and highlights some of the challenges across the academic/clinical interface.

Growing the medical academic workforce

A survey undertaken by Zarkovic et al suggests that rotation in a specialty was the strongest factor influencing career decisions.²⁵ While there are some opportunities²⁶ for undertaking research during student years, feedback suggests the loss of links with research is a particular problem during the post graduate years, before vocational training, resulting in fewer clinical academics coming through.

Examples of career pathways for research and clinical academics in other jurisdictions can be found in Appendix 2.

Access to research funding

Sources of research funding

The Health Research Council (HRC) is the main public funder of health and disability research in New Zealand. The HRC administers government funding through Vote Research, Science and Technology funds and through the Ministry of Health and DHBs (through Vote Health funds). There is also a range of other funding sources, including:

²⁵ Zarkovic, Andrea, Stephen Child, Gill Naden, Career Choices of New Zealand Junior Doctors, *New Zealand Medical Journal*, Vol 119, No.1229, 17 February 2006, p.8.

²⁶ Both Otago and Auckland Universities support Summer Studentship programmes for undergraduates and the New Zealand Medical Council offers research awards to undergraduates.

- other government sources, such as the Foundation for Research, Science and Technology and the Tertiary Education Commission
- non-government organisation funders, such as the Cancer Society
- private sector businesses
- international funders (both public and private), such as the National Institutes of Health and the Gates Foundation.²⁷

Health features strongly in overall research in New Zealand. “In 2006, research expenditure across government, business and university sectors on health was \$268.7 million, 15% of total research expenditure (\$1,825.6 million) and the largest individual research expenditure category. Within the total of health-related research expenditure, the ... higher education sector [undertook research to the value of] \$124.2 million (46%).”²⁸

Health delivery research comparisons with other countries are difficult as there is no standard or routine categorisation of health delivery research and different countries have different funding models. We can, however, note research funding data from:

- the United Kingdom, where the government is supporting budget increases to £1 billion for the National Institute for Health Research (health sector focused research) and £0.7 billion for the Medical Research Council (mostly early stage and discovery research) by 2010/11. Notably, NIHR research centres have £459 million over five years to enable leading NHS and university partnerships to drive progress on innovation and translational research in Biomedicines and MHS Patient Safety and Service Quality.
- Australia, where in 2007 government funding through the National Health and Medical Research Council, their primary funder of health research, was AU\$342 million for basic science and AU\$296 million for other research areas including ‘clinical medicine and science’, ‘public health’ and ‘health services research’.²⁹

The main concern of the academic community is that “‘HRC funding is diminishing in real terms because of increasing research cost, particularly academic and medical salaries. Thus volumes of research are falling.”³⁰ This view is reiterated in comments from Professor Ian Reid and Professor Peter Joyce in their discussion paper on health research.³¹ They argue, “staff within our hospitals and universities have been willing, for many years, to accept lower pay rates than in comparator countries. However, they are much less accepting of the lack of opportunity to carry out research, since they regard this as a defining part of their professional lives.... This is of particular concern in light of the recent expansion of the number and size of Australian medical schools, which is already making the Australasian market for health academic staff very competitive. With

²⁷ Ministry of Research, Science and Technology, *Health Delivery Research Landscape: An overview of New Zealand research capability focused on health delivery*, Wellington, New Zealand, March 2009, p.13.

²⁸ Ibid, p.13

²⁹ Ibid, p.16

³⁰ Reid, Professor Ian, and Professor Peter Joyce, *Health Research: A critical investment for New Zealand*, University of Auckland and University of Otago, Christchurch, July 2008, p.2.

³¹ Ibid.

this loss of staff, there will be a progressive inability for our tertiary institutions to train the New Zealand health workforce.”³²

DHB funding

Though there is considerable research undertaken within DHBs, research is specifically excluded from DHBs operating funds. “As a result, DHB management is seen by some researchers to be indifferent to research or discouraging staff involvement because of the effect on outputs.”³³ This notwithstanding, the District Health Board Research Fund (DHBRF) was established in 2005 to fund small to medium sized research projects of direct relevance to DHBs. The DHBRF has \$6.2 million available over four years,³⁴ and has been taken up by a variety of university and non-university research groups.

Academic workforce

“The majority of publicly funded health research, and health delivery research, is carried out through universities, principally through the schools of medicine and health sciences at both the University of Otago and Auckland, and often in conjunction with DHBs.”³⁵

Clinical academics (with joint DHB and university appointments) working on HRC funded projects have increased from 21 to 36 FTEs (151 to 273 individuals) between 2003 and 2007. Clinical academics are now the second largest HRC workforce category (after academics), making up 21 percent of the workforce. Data suggests, however, that they are very much ‘part-time’ researchers, most with only a ‘few-tenths’ of their time allocated for research.³⁶

“The Universities of Otago, Auckland and Victoria have expressed concerns about their ability to retain and recruit promising researchers ... because of the relatively low levels of funding here and the difficulty in obtaining funding, compared with elsewhere. These difficulties are compounded by the fact that many people working in health services research are not in academic teaching positions and are on fixed term contracts.”³⁷ Most health researchers rely on research grants to support some or all of their salary and hence experience a degree of job insecurity.

³² Ibid.

³³ Ministry of Research, Science and Technology, Health Delivery Research Landscape: An overview of New Zealand Research capability focused on health delivery, Wellington, New Zealand, March 2009, p.24.

³⁴ Ibid.

³⁵ Ibid, p.29

³⁶ Ibid, p.41

³⁷ Ibid, p.42.

SMO teaching and training roles

Director of clinical training

Usually only found in larger the DHBs, their role is to have an overview of clinical training across the DHB. They are often the key liaison person with the hospital, colleges, the intern supervisors, the Medical Council and the Ministry. currently there are directors of clinical training at Counties Manukau DHB and Capital & Coast DHB.

Intern supervision and training

Intern Supervisors are the Medical Council's agents and are responsible for ensuring that the standards of clinical experience and education are maintained at their hospital. Their focus is on post Graduate year (PGY) 1 doctors in training and they have a statutory role in signing off assessments as part of the requirements for registration. Run reports are completed at the beginning, middle and end of runs, along with a three monthly report completed by the supervisor. Generally any one supervisor should only be responsible for up to 10 doctors in training. Intern supervisors are also responsible for organising teaching activities, including tutorials.

Some hospitals are now putting into place a similar structure for PGY2 graduates.

On a day-to-day basis, the supervising specialist also undertakes a critical role in supervision and training. They are expected to act as role models, provide regular feedback, incorporate interns into the ward team, ensure the Registrar is actively engaged with the intern, support formal teaching programmes, make specific time for clinical teaching about issues for a particular patient and meet with the interns three or four times during the run outside of formal teaching time to provide feedback and performance evaluation.

Registrar supervision and training

This description of supervision and training comes from the College of Physicians, though the requirements for other colleges are similar. Support is provided through a four tier structure within each training institute. Key elements of this support centre around planning and facilitating the trainee's learning path, the facilitation of effective teaching and learning opportunities and the provision of comprehensive and feedback on the trainee's progress and achievement of the curricula learning objectives.

