Clinical Training Agency Strategic Intentions

2004–2013

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Foreword

This year the Clinical Training Agency (CTA) has continued to develop its understanding of workforce issues.

The preparation of this document included extensive consultation with stakeholders to help forecast the required numbers of trainees for the next 10 years. The feedback from the consultation process supported the approach of forecasting labour market conditions to estimate the number of trainees. However, the feedback also showed that the CTA needs to do more work to extend its understanding of labour market conditions, and that the quality of data available for the forecasting models needs to be improved.

Aligning training to future workforce requirements significantly improves the return from the investment in training. The CTA is one of few groups internationally that link training funding with future workforce requirements. The CTA has a commitment to work with stakeholders over the next 12 months to augment its knowledge base and improve the quality of data available for its forecasting models, and welcomes any comments or suggestions.

During 2003 the CTA established new initiatives in several areas. Support and access for Māori and Pacific trainees have been developed, a major review of training for rural medical practitioners was initiated, and a new specification for the training of medical physicists was developed. A pilot programme for first-year clinical nursing practice was carried out during the year, and the results of the evaluation have been published.

This plan provides a direction for the purchase of post-entry clinical training, and enables the CTA to signal workforce issues to the sector. It is inevitable that there will be future changes to the number and type of trainees funded by the CTA as the threshold of available funds is reached. However, any change in the overall direction of CTA funding is likely to be gradual and will be signalled well in advance to the sector. It is important to note that the funded positions are not the ideal, but simply the result of prioritising within the financial capacity of the CTA.

Gordon Davies
Deputy Director-General
DHB Funding and Performance

Acknowledgements

In developing this strategic plan, many colleagues within the Ministry of Health gave their time to provide valuable information. In particular, we acknowledge colleagues within the CTA for their input and advice. We would also like to acknowledge:

- District Health Boards New Zealand (including individual Boards, with whom there have been discussions on various aspects of training)
- Health Workforce Advisory Committee
- District Health Board Mental Health Managers
- Regional Co-ordinators for Psychiatry Training
- Ministry of Health Nursing memorandum of understanding partners (including the National Nursing Organisation), who made a significant contribution to the development of the nursing post-entry clinical training strategy that forms the current intentions for nursing trainees
- Māori Workforce Advisory Group, for their ongoing assistance to develop a 10-year strategy for Māori
- Pacific Advisory Group, who helped developed the strategy for Pacific peoples
- Royal Australasian College of Physicians – New Zealand Committee
- Royal Australasian College of Surgeons – New Zealand National Board
- Royal New Zealand College of General Practitioners
- Royal Australian and New Zealand College of Psychiatrists
- Royal Australian and New Zealand College of Radiologists
- Royal College of Pathologists of Australasia
- Royal Australian and New Zealand College of Ophthalmologists
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists Joint Faculty of Intensive Care Medicine
- Pharmaceutical Society of New Zealand
- Australasian College of Public Health
- Australian and New Zealand College of Anaesthetists
- Australasian Society of Emergency Medicine.

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Executive Summary

To facilitate development of a health and disability workforce which can meet the future requirements of health and disability services in New Zealand. (CTA vision)

Clinical Training Agency Strategic Intentions 2004–2013 communicates the areas in which available post-entry clinical training (PECT)[1] funds are being invested, and will be invested in the future. This strategy was developed after an extensive consultation process and all forecasts are based on currently available data. Budget availability, workforce needs analysis, government priorities, and the impacts on Māori development are the core influences determining the quantity of training purchased.

Planning does not stop with the publication of this document. It will always be necessary to refine and update predictions to ensure that we maintain ongoing consistency with government direction, service requirements and workforce trends. The health sector environment itself is constantly changing. This year significant changes have impacted on training, including government strategies, the establishment of the Tertiary Education Commission, the Health Practitioners' Competence Assurance Bill, and the introduction of Nurse Practitioners™. Despite these changes, the general directions of the strategy should be stable.

This plan has been developed with certainty of funding for three years. Any planning outside three years is subject to the available budget. The plan has a strongly practical basis for implementation and presents a viable way forward.

In the next 12 months the CTA and the sector have the opportunity to take significant steps in a number of areas. These include ongoing improvement of workforce information, the specification of postgraduate year two (PGY2) medical training, publication and implementation of the nurse PECT strategies, and the review of rural general practitioner training.

In the coming months a programme to improve the robustness of the estimates of service need – the 'demand for workforce' – will be carried out. The programme will involve a partnership with major stakeholders including District Health Boards, District Health Boards New Zealand, medical colleges, the Nursing Council, and other directorates of the Ministry of Health.

PGY2 training, in its current form, does not provide measurable outcomes. In response, the CTA has initiated consultation on the future shape of PGY2 training. There are four options available, but there is disagreement within the sector over the best use of the training funds. The CTA intends to work closely with the District Health Boards New Zealand workforce development group and the Medical Council to reach a decision that will give New Zealand the best value for its training investment.

[1] Post-entry clinical training is training that is vocational, clinical, post-entry to a health profession, formal, a minimum of six months and nationally recognised. A full definition is given in the Glossary.

During 2003 consultation on the nursing PECT document was completed. In future years CTA nurse funding will be directed towards 800-level programmes that are focused on priority areas, which may assist the development of the Nurse Practitioner™ role. This will require a transfer of CTA funding from the ex-deficit and miscellaneous specialty programmes to nationally specified programmes that enable nurses to better meet population health needs.

A review of rural general practitioner training and the future needs of the rural sector commenced in 2003, and a specification for a rural nursing training programme will be developed during 2003/04.

The CTA has made progress in a number of areas since the publication of the 2003–2013 *Strategic Intentions*. Some of the significant new initiatives during 2002/03 include:

- evaluation of the nursing first year of clinical practice programmes
- the extended number of Māori trainees taking part in CTA-funded programmes
- initiation of a review of rural primary health training requirements
- the introduction of a Diploma in Sexual and Reproductive Health
- a programme for the delivery of medical physicist training was put in place
- a return-to work-programme for registered radiation therapy technicians was put in place
- a national Pacific provider was contracted to provide support and access to Pacific trainees
- an audit of all current CTA-contracted providers was conducted to ascertain the level of compliance with cultural expectations outlined in CTA contracts.

This *Strategic Intentions* document communicates the areas in which available PECT funds are being invested, and will be invested in the future. Ongoing commitment and focus from the CTA and the health sector will be required to consistently improve the benefits from investing in training the workforce. These include the agreement of a specification for PGY2 training and the transfer of ex-deficit funds to national nursing programmes.

The CTA is committed to the ongoing improvement of its relationships with external stakeholders and welcomes any feedback on this report.

1. Introduction

1.1 Vision, scope and aim

The CTA's vision is:

> To facilitate development of a health and disability workforce which can meet the future requirements of health and disability services in New Zealand.

This strategic plan has been developed in the context of the Government's commitment to resolving health workforce issues, and on the basis of a clear and growing understanding of the sector. Ensuring the existence of a health workforce that provides high-quality services involves aligning a number of functions, including:

- pre-entry training through Ministry of Education-funded programmes
- post-entry clinical training (PECT)
- in-service training and ongoing professional development
- service infrastructures that encourage retention of the workforce.

