Treating Doctors Well, Treating People Well

A plan to retain a sustainable, predominantly New Zealand trained medical workforce to deliver high quality health care to the people of New Zealand.

Treating Doctors Well, Treating People Well:
A plan to retain a sustainable, predominantly New Zealand trained medical workforce to deliver high quality health care to the people of New Zealand.

1. Incentivise permanent employment in public health services.

2. Ensure sufficient and appropriate positions for the increased number of New Zealand medical graduates.

3. Integrate general practice and hospital-based training options.

4. Provide sufficient resources for doctors to train and be trained.

5. Recognise and respond to the work-life balance needs of doctors and their families.

6. Provide facilities and resources for doctors that are conducive with, and encourage a healthy and productive work environment.

7. Provide reliable health care and workforce data to inform and plan for the future needs of the New Zealand health system.

8. Foster the relationship between doctors and their employers characterised by constructive engagement.

9. Provide a healthy and safe medical workforce.

INTRODUCTION

The current government campaigned on a platform of reducing bureaucracy, making DHBs accountable and not inflicting yet more structural change on the health sector. Yet we find that the two reports released earlier this year, *Treating People Well* ("the RMO Commission Report") and *Review of health workforce education funding in New Zealand – how the training of the New Zealand health workforce is planned and funded: a proposal for a reconfiguration of the Clinical Training Agency* ("the Gorman Report") suggests exactly the opposite is proposed.

Whilst the New Zealand Resident Doctors' Association ("NZRDA") agrees that there is a need for a centralised system for such things as workforce data collection and projections, the benefit attributed to having yet another structure to "coordinate" training for resident doctors is not clear. Surely making the Ministry and DHBs accountable for their activities would avoid the creation of further bureaucracy but achieve the same result.

In responding to the current plethora of committee documents on the medical workforce, NZRDA considered a list of matters that appear agreed, and which if put into practical operation would retain a sustainable, predominantly New Zealand trained medical workforce to deliver high quality health care to the people of New Zealand. These appear on the first page of this document.

We believe that given the level of agreement to these principles, lines of accountability to achieving such are where our energies should be focused, not on the creation of more bureaucracy to reinvent the wheel, or potentially break it.

What follows is a series of documents, amalgamated as best we can, which seek to raise some potential unintended consequences that could flow from the reports currently under consideration. we also enclose more information on potential benefits from change in the integration of general practice training with that of secondary/tertiary training; a matter that is already under consideration between the RNZCGP, NZRDA and DHBs through our MoU partnership programme.

We are concerned that the reports relied on far too little factual information and worse still incorrect assertions, and that throughout a flavour of “doing it to” the workforce exists in contrast to “doing it with” us. As the recent Labtest debacle should have taught us, failing to listen to the clinicians directly affected is a mistake and in this day and age of clinical governance, contrary to accepted practice.

The NZRDA reiterates:

1. We already have national coordination of first year house officer training through the Medical Council and for those in vocational training programmes through college programmes. Integration of house officer and registrar training, recognition of prior learning and “cross crediting” is already occurring. The option of seeking further flexibility within college training structures is available by direct discussion with the colleges.

2. In the other house officer years we already have doctors:

    a. Enrolled formally or following pathways informally towards their vocational pathway, or

    b. Choosing runs and work experience that allow expansion of their experiences, or

    c. Taking time out whilst still undertaking a process outlined in (b) above, simply at a slower pace.

3. Those house officers in the latter group are not in some training void as evidenced by the fact that they can be undertaking the same runs as first years, with the same experiences and options for training simply at a higher level, or runs denied to first years due to the greater skill development required – which second years and above have.

As another example, NZRDA, DHBs and the RNZCGPs have already commenced discussion on the integration of primary sector training with secondary at house officer, registrar, rural and urban levels. Would a third party bureaucracy have assisted with this?

We doubt it would have assisted with the pragmatic applications needed to be considered, although could have provided data and planning information material. However, should that not have been the role of the Ministry?

Given that the CTAB has already been formed, our views on this matter may be somewhat after the fact. However what happens next should not be. There is very real potential that some of the notions behind these reports will be detrimental to the retention of this workforce. For instance, is "central coordination" jargon for (amongst other things) deployment. This will be strongly resisted by resident doctors and many will simply choose not to practice in our vocational pathway system if that means the sacrifice of having to leave family etc behind. In today's world, the suggestion that any professional group of employees could be so used, is quite simply outrageous, yet implicitly underpins the reports' aims.

Much has been said about the MECA, but unfortunately little commentary has been based in fact or a genuine understanding of the provisions of this document.