The four tiers are:

- director of physician education
- educational supervisor (basic / advanced training)
- rotational supervisor (ward consultant)
- professional development advisor (PDA).

There is one director of physician education per geographic network or large hospital. Their focus is on strategic and macro level educative leadership links between college and hospital(s). Their role is to:

- Provide leadership within their workplace / geographic area
- Oversight basic and advanced training programs and support within network / hospital
- Drive training and support of educational / rotational supervisors in conjunction with regional committees

- Present 2 X 3 hour physician educator core training modules for educational / rotational supervisors within their network / hospitals
- Establish and facilitate local support networks
- Provide advice to College Education Committee through the Expert Advisory Group
- Complete program administrative work as required.

There is at least one educational supervisor for basic and advanced training within each hospital: 1 per 10 - 15 Trainees (dependant on location). The focus of the educational supervisor is on the operational level educative leadership and management link between the college and hospital and they provide a direct link between the college and the trainee. Their role is to provide:

- Oversight training programmes for a small group (max 10 - 15) of basic or advanced trainees within their hospital
- meet with each trainee a minimum of four times per year to develop and implement an appropriate plan of training
- conduct regular formative assessments and monitoring of trainees' progress (in conjunction with rotational / run supervisor)
- provide regular and timely feedback to trainees within their group
- ensures specific training program requirements are satisfied
- provide direct guidance and support for rotational / run supervisors working with trainees in their group
- facilitate / assist with teaching and learning
- facilitate / assist with formative assessments
- facilitate conduct of penultimate year review (advanced trainees)
- assist with presentation of 2 x 3 hour physician educator core training modules for rotational supervisors within their hospital
- complete programme administrative work.

The next layer is the rotational supervisor, of which there is one per basic or advanced trainee. Their focus is on actively supervising and supporting the training of individual trainee(s) and providing direct teaching and learning support to their trainee(s). The role of the rotational supervisor is to:

- as ward consultant, be actively involved in the direct teaching of their trainee(s)
- guide and facilitate development of knowledge and skills outlined in basic or advanced training curricula as applicable
- role model exemplar clinical practice and procedures
- conduct formative assessments and provide direct feedback to the trainee
- assist with conduct of penultimate year review (advanced trainees)
- monitor trainee progress and provide advice to educational supervisor as appropriate
- complete supervisor's reports.

The professional development advisor (PDA) will, ideally, follow trainee through both basic and advanced training. Their focus is on facilitating personal and professional development support. They do this by:

- guiding and facilitating development of knowledge and skills as detailed in the professional qualities curriculum
- meeting with the trainee a minimum of 2 times per year
- facilitating critical reviews and reflection on the trainee's practice through discussion and use of e - portfolio / reflective journal
- using multi source feedback assessments to conduct formative assessment of professional qualities curriculum domains / learning objectives (1 per year)
- providing comprehensive feedback to the trainee
- assisting with conduct of the penultimate year review (advanced trainees).

Mentoring and peer supervision roles

SMOs may also provide medical student training. This requirement varies as trainee Interns are the primary responsibility of the university. That notwithstanding, SMOs commonly undertake training for students while they are attached to a consultants team. SMOs also provide teaching for other health professional groups.

In addition to teaching, SMOs also undertake general mentoring roles. This may happen with trainees across the spectrum and often for more than one doctor in training. There can be additional demands on women consultants where women trainees particularly seek out a senior woman doctor as a mentor.

SMOs may also provide mentoring and supervision for their IMG colleagues.

Appendix 2

Formal career pathways for research and clinical academics in other jurisdictions

United Kingdom

The UK Clinical Research Collaboration (UKCRC) was established in 2004 with the aim of re-engineering the clinical research environment in the UK. The Partnership brings together the major stakeholders that influence clinical research in the UK, and includes the main UK research funding bodies; academia; the NHS; regulatory bodies; the bioscience, healthcare and pharmaceutical industries; and patients.

The partnership model arose out of the Walport report, published in 2005 by a subcommittee of the UK Clinical Research Collaboration (UKCRC) and the NHS Modernising Medical Careers (MMC), which made recommendations for initiatives to integrate the development of academic skills with each of the key stages of a clinician's career. As a result, Integrated Academic Training Pathways have now been established through partnerships between Universities, local NHS Trusts and Postgraduate Deaneries. The Integrated Academic Training Pathway consists of three phases:

- academic clinical fellowships (ACFs)
- clinical lectureships
- clinical senior lectureships.

The scheme is available in England and Wales.

Australia

The Australian Clinical Research Fellowship provides full-time training in the area of clinical research, including the social and behavioural sciences. Eligibility is not restricted to doctors, but applicants must hold a doctorate in a health-related field.

The National Health and Medical Research Council also run Training (Postdoctoral) Fellowships, the purpose of which is to provide opportunities for Australian researchers to undertake research that is both of major importance in its field and of benefit to Australian health. Training (Postdoctoral) Fellowships provide a vehicle for training in basic research either in Australia or overseas (where appropriate), to enable Fellows to work on research projects with nominated advisers.

The Training (Postdoctoral) Fellowship funding includes Health Professional Research Training Fellowships which aims to provide part-time (50-70%) training for awardees who wish to combine their professional career development with a research training fellowship in Australia.

In addition there are State initiatives. For example, the Queensland government has launched a \$20 million clinical research fellowship scheme, commencing in 2010. Six fellowships will be awarded each year, each worth up to \$850,000 a year over five years. Fellowship recipients will be required to deliver clinical care as well as undertake research.

Appendix 8: Cross-Tasman Comparison of Agreements

Caution:

- All of the agreements are complex documents and while this table attempts to summarise the main provisions, the specific circumstances under which some allowances or penal rates apply will vary tremendously.
- The rates are in local currencies, pre-tax. There are a number of factors that would convert nominal pay rates into comparable living standards: exchange rates; different income and sales tax rates; divergence between ACC and Medicare levies, purchasing power parity between the countries, and the tax treatment of various allowances and entitlements. These variations are explored later.
- There is some interest in Australia around how ACC impacts on professional indemnity insurance costs in New Zealand, but it is not clear if these are reimbursed anyway, so no allowance has been made for a reduced “cost of practicing” in New Zealand.
- The rates quoted are current. Most agreements (including the New Zealand MECA) are multi-year and have staged increments during their terms.
- Special provisions applying in “hard to staff” locations are common in both countries, but may be used more aggressively in Australia given the larger distances between more remote communities and the nearest urban centres.
- For ease of comparison, the lowest, highest and two intermediate paying states have been selected. The pattern would not alter materially if all states had been included.
- Heads of Agreement have recently been signed for the collective agreement in Victoria.
- None of this takes account of special conditions negotiated by individual specialists nor of private income earned, both of which are likely to vary by region and by subspeciality.