While the purchase of PECT is only one of the tools available to ensure an adequately skilled and qualified health workforce, it plays a vital part. Funding for PECT is approximately $90 million, and there are significant demands on this funding – including some existing unfunded training.

This plan covers the years 2004 to 2013, and it will be revised annually to ensure consistency with government priorities and changing workforce needs, and to reflect ongoing environmental analysis.

It is the CTA's aim to predict and prevent workforce deficits by purchasing appropriate training. Most health professional workforce training is long term, and a number of programmes take many years to complete. The focus for the CTA is on avoiding future – not current – crises. However, if it is within our ability to react to changing circumstances, funding will be targeted to assist short-term solutions.

1.2 Environmental analysis

The health sector environment is constantly changing. To understand the context in which the CTA operates, a thorough environmental analysis was performed for the *Purchasing Intentions Plan 2001/02: Clinical Training Agency* (Ministry of Health 2001e). This year significant changes that will have an impact on training include government strategies, the establishment of the Tertiary Education Commission, the draft Health Practitioners' Competence Assurance Bill, and the introduction of Nurse Practitioners™.

1.2.1 Key strategies

The Minister of Health has directed the Ministry of Health and the sector to focus on the following areas:

- service delivery, while keeping infrastructure costs as low as possible
- primary health care
- the Māori Health Strategy (He Korowai Oranga)
- the Disability Strategy
- waiting times (medical/surgical/radiotherapy)
- diabetes incidence and impact
- inequalities
- mental health *Blueprint* implementation.

Where training funded by the CTA is able to enhance service delivery in the areas listed above, priority is given to funding training in these areas. Infrastructure costs and managing within budget are key components of the CTA's planning for both the training and operational budgets.

1.2.2 Education sector

The Tertiary Education Commission (TEC) was established under the provisions of the Education (Tertiary Reform) Amendment Act 2002. The TEC will oversee the implementation of the Tertiary Education Strategy and the associated set of priorities. The TEC will also take an active role in facilitating collaboration and co-operation in the tertiary education system, and a greater system connectedness to New Zealand businesses, communities, iwi and enterprises.

The TEC is responsible for funding all post-compulsory education and training offered by universities, polytechnics, colleges of education, wānanga, private training establishments, foundation education agencies, industry training organisations, and adult and community education providers. The Ministry of Health is working with the TEC to establish links between the health and education sectors to ensure education programmes meet the future needs of the health and disability sector.

1.2.3 Health Practitioners Competence Assurance Bill

The Health Practitioners Competence Assurance Bill (HPCA) provides a framework for the regulation of all health practitioners where there is a risk of harm to the public. The bill will create a consistent set of processes for the registration and ongoing competence assurance of medical practitioners who are currently regulated, and a process for the inclusion of health professions, where appropriate.

The CTA will work with professional colleges whose professional training or structure is affected by the implementation of the HPCA.

1.3 Planning for the future

The CTA's strategic plan will take the purchase of PECT into the future. The plan will be revised annually and will take into account the changing environment for health, the actual

output of training programmes, and the retention of trained health professionals. It is important to note that while the CTA will endeavour to purchase according to the directions outlined, we anticipate that priorities may change. However, the direction of purchasing in individual programme areas, at least for the short term, is clear.

Note that this plan has been developed with certainty of a funding for three years. Any planning outside three years is indicative only and subject to budget availability, workforce needs analysis, government priorities, and the impacts on Māori development.

We encourage you to provide comments and feedback, by contacting:

The Manager
Clinical Training Agency
Ministry of Health
PO Box 3877
Christchurch.

2 Developing a Strategic Plan

The purpose of this strategic plan is to determine which programmes will best meet the needs of the future health workforce. This in turn determines the distribution and levels of funding provided by the CTA. In order to do this, new and proposed programmes were ranked according to:

- government strategic priorities
- workforce need
- Māori development.

A score between 1 and 20 was allocated for each of the criteria, depending on how well the programme met the criteria. For example, programmes where there was a large workforce deficit scored very high on workforce need.

Once this ranking is completed, optimal numbers of trainee full-time equivalents for each training programme were developed. The estimation of the optimal numbers of trainee full-time equivalents takes into account the following principles.

- Changes will be incremental rather than sudden.
- Contracted volumes will be retained (as a minimum) for the term of the contracts.
- Initial estimates for optimal numbers will be at currently funded levels, unless evidence suggests an increase or decrease is required.
- New programmes to be phased in will, in most cases, be expected to have a minimum life span to ensure that the costs of developing the programme are met.
- The timeframe for phasing in new programmes will be reasonable and achievable (eg, where a programme is required to have accreditation, then sufficient time will be given to achieve this).
- Planned increases will be clearly possible, both in terms of supervised positions and placements available and/or trainee availability.
- Reductions of training funding will not leave trainees unfunded partway through a programme.
- Any changes to volumes will be on a calendar year or training year basis in order to reflect actual training programme intakes.

The resulting calculated optimal numbers provide an estimate of the volumes that would be purchased if the programme were considered a high priority and funding were available. Because there is more potential and demand for training than there is funding available, reductions were then made to optimal trainee numbers to meet the budget available and to ensure training funds are spent appropriately. Reductions were made to programmes with the following status, in the order given:

- lower-priority programmes not currently provided/purchased.
- current programmes with a low priority ranking.
- programmes where there is more training funded than is required to meet future workforce needs.

There are usually several options for reducing optimal training numbers, including:

- delaying the start year of a training programme, where the programme is not currently purchased
- reducing the volume from an optimal to a sustainable level
- removing any funding or potential for funding.

There are many areas within health and disability support where training for professionals does not exist and/or is not clearly defined. The CTA will work towards understanding these areas, and funding will be targeted once appropriate training programmes are developed. In some cases there will not be sufficient funding to meet the training requirements of a specific area. When this occurs, the CTA will first look at the potential for reprioritising within its current budget, and then, if a strong case can be made, it will present bids for further funding during the Ministry's budget process.

2.1 Forecasting models

Various models have been developed with the aim of forecasting PECT requirements for the health and disability workforce over the next 10 years. The forecasts presented in this report build on the work completed since the publication of the first 2003–2012 *Strategic Intentions* document. Over the next 12 months we intend to develop the capability to do scenario analysis to enhance the accuracy of our forecasting.

The models are still in an early stage of development and are reliant on data of varying quality. The CTA is committed to an ongoing process of quality improvement over the next 12 months. We believe that the sector can play a crucial role in the development of our forecasting capacity, especially in the areas of:

- forecasting service demand
- information on the demographic and geographic distribution of the workforce
- factors that will influence the workforce in the future.

We expect that the results of the work carried out over the coming months will lead to an improvement in the quality of the input data, which will help to ensure that later forecasts accurately reflect future workforce and service needs.

2.1.1 Model structure

Demand for PECT

Very simply, the optimal number of health practitioners depends on the number of people needing health care. Therefore, the demand for PECT should be a function of the forecast population health need. At this stage the best proxy for population need is the ratio of specialists to population. These ratios are sourced from medical colleges, international standards, the World Health Organization, and the Australian Medical Workforce Advisory Committee. The lack of information leads to considerable debate. The CTA will be working with stakeholders to produce robust demand-side information over the coming months.