We suspect the Commission's failure to appreciate significant elements of the MECA provisions stem from the paucity of factual submissions made. Even DHBNZ (the DHBs' industrial submission) incorrectly attributed provisions to the RDA MECA such as long service leave. Other submissions referred to maximum working hours as 55 per week where as MECA actually provides for a 72 hour per week maximum. The list of misinformation through to frankly wrong assertions is considerable.

We did challenge the Commission to seek examples of what is allegedly wrong with the MECA as opposed to vague references to flexibility and other terminology conveniently used to invoke a political reaction, however they appear to have failed to do so. Reference to the need to have protected training time contained in our job descriptions is a case in point – it already is. The problem is not the MECA but the ability to access the time due to the pressure of patient workloads. NZRDA could certainly be more industrially assertive in demanding the contractual entitlement to protected training time, although at this time is working through that issue (amongst others) in our partnership process (MoU) with the DHBs.

Furthermore to assert (as the current Gorman Road show is) that we need a Greenfields approach to MECA (starting again with a blank page) is irresponsible at best and tantamount to inflicting industrial mayhem on the parties.

The MECA has been signed by the employer and employee parties to it; claims from the employers to change the MECA are rare, suggesting a level of acceptance of its provisions, or at least an inability to mount any sufficiently robust argument against such. At law, employees are entitled to negotiate their employment agreement containing terms and conditions. Why should resident doctors not be entitled to the same respect and rights as any other group of employee, whether inside the health sector or not?

The suggestion inferred in the above section on MECA that resident doctors should not have some fundamental rights (e.g. to negotiate terms and conditions of employment) resonates through the Gorman Report. After the Labtests debacle in Auckland, we would have thought the importance of listening to those directly affected by change, especially when that change can have a sizable impact clinically, should be respected. However the Gorman Report fails to do this.

Resident doctors are treated by the report as if a commodity, something that will simply follow a centrally designed grand plan. This is not necessarily the case. Ignoring the views and wishes of this essential current and future workforce and, worse still, assuming that they will respond to having things done "to them" as opposed to "with them" is a mistake.

Whilst the future SMO workforce[1] will comprise current SMOs, it will increasingly comprise current resident doctors who will become SMOs. With an expressed desire to have more SMOs especially GPs and as a result 200 more medical student placements being funded, our focus should be directed to ensuring that these additional resident doctors are retained and trained to become those SMOs and then retained as SMOs. Incentivising doctors with this fundamental goal in mind must be a core goal and is acknowledged by the Commission report in that it recommends incentivising permanent employment (over locum work) through remuneration as well as improvements in physical facilities. NZRDA agrees with this approach.

[1] Reference to SMO in this document means vocational registrant including those on general practice.

TRAINING VS SERVICE

Introduction

1. This document is in part the New Zealand Resident Doctors' Association's response to a number of Commission and other reports released by the Minister of Health mid-2009, in particular:

    a. *Treating People Well* - the report of the Director-General of Health's Commission on the Resident Medical Officer Workforce, dated 11 June 2009 ("the RMO Commission Report"); and

    b. *Review of health workforce education funding in New Zealand - how the training of the New Zealand health workforce is planned and funded: a proposal for a reconfiguration of the Clinical Training Agency*, the report of the Minister of Health's Taskforce (headed by Professor Des Gorman) dated 17 April 2009 ("the Gorman Report").

2. Both these reports recommend that third party entities should be established or strengthened to (i) employ resident doctors (the RMO Commission Report) or (ii) oversee doctors' post-graduate training (the Gorman Report).

3. We consider the former proposition doomed to failure if put into effect by the Government (both propositions requiring considerable legislative change).

4. Both reports were produced by a Committee or Taskforce heavily stacked with academics, and the reports produced by those committees reflect their constituency. The reports fail to consider the workforce dynamics of:
    a. The labour market in which doctors are employed;
    b. The doctors' views as to their employment, now and in the future;
    c. The operational realities for doctors in the workplace; and
    d. The importance of maintaining quality and standards.

5. The reports also fail to appreciate the holistic way in which training occurs for resident doctors while they work – which again, may be because of the

university academic background of most of the Committees. Resident doctors begin their working lives after six years of academic study and must then face the task of turning that academic knowledge into the art of caring for patients. That learning is done by caring for patients, in a team (where the registrars will teach and supervise the house officers and the consultants will teach and supervise the registrars).