Table 23: Comparison of New Zealand and Australian SMO collective agreements

Condition	New Zealand (NZ\$)	Victoria (AUD)	NSW (AUD)	Sth Aust (AUD)	Queensland (AUD)
Minimum step	123,353	129,646	127,152	153,000	130,491
No of steps	14	11	6	9	7
Maximum step	182,583	170,695	171,787	201,600	151,574
Increase due '09	4.25% plus extra top step (effectively 7% at top)	3.25%	3.9%	3.5%	Expired
Private practice allowance	Nil	25% (min)	20%	30% (min)	50 – 90% depending on region but inclusive of 25% loading for extended hours in ED
Recruitment and retention benefit	Individually negotiated alongside need to consider equity with others	Not known	Not known	Not known	Not known
Special conditions benefit	Individual contract variation	Not known	Not known	Not known	“Inaccessibility incentive, and variable regional incentives
Availability and immediacy of requirement (“on-call” allowance)	Varies across DHBs. 8 – 15% common	10%	17.4% (incl payment for hours > 40 per week)	5% (min)	\$8.71/hr
Night and weekend shift rates	T 1.5	Not specified	T 1.5–T 1.75 (ED only)	T 1.5	T1.5 – T2 (after first 3 hrs and on Sundays)
Annual leave	6 weeks	4 weeks	5 weeks	4 weeks	4 weeks
Leave loading	Nil	Up to \$702	Up to \$1421	Up to \$633	17.5% for 4 weeks
Superannuation	6%	9%	9%	9%	Up to 12.75%
Education and development leave	10 days	10 days	25 days	5days	1 wk conf leave. 3.6 wks study leave
Reimbursement of education expenses (up to)	\$16,000	\$30,000	\$20,000	\$14,000	\$20,000

Source: SMO collective agreements, New Zealand and Australia

Interpretation of Table 23

The “nominal dollar” minimum and maximum rates in the base salary scales are not inordinately different between the jurisdictions, although the New Zealand scales are more extended. South Australian rates (and to a similar degree those in Western Australia) are

noticeably higher than the rates in New Zealand and New South Wales, by 20 percent or more across different parts of the salary range.

The stark difference between New Zealand and Australia is the “private practice allowance”, which reflects the way that some medical treatments carried out in Australian public hospitals are paid for, and how that payment is shared between the hospital and the doctors. This allowance adds at least 20 percent to the basic salary. Superannuation subsidy levels are also markedly higher in Australia.

Various allowances such as for being on call, working night shifts, and working in weekends and on public holidays are largely similar, although the circumstances under which they apply can vary in the particular. The New Zealand multi-employer collective agreement grandparents district health board–specific leave entitlements (long service, onerous duties).

The South Australian package relies less on special allowances and payments than do the other jurisdictions. For example, apart from the lower on-call allowance, annual leave, leave for education and personal development, and the level of reimbursement of costs associated with it are all low by comparison. Within Australia, the leave loading is also lower than for most states. This feature would reduce the apparent gap between the nominal rates paid in South Australia and in New South Wales.

The provisions in the New Zealand multi-employer collective agreement for “specific to person” allowances on recruitment, retention and special contribution may close the gap between the nominal differences in these agreements, but no details are available about how extensive these are in practice. Equally, similar arrangements, either formally or through custom and practice, may apply in Australia.

Validation

In late 2007, District Health Boards New Zealand carried out a detailed analysis of the specific elements of the package offered to an individual New Zealand based anaesthetist to move to Australia. While that case study is now somewhat dated, the key components would probably have moved in similar ways in both countries since then, so it can be used as a “comfort check” to validate the broad level findings of the above analysis.

That case study indicated:

- A small (\$5,000 – albeit in Australian dollars compared with the New Zealand dollar base) increase in the basic salary.
- Significantly higher superannuation (\$8,500)
- A private practice allowance, that contributed to an approximate \$55,000 higher “all up” allowance package than the allowances received in New Zealand.
- A generous motor vehicle package, and (by the then comparison) a more extensive professional development scheme.
- By contrast, taxes were considerably higher (by over \$30,000) as were Medicare levies compared to ACC.

Putting all of this together, the take home remuneration was 31 percent higher than in New Zealand and with superannuation added, 33 percent higher.

Professional development appears to be equalising, and it is difficult to compare motor vehicle and other specific to person recruitment inducements in an exercise that looks at variations between collective agreements. In addition, it is not clear if some of these payments were “one-off” relocation allowances.

With all the heavy qualifications mentioned earlier (but taking no account of the opportunities for, or value of, salary sacrifice) this exercise tends to confirm the very high level “ballpark” gap between the collective salary packages across the Tasman. The single biggest factor that delineates Australian packages from those in New Zealand collective agreements is the private practice allowance, which adds between 20 and 30 percent to the package, and the employer contribution to Superannuation which adds another 3 percent.

Adjustments

1. Exchange rates

At present NZ\$1 = AU\$0.8. Hence for comparison purposes it is more relevant to reduce New Zealand dollar salary scales by 25 percent to establish an exchange rate adjusted comparison.

2. Relative cost of living

A factor that would offset the exchange rate difference is if the cost of living between the two countries differed. OECD estimates of comparative price levels (February 2009) show that the relative cost of living in New Zealand is 86 percent of that in Australia. (As at February 2009. OECD Main Economic Indicators, April 2009 p282.) Hence the differences in comparative prices almost offset the exchange adjusted nominal salaries.

3. Income taxes, Medicare levies and ACC.

There has been something of a convergence in the level of taxation of these salary levels between the two jurisdictions.

Currently, a salary of AUD 200,000 is taxed at an average rate of 35 percent (including Medicare). A salary of NZ\$200,000 is taxed at 34.5 percent (including ACC). Adjusting the New Zealand figure for the exchange rate differences gives a New Zealand dollar equivalent of 250,000 which would attract an average tax rate of 35.5 percent. The tax impacts are therefore virtually identical.

4. Exchange rate, tax and comparative prices

A 7.5 percent reduction in New Zealand salary rates* would make them directly comparable with the equivalent Australian denominated rates, after adjusting for exchange rates, comparative prices, and different direct taxes. Of these factors, the exchange rate comparison is most volatile. *[\$125 x 0.86 = \$107.5]

5. Salary sacrifice

Conceptually, this is the most difficult area to adjust for. It emerges from differences in the tax structures of the two countries. Also, it is not a “right” of the employee but requires the employer to agree to pay part of the salary in a form that qualifies for the “sacrifice”. Specifically, some forms of payment (like the provision of a car or superannuation contributions) would not be regarded as taxable income in the hands of the employee, but the employer would be liable for any charges levied on those payments (such as fringe benefit tax or superannuation contributions taxes). If the cost to the employer is less than the value to the employee, employers may agree to packaging the qualifying part of the remuneration in forms that qualify for the exemption.

(i) Provisions in New Zealand

The ability to make salary sacrifice arrangements has existed in New Zealand for some time. Essentially, when the top rate of income tax was 39 percent and employers had to make

withholding tax payments on superannuation contributions at 33 percent, there was a 6c “wedge” that could be used to lower overall tax rates on the sacrificed amount provided the agreement was to convert a part of salary into an employer contribution to a superannuation scheme. Subsequently, the Government tightened up on “excessive salary sacrifice.”