Workforce supply

The size of the workforce is a function of the following factors:

- existing workforce
- emigration and immigration
- graduation from programmes
- retirement.

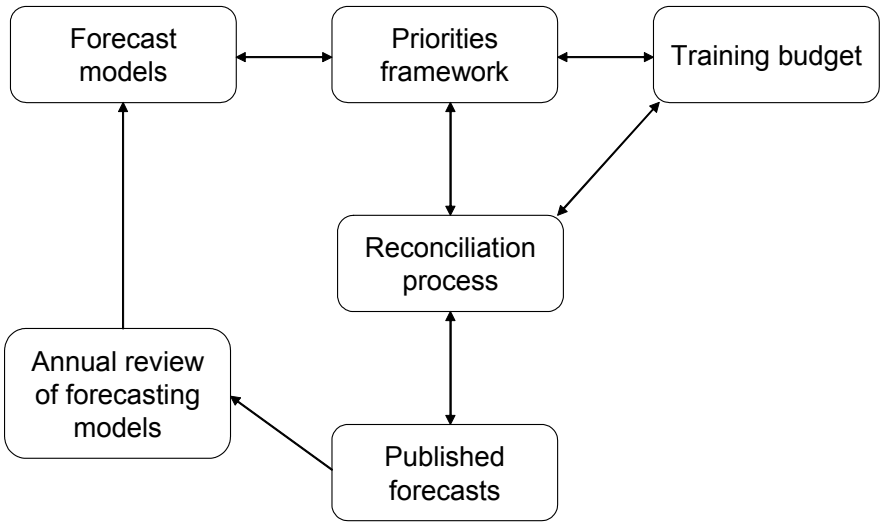
Workforce deficit or surplus and trainee forecasts

The workforce balance (deficit or surplus) is a measure of the gap between the estimates of supply and demand for clinicians. A deficit is where workforce demand exceeds workforce supply, and a surplus is where workforce supply exceeds workforce demand. The forecast number of trainees entering programmes is a function of the workforce imbalance. Where there is a workforce deficit, the number of funded trainees entering programmes is forecast to increase. A workforce surplus forecast leads to a reduction in the forecast of funded trainees entering programmes.

2.1.2 Development of forecasts in the strategic plan

The following figure summarises the process for producing the forecasts.

Figure 1: Summary of the process for producing trainee forecasts



As shown in Figure 1, the *forecast models* estimate the number of required trainees based on projections of workforce deficit or surplus. *The priorities framework* incorporates priorities set by government policy and the CTA. *The training budget* is the amount of funding available for training for the current year. The *reconciliation process* is the process for estimating the optimal number of trainees. The forecast models and the priorities framework produce an estimate of the optimal number of trainees. The cost of funding the optimal number of trainees is found using prices from the training budget, and the cost is compared to the budget available for training. Where the cost varies from the training budget, the number of trainees is adjusted so that the

optimal number of trainees is funded for the funds available. The process for estimating the optimal number of trainees is independent of the funding available for training. Finally, the *annual review* of the models takes into account additional workforce information received by the CTA between each forecasting round.

2.2 Consultation for the 2004–2013 *Strategic Intentions* document

The CTA conducted extensive consultation in the preparation of the 2004-2013 *Strategic Intentions* document. The consultation process included distribution of consultation documents and follow-up visits to the following:

- District Health Boards New Zealand
- Health Workforce Advisory Committee
- District Health Board Mental Health Managers
- Regional Co-ordinators for Psychiatry Training
- Ministry of Health Nursing memorandum of understanding partners
- Māori Workforce Advisory Group
- Pacific Advisory Group
- Royal Australasian College of Physicians – New Zealand Committee
- Royal Australasian College of Surgeons – New Zealand National Board
- Royal New Zealand College of General Practitioners
- Royal Australian and New Zealand College of Psychiatrists
- Royal Australian and New Zealand College of Radiologists
- Royal College of Pathologists of Australasia
- Royal Australian and New Zealand College of Ophthalmologists
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists
- Joint Faculty of Intensive Care Medicine
- Pharmaceutical Society of New Zealand
- Australasian College of Public Health
- Australian and New Zealand College of Anaesthetists
- Australasian Society of Emergency Medicine.

The consultation focused on the:

- structure of the forecast models
- quality of the input data and its impact on the quality of the forecasts
- process for producing the forecasts.

The structure of the forecast models was generally accepted. It was agreed that the use of the supply and demand framework enabled the CTA to forecast workforce conditions and the required number of trainees. However, concern was expressed at the quality and quantity of the input data available to the CTA and its effect on the resulting forecasts. The CTA acknowledges there were limitations with the input data and requested assistance in the improvement of the

input data. There was also general advice given that our predictions should be based on different scenarios, and that the most likely scenario should be chosen for our planning.

The process for producing the published forecasts was explained during the consultation process, and the independence of the forecasting models from funding constraints was emphasised. There was agreement with stakeholders to work with the CTA on improving the quality of the input data. The role of medical colleges, District Health Boards (DHBs) , DHBNZ and the Health Workforce Advisory Committee is vital to the improvement of the CTA's forecasting capacity.

3. Work Plan

The CTA is committed to producing a strategic plan that has a practical implementation. We are committed to consistently improving the quality of both our own systems and the programmes funded by the CTA. During 2004 we will continue to develop our knowledge base through research and analysis. We will also carry out our contract management, monitoring, and auditing functions, and a series of projects that are designed to improve the benefits from investment in training the workforce.

Specific CTA projects, both current and planned to commence in 2004, include:

- working with DHBs, DHBNZ, medical colleges, the Nursing Council, and other directorates of the Ministry of Health to improve estimates of workforce supply and demand, including a review of the input data for the surgery and anaesthesia forecasting models
- reviewing the specification for PGY2 training
- implementing the PECT nursing document strategies
- reviewing rural GP training
- evaluating Māori support and access
- reviewing Māori training programmes
- evaluation of first year of clinical practice (nursing)
- developing a Māori health practitioners training plan with a 10-year strategic plan
- reviewing the new monitoring systems implemented over the last two years
- implementing support and access programme for Pacific trainees
- finalising specifications and training strategies for:
  - diploma in primary health care (nursing, rural health)
  - rural and provincial hospital practice
  - advanced specialist dentistry
  - advanced vocational training in psychiatry
  - accident and medical practice
  - cardiac technology
- carrying out new programme evaluations for:
  - autism
  - care management and co-ordination
  - rehabilitation
  - rongoā Māori
  - Māori psychiatry training (pilot)

- carrying out longer-term projects involving the evaluation of programmes, including:
  - palliative care nursing
  - rural rotations for medical PGY2
  - Māori child and family
  - hauora Māori
  - clinical teaching (Māori)
  - Māori support and access grants
  - evaluation of the Pacific support and access programme
  - development of a Pacific 'train the trainers' programme.

The CTA uses panels comprising experts in their respective fields to ensure the best-quality outcomes.

4. Service Plans

All training funded by the CTA is managed through the following portfolios: Medical, Mental Health / Psychiatry, Nursing, Māori, Pacific, and Disability Support Services. The following list summarises training within each portfolio.