6. The team learning experience is frequently described as an apprenticeship (we have done so ourselves) but it should not be forgotten that resident doctors are in fact doctors, and although supervised by vocational registrant doctors, the residents work alone "at the coalface" of our public hospitals for much of their time. Overnight and in the evenings, our public hospitals are manned by residents, with few if any vocational registrants on duty.[2]

Training versus service

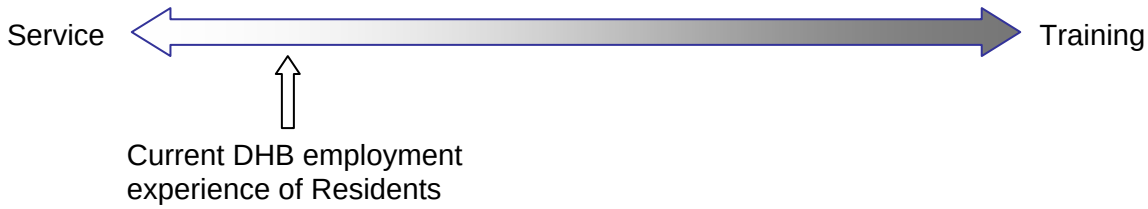
7. Having completed their degrees and become doctors, residents who stay in New Zealand commence work at pubic sector hospitals and begin working. Their post graduate training now principally occurs at the workplace in an organic fashion. Certainly there are more formalised learning experiences offered by the DHB employers (or there should be) with Grand Rounds, and studying for College exams if in a vocational training programme[3], or seeking to enter one, but the great majority of a resident's learning now happens "at the coalface" while caring for patients.

8. Residents and their supervisors understand that there is this interrelationship between training and service, and appreciate it (as do most hospital consultants): they will resist any disruption of the link between training and service. The DHBs, too, ought to understand the interrelationship of service and training and enhance and promote it.

9. The interrelationship can be depicted as a continuum, as follows:

[2] Timaru Hospital for example, has only house officers on duty at night.

[3] Some registrars will enter vocational training, but not all. Vocational training is overseen by the medical colleges, which apart from the RNZCGP, are all Australasian organisations. The Colleges arrange for their own supervision of trainees, but these supervisors are typically College members who are employed at the DHB where the resident is employed.



10. More recently, DHBs have been under such pressure to deliver service that the pendulum has moved too far towards the service end of the spectrum, and the quality of training of residents has suffered. An example is when budgetary pressures are such that a full complement of medical staff cannot be retained/recruited so that the team structure of house officer – registrar – consultant collapses. The training delivered by that structure while caring for patients is lost, and also the quality of the patient care is compromised.

11. When the pendulum moves too far in the direction of service (as is occurring now), the following will occur:

    a. Residents become disillusioned with their training and their employment, and their attitude to both will change as a result;

    b. The costs to the DHB employer will increase because (i) "service only" doctors are more expensive to employ; and (ii) if training is not delivered, residents will seek to be rewarded in some other way by their employer;

    c. Residents leave their DHB employers to work elsewhere. At present residents are leaving DHB employment to work as locums, as general practitioners, and to work outside NZ, principally in Australia;

    d. The quality of the service delivered to patients' decreases because of the discontent of the workforce, the lack of training, and effects such as the breakdown of teams as described above.

12. If the pendulum moves too far in favour of training:

    a. The quantity and quality of the service will suffer;

b. The quality of the training actually diminishes, as the residents need the training offered by caring for patients, rather than academic or didactic type training[4]; and

c. The relevance of the training diminishes[5].

13. NZRDA contends that the establishment of a third party employer which does not also offer service to patients will disrupt the continuum, and possibly destroy it all together.

14. Similarly the establishment of an external training body which may fail to appreciate the nature of the continuum or fail to enhance the balance between service and training will be catastrophic for the New Zealand health system.

Implications for the NZ health system if a new single employer is established (as recommended by the RMO Commission)

15. The RMO Commission recommends that a stand-alone body should be established responsible for employing residents:

> "*We recommend a single national employer and a national employment agreement that governs pay, terms and conditions for resident doctors[6]. Developing national employment arrangements that support flexible service delivery for patients and strong mentoring relationships between RMOs and clinical teams is an urgent issue.*
>
> *While we recognise that the sector is already fragmented, and there needs to be clear justification for recommending an additional body, we are of the view that providing oversight and setting standards for medical education and training and good employment practice requires different skills which cannot both be done to a high level by one body."*

[4] A simple example is the requirement for all surgical trainees to accumulate a certain number and variety of surgical procedures, which are recorded in a logbook which a trainee is required to keep.
[5] E.g. NZ practitioners become more highly skilled than their overseas counterparts at treating children with asthma, because of NZ's high incidence rates, when compared to the rest of the world.
[6] Residents already have a national employment agreement for those in DHB employment – the DHB/NZRDA MECA – which governs their pay, terms and conditions.

16. We believe that a new single employer will completely disrupt and possibly destroy the interrelationship between service and training. We also doubt whether it could even be implemented, for the following reasons.

    a. There are already multiple employers of residents in New Zealand. There are the 21 DHBs, the Ministry of Health[7], numerous General Practices, entities such as community trusts which operate hospices, the Universities[8], locum agencies and some are self-employed. While the Government might pass legislation to allow the establishment of a new employer of resident doctors, residents cannot be obliged to work for that new employer. They may exercise their right to be employed by another employer, which could be any of the above list of current employers, or any new employer which might wish to set itself up in competition to the new employer established by the Government.

    b. The employer will have to enter into contracts of service with the DHBs whereby the residents' labour or service will be sold to the DHBs so that they can staff their hospitals. As such it will be little different from the other locum agencies that currently exist.

17. So with a separate employer, where will the residents get their training? The DHBs will have the training opportunities available to residents "at the coalface" as described above, but their responsibility for training will be left up to the new employer: the DHBs will now have NO obligation to ensure that the residents are trained. Unless of course the new entity focuses on training as a priority in their contracts with the DHBs which will push our pendulum towards the training end of the spectrum, at the expense of service and our DHBs will inevitably react to deliver the service through other means. These other means may be through SODs (see below) or alternative systems such as physician's assistants which risk access for those in training to the clinical material needed to train.

18. Meanwhile the consultants presumably may still be employed by the DHBs (although the establishment of a separate employer for residents may encourage consultants to consider new contracting arrangements for their

[7] The Ministry of Health employs public health registrars
[8] The Universities with Medical Schools employ residents to work in areas of research.

employment too). With DHBs no longer obligated to provide training to their own resident employees, we anticipate a distancing effect, with less impetus upon the consultants to deliver good training experiences for the residents. The only way in which a resident can ensure that their training is provided by the consultant is to rely upon their separate employer to enforce its contract with the DHBs. Inevitably, we believe that less and less training will be delivered by the DHBs or the DHB working experience to resident doctors.

19. Ultimately we believe that the following will occur:

a. Residents will not all agree to be employed by the new "single" employer;

b. Those that do will be less well trained, with a diminution in the quality of NZ trained doctors and/or the training will take longer to complete;

c. New Zealand will no longer be a competitive training provider of residents in the international labour market, so that more NZ trained doctors will move overseas to take up training opportunities there, and fewer overseas trained residents will wish to come to NZ to take up employment;

d. The "single" employer will have insufficient residents employed in order to meet the service demands of the DHBs, and the DHBs will have to contract that labour from other employers, leading to higher costs for the DHBs.

e. The 21 DHBs will consequently have to compete with each other for the labour of the residents offered to them by the various employment agencies, including the "single" employer.

f. There will be an increase in the "casualisation" of the resident workforce, as the residents increasingly view their labour as separate from their training.

g. While the current exponential growth of the locum workforce is currently of concern to the DHBs and the Government, we think it

inevitable that the establishment of a new employer separate to the DHBs as akin to the establishment of a new locum agency, simply larger and Government operated than the locum agencies already in existence.

h. There may be nothing to prevent DHBs from directly employing residents.

Implications for the NZ health system if a new training entity is established (as recommended by the RMO Commission Report) or if the CTA is revamped (as recommended by the Gorman Report)

20. The RMO Commission recommends:

"The Commission recommends that …leadership and accountability for RMO training is assigned. The Commission supports the directions of the MTB reports and the CTA review to a new national training body. We recommend such a training leadership body:

- *Takes responsibility for health workforce planning in response to service configuration, models of care and in turn to national, regional and district service plans*
- *Ensures training time is protected in RMO job descriptions*[9]
- *Increases RMO training opportunities in the primary health sector*[10]
- *Ensures locum positions do not count toward training requirements*[11]*"*

21. The Gorman Report states:

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

[9] This already is the case – residents' job descriptions are known as run descriptions, which are required to set out the Protected Training Time entitlements for that run, pursuant to the DHB/NZRDA MECA.
[10] This is already currently occurring, but there are issues to be addressed in respect of those registrars. NZRDA and the RNZCGP are currently working together attempting to address those issues, and that work has been tabled at the MOU [Memorandum of Understanding] Executive (established pursuant to the DHB/NZRDA partnership agreement).
[11] There is no logical basis to this assertion. Locum duties can consist of a few hours work, to a complete run of 3 or 6 months, or 1 year (for example when filling in for another employee on parental leave). The actual work and training experiences enjoyed by a locum can be indistinguishable from those of a permanent employee. It is the quality of the training experience which should be considered when determining whether it should be counted, not the employment status of the resident at the time.

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

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

…

- *The Minister of Health should be responsible for the purchasing of health worker training on the advice of a singular health workforce training (planning and funding) agency.*
- *The health workforce training (planning and funding) agency should be governed by a board that is strongly representative of employers in the broader health service.*

…

CTA reference groups …Each program and project leader will have access to a reference group or groups, which, in turn, will either be amalgamated with or that will have unfettered access to the relevant MoH date and personnel. Some such as the medical reference group (MTB) … will underpin core programs and will meet regularly as part of the CTA annual planning cycle. The medical reference group should also serve as the junior doctor apprenticeship board.

...

22. As to these recommendations, again, we foresee a diminution in the quality of training offered to residents, if it is separated from their DHB employment.
As per our submission to that Commission, we agree that there are currently problems as regards resident employment and training, but we see the solution lies in moving the pendulum in the training vs. service continuum towards the middle of the spectrum. We suggested that the DHBs should be made to account to the Ministry of Health for successfully retaining resident doctors in their employment, in a fashion similar to the way DHBs are currently required to account for their financial performances.

Service only doctors

23. We foresee all the recommendations of the Commission/Taskforce as discussed to date as likely, if implemented, to trigger a growth in the employment of "service only" doctors or SODs. There are SODs already in the NZ health sector – such a doctor can be known as a MOSS[12] and many such doctors practise as general practitioners as general registrants who are not pursuing vocational registration.

24. We see the growth in their number as a flow on effect from the breakdown of the training vs. service continuum, and the effects of that breakdown as described above.

25. Those flow on effects will be exacerbated by the increase in medical school graduates with 200 more positions to be created at NZ Medical Schools.

26. Currently the great majority of NZ medical graduates enter DHB employment and become residents[13]. After completion of their house officer years, most will become registrars, some of whom will move to general practice employment and/or training. The sector then has an expectation that registrars will seek to enter vocational training with a medical college, and upon completion of that training, will then join the SMO workforce needed for the delivery of healthcare in New Zealand, although both resident and SMO numbers are also supplemented by overseas trained doctors.

27. The NZ healthcare system is therefore dependent upon residents wanting to strive for vocational registration in sufficient numbers to provide for the SMO workforce of the future. It has been recognised by numerous recent publications that NZ's health system will be at serious risk if it relies too heavily on a continuing inflow of overseas trained doctors and there are also recent signs that interest amongst such doctors may be waning, and there are other attendant problems with reliance on overseas sources of medical training.

[12] Medical Officers on Specialist Scale, being a general registrant who is employed pursuant to the ASMS collective employment agreement.
[13] Until 2007, almost 100% of NZ graduates entered DHB employment.

28. So we need to be wary of factors which might influence residents in their career decisions. We see the following as major influences:

a. DHBs will employ more SODs if there are insufficient residents to provide for service needs;

b. DHBs may employ SODs in preference to residents e.g. SODs do not need to move between DHB employers, do not need to be away from the service in order to study and sit exams etc;

c. SODs are currently paid more (especially when allowances such as Continuing Medical Education allowances are taken into account) than residents[14]

d. DHBs, if solely concerned with service delivery, may seek to have residents work proportionately more hours outside ordinary hours.

29. Besides the likely effect of such a change on residents, we expect that:

a. NZ will produce fewer SMOs from its own workforce;

b. Costs of employment will rise (SODs are not cheaper to employ than residents);

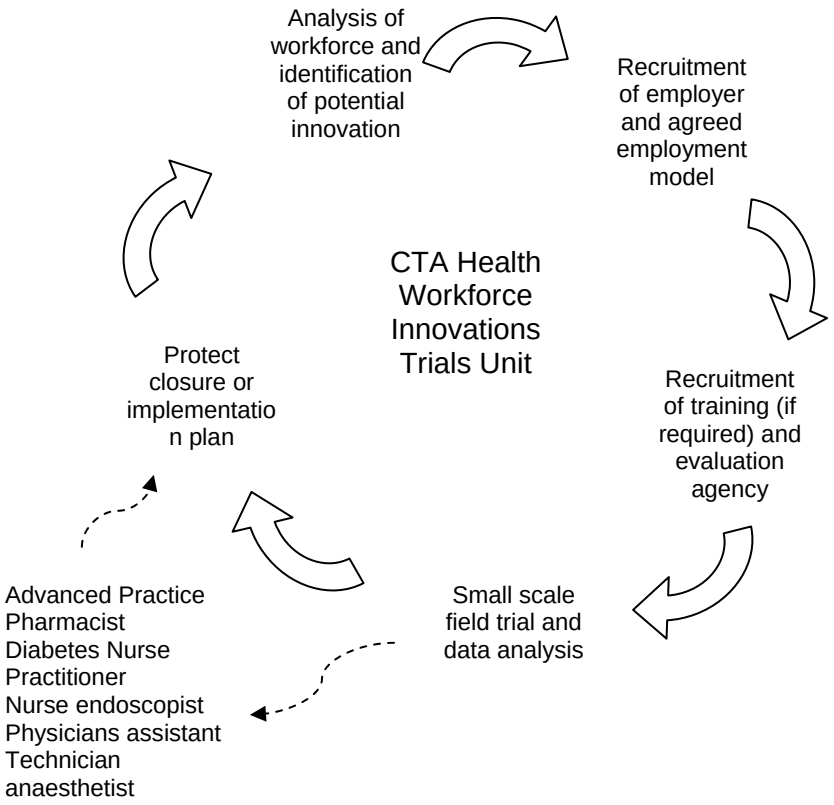
c. Residents will exit the NZ system (to go overseas or work in general practice); fewer will seek to enter vocational training and/or will take longer to complete their training;

d. There will be a diminution in the quality of NZ doctors, with residents training less vigorously and more SODs (being general registrants not in training, with an attendant risk of their skills not being kept up to date or advanced).

Innovative health service provision

[14] See Appendix A

CTA Health Workforce Annual Planning Cycle



30. The above diagram is taken from the Gorman Report. The report states that a single agency (a re-constituted CTA) is needed if NZ is to have "an affordable and fit-for-purpose health and disability services workforce".

31. We are concerned that the report does not attempt to address the inherent conflict between affordability and quality when discussing NZ's workforce. As a result there is no attempt to address how quality might be maintained or attained. At present the registration boards' (working under the HPCA) main emphasis is on quality, by virtue of the statutory requirement that they should ensure the safety of the public.

32. Somewhat ironically (to us given our concerns in this regard) the Gorman Report describes the HPCA as a "barrier to reform". The report notes that only one new health profession has been recognised (the implication being that the HPCA somehow inhibits other groups from being registered) but does

not attempt to analyse why this should be so, or even whether or why other potential groups have not been recognised.

33. For the reasons described earlier in this report, we expect that the reforms recommended by both reports will reduce the number of “fit for purpose” doctors, will cost more than the current system and will result in a reduction in quality of our doctor workforce.

34. Physicians assistants (specifically mentioned in the diagram above) may be intended to assume some of the roles currently undertaken by doctors. It is our expectation that the introduction of this new health workforce will lead to an increase in cost, competition for access to training resources need for doctors to train and a decrease in quality. There is no evidence to suggest that this workforce (if established) would cost any less than the resident doctor workforce – in the US, physicians assistants earn more than US$80,000 pa and those in Australia are already claiming to be paid the same as doctors.

35. Any new health workforce group, once present in the system in any kind of number, can be expected to collectively organise and seek improved terms and conditions, including pay. The skills they have and the work they perform will be then assessed as against other groups, but if they are in demand in terms of delivering to the health service, they would be expected to be able to achieve higher terms and conditions.

36. We note, too, that there is discussion of the potential for training in the private sector. This issue alone is deserving of a paper in its own right, and we should not ignore the Australian experience (where consultants employ health practitioners in training in their private practices and the service/training continuum again becomes tipped in favour of service delivery at the expense of the quality of the training – whether the trainee is a doctor or not).

The Future Direction for Training in General Practice in NZ

Overall Consensus appears to exist on the following:

1. We need to train more GPs, rural and urban.
2. The training of general practitioners requires a programme and ideally for all new GPs to undertake the programme.
3. We need better integration of community and secondary/tertiary training.
4. We need a better continuum between house officer opportunities and registrar training in GP
5. Those training in GP must be treated fairly and in an equitable manner to those training in any other specialty. Fairness and equity must apply to both the training and employment of those in GP as to any other specialty.

Brief description of the General Practice Education Programme (GPEP)

Few house officers get the opportunity to undertake a run in general practice. Not only are the available placements limited they are primarily in rural GP. Furthermore in order to undertake such a run, the house officers are at the very least required to take leave without pay from their employing DHB during which time they will enjoy lesser conditions and benefits than their counterparts who remain in hospital employment.

Post graduate training in general practice predominantly starts as a registrar. The first year is 10 months long where the GPEP 1 registrar will spend time in two different practices. Formal teaching sessions one day a week are provided by the college. At the end of this time the registrar will be expected to sit the “Part I” (PRIMEX examination).

Post PRIMEX registrars in GPEP 2 and 3 arrange their own employment and continue to pursue a largely extramural programme with the college with regular assessments and course work to be completed throughout.

Completion of the entire programme gains the individual vocational registration in general practice and admission to the college as a fellow.

1. Inequity between specialist training in general practice and other specialties.

The training of general practitioners is organised on a different basis to that of almost all other specialties due to a number of primary factors including:

a) Historically, the view that only general practitioners could train those in general practice. This view was understandable given the previous failure to recognise general practice as a specialty in its own right. Today however there is no argument that general practice is a vocational scope of practice. Furthermore the college recognises prior learning and is open to registrars at GPEP 2 and above levels, undertaking public hospital allocations (up to six months) that are relevant and appropriate to general practice. The college is also keen to introduce resident doctors to the specialty earlier (2nd year house officer and above) and should such be enabled, in the due course of time it is envisaged this experience will become integrated into the overall training programme.

b) Previous funder-provider splits within health structures prohibited coordination between primary and secondary services. However this is no longer the case with District Health Boards responsible for the funding of both primary and secondary / tertiary services to their populations.

c) The resident doctors have had to leave public hospital employment to directly become GPs or general practice registrars and thereafter general practitioners in their own right. The option of undertaking a general practice run as a house officer was restricted due to the discontinuous employment such imposed and the lack of a robust process to ensure appropriate placement and seamless transition between general practice and public hospital employment.

d) Whilst largely funded by Vote Health, general practice is nonetheless performed primarily in a private setting.

The process by which training in general practice has developed has seen the RNZCGP's role differ from that of other specialties. In addition to the normal roles of a college, the RNZCGPs negotiates funding, numbers of registrars that can be (financially) accommodated, and is the "quasi employer" through bursary and practice subsidies.

Funding is derived directly from the CTA, however the college oversees the programme providing for:

1. The accreditation of practices;
2. Allocation arrangements for registrars;
3. Formal training programme sessions;
4. Payment for the practice hosting the registrar; and
5. Payment of a bursary for the registrar enrolled in the scheme.

Unlike other college training programmes, the RNZCGPs have a number of potential conflicts of interest or competing interests as a result of this setup. In particular tension can exist between the allocation of a fixed budget from the CTA, to the administrative costs, practice costs and bursary for the registrars. This also brings the number of registrar positions the college is able to sustain into question.

As it currently stands the GPEP is unable to attract sufficient registrars to fill its positions (see reasons below). Even if it could, however, the number of positions is insufficient to provide for all those currently entering general practice let alone for the increased number of general practitioners NZ needs.

2. The need to train more doctors in General Practice

It is well recognised that NZ has a need for more general practitioners and a need to train more, both in rural and urban settings. More general practitioners improve the health status of the population and improved primary care, especially where well integrated with secondary service, improves overall health resource utilization.

To train more, the programme must be able to deliver a quality product as well as attract sufficient registrars into it. Providing for more places without either the practices within which to train the registrars, or without sufficient applicants to fill the places, will defeat any attempt to increase overall output.

3. Barriers between secondary/tertiary setting and general practice

The separation of training in a hospital setting and general practice is largely a historical one as described above. However, in 2009 the coordination between hospitals and general practice is still haphazard and imposes barriers to resident doctors who may wish to undertake GP runs. These fall largely into two categories:

a) Run allocation and arrangements for a GP run are made separately from all other run processes; and
b) Employment terms and conditions are distinctly different.

In most circumstances the resident doctor must resign their employment from a DHB if they wish to participate in a GP run. This results in a loss of continuous service as well as placing the resident doctor in the less attractive situation of not being an employee whilst in the GP setting (see below). If able to take leave without pay from a DHB, the run allocation and coordination process is still a barrier and financial / employment difficulties still arise.

4. Equity for resident doctors in GP

Currently general practice training is seen at best as the poor cousin of the hospital based training specialties and, at worst, registrars will simply not undertake the programme as it is financially unsustainable for them.

The GP house officers and GPEP 1 registrars are not classed as employees. This imposes a significant number of disadvantages on them as opposed to their hospital employed cousins, including but not restricted to:

a) Paid Parental Leave
b) Sick Leave
c) ACC
d) KiwiSaver

In addition, the terms and conditions provided through the RNZCGPs are inferior to those in hospital employment:

a) Salary: The GPEP runs for 10 months and so the annual salary quoted is reduced by 1/6th in real terms. Whilst the bursary was set to reflect the same (12 month) nett salary as provided for in the MECA, this is at year 3 level. Most GPEP 1 registrars will be year 4 minimum. Also, the bursary has failed to catch up with the amalgamation of category "E", "F" and "D". A more senior registrar can earn up to 30% less on GPEP1 than as a registrar continuing in DHB employment.

b) Reimbursements: the most significant of these include costs of training (GPEP registrars pay to sit the PRIMEX examination and most have to pay their own way to the annual GP conference in NZ). Indemnity insurance, annual practicing certification, superannuation contributions, and transfer expenses are amongst the other reimbursements unavailable to the GP resident doctor but readily available to any other resident doctor training to be a vocational specialist in NZ.

This inequity is the primary cause of suitable registrars failing to enrol in the programme; they simply can't afford to. The RNZCGPs considers that should funding not increase, rather than continue to offer more places, that due to the inherent unattractiveness of this training option remain unfilled they are better to have less places but improve conditions so as to attract a full (if fewer) component of registrars. Creating demand for positions on the GPEP is seen as important for the continued health and development of the programme, however within the current structure that is impossible.

Summary

Training in general practice has become the poor cousin of training in any other specialty in NZ. At a time when we desire to increase our population of general practitioners, this poses a serious barrier.

We recommend the following:

1. Resident doctors in general practice should be employed on the same terms and conditions as those in hospital practice. Who the employer should be is open to debate, however it would appear sensible for this to be the District Health Boards as:

    a) They are the current employers of the vast majority of resident doctors in their region;
    b) They are responsible for the delivery of primary as well as secondary / tertiary health services to the populations they serve; and
    c) The current barriers to house officer rotation into general practice could be significantly lessened if the run allocation systems could be integrated.

2. The RNZCGPs should retain a similar role to other colleges:

    a) In the supervisor of training;
    b) Accrediting practices; and
    c) Setting of standards for entry into this vocational branch.

3. CTA funding for the running of the training programme should be provided directly to the college, however money allocated to the payment of registrars and to practices should be directed to the District Health Boards.

4. We recommend this change be put in place by November 2010.

APPENDIX A

Both Resident Doctors and MOSSs are general registrants. They must both work under the supervision of a vocational registrant. The source of MOSSs is largely from the pool of resident doctors: distribution from resident doctor pool into the MOSS pool detracts from the overall production of vocational registrants or SMOs.

Below is a comparison of the Base Salaries and Continuing Medical Education costs for both MOSSs and registrars:

1. Salaries. Below is a table outlining the current base salary scale for MOSSs and registrars (urban and non urban) with a percentage difference calculation. The MOSSs have a 15 step scale, the registrars have a ceiling at year 10 where they remain until qualification as a vocational registrant.

Year	Registrar - Urban	Registrars - Non Urban	MOSS Scale	Percentage diff with Urban Reg	Percentage diff with Non Urban Reg
1	67,156	69,842	93,472	39.19%	33.83%
2	70,758	73,589	97,437	37.70%	32.41%
3	74,332	77,306	101,403	36.42%	31.17%
4	77,928	81,045	105,370	35.21%	30.01%
5	81,492	84,751	109,334	34.17%	29.01%
6	97,894	101,810	113,300	15.74%	11.29%
7	102,032	106,114	117,266	14.93%	10.51%
8	106,316	110,570	121,797	14.56%	10.15%
9	110,783	115,213	126,329	14.03%	9.65%
10	115,435	120,053	130,861	13.36%	9.00%
11	*115,435*	*120,053*	135,394	17.29%	12.78%
12	*115,435*	*120,053*	139,925	21.22%	16.55%
13	*115,435*	*120,053*	144,457	25.14%	20.33%
14	*115,435*	*120,053*	148,989	29.07%	24.10%
15	*115,435*	*120,053*	153,521	32.99%	27.88%

2. Continuing Medical Education Costs.

Registrars are reimbursed all their costs of training. ARRMOS data confirms that the average cost of training for a resident doctor in the Auckland region is $5,000 per annum. We would expect this average to be higher than elsewhere in NZ as a result of the Auckland region proportionally supporting more registrars than elsewhere in NZ.

Registrars over year 5 are entitled to a total of $6,000 conference leave expenses (no more than $3,000 of this amount to be taken in any one year).

MOSSs are reimbursed actual and reasonable expense sup to $16,000 per annum.