However, up to a certain level (currently 2 percent of salary), employer contributions to Kiwisaver are tax exempt to employers, so scope exists to benefit from the full (now) 38 percent top marginal tax rate if paid into superannuation. However, the rules on Kiwisaver can be varied by the Government, so this remains a somewhat volatile discretion, and one that is certainly outside of any control by SMOs or their employers.

(ii) Provisions in Australia.

In Australia, the rules surrounding salary sacrifice are complex. Summarising, there are three categories:

- Payments that attract fringe benefit tax (cars, school fees, home phone etc.)
- Fringe benefits that are not subject to tax (these tend to be limited to work related expenses such as relocation costs and items such as a laptop computer or a cellphone used primarily for work).
- Payments into a complying superannuation scheme (which are then subject to the tax rules that apply to such schemes).

FBT is set at the top marginal tax rate plus Medicare levy, so there is no incentive for the employer to agree to converting part of salary into a fringe benefit, and if the employee sacrifices an equivalent amount of salary there is no advantage. However, there are certain exempt thresholds, and in this case fringe benefits provided by public hospitals to employers are FBT exempt up to a maximum of \$9,095 per annum. This gives a salary sacrifice tax potential to the SMO in an Australian public hospital of around \$4,000 per annum. However, that benefit cannot subsequently be “cashed out” or it is again taxable income. It must be consumed in the form provided (say car, or school fees).

Superannuation is probably the “cleanest” form of sacrifice, but access to the sacrificed amount is limited until retirement or as provided for in the terms of the complying scheme.

The four points to note are:

- It needs to be in a form that qualifies as tax exempt (which may not be the form in which the employee would prefer to be paid).
- It must be agreed in advance of the payment.
- It needs employer consent.
- It cannot subsequently be cashed out.

As with New Zealand, the rules on taxation are changeable and out of the control of the employer and the SMO.

Appendix 9: Key Agencies in Medical Training and Education

The following is a paper prepared by the RMO & SMO Commission secretariat as background to our deliberations. It explores the roles and responsibilities of key agencies with a role in medical training and continuing education.

Introduction

The Doctors in Training Workforce Roundtable aptly describe medical training as a continuum, “from the first days in medical school through a lifetime of academic learning, refining skills and developing a deeper understanding of the human condition in the service of the patient.”¹ “Undergraduate medical education in New Zealand spans six years and is provided through two universities, Auckland and Otago, with clinical teaching provided in clinical schools in Auckland, Hamilton, Wellington, Christchurch and Dunedin, in several provincial hospitals, and in general practice environments.”²

Following graduation, medical training transitions into the clinical setting with first year post graduate doctors (interns) acting under provisional Medical Council registration in a general scope. Practice is supported by ongoing supervision, an obligatory educational programme and regular assessments provided to the Council. Most graduates achieve full registration in a general scope in their second post graduate year and continue to work for a year or more across a range of specialties until they decide on a future career pathway.³ General practice is notably absent from the PGY1-3 experience of most trainees.

The next step on the training continuum is post graduate training. Having identified a field of interest, doctors must seek acceptance into the vocational training programme with a medical college. Vocational training may take upwards of four years and culminates in vocational registration with the Medical Council and Fellowship with the appropriate medical college.

Once formal training is complete, doctors participate in continuing medical education (CME). This reflects requirements of the Health Practitioners Competence Assurance Act 2003 which requires the Medical Council to ensure that doctors are competent to practice, including a requirement to participate in continuing professional development.⁴ CME also is also intended to support doctors in keeping their knowledge and practice current.⁵

The structure of medical training and education is supported by a diverse range of agencies, whose responsibilities traverse delivery of curriculum and funding, through to registration and accreditation.

¹ The Doctors in Training Workforce Roundtable, *Training the Medical Workforce 2006 and Beyond*, Ministry of Health, Wellington, May 2006, p.8.

² Ibid.

³ Ibid.

⁴ Advice on the Medical Council of New Zealand website.

⁵ Royal New Zealand College of General Practitioners website.

Purpose

This paper responds to a request from the RMO Commission for information about the agencies, and their roles and responsibilities in the training and continuing medical education of New Zealand doctors.

The medical education and training system

The diagram below provides a pictorial overview of the medical education system, including funding sources:

Figure 1: The medical education system

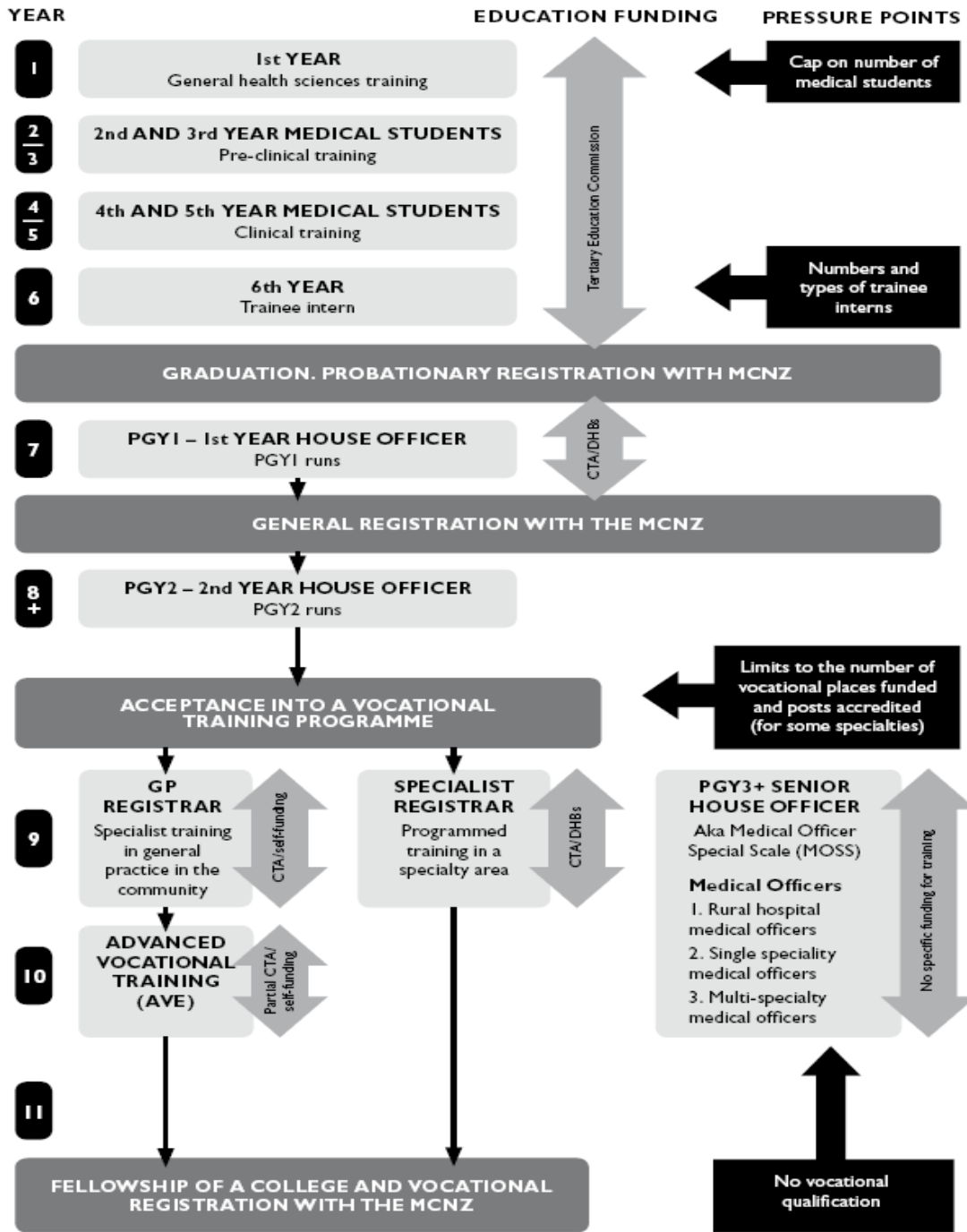


Diagram sourced from *Fit for Purpose and for Practice: Advice to the Minister of Health on the issues concerning the medical workforce in New Zealand*, Medical Reference Group, Health Workforce Advisory Committee, 2006, p.8.