Medical

- Pre-vocational
- Vocational
- Overseas-trained doctors
- Dentists
- Pharmacists
- Technicians/technologists

Mental health/psychiatry

- Psychiatry vocational
- Child and adolescent psychiatry vocational
- Other mental health

Nursing

- Child and family
- Emergency
- Speciality nursing practice
- Palliative care nursing
- Primary care (rural nursing)
- Ex-deficit nursing
- First year of clinical practice

Māori

- Clinical teaching
- Hauora Māori
- Child and family
- Support and access to Māori trainees

Pacific

- Support and access to Pacific trainees

Disability support services

- Autism
- Care co-ordination and management
- Rehabilitation.

All portfolios are assigned a portfolio manager, who is responsible for contracts between the CTA and providers. The portfolio managers build an in-depth knowledge of the activities in their portfolios through their contracting activity and the relationships they build with providers.

The CTA also funds training in primary health. This is consistent with the Government's priority of increasing the role of the primary sector in the delivery of health services.

4.1 Medical training

Access to appropriate care is a cornerstone of the New Zealand Health and Disability Strategies. It is essential for any health workforce to have an adequate number of skilled specialists, and much of the focus of medical training funded by the CTA is on developing the skills, knowledge and attitudes required to practise at the specialist level.

The medical workforce comprises doctors at all levels of training. The CTA currently funds all training years, including PGY1, PGY2, the Diploma in Paediatric and Child Health, and advanced vocational training in most specialties in the primary and secondary areas. If training is undertaken in an unbroken sequence, the age groups in the workforce can be characterised as in Table 1. A vocationally registered doctor may have a working life as a consultant of approximately 30 years, and may be a registrar for approximately 10 years. During the next 12 months the CTA will establish the criteria and policies relating to the fundable length of training programmes.

Table 1: Medical workforce: years of practice, by level*

Level of doctor	Age (years)	Length of practice
PGY1/2	24–26	2 years
Registrar	26–35	Up to 10 years
Consultant	35–65	Approximately 30 years

* These figures assume that training is taken in an unbroken sequence.

4.1.1 Pre-vocational training

The CTA acknowledges the importance of the initial years of medical training, and will continue to fund all eligible trainees in PGY1. However, PGY2 training in its current form does not meet the CTA's funding criteria. The CTA has initiated consultation on the future shape of PGY2 training and there appear to be four options available, although there is disagreement within the sector concerning the best use of these training funds.

These are the four options that will be presented to the DHBNZ workforce development group by the CTA for their consideration.

- Re-specify the programme to a skill-based programme with measurable outcomes – due to the wide range of options available for the PGY2 year(s), consensus on any specification does not seem achievable.
- Train New Zealand Registration Examination (NZREX) doctors to ensure a common standard of competence – for some time, training co-ordinators within hospitals have indicated a need for a specified training programme for doctors coming into New Zealand.
- Generate a training programme and a career path for Medical Officers of Special Scale (MOSSs), to improve their competence and utility to public hospitals – this option could help MOSSs meet the requirements of the proposed HPCA legislation.
- Divert funds into other priority training areas.

A decision needs to be made on these four options, as continued funding without a clear outcome is not acceptable. The CTA intends to work closely with the DHBNZ workforce development group and the Medical Council to reach a decision before the end of 2003 that will give New Zealand the best value for its training investment.

Table 2 shows the pre-vocational training volumes, contracted and forecast, for the period 2003–2014.

Table 2: Pre-vocational medical training: current purchasing and future direction

Programme area	2003 volumes contracted	2004 volumes forecast	2005 volumes forecast	Direction of future purchasing (volumes) 2005–2013
Year 1 house surgeons	276	All eligible	All eligible	No change
PGY2	341	Subject to sector agreement on the use of funds		
Diploma in Obstetrics & Gynaecology	14	Programme to be funded by the Ministry of Education		
Diploma in Paediatrics / Child Health	29	42	42	Under review
Diploma in Sexual & Reproductive Health	0	7	14	Under review

4.1.2 Vocational training

There are currently shortages in many of the medical specialties. Over the longer term it is anticipated that initiatives under way or planned will positively impact on these shortages, and numbers in training may subsequently decrease to ensure that CTA funds continue to be channelled into areas where they can be most effective. Any proposed reductions will ensure that an adequate number of consultant specialists are trained to maintain the workforce at appropriate levels. This situation will continue to be monitored closely.

Table 3: Advanced vocational medical training: current and future purchasing

Programme area	2003 volumes contracted	2004 volumes forecast	2005 volumes forecast	Direction of future purchasing (volumes) 2005–2013
Anaesthesia	113	114	Under review	
Emergency medicine	59	59	57	Under review
General practice	50	50	50	Under review
Obstetrics and gynaecology	33	33	33	Under review
Ophthalmology	15	15	14	Under review
Pathology*	42	44	44	Under review
Physician training – adult medicine**	179	179	182	Under review
Public health medicine	32	35	35	Under review
Physician training – paediatrics	58	58	58	Under review
Radiation oncology	17	17	15	Under review
Radiology	62	59	58	Under review
Surgery	201	201	Under review	

* As a result of dual training there are a further 11 trainees in haematology, which is included in Physician training – adult medicine.

** While the overall training numbers are not expected to change, there will be an increased focus on sub-specialties within adult medicine, including targeted purchasing for general adult medicine, geriatric medicine, medical oncology, rheumatology and dermatology.

Note: these numbers are the minimum volume the CTA expects to purchase, assuming trainees are available.

The models for forecasting the number of trainees for surgical and anaesthesia training are under ongoing review, and will continue to improve as more robust data becomes available. In particular, consultation for this plan indicated that the data used to estimate the surgical and anaesthesia workforce requirement was inadequate. In response, the CTA, DHBNZ and the medical colleges will work to develop a robust estimate of demand for surgical and anaesthetic services, to be carried out over the next 12 months.

Vocational training for psychiatry is discussed in the mental health section (4.9).

4.2 Overseas-trained doctors

On 8 June 2000 the Minister of Health announced a bridging programme to provide an alternative pathway to the New Zealand Registration Examination (NZREX) for overseas-trained doctors who were granted residence in New Zealand under the General Skills Policy (points system) that was in force between 18 November 1991 and 29 October 1995. Later in 2000 the Medical Council of New Zealand called for applications and assessed the eligibility of overseas-trained doctors to participate in the bridging programme. Over 1200 applications were received for the original 250 placements on the programme.

The programme comprises an academic course followed by an internship, during which the trainee observes clinical practice. Placements began in February 2001 and the final cohort will complete the programme in July 2005, including an additional three intakes. Once trainees have successfully completed the programme they are able to sit NZREX, which could lead to registration with the Medical Council of New Zealand.

Table 4: Summary of the trainees in the Overseas Doctors Bridging Programme, as at July 2003

Status	Number of trainees
In training, selected for a course or waiting to sit NZREX	156
Passed NZREX	139
Failed NZREX after completion of Bridging Programme	37
Failed Bridging Programme	24
Withdrawn applications	59

Once the specification for training in PGY2 and its alternatives have been implemented, the CTA will assess the potential for specifying and funding training and supervision for NZREX doctors.

