NZRDA

New Zealand Resident Doctors' Association

Rural Hospital Training Programme - Update

20 February 2018

Dear Colleagues

NZRDA has been participating in a Rural Hospital Medicine (RHM) Training Programme "group" for a little over 18 months now. First established to try to assist the RHM programme, it includes DHB representatives at both CMO and RMO Unit level, the Rural Health Medicine chapter of the RNZCGP and the college itself, and the director of the South Island Workforce Development Hub.

Things have moved at glacial pace; however, it is now getting to the pointy end of the discussion, and therefore this report is in order. Key issues include funding and placements, given that the programme requires both rural GP and rural hospital placements but also DHB-based rotations such as those in paediatrics, ED, medicine, ICU/anaesthetics and possibly O&G.

Placements are arranged through the RHM coordinators through the RNZCGP. Rural hospital and GP placements appear slightly easier to arrange than DHB placements, although funding is a potential barrier (see below). When it comes to hospital-based placements, both benefits and problems arise. In no particular order:

1. Given the inconsistent need for runs (both in terms of what type and also when), it is hard for DHBs to plan and therefore accommodate.
2. There is the risk RHM trainees could displace hospital-based specialist trainees or vice versa. Priority at law goes to current employees, which the RHM trainees are least likely to be. However, they would also be competing with other trainees coming from other DHBs. In specialties where there is competition for runs, this issue will be acutely felt.
3. The RHM Programme is not an employer so it has no authority in the employment relationship and cannot require runs. However, it can dictate, as the training provider, which runs must be performed to qualify. This is cold comfort to the programme, however, when what they are seeking to achieve is a viable programme producing fellows at the end of it.
4. When a RHM trainee is DHB-employed, they receive the benefits of the MECA, including costs of training, which they do not get in other placements in GP or non-DHB-run rural hospitals (e.g. those run by trusts). This results in trainees "saving up" receipts for costs of training associated with the RHM programme and submitting them to the DHB for reimbursement.
5. The registrars do not routinely get transfer expenses, again because their employers in rural hospital trusts etc. are not party to the MECA. Again, they are disadvantaged over colleagues in hospital-based training programmes.

This brings us to funding. This is currently somewhat *ad hoc*, with HWNZ providing some funding but on an individual basis and to non-DHB employers through a number of avenues. The lack of funding, lack of coordination and transfer of costs to the DHBs produces inequities across myriad stakeholders.

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What are we planning on doing…?

1. We are forming a group to look at the employment and run access issues for RHM Trainees in the DHBs.
2. The matter of funding will be raised at HWNZ's Medical Advisory Group for discussion. Hopefully we will be able to secure sufficient funding through a secure route to assist trainee progress through the required elements of the programme. Should a funding bucket be kept by a DHB entity or the college? Can we secure a funding stream that has a 3-year window rather than the current annual allocation, which prevents future planning and security for participants in a programme that takes 4 years to complete.
3. We are looking at mechanisms to entitle RHM Trainees to access the MECA even if their employers are not specific parties (because the DHBs will resist this).

The group will continue to meet to progress issues and we will report back when anything significant arises. In the interim, please let us know your thoughts.