Training Agencies

Universities

6.

Otago and Auckland Universities are the two providers of medical undergraduate training. The Faculty of Medicine at Auckland consists of three clinical schools based in Auckland, South Auckland and Waikato. The Faculty of Medicine at Otago University consists of four Schools: the Otago School of Medical Sciences; the Dunedin School of Medicine; the University of Otago, Christchurch School of Medicine and Health Sciences; and the University of Otago, Wellington School of Medicine and Health Sciences.

The University of Otago has the only Faculty and School of Dentistry in New Zealand. Like the Faculty of Medicine, it is located within the Division of Health Sciences within the university. It offers courses in all branches of dentistry, dental therapy, dental hygiene, dental technology, and clinical dental technology.

University funding is provided through the Tertiary Education Commission (see below) for teaching and learning (SAC funding) and for research (PBRF). Additional research funding is also provided through Vote Research and Science Technology.

The number of domestic students accepted into medical undergraduate training in New Zealand is subject to a cap. This is currently set at 365 full-time equivalent undergraduate students at Otago and 155 full-time equivalent undergraduate students at Auckland. The regulatory cap on placements was increased in both 2004 and 2007 by 40 places each time and split evenly between both universities.

Dental training places are not subject to a cap per se, but limited by available funding]. There is a first year limit of 54 domestic students.

Undergraduate curriculum

“The development, assessment and delivery of the undergraduate medical curriculum involves a number of bodies with different functions:

*the universities are respective owners of their course content and length
the Committee on University Academic Programmes (CUAP) is responsible for the quality assurance of university courses
the Medical Council of New Zealand has the authority to say whether a course is sufficient for the training of doctors
the Australian Medical Council audits the courses approved by the Medical Council of New Zealand
the Medical Council of New Zealand and the Australian Medical Council jointly accredit medical schools in Australia and New Zealand.”⁶*

The Dental Council of New Zealand accredits the Bachelor of Dental Surgery (undergraduate) programme. BDS graduates are automatically eligible to register with the Dental Councils of both New Zealand and Australia without further training. The content of the BDS programme also has to be approved by the CUAP.

⁶ Medical Reference Group, *Fit for Purpose and Practice: Advice to the Minister of Health on the issues concerning the medical workforce in New Zealand*, Health Workforce Advisory Committee, Wellington, New Zealand, May 2006, p.13.

The accreditation process for the University of Otago Dental School and the Australian Dental Schools is organized under the auspices of a joint Committee of the Australian and New Zealand Dental Councils. Both the BDS and their Australian equivalents are recognised in both countries.

Postgraduate programmes

In addition to undergraduate training, the medical schools offer postgraduate programmes in health-related topics, for example the University of Otago Wellington offers a Masters of Health Sciences, a Postgraduate Diploma in Health Sciences and a Postgraduate Certificate in Health Sciences; and conduct health-related research.

The School of Dentistry at Otago also offers postgraduate training at diploma, masters and doctoral levels and is developing programmes for all professional groups in dentistry.

Medical colleges

The colleges are the educational bodies responsible for organising, supervising, examining and subsequent recertification of medical practitioners in their vocational field. The duration and content of vocational training is dependent on individual college training programmes.

Colleges undertake the following functions:

- selecting medical graduates for vocational training, and providing training and assess trainees, including by administering written and clinical examinations
- assessing applications from specialists trained overseas who wish to practice in a specified clinical field in New Zealand
- accrediting hospitals for training positions
- specialist training, issuing a Fellowship or other certification, attesting to the attainment or maintenance of appropriate levels of skills, knowledge and competencies appropriate to specialist practice
- providing continuing professional education and other educational opportunities for Fellows
- representing Fellows' interests in various forums, including to government bodies or other organisations.

In addition, every college has guidelines about a broad range of matters relating to patient care, including training, equipment issues, staffing levels, safe practices, supervision and assistant skills.

The colleges are generally combined Australian and New Zealand (Australasian) colleges, with notable exceptions in the recently independent New Zealand College of Public Health Medicine and the Royal New Zealand College of General Practitioners. The 14 colleges are the:

- Australian and New Zealand College of Anaesthetists
- Royal Australasian College of Dental Surgeons
- Australasian College of Dermatologists
- Australasian College for Emergency Medicine
- Royal New Zealand College of General Practitioners
- Royal Australasian College of Medical Administrators
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists

- Royal Australian and New Zealand College of Ophthalmologists
- Royal College of Pathologists of Australasia
- Royal Australasian College of Physicians
- Royal Australian and New Zealand College of Psychiatrists
- New Zealand College of Public Health Medicine
- Royal Australian and New Zealand College of Radiologists
- Royal Australasian College of Surgeons.

Some colleges have established faculties or divisions for subspecialties. In some cases these are independent bodies offering their own vocational training programmes. The training and education programmes of the colleges are accredited by the Medical Council of New Zealand and, in the case of the combined colleges, the Australian Medical Council, to ensure they meet appropriate standards.

Training is delivered by Fellows of the colleges, without additional payment.

Medical Training Board

The Medical Training Board (MTB) was established in 2007 in response to a recommendation from the Workforce Taskforce. The MTB is accountable and provides advice to the Minister of Health and the Minister for Tertiary Education. Board members are appointed jointly by these Ministers.

The purpose of the MTB is to provide strategic oversight of the education and training of medical practitioners, ensuring that practitioners are 'fit for purpose' and meet the current and future needs of the health sector.

Their terms of reference charge the MTB with the following:

- ensuring effective oversight and co-ordination of the continuum of medical education and training in New Zealand from entry to medical school to registration in a vocational scope of practice, with a specific focus initially on the transition years and training in general practice
- receiving advice from the district health boards (DHBs), other providers of health care and training providers on the number and mix of medical practitioners required to meet future health care needs
- developing a national view on the appropriate number and type of training positions required to provide an appropriate number and balance of vocationally trained medical practitioners to meet the needs of the New Zealand population
- reviewing clinical training specifications and funding intentions
- developing mechanisms to collect appropriate data to facilitate medical workforce development.