A frequent question raised during discussions with DHBs concerned the CTA's ability to fund teaching and supervision for doctors on probationary registration who have passed NZREX. The CTA acknowledges that this represents a cost to hospitals and have put this forward as one option for the use of existing PGY2 funds.

4.3 Nurse training

Nursing is a key workforce requirement in the New Zealand health system. The New Zealand Health Strategy (Minister of Health 2000) identifies the need for increased support and supervision of health professionals in training, and the Primary Health Care Strategy (Ministry of Health 2001d) identifies an increased need for primary health care nurses with advanced training.

During 2003 consultation on the nursing PECT document was completed. In future years CTA funding will be directed towards 800-level programmes that are focused on priority areas and will provide nurses with a stepping stone towards Nurse Practitioner™ status.

The initial unbundling of PECT funding from various sources to Vote Health resulted in only one programme for nursing staff – the graduate certificate in specialty nursing practice. In 1998 the CTA received additional funding through the 'deficit switch' project. This funding was estimated based on the amount of clinical training that hospitals reported they were providing for nurses. Subsequent contracting of these funds has directed similar amounts back to individual hospitals, regardless of overall need. This arrangement will be changed as nationally provided programmes become available. Additional funding from the base CTA budget and the Mason[2] allocation has also been directed towards nursing training.

This process provided three streams of funding for nurse training:

- ex-deficit funds, used to access mainly academic programmes at a mixture of 700 and 800 levels in DHBs only
- the base CTA budget, with purchasing focused on advanced national PECT programmes, including Emergency Nursing, Palliative Care, and Child and Family
- ex-Mason funding, with two programmes purchased in mental health nursing – the CTA administers these programmes in line with the *Mental Health (Alcohol and Other Drugs) Workforce Development Framework* (Ministry of Health 2002a).

The recent development of a framework for the Nurse Practitioner™ has highlighted the need for PECT for nurses. The Minister of Health noted that:

> There is considerable potential for more nurses to contribute positively to health gain, offering a responsive, innovative, effective and collaborative health service. (Nursing Council of New Zealand 2001).

Strategies developed by the Taskforce on Nursing and sector reference group[3] indicated that CTA funds should be directed towards a first year of clinical practice programme and 800-level papers that may later lead to a master's level education and to the development of the Nurse Practitioner™ role. This will require a transfer of CTA funding from the ex-deficit and miscellaneous specialty programmes to nationally specified programmes that enable nurses to better meet population health needs. The focus will be on supporting nurses in training at a level equivalent to 800 on the New Zealand Qualifications Framework and will be consistent with the recommendations included in the *National Strategy for Purchasing Post-Entry Clinical Nurse Training Programmes* report.

The first of these changes is the specification of a rural nursing programme. A draft specification will be available for consultation in the coming months.

[2] In 1996 a review team led by Judge Ken Mason produced *Inquiry under Section 47 of the Health and Disability Services Act 1993 in respect of Certain Mental Health Services* (The Mason Report), leading to additional funding being made available to health sector purchasers.

[3] The sector reference group comprises representatives from DHBs, the education sector, Māori and Pacific communities, and the Ministry of Health.

During 2002 the CTA piloted a first year of clinical practice programme. This programme was evaluated in 2003, and the results indicated that some changes of the draft specification are required. Current funding would enable a subsidy of between 10 and 30 percent of the total cost to support national first year of clinical practice programmes in future years, although the evaluation indicated that a subsidy of this nature would not provide the incentive for providers to move to a national qualification framework. The evaluation of these pilot programmes does, however, provide DHBs with information for further training programmes.

National nursing programmes have also been developed in response to earlier strategies, including child and family health, palliative care and emergency nursing. In the short term these programmes will remain in place, and are subject to evaluation in 2004. Over the next 10 years it is expected that all CTA nursing funds will be channelled into first year of clinical practice and 800-level programmes focused on priority scopes of practice.

Any transition from ex-deficit funding to national nursing programmes will be carefully managed to ensure nurses continue to have options available for training during the transition. Consultation will ensure there are no surprises for providers and nurses, and long term there will be clearer options available for nurses, targeted at enabling nurses to provide better health care. A specification for primary care (rural) nursing is being developed in consultation with the sector. The programme is expected to be in place in 2004.

Table 5: Nursing training: current purchasing and future direction

Programme area	**2003 volumes contracted**	**2004 volumes forecast**	**2005 volumes forecast**	**Direction of future purchasing (volumes) 2005–2013**
Rural nursing	–	40	40	Under review
Child and family nursing	84	100	100	Subject to evaluation and sector reference group report
Emergency nursing	40	40	40	
Specialty nursing practice	44	22	0	
Palliative care nursing	36	40	40	
First year of clinical practice	–	Subject to evaluation and sector reference group report		
Ex-deficit nursing	640 approx	640 approx	Subject to evaluation and sector reference group report	

4.4 Dentistry training

The career pathway for dentists involves an undergraduate degree, after which graduates can choose to work as a general dentist or undertake specialist postgraduate training. Approximately 79 percent of dentists worked in general dentistry in 2000 (New Zealand Health Information Service). Funding of training for dentistry is split between the Ministry of Education and the CTA, with the responsibilities identified in Table 6.

Table 6: Dentistry training: funding responsibilities

Qualification	Funder
Undergraduate training	
Bachelor of Dental Surgery	Ministry of Education
Postgraduate training	
Postgraduate Diploma in Clinical Dentistry	CTA
Postgraduate Diploma in Community Dentistry	Ministry of Education
Oral and Maxillofacial Surgery	CTA
Master of Dental Surgery	CTA
Special Needs Dentistry	CTA
Master of Community Dentistry	Ministry of Education
Doctor of Dental Sciences	Ministry of Education
Doctor of Philosophy	Ministry of Education

The CTA will continue to work with the sector to finalise specifications and review current pricing. A draft specification has been developed for Special Needs Dentistry. It is expected that this specification will be finalised during 2003, with the programme to be contracted using the new specifications in 2004. A specification for advanced training in Oral and Maxillofacial Surgery is also under development. This specification defines existing training and is not expected to result in any change in trainee volumes.

Table 7: Dentistry training: current purchasing and future direction

Programme name	2003 volumes contracted	2004 volumes forecast	2005 volumes forecast	Direction of future purchasing (volumes) 2005–2013
Postgraduate Diploma in Clinical Dentistry	0	4	4	Under review
Master of Dental Surgery	18	14	14	Under review
Oral and Maxillofacial Surgery	2	2	2	Under review
Special Needs Dentistry	0	1	2	Under review

4.5 Pharmacist training

The role of the pharmacist is evolving, and the focus is now more on providing primary health care services rather than on counting and dispensing drugs.[4] There are also wider employment opportunities, including key roles within independent practitioner associations (IPAs) and, probably, primary health organisations. The CTA funds the pharmacy intern year (immediately after completion of the undergraduate pharmacy degree).

In July 2003 the Pharmaceutical Management Agency (PHARMAC) announced a change in the regulations concerning the dispensing of prescriptions. The CTA assumes that the change in dispensing practice will change the workforce environment and may make the current assumptions behind the workforce model invalid. The CTA will be working with the Pharmaceutical Society of New Zealand over the coming months to investigate the impact of changes on future trainee numbers.

During 2004 the CTA will work with the Pharmaceutical Society of New Zealand on reviewing funding per trainee and the possible impact of the HPCA Bill on the structure of current funding contracts.

Table 8: Pharmacy training: current purchasing and future direction

Programme area	2003 volumes contracted	2004 volumes forecast	2005 volumes forecast	Direction of future purchasing (volumes) 2005–2013
Pharmacy intern training	96	110 minimum	110	To be reviewed

4.6 Technician, technologist and physicist training

In December 2002 the CTA published *Health Technologist and Technician Training in New Zealand* (Ministry of Health 2002e), the paper scoped occupational, workforce and training issues for health technologists and technicians. During 2004, the CTA will initiate a consultation process with medical colleges and associations to:

- ascertain whether the technician/technologist training programmes will continue to receive CTA funding
- investigate the impact of changes in training programmes resulting from the implementation of the HPCA Bill.

Current programmes

The CTA currently funds some training for anaesthetic technicians, cardiopulmonary technicians, physiology technicians and sonographers.

[4] Cabinet minute EHC (01) 15/6.

Table 9: Technician/technologist training: current purchasing and future direction

Programme area	2003 volumes contracted	2004 volumes forecast	2005 volumes forecast	Direction of future purchasing (volumes) 2005–2013
Anaesthetic technicians	53	50	50	Under review
Ultrasonography	24	To be reviewed		
Cardiac technicians	4	To be reviewed		
Physiology technicians	16	To be reviewed		

Radiation therapists

The CTA has negotiated with providers to develop a return-to-work programme for registered radiation therapy technicians who have withdrawn from the workforce and wish to rejoin the workforce. The programme will have two components.

- From July 2003 the provider will be delivering a level-700 pre-entry course for prospective return-to-work trainees. This three-month 'pre-entry' course (trainees will receive a certificate of proficiency) is funded by the Ministry of Education.
- A one-year postgraduate certificate programme, funded by the CTA, is available. Where there are unfilled places in the postgraduate programme, these will be available to currently practising radiation therapists.

Medical physicist training

The CTA has worked with the sector to develop a specification for the delivery of medical physicist training. An agreement on the price for academic training has been reached. However, at the time of writing no agreement has been achieved within the DHB sector concerning the delivery of the clinical component.

Table 10: Technician/technologist training: new purchasing and future direction

Programme area	2003 volumes contracted	2004 volumes forecast	2005 volumes forecast	Direction of future purchasing (volumes) 2005–2013
Medical physicists (therapy)	3	5	10	Currently under discussion
Medical physicists (imaging)	2	–	–	
Radiation therapists	–	10	10	Ongoing

Cytology

During 2003 the CTA provided advice, through membership of the steering committee, to the National Screening Unit (NSU) on the development of a national standard orientation programme for Bachelor of Medical Laboratory Science graduates. There is an ongoing need for information to be collected on trainee registrars in pathology, radiology, and obstetrics/gynaecology for the NSU. The NSU has requested that CTA audit pathology, radiology and obstetrics/gynaecology training.

4.7 Māori health training

The CTA recognises that Māori have a special relationship with the Crown, and that three principles of the Treaty of Waitangi – partnership, participation and protection – need to underpin Māori health workforce development.

He Korowai Oranga (Ministry of Health 2001b) states:

> Trained Māori professionals, managers, community and voluntary workers are necessary to strengthen the health and disability sector's capacity to deliver effective and appropriate services to whānau wherever they are located.

He Korowai Oranga further notes the need for the Ministry of Health to continue to:

- identify barriers to participation in the health and disability workforce
- identify workforce development needs
- implement initiatives to meet these needs.

In 1997 a report (Lawson-Te Aho 1997) to the CTA identified that the Māori health professional workforce had reached a crisis of underdevelopment. The report identified the need for a dual approach to Māori health workforce development, involving both mainstream enhancement and Māori development. A scoping report to the CTA (Hodges and MacDonald 2000) carried out several years later identified an increasing number of Māori participating in PECT, although there remained a low number of Māori health professionals overall. This report recommended building capacity at a pre-entry level to increase Māori participation in post-entry training.

The CTA is guided by these reports, and by He Korowai Oranga. Initial programme purchasing has focused on providing training at entry level, to ensure an advanced workforce exists. Initiatives to further develop the Māori health workforce will include the development of a 10-year strategic plan for Māori health practitioner training.

In the short term, current programmes in Māori health will continue to be funded subject to evaluation. These include Hauora Māori, Rongoā Māori, Clinical Teaching (Māori health) and Māori Child and Family Health. In addition, support will continue to be offered to Māori trainees in mainstream programmes.

Funding of Māori-specific training programmes to replace Hauora Māori and Child and Family will be identified and guided by the 10-year strategic Māori health plan currently under development. This should be completed by December 2003. Mainstream developments in Māori health training include general practice rural rotations with Māori providers for trainees in their PGY2 year, and funding targeted towards co-ordinating Māori medical trainees in the general practice and public health medical programmes.

An audit of all current CTA-contracted providers has been conducted to gauge the level of compliance with cultural expectations outlined in CTA contracts.

Table 11: Training in Māori health: current purchasing and future direction

Programme area	2003 volumes contracted	Direction of future purchasing (volumes) 2005–2013
Clinical teaching	32	To be evaluated; entry-level training CTA funding is expected to cease
Hauora Māori	109	
Child and Family	40	
Rongoā Māori	16	
Māori support and access	296	To be evaluated

4.8 Pacific health training

During 2002/03 the CTA consulted on the best means of increasing the number of Pacific health practitioners. Providing support and access to Pacific trainees was thought to be the most effective way of increasing the number of Pacific health practitioners. The CTA has completed a tender process and awarded a contract to a Pacific provider. The objectives of the contract are to:

- link trainees with appropriate mentors
- administer the support and access payments
- develop a 'train the trainers' type of programme.

The CTA will monitor the effectiveness of the contract for the next two to three years.

4.9 Mental health training

The vision for mental health workforce development is:

- a workforce sustained to respond to the needs of mental health consumers
- a workforce confident in their positive and unique contribution to the journey of recovery
- DHBs and non-governmental organisations owning and driving workforce development (Ministry of Health 2002a).

Benchmarks for the New Zealand mental health workforce have been established by the Mental Health Commission and reported in the *Blueprint for Mental Health Service in New Zealand* (Mental Health Commission 1998). In addition, the World Health Organization (WHO) recommends international population-to-specialist psychiatrist ratios. These documents, along with other information, inform mental health workforce planning. Together they indicate significant deficits in workforce capacity that need to be addressed.

4.9.1 Psychiatry training

General psychiatry

The Advanced Vocational Training in Psychiatry programme is registrar training that leads to specialist psychiatry qualifications. Trainees in this programme form an essential role in the delivery of mental health services, and therefore form a key component of the mental health workforce.

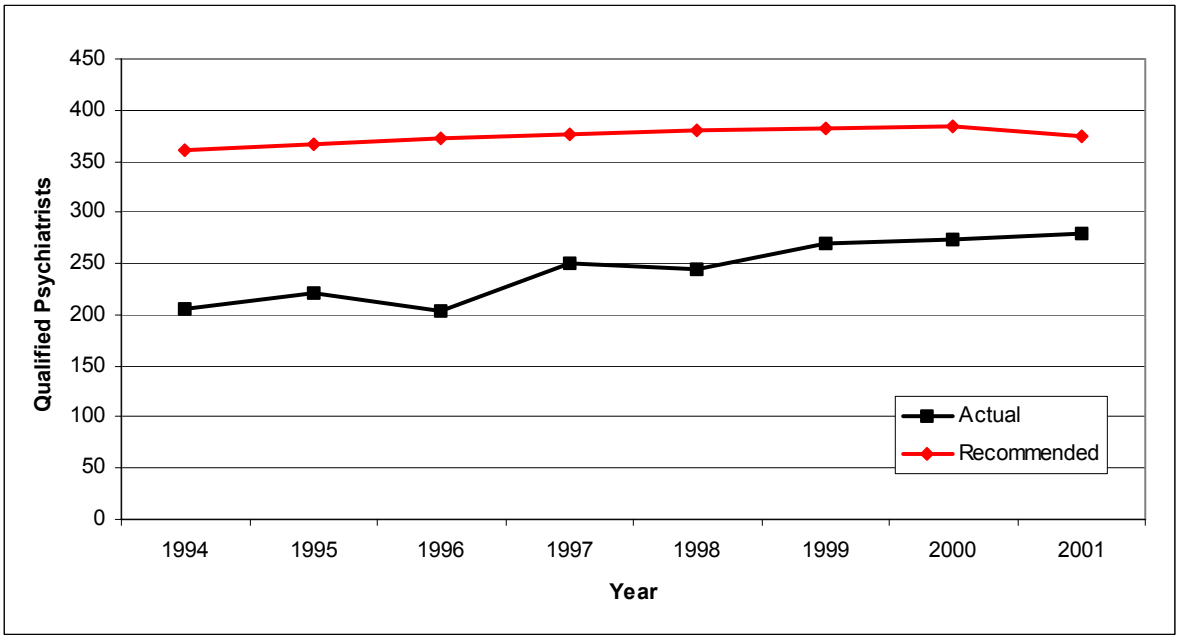
The New Zealand Medical Council's annual workforce survey shows that there were 282 psychiatrists practising in New Zealand as at March 2001. This represented a ratio of approximately one psychiatrist for every 14,000 people. The New Zealand Medical Register at June 2003 indicates that the number of psychiatrists currently holding annual practising certificates is 302. This represents a ratio of approximately one psychiatrist for every 13,000 people.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) recommend a range of specialist-to-population ratios, including:

- 1:7500 for deprived locations
- 1:10,000 for urban areas
- 1:20,000 in large rural areas.

The WHO-recommended ratio for psychiatrists to population is 1:10,000 (Andrews 1991). This is acknowledged as appropriate for this plan. It indicates that New Zealand has a current workforce deficit of approximately 118 qualified psychiatrists.

Figure 2: Number of qualified psychiatrists, actual versus recommended by WHO, New Zealand 2001



The New Zealand psychiatry workforce is heavily reliant on overseas-trained psychiatrists. The RANZCP has informed the CTA that in 2002 half of the active psychiatrist workforce in New Zealand were trained overseas. International and New Zealand evidence indicates that services delivered by providers and workers from the relevant communities are likely to be more effective than services delivered by members of other communities (*The Health and Independence Report*, Ministry of Health 2002d). It is therefore desirable to increase the number of New Zealand-trained psychiatrists in the workforce.

Advanced Vocational Training in Psychiatry is a five-year registrar programme that takes most trainees between six and seven years to complete. The CTA funds this programme on a named trainee basis, contingent upon satisfactory progress and subject to available funds. Satisfactory progress is based on expected programme completion within seven years and is monitored by the CTA in collaboration with the RANZCP.

In November 2002 the RANZCP ratified new regulations for training and assessment. These regulations replace the previous RANZCP Training and Examination By-Laws. Key changes include a greater focus on supervision; the involvement in training of people with mental health illness, carers, non-governmental and other community organisations; and mandatory training in addiction psychiatry, electro-convulsive therapy and the psychiatry of old age. The training programme involves a minimum of three years' basic training, followed by a minimum of two years' advanced training.

The first of these changes to the training programme were implemented for first-year trainees by the RANZCP in December 2002. The changes to the remainder of the programme are due to be implemented in December 2003 (at the commencement of the 2004 training year). The CTA is currently working with RANZCP representatives to revise the training programme specification to incorporate the new regulations. Consultation on the revised specification will take place in September/October 2003, followed by a pricing review. Outcomes of this review will be implemented in the 2004 training year contracts.

The focus for 2004 to 2013 will continue to be on attracting, training and retaining medical health professionals in the field of general psychiatry. Specific attention needs to be paid to reducing training programme and specialist attrition.

Table 12: General psychiatry: current purchasing and future direction

Programme area	2003 volumes contracted	2004 volumes forecast	2005 volumes forecast	Direction of future purchasing (volumes) 2005–2013
Psychiatry	138	132	139	Under review

Child and adolescent psychiatry

The WHO's recommended benchmark for child and adolescent psychiatrists is one per 50,000 population (National Child and Adolescent Psychiatry Task Force 2002). As at March 2002 there were 25 active child and adolescent qualified psychiatrists working in New Zealand, representing a ratio of approximately one psychiatrist for every 156,000 people. Recent work undertaken by the Ministry of Health and DHBNZ suggests there is a workforce deficit of at least 40 child and adolescent qualified psychiatrists in New Zealand (National Child and Adolescent Psychiatry Task Force 2002).

From December 2003 the implementation of the new training regulations will see child and adolescent psychiatry incorporated as sub-specialty training within the advanced training component of the programme (ie, years four and five of the programme).

Table 13: Child and adolescent psychiatry: current purchasing and future direction

Programme area	2003 volumes contracted	2004 volumes forecast	2005 volumes forecast	Direction of future purchasing (volumes) 2005–2013
Psychiatry (child and adolescent)	7	9	11	Under review

4.9.2 Other mental health

A review of mental health workforce training is planned by the Ministry to be implemented in the second half of 2003. The review will include a stock-take of currently funded training, identification of workforce training needs and priorities, and an investigation of the most appropriate and effective means of meeting the workforce training needs. The outcome of this review is intended to guide purchasing directions for the 2005 training year forward.

In 2004, in line with the mental health purchase plan, the CTA will focus on consolidating existing purchases. Any new initiatives/programmes will be subject to the outcome of the review.

4.10 Primary health care training

The Primary Health Care Strategy identifies a new direction for primary health care, with a greater emphasis on population health and the role of the community, health promotion and preventive care (Ministry of Health 2001d). The main change as the vision of the Primary Health Care Strategy becomes reality will be the new focus of practitioners. Teamwork, collaboration and multidisciplinary care are emphasised, and to this end the CTA will work to develop key interdisciplinary training programmes. Some regulatory and accrediting agencies will need to move to recognise such programmes.

Primary health care nurses need to develop advanced skills in particular areas of professional practice, and the CTA will work with the sector to develop appropriate PECT programmes for primary health care nurses. It is envisaged that Nurse Practitioners™ will play a key part in the implementation of the Primary Health Care Strategy.

Other programmes that target primary health care practitioners are discussed in the Medical, Pharmacist and Dentistry training sections.

4.10.1 Rural health

A vision of the New Zealand Health Strategy (Minister of Health 2000) is that accessible and appropriate services are available to people in rural areas. There are many challenges to providing services in rural areas.

In 2003 the CTA commenced a review of rural GP training and the future needs of the rural sector. In addition, the development of a specification for a rural nursing programme has commenced. Both these projects will be completed during 2003, with the intention of implementing the outcomes during 2004. The CTA has allocated an additional $1.6 million to these initiatives.

The initiatives set out in Table 14 are targeted specifically towards health professionals practising in a rural setting.

Table 14: Rural health: current purchasing and future direction

Programme area	2003 volumes contracted	Direction of future purchasing (volumes) 2005–2013
Postgraduate diploma in rural and provincial hospital practice	10	Under review
Rural primary health care*	20	Under review
Scholarship for Rural General Practice	10	Under review
Primary health nursing (discussed in nursing section)	0	Under review
PGY2 rural rotations	10	Under review

* The CTA signalled the withdrawal of funding from the postgraduate certificate and diploma in rural primary health care at the end of 2004. A new nursing programme that will support the career pathway for Nurse Practitioners™ will replace this at the start of 2004.

4.11 Disability issues training

The New Zealand Disability Strategy is mainly focused on creating an inclusive society, in which people with impairment can participate: 'A society that highly values our lives and continually enhances our full participation' (Minister for Disability Issues 2001). One goal within the strategy is to 'develop a highly skilled workforce to support disabled people'.

The first goal for an inclusive society includes health professionals themselves. Therefore one challenge for the CTA in implementing this strategy is to ensure people with disabilities have access to, and are encouraged to participate in, PECT. The second goal of developing a highly skilled workforce to support disabled people can be divided into two areas: disability-specific and/or disability awareness training within mainstream training programmes, and specific training for health professionals and health workers who specialise in providing support to people with disabling conditions.

Enabling access to PECT for health professionals with a disability

The CTA expects providers of programmes to be aware of the New Zealand Disability Strategy and ensure that there are no barriers to people with disabling conditions participating fully in PECT programmes. As CTA develops new specifications and reviews existing specifications, the clauses will be strengthened to ensure that people with disabling conditions will have full opportunity to complete these programmes.

Training for health professionals in mainstream services

It is important that health professionals understand the special needs of disabled people, and are able to provide them with quality health services. This is especially relevant for health professionals working in primary health care. Other professionals working in areas such as paediatrics and rehabilitation are also required to be competent to understand the needs of patients with disabilities. Options for establishing competence should be available in undergraduate programmes, and competence should be extended and maintained through continuing education programmes.

Where specific training is required within mainstream programmes funded by the CTA, this will be progressively introduced into specifications.

Training for workers employed in disability support services

The disability support workforce is made up of a large number of paid and unpaid workers. The level of qualification ranges from unqualified support worker to medical specialist with an advanced vocational qualification. A large number of disability support workers may not require or be able to participate in advanced training.

Three PECT programmes have been developed to meet defined gaps in the availability of advanced clinical education for people working in disability support services. These are focused on autism, rehabilitation, and care co-ordination and management of people with an intellectual disability. All three programmes will be evaluated in 2003/04.

Table 15: Disability services: current purchasing and future direction

Programme area	2003 volumes contracted	Direction of future purchasing (volumes) 2005–2013
Autism	16	To be evaluated
Care co-ordination and management	20	
Rehabilitation	20	

There remains the need to develop further programmes for practitioners who will progress to an advanced level of practice. The CTA will work to gather further information and assess the requirement for further PECT programmes.

Research into the disability workforce was undertaken in 2002, the results were published in 2003 in a report titled *Disability Workforce Analysis* (Ministry of Health 2003a). The aim of the research was to identify major gaps in the workforce and the training currently available, and provide recommendations to the CTA on future planning and purchasing.

Appendix A: Financial Position 2003–2006

The CTA financial position for 2003/06 is shown below. The years are financial (not training) years. The CTA financial year covers a portion of two training years.

Please note: if the CTA financial situation changes during this period because current levels of funding are not made available, the CTA will need to reduce the training it is currently funding. Budget figures are GST exclusive.

	2003/04 Budget $000	2004/05 Budget $000	2005/06 Budget $000
Nursing	7,658	7,526	7,544
Pre-vocational medical	16,642	16,126	16,126
Vocational medical	42,243	43,443	43,302
Technician / technologist	2,526	2,551	2,475
Mental health	1,150	1,150	1,150
Psychiatry	6,675	6,233	6,599
Disability support services	598	598	598
Māori health	3,000	3,000	3,000
Pacific health	500	500	500
Rural health	2,240	2,240	2,240
Pharmacy	318	550	571
Dentistry	789	837	819
Provider expenditure	**84,340**	**84,755**	**84,924**
Estimation of under-provision	-56	-471	-640
Total provider expenditure	**84,284**	**84,284**	**84,284**
Overseas-trained doctors/dentists[1]	1,954	1,184	1,184
Ex- Mason[2]	6,071	5,806	5,806
Total provider expenditure	**92,309**	**91,274**	**91,274**

Notes:

1. The CTA has received additional funding for five years to administer academic and clinical refresher training programmes. Overseas dentist training programme is yet to be confirmed and is not likely to start until 2005/06.
2. The amount of $6,071,000 in 2003/04 is funding from the Mental Health Directorate and is the maximum amount to be funded. This is funded on an 'actual' basis, and should there be any under-delivery against mental health-funded training programmes then the funding will be reduced accordingly.

Appendix B: Predicted Volumes

The following table summarises the minimum purchasing anticipated in currently funded programmes. The forecast models are under review. In the next 12 to 18 months a Ministry project will be developing a robust model for projecting future workforce requirements.

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	% Change
Pre-vocational medical	636	636	Under review								
Vocational medical	923	926	Under review								
Nursing	845	833	Under review								
Dentistry	21	21	Under review								
Pharmacy	110	110	Under review								
Technical	117	112	Under review								
Māori health	197	197	Under review								
Mental health	53	53	Under review								
Rural health	129	129	Under review								
Disability	60	60	Under review								

Appendix C: New Initiatives

The health and disability sector is constantly evolving. There are many opportunities for training, and there are often more training needs than there is budget available. In the past the CTA has sometimes been able to target funding towards new initiatives, such as when previously budgeted programmes have had a delayed start, or fewer trainees enrol than anticipated.

There are two pathways through which the CTA receives proposals for new training initiatives:

- unsolicited proposals
- proposals received through a tender process.

The CTA new initiatives process is designed to meet government guidelines to ensure all purchases are transparent, fair, and legally correct.

The new initiatives process

When an unsolicited proposal is received, the proposal is first analysed to determine whether it meets the post-entry clinical training criteria. This is training that is:

- *vocational:* rather than academic or research-based
- *clinical:* clinically based, with a substantial clinical component where employment in a clinical setting is integral to completion of the qualification
- *post-entry:* occurs after entry to a health profession, so that a person is eligible to practise in a particular occupation
- *formal:* a trainee is formally enrolled in a training programme that leads to a recognised qualification
- