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Dear Paul

Re: Post-entry training of New Zealand's future health workforce: proposed investment approach

Thank you for the opportunity to comment on the above consultation.

About the NZSA
The NZSA is a professional medical education society, which represents over 550 medical anaesthetists in New Zealand. Our members include specialist anaesthetists in public and private practice, and trainee anaesthetists. We facilitate and promote education and research into anaesthesia and advocate on behalf of our members, representing and championing their professional interests and the safety of their patients. As an advocacy organisation, we develop submissions on government policy and legislation, work collaboratively with key stakeholders, and foster networks of anaesthetists nationwide. The NZSA, established in 1948, also has strong global connections and is a Member Society of the World Federation of Societies of Anaesthesiologists (WFSA).

Overview
The NZSA has considered HWNZ's proposed investment approach for post-entry training and has some serious misgivings. The case for change made by HWNZ is that "the way in which training is funded is not responsive to future health needs" and that investment in post-entry workforce training is not currently able to be prioritised towards the Ministry of Health's strategic priorities. HWNZ says that it will invest less in low-priority training areas and redirect funding to high priority areas, seeking to justify a reduction in funding for current post-entry training. We agree with the statement made by the Australian and New Zealand College of Anaesthetists (ANZCA) that there is a growing consensus across the sector that there is a deficit in funding for vocational training, placing the sector under considerable pressure.

This deficit is apparent, and is in part illustrated by our high reliance on international medical graduates, and that the increase in medical student numbers has not led to commensurate funding increases for vocational training places. Rather than HWNZ's disinvestment approach, we need increased funding to invest and train in areas of need, without undermining our existing, high quality, safe training programmes which have a time proven

national and international level of competence. Shifting workforce vulnerability between specialty groups is not the answer. Additionally, HWNZ's proposal does not consider the interdependence of health roles and the multidisciplinary nature of health delivery, with a change in one profession, affecting other roles. ANZCA's example of an increase in cardiothoracic surgeons leading to an increased demand for anaesthetists and nurses is a case in point.

We have concerns about the proposed funding model, which would make it a 'contest' to obtain funding. A funding model which requires priority specialties to be determined on an annual basis will destablise the funding process, place a high administrative workload on our already struggling health sector, and fail to achieve an effective and efficient approach to recruitment and retention. In our submission, we also outline additional concerns, including issues relating to New Zealand's allied health workforce and overlapping scopes of practice. Ultimately, we don't believe HWNZ's approach is likely to resolve workforce problems such as shortages of certain specialties, and maldistribution.

Effective health reform
In light of HWNZ's proposed changes, we draw your attention to a recent publication that evaluates principles of effective health reform.

How to do better health reform: a snapshot of change and improvement initiatives in the health systems of 30 countries. Braithwaite J, Matsuyama Y, Mannion R et al. Int.J Qual.Healthcare. 2016 28 (6) 843-46.

New Zealand is included as one of these 30 countries. The conclusions in this review paper, of the recently published book by the same authors, make for interesting reading:

'*Our central point, however, remains: in all countries, rich and poor alike, effective independent evaluation of reform initiatives is currently lacking. Policymakers around the world tend to conduct retrospective, often politically motivated reviews, cherry picking programmes, which seem to work, so that they can report success to their superiors. This must change if reform is to succeed. Robust, comprehensive evaluation is essential. The positive hindsight bias these present "evaluations" rest on must not continue to prevent us from learning from success and failure.*

The experiences the book describes offer valuable lessons for health reformers. Firstly, before embarking on any reform or improvement journey, it is necessary to record baseline measures. Secondly, treat the change as an intervention, and measure the impact over time, using an arm's length group that is independent of those who funded, sponsored or managed the intervention. If feasible, have a control group in place which does not receive the reform or improvement to enable comparisons.

The New Zealand Health Strategy
In addition to the proposed investment approach document, we have assessed HWNZ's Annual Report to the Minister of Health 2015-16 and agree with the principles outlined in the New Zealand Health Strategy:

- Participants in the sector work together, sharing innovation and good practice, and supporting each other
- Professions' roles are clear and widely understood
- The sector sees improvement in sector leadership, cohesion, flexibility, diversity and sustainability.

We welcome the review of the role of the six work taskforces and their respective work programmes and, in particular, the review of the Workforce Service forecasts, commissioned by HWNZ in 2010-11, so that HWNZ can fully explain why "investment…is not currently able to be prioritised."

Health workforce maldistribution

HWNZ identifies the uneven distribution of the health workforce across the country, particularly in the rural and provincial areas and says that it needs to examine its whole investment in post-entry training (rather than just medical training), and to make funding more flexible, so the health workforce can meet "the changing needs of New Zealanders, changing models of care and changing practice attitudes." Changing models of care may involve expanding scopes of practice of non-medical health practitioners. The process for this must be transparent and evidence-based. Even more importantly, before changes are considered, barriers to working in rural areas must be identified and effective solutions developed. There is considerable data on this topic:

- A survey of New Zealand anaesthetic trainees in 2005 found that a rotation during training to a smaller rural hospital had a positive effect on trainees' attitudes to returning to rural hospitals as specialists.[1]
- In terms of specialist training, lessons can be learnt from the recent Queensland branch of a Royal Australasian College of Physician's commissioned study on the characteristics of Queensland physicians and the influence of rural exposure on practice location. Whilst a rural practice was associated with a rural childhood (OR 1.89), any time spent as an intern (OR 4.07) or registrar in a rural area (OR 4) made a more significant impact on taking up a rural post. Those with a metropolitan childhood and a rural internship were five times more likely to be working in rural practice.[2]
- Key recommendations from the paper *Funding of vocational training programmes for GP/family medicine in Europe* should be considered for all training programmes.[3]
    I. A structured curriculum for specialist/vocational training with appropriate placements more focused towards general practice and supported by protected time for teaching, courses, and seminars, personal learning plans and other teaching resources.
    II. Adequate funding for structured vocational training.

[1] King SY, McGeorge AD. New Zealand anaesthesia trainees and implications for the future workforce. Anesthesia and Intensive Care 2005; 33:651-655

[2] Runge CE, MacKenzie A, Loos C, Waller M., et al. Characteristics of Queensland Physicians and the influence of rural exposure on practice location. Intern. Med.J 2016; Vol.46 (8): 981-985

[3] Sammut MR, Lindh M, Rindlisbiacher B and on behalf of the European Academy of Teachers in GP. Funding of vocational training programmes for GP/Family medicine in Europe. European J.of GP. 2008 14(2): 83-88

III. Professional recognition of trainers, which includes a fair and appropriate salary for teaching and supervisory duties.
IV. Equity of salary for GP trainees in community and hospital posts within their community and hospital posts within their country, and for all trainees at a similar point in their careers in whatever specialty.

The anaesthesia workforce

The NZSA and ANZCA New Zealand National Committee jointly undertook a pilot anaesthetic workforce census in 2015 with clinical directors of public hospital anaesthesia departments. The response rate covered virtually the entire publicly employed anaesthesia workforce. The key findings were that maldistribution continues to be an issue for New Zealand's anaesthesia workforce and that overall it is in a delicate balance, with heavy reliance on international medical graduates (44.8 percent) and difficulty recruiting specialists to permanent posts in smaller provincial hospitals. Other findings included:

- A high proportion of anaesthetists aged 50 years and over (40%)
- Sixty-seven per cent of clinical directors considered their department's FTE was inadequate to meet their caseload
- Seventy percent of department heads cancelled lists due to *no anaesthetist*, in the previous 12 months
- Seventy percent cancelled annual leave or other leave requests
- There were a relatively low number of eligible applicants per vacancy (especially in the smaller hospitals).

The NZSA supports an investment approach to address the maldistribution of anaesthetists in New Zealand and would like to see funding allocated to establish ANZCA accredited training posts in rural areas, with rotation of trainees from the metropolitan centres. Funding would enable specialists in those areas to provide teaching and supervision and would allow trainees to gain experience in the area and to be knowledgeable about the area's health needs. This approach would also improve continuing professional development for local specialists.

The specialty of pain medicine

The NZSA supports ANZCA's view that there is a need for HWNZ to fund secondary specialties, such as pain medicine physicians. As ANZCA highlights in its submission: "New Zealand has a significant shortage of this sub-specialty with about 11 FTE, versus an internationally recommended 47 FTE based on population size. New Zealanders also have a high burden of chronic pain with 20.8 per cent of the population suffering from chronic pain according to the 2015-16 results of the Ministry's National Health Survey." Increased investment is needed to address significant unmet need in treating pain. If a disinvestment approach is followed this may lead to reduced trainee numbers in this specialty. We also note that acute pain management is poorly taught at all levels beginning at medical school, through to primary care level programmes, nursing and so forth and may be contributing to the burden of narcotic addiction. Funding should also be directed to training pain specialists who can contribute to education throughout the sector.

Changes to specialties and overlap of vocational roles
We believe HWNZ's investment approach should be underpinned by an increase in the overall vocational training budget, with more funding directed to areas of shortage without placing other areas which are in delicate balance at risk. Funding could be allocated to DHBs with HWNZ's role being to advise where funding should be focused, based on workforce projections.

The NZSA supports HWNZ establishing formal access to the expertise required to oversee and drive the rationalisation of workforce planning, education, training, development and purchasing. This could be via expert advisory groups, but these groups would need to be carefully configured to ensure they offer the required expertise. HWNZ's current workforce taskforces may need to be disbanded and more recognition given to the overlapping nature of vocational roles, the interaction between vocational training programmes, and the establishment of national standards to ensure consistency and competence. These principles are highlighted in HWNZ's Annual Report 2015-2016 case study of nurse endoscopy. Representatives from a range of organisations, including the NZSA, developed the nurses performing endoscopies training programme to increase health workforce capacity and capability in anticipation of the national bowel screening programme. Members of the NZSA Executive provided input into the training process. The NZSA was brought into this process at a much later stage than the other groups, when sedation services were being considered. It became apparent that the dual role undertaken by New Zealand Gastroenterologists i.e. as endoscopist and prescriber of sedation, needed careful consideration in the new proposed expanded scope of practice. The ANZCA document PS09 on the provision of safe sedation had not been ratified by the New Zealand Gastroenterology community – however, this has now been corrected. The process led to consideration of vocational training in sedation within ANZCA, the sedation training needs of other vocational trainees e.g. gastroenterology and oral surgery, and the need to establish national guidelines for sedation services as per recommendations made by the Royal Colleges of Great Britain.[4]

The essential role played by disciplines such as anaesthesia in vocational training of other groups could be undermined by HWNZ's proposed investment approach. Trainees in other disciplines may have less access to essential training in an environment where access may already be limited. The following review highlights these concerns:

A lack of anaesthetic clinical attachments for Emergency Medicine Advanced Trainees in NZ: perceptions of directors of emergency medical training. The results and conclusions from this 2015 review are as follows:[5]

Every year 15 anaesthetic training posts are set aside for 145 advanced trainees (ATs). Most Directors of Emergency Medical Training (DEMTs) thought that an anaesthetic term was important for progression of vocational training, and a majority thought that term availability was a significant barrier to progression of training. A number of DEMTs felt that

[4] Chapter 19, Guidelines for the provision of anaesthesia services, Guidance on the provision of sedation services 2016 https://www.rcoa.ac.uk/system/files/GPAS-2016-19-SEDATION.pdf
[5] Browne A. A lack of anaesthetic clinical attachments for Emergency Medicine Advanced Trainees in NZ: perceptions of directors of emergency medical training. NZ Med.Journal Aug. 07 2015, 128 (1419): 45-

procuring and maintaining anaesthetic posts was difficult, some citing a lack of collegiality from anaesthetic departments. Some DEMTs and ATs used novel approaches to procure anaesthetic attachments.

The disestablishment of these positions remains a concern for some departments, and the lack of availability in some hospitals means that trainees are lost to these institutions, as they have to relocate to maintain training momentum. The view of DEMTs is that ACEM, ANZCA, anaesthetic departments, HWNZ and DHBs need to collaboratively address the paucity of anaesthetic training positions available for emergency trainees.

New Zealand's carefully planned and innovative Rural Practice Training Scheme,[6] based on successful overseas models, also requires rotations of three months within anaesthesia or intensive care. Establishing accredited anaesthetic training positions in our country's rural hospitals could improve access for these trainees and lessen the need to move districts to complete their training modules.

Anaesthesia and the allied health workforce

Anaesthesia is involved in the training of the allied health workforce, namely assistants to the anaesthetist. As early as 1968, the NZSA was campaigning for a training scheme for technicians. The NZSA has been a strong supporter of this profession (whether anaesthetic technicians or registered nurses to the anaesthetist) to ensure comparable standards and competencies which deliver the best care to patients. This support has included training and assessment of competence that adheres to standards outlined in the ANZCA document PS08 Statement on the Assistant for the Anaesthetist, input into the curriculum and examination process, and ongoing dialogue with stakeholders such as the education provider (AUT) and the representative bodies for ATs and RNAAs.

Almost 50 years since the inception of the innovative training process for technical assistants we are still facing a severe shortage of assistants to the anaesthetist. The scope of practice of these allied practitioners is limited. If the expansion of scope and training had been supported and funded appropriately in the past, we would now have a multifunctional technical workforce able to provide support not only in theatre but in EDs, ICU and for management of emergencies in other areas of our DHBs.

Although not directly related to anaesthesia, Skinner et al in their article "Future of specialized roles in allied health practice: who is responsible?"[7] provide valuable insight and comments on the situation in New Zealand.

The abstract outlines that allied health professions have developed specialised advanced and extended scopes for their roles over the past decade, for the benefit of patient outcomes, and to meet labour and workforce demands. There is an essential need for formalised, widely recognised training to support these roles, and significant challenges to the delivery of this training remain. Many of these roles function in the absence of specifically

[6] Nixon G, Blattner K, Williamson M, McHugh P, Reid J. Training generalist doctors for rural practice in New Zealand. Rural and Remote Health 17:4047 (online) 2017

[7] Skinner EH, Haines KJ, Hayes K, Seller D et al. Future of specialized roles in allied health practice: who is responsible. Aust. Health Review 2015; Vol.39 (3): 255-259

defined standards of clinical practice and it is unclear where the responsibility for training provision lies. In a case example of physiotherapy practice in the ICU, clinical placements and independence of practice are not core components of undergraduate physiotherapy degrees. Universities face barriers to the delivery of postgraduate specialised training and, although hospital physiotherapy departments are ideally placed, resources for training are lacking and education is not traditionally considered part of healthcare service providers' core business. Substantial variability in training, and its evaluation, leads to variability in practice and may affect patient care and outcomes. Allied health professionals working in specialised roles should develop specific clinical standards of practice, restructured models of healthcare delivery to facilitate training, continue to develop the evidence base for their roles and target and evaluate training efficacy to achieve independent practice cost-effectively. Healthcare providers must work with universities, the vocational training sector and government to optimise the ability of allied health to influence decision making and care outcomes for patients.

HWNZ appears to have little appreciation of the time and effort undertaken by the local societies, professional bodies and colleges to support, promote standards, train, and assist assessment of competence which helps to maintain an allied health service of the highest standard. The proposed disinvestment approach to post entry training has the potential to undermine this process.

Potential reduction in trainee numbers
HWNZ's approach has the potential to reduce trainee numbers, which would exacerbate the vulnerability of our health workforce. This would have far ranging consequences including making rosters more difficult to manage, especially in our smaller hospitals, adversely impacting on patients with less staff available, and reducing the volume of practice available to trainees.

Administrative burden and patient care
HWNZ's proposed model for contestable funding would aggravate the pressure on our health sector by requiring groups to invest time, expertise and resources to develop funding proposals. The high administrative burden would increase the workload of already overburdened Clinical Directors.[8] Clinician time will be diverted from providing a service by constant demands to justify trainee positions and why their specialty is one of need and high priority – potentially affecting the quality of services to patients.

Thank you again for the opportunity to comment. If you would like further information or have any questions please email: president@anaesthesia.nz

Yours sincerely

David Kibblewhite

David Kibblewhite
President

[8] Thomas GL, McHugh GA, Pollard BJ, Moore J. Anaesthesia Clinical Directors in the UK: organization objectives and support needs. Anaesthesia 54 (8):753-60 Aug.1999