District health boards

Post graduate, clinical medical training is based on an apprenticeship model. This means that most clinical training occurs in DHBs which are the employers of both the trainees and the specialist staff (Fellows of colleges) who provide their training. This is a source of some tension for DHBs whose primary focus and accountabilities are in respect of service provision within the limits of the resources available.

Though clinical training occurs in DHBs, undergraduate medical training is the responsibility of the universities, the Medical Council supervises PGY1 training and the colleges have responsibility for vocational training. In the absence of formal oversight by any other organisation, DHBs effectively have responsibility for determining training and education content for PGY2 doctors (and onwards) until they move into a vocational training programme. They do this through clinical placements, day-to-day training opportunities and in some cases formal training programmes. Training for PGY2 doctors is generally relatively unstructured, though some DHBs offer a formal training programme for PGY2 doctors, and some are now putting such programmes in place.

Training funding

In 2004, the TEC and the Ministry of Health undertook a joint project to provide an insight into the tertiary education sector's delivery of health sector qualifications and post-entry clinical training. In relation to medicine, the analysis, based on 2002 data, showed that of the \$121.0 million per annum spent on medical education and clinical training by the Government, \$43 million was met by the TEC for both undergraduate and post graduate education, \$62.9 million by the CTA on clinical training and an estimated \$15 million was spent indirectly on clinical training by DHBs.

The Regulator

The Medical Council of New Zealand

The Medical Council of New Zealand (the Council) operates under the Health Practitioners Competence Assurance Act 2003 (HPCAA) and has the following responsibilities:

- authorises the registration of practising doctors.
- maintains a medical register of practising doctors.
- issues annual practising certificates only to doctors who have maintained their competence to continue practising medicine.
- monitors the training of medical students and new doctors to ensure their medical education is appropriate, including hospital accreditation.
- requires doctors to continue their medical education once they enter the workforce.
- can require a doctor to receive treatment if he or she is suffering from an illness which is affecting his or her practice.
- can suspend a doctor's practice.
- carries out performance assessments of doctors in response to a concern expressed by a patient, colleague or any other person.
- assessment and recognition of new vocational scopes of practice.

The Council is responsible for ensuring that medical practitioners are safe and fit to practice in New Zealand. This is managed initially through the registration process and then ongoing through annual certification (annual practising certificates). The Council must be satisfied that New Zealand registered medical practitioners have reached “a safe and acceptable standard and are maintaining and developing their competence as their careers progress.”⁷ The Council is assisted in assessing this by “the universities, hospitals and general practices accredited for intern training, and the medical colleges.”⁸ No person can claim to be a medical practitioner in New Zealand unless they are registered by the Council and hold an annual practising certificate.

⁷ The Doctors in Training Workforce Roundtable, *Training the Medical Workforce 2006 and Beyond*, Ministry of Health, Wellington, May 2006, p.7.

⁸ Ibid.

The Council also, in association with the Australian Medical Council, “accredits Australian and New Zealand medical schools and the training and continuing professional development (CPD) programmes of the Australasian medical colleges. The Council also accredits the training and CPD programmes of New Zealand-only vocational branches. Regulations and standards may also be set or may evolve externally or internally by other bodies, for example through the Health and Disability Commissioner.”⁹

The Medical Council is funded by registration and annual practising fees paid by all practising doctors.

The Dental Council

Like the Medical Council, the Dental Council is the statutory body under the HPCAA responsible for promoting and protecting the public interest by ensuring that oral health practitioners are safe and competent to practice.

The Dental Council protects the public and promotes good dental practice by carrying out its statutory responsibilities in relation to the registration, competence, conduct, health and education of registered oral health practitioners. These include:

- ensuring that undergraduate and postgraduate programmes leading to dental registration meet acceptable national and international standards
- setting the clinical, cultural and ethical standards for oral health practitioners
- authorising the registration of practitioners and considering applications for annual practicing certificates
- establishing systems and processes to ensure that practitioners maintain competence throughout their practicing lives
- promoting the health of practitioners and developing programmes for health-impaired practitioners to ensure a speedy return to practice while assuring public safety
- dealing with practitioners whose competence or fitness to practice has been called into question.

The professions regulated by the Council are dentists, dental specialists, dental therapists, dental technicians, clinical dental technicians, dental hygienists, dental auxiliaries and orthodontic auxiliaries.

The Council is funded by the registration and practicing fees paid by practitioners.

Funding

Tertiary Education Commission

The Tertiary Education Commission (TEC) is a Crown Entity established under section 159C of the Education Act 1989. It is governed by a board of Commissioners, appointed by, and responsible to, the Minister for Tertiary Education. The TEC is a Crown agent under the Crown Entities Act 2004 and must therefore give effect to Government policy.

⁹ Ibid.

In addition, the TEC also has statutorily independent powers in respect of the planning and approval of funding for individual tertiary education organisations, and monitoring financial performance and governance of tertiary institutions. These powers are exercised within the strategic and policy frameworks set by the Government under the Education Act. Notably, the Education Act 1989 gives the Minister for Tertiary Education responsibility for determining the design of the funding mechanisms the TEC must use to fund tertiary education organisations. This includes the purpose of a fund, general eligibility requirements, policy parameters, and conditions on funding. The Minister for Tertiary Education issues funding determinations to the TEC by letter under section 159L of the Education Act 1989.

The funding mechanisms of interest with respect to medical undergraduate training are the:

- Student Achievement Component (SAC) and Tertiary Education Organisation Component (TEOC)
- Performance-Based Research Fund
- Special Supplementary Grants.

Student Achievement Component and Tertiary Education Organisation Component (TEOC)

This comprises two separate funds, SAC and TEOC. Money from the two components is allocated through the TEC's approval for funding of investments plans submitted by tertiary education organisations. SAC funding per full-time equivalent medicine undergraduate student in 2009 is \$30,477 for each year of years two and three; and \$35,945 for each year of year's four to six. This compares with Dentistry at \$43,592; veterinary science at \$23,209; engineering at \$9,512; nursing at \$8,892; science \$8,892 and arts at \$5,171.

The Performance-based Research Fund (PBRF) is part of TEOC, but allocated under a separate funding mechanism, outlined below.

Performance-Based Research Fund

The purpose of PBRF includes aims to:

- improve the quality of research
- ensure that research continues to support degree and postgraduate teaching
- ensure that funding is available for postgraduate students and new researchers.

PBRF allocations, including any proposed portion for medical or health-related research, are made annually subject to TEC approval of investment plans submitted by the Universities. The overall amount of funding received varies according to cost weightings for subject areas and a performance assessment process.

Special Supplementary Grants

Special Supplementary Grants (SSGs) provide an additional funding contribution to tertiary education institutions to meet the needs of specific groups of students. There are currently two SSGs:

- SSG for Special Education
- The Medical Trainee Intern SSG.

The purpose of the Medical Trainee Intern SSG is to provide a stipend for medical students working as interns as part of their sixth year of study. Tertiary education institutions applying

for this funding must apply annually and are required to identify proposed initiatives and set performance targets and indicators for these initiatives. At the conclusion of each academic year, institutions are required to report back to the TEC on how funding has been used and on whether objectives were met.

Clinical Training Agency

The Clinical Training Agency (CTA) is a business unit of the Ministry of Health. It is part of the Health and Disability National Services Directorate, which brings together the Ministry's national contracts for clinical training, disability support, population screening, personal health and public health.

The CTA's role is to purchase post-entry clinical training (PECT) for New Zealand health professionals. This means training that is substantially clinical, vocational and nationally recognised. To attract funding, training must be equivalent to a minimum of six months full time training and occur after entry into a health profession so that a person is eligible to practice as a health practitioner under the Health Practitioners Competence Assurance Act 2003.

The CTA is also involved in workforce analysis and development. This includes joint projects with the Population Health, Health & Disability National Services, Māori Health and Health & Disability Systems Strategy Directorates, as well as utilising sector reference groups. The CTA also has responsibility for the Overseas Trained Doctors Programme and for funds managed on behalf of the Mental Health Directorate.

Key projects for 2008/09 include the development of a new funding model for the training purchases, and the implementation of the outcomes of the surgery review and of the new funding model for Māori health training.

The CTA baseline budget has increased to approximately \$120.2 million in 2008/09. This includes increased funding of more than \$10 million for ongoing provision of the Nursing Entry to Practice (NETP), Midwifery First Year of Practice Programmes and General Practice training places.

The Industrial Framework

RMO MECA

The RMO MECA contains two sections directly referring to training and education. Section 7 'Protection of Training Programmes' explicitly acknowledges that RMOs "are training under the supervision of district health board employees and in the case of training programmes, the appropriate professional college or vocational registration training body".

Section 26 'Medical (Dental) Education' recognises the importance of ongoing medical education and describes provisions to support this including:

- the number of hours of rostered duty per week in each DHB that will be set aside for the purpose of medical learning
- employees in their second and subsequent years of service being entitled to five days medical education leave each year
- medical education leave entitlements (six weeks) for college or university study
- medical education leave of up to 12 weeks per annum for vocational training
- additional medical education leave allowed and determined on a case-by-case basis

- registrar entitlement to conference leave (six days plus expenses of up to \$6,000 in total with a maximum of 3 days plus \$3,000 in any one year)
- away training expenses, for employees who are required to spend part of their training away from their base hospital, including travel expenses.

The MECA also sets out run requirements which closely link to training and learning opportunities.

SMO MECA

Part 5 of the SMO MECA addresses 'Professional Matters' including quality improvement, credentialing, professional development and education provisions. Professional development and educational provisions include:

- continuing medical education –leave for 10 working days, plus agreed travelling time
- expenses of up to \$16,000
- employees enrolled in two or more maintenance of professional standards (MOPS) programmes reimbursed up to an additional \$500 per annum
- secondment of two weeks every three years to a recognised unit for the purpose of professional development
- sabbatical of three months (or other agreed period) on full pay after every six years of service.

Advocacy

Council of Medical Colleges

The Council of Medical Colleges (CMC) has been established to allow the colleges to discuss issues of common interest and to enable them to share knowledge, objectives and policies. Such discussions enable CMC to then inform and advise Ministers, Government agencies and other relevant bodies on relevant health issues.

The Council of Medical Colleges (CMC) exists as a forum of educational bodies, established to allow the colleges to discuss issues of common interest and to enable them to share knowledge, objectives and policies, and to interact with Government and Government agencies on relevant health matters. The "CMC seeks to ensure – through the voluntary, co-operative and coordinated action of its Member Medical colleges – that individual medical specialties have a broad base of intercollegiate knowledge. This enables them, both collectively as CMC and individually as Medical Colleges, to provide for the community the highest quality of medical care delivered in accordance with accepted clinical principles and to improve, protect, and promote the public health."

The Following are Member colleges:

- Australian and New Zealand College of Anaesthetists
- Australasian College for Emergency Medicine
- The Royal New Zealand College of General Practitioners
- Royal Australasian College of Medical Administrators
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists
- The Royal Australian and New Zealand College of Ophthalmologists

- The Royal College of Pathologists of Australasia
- The Royal Australasian College of Physicians and the Board of Paediatrics and Child Health
- The Royal Australian and New Zealand College of Psychiatrists
- Australasian Faculty of Public Health Medicine¹⁰
- Joint Faculty of Intensive Care Medicine
- The Royal Australian and New Zealand College of Radiologists
- Royal Australasian College of Surgeons.

New Zealand Medical Association and Doctors in Training Council

The New Zealand Medical Association is a pan-professional medical organisation with a membership encompassing all disciplines within the medical profession, doctors-in-training and medical students.

The key roles of the NZMA are to:

- provide advocacy on behalf of doctors and their patients
- provide support and services to members and their practices
- publish and maintain the code of ethics for the profession
- publish the *New Zealand Medical Journal*.

NZMA has several standing committees including the Doctors-in-Training Council (DITC). The DITC represents the interests of NZMA trainee intern, RMO and medical student members.

The DITC was established in 2002 to provide support and representation to NZMA members who are the future of the medical profession. The DITC advises the NZMA Board of issues of relevance to doctors-in-training (DIT), contributes to NZMA responses to government policy proposals and develops its own policy proposals. It participates in advocacy and representation on DIT issues. The DITC also provides a forum for collaboration with non-RMO doctor groups.

The DITC meets four times a year, plus is represented at the twice yearly NZMA Council. The Chair of the DITC sits on the NZMA Board. The DITC chair is ex officio on the New Zealand Medical Students Association executive and is also an invited observer to the Australian Medical Association Council of Doctors-in-Training.

New Zealand Medical Students Association

The New Zealand Medical Students Association (NZMSA) was established in 1972 and is affiliated to the NZMA. NZMSA is governed by an executive board made up of 10 elected representatives and the 4 regional presidents. Their role is primarily one of advocating for and representing medical students on issues of interest; including researching medical education and educating for educational best practice.

¹⁰ There is now also a New Zealand College of Public Health Medicine. The New Zealand College is not currently a member of the Council. Almost all NZ registered public health physicians are members of the College, but many currently retain dual membership with the Australasian Faculty (which is a Faculty of the Royal Australasian College of Physicians).

New Zealand Dental Association

The New Zealand Dental Association (NZDA) is the professional association for New Zealand dentists. As well as providing services for its members, the NZDA sees itself as the one body able to speak on behalf of New Zealand dentistry as a whole.

Key roles of NZDA are:

- publish and maintain codes of practice, including the NZDA code of ethics
- publish the *New Zealand Dental Journal*
- provide support for research
- provide support and services to members and their practices
- provide advocacy and support for dentists and their patients.

Appendix 10: Overview of Non-Clinical Training

The following describes some of the key non-clinical training options currently available to SMOs, both in New Zealand and in other jurisdictions.

Royal Australasian College of Medical Administrators

The Royal Australasian College of Medical Administrators (RACMA) operates in Australia and New Zealand and provides one non-clinical training avenue.¹ RACMA sees medical administration training as important because:

- it provides an understanding of the health system, health service organisation and management responsibilities
- it provides an appreciation of the drivers and incentives inherent in other team members' roles
- it equips a person to identify risk, particularly legal risk in human resource, communication and contractual elements of the non-medical role
- it teaches the skills to manage resources effectively
- it teaches the skills to communicate business cases for required service development or effectively highlight clinical risk or quality improvements.

RACMA requires the completion of academic studies in: health law, health economics, health care systems, financial management in health, epidemiology and statistics, and at least two management-related subjects.

New Zealand currently has 36 RACMA members, 23 Fellows and 12 training for Fellowship. Membership includes a number of chief medical advisors, public health and general practitioners.

Other non-medical training in New Zealand

Aside from the RACMA training programme, there is some other training available to equip doctors to participate in clinical leadership while retaining their core clinical role. This training often lacks consistency and co-ordination between the different levels of training (undergraduate, prevocational, vocational and beyond) and between different medical colleges and employers.

Undergraduate training does include some non-clinical training but there is no particular emphasis on preparing a doctor for future clinical leadership roles. It covers some aspects that may be of use such as time management, lifestyle and managing a business. The undergraduate curriculum does include working with other clinical disciplines in the clinical service and planning environment.

At the vocational training level, the degree of non-clinical training varies between the different medical colleges. A few colleges are starting to introduce non-clinical components to their vocational training programmes. The Royal Australasian College of Physicians has recently produced a professional qualities curriculum that contains a number of non-clinical

¹ RACMA training is not considered clinical training and therefore does not fit the Clinical Training Agency's funding criteria.

domains. A Masters in Public Health includes non-clinical papers such as health management, health economics and health policy. The Royal College of Pathologists of Australasia vocational programme has a strong emphasis on quality control and there is a component on practice and business management.

With specific regard to “training the trainers”, most colleges are teaching senior medical officers how to teach but this training is not co-ordinated across the specialties. Universities offer a range of courses that are optional, and highly recommended for the university-appointed teachers.

District Health Boards New Zealand (DHBNZ) has a Leadership and Management Programme (LAMP). LAMP’s broad goals are to:

- develop the leadership and management skills of individuals participants
- deliver measurable return on investment to the sector through projects and improved skills
- provide an opportunity for personal development for individuals
- build national and international relationships and networks to advance the health and wellbeing of New Zealanders.

Four programmes are offered.

- Top Management Programme: a 12-month programme for senior managers.
- Management Action Programme: a nine-month programme for existing DHB, Ministry of Health and other health sector managers.
- Health Systems and Management for Clinicians: a six-month programme for clinical leaders in leadership roles that may include a management component.
- Primary Health Leadership and Management: a five-month programme designed for people with an advisory or leadership role, board members or those with a good deal of experience.

Non-clinical training internationally

Australia

The new Australian curriculum for junior doctors implies that there will be clinical leadership training at undergraduate level. The Royal Australasian College of Surgeons offers non-clinical training, but some surgeons have commented that only half of the course is relevant to clinical leadership in the public sector as the other half is about managing a private practice. RACMA offers a clinical leadership training programme (as outlined above) and has a higher profile in Australia, with some clinical leadership positions requiring RACMA membership as a pre-requisite to employment.

United Kingdom

Various medical colleges in the United Kingdom offer leadership training. At the post-fellowship level, clinical leadership programmes are offered by a number of medical colleges, universities and training institutions.

Denmark

In Denmark, during clinical rotations at hospitals, students meet with consultants who are perceived as clinical leaders and are considered role models. At postgraduate level, it is compulsory for future medical specialists to document core competencies in seven basic roles and training includes a 10 day mandatory course in leadership, administration and collaboration. At the post-fellowship level, specialists are offered a 5 day basic leadership course covering leading professionals, quality, change, leadership in a political context and personal leadership.

Finland

In Finland, undergraduate medical training focuses on the basics of the health care system, legislation, professional role and responsibilities. At postgraduate level, house officers have a mandatory 16 hour course on the health care system and legislation as well as social insurance; registrars have a mandatory 20 hour course in health administration which includes the specialist's role as a leader of a clinical team/unit. Post-fellowship clinical leadership training is offered in-house.

Sweden and Norway

As with Finland, Undergraduate medical training in these countries focuses on the basics of the health care system, legislation and professional roles and responsibilities. Post-fellowship clinical leadership training is offered in-house.

The Netherlands

The Netherlands has compulsory training and preparation based on the seven competencies of CANMEDS² model (medical expert, communicator, collaborator, manager, health advocate, scholar and professional).

Germany

At the post-fellowship level, Germany has a curriculum on medical leadership as part of continuing medical education.

² Canadian Medical Education Directions for Specialists

Appendix 11: Excerpt from ‘*In Good Hands*’¹

Structure of Clinical Governance in the New Zealand Health System

The structure necessary to operationalise the Time for Quality agreement and the Quality Improvement Strategy for the best care of citizens/patients within the New Zealand health system encompasses the whole spectrum of care, from primary to tertiary and national services. The following adjustments are imperative for the successful transformation of healthcare and effective clinical governance.

1. **DHB Boards** must establish governance structures which ensure effective partnership of clinical and corporate management. DHB Boards must be required to report on clinical outcomes and clinical effectiveness, via a nationally consistent framework. Quality and safety must be at the top of every agenda of every Board meeting and Board report.
2. **The Chief Executive** must enable strong clinical leadership and decision making throughout the organisation. Assessment of Chief Executive performance must include clinical outcomes, clinical effectiveness, and the establishment of clinical governance.
3. **DHB Governance** will promote and support clinical leadership and clinical governance at every level of the organisation. DHBs must report on clinical leadership and clinical governance through their District Annual Plans, their Statement of Intent, and scorecard reports to the Ministry. This reporting includes, but is not limited to, the functions of their Clinical Board.
4. **Clinical governance** must cover the whole patient journey, including horizontal integration across the sector and across primary and secondary/tertiary services. Tangible examples of clinical governance, which DHBs must report on, include:
 - a) Clinicians on the Executive Management Team as full active participants in all decision making
 - b) Effective partnership between clinicians and management at all levels of the organisation with shared decision making, responsibility and accountability
 - c) Decisions and trust devolved to the most appropriate clinical units or teams, which are many and varied, including clinics, offices and practices, wards and departments, hospitals and networks, regional and national bodies.
5. **Clinical leadership** must include the whole spectrum from inherent (eg surgery, clinic, bedside, theatre relationships) through peer-elect (eg practice, ward, department arrangements) to clinician-management appointment (eg clinical directors, clinical board). DHBs must report on the establishment, and effectiveness, of clinical leadership across the spectrum of their activities, aligning management to clinical activities.
6. DHBs and the health system must **identify actual and potential clinical leaders**, and foster and support the development of clinical leadership at all levels. To this end DHBs must together establish strategies to:
 - a) Provide on the job training to strengthen the competencies and attributes of clinical leaders
 - b) Measure the achievement of leadership competencies in their workforce

¹ *In Good Hands: Transforming Clinical Governance in New Zealand*, Report of the Ministerial Task Group on Clinical Leadership, March 2009, p3

- c) Link with Universities, colleges, and professional associations to coordinate funding, access to internal and external training, and support for coaching and mentoring of leadership at all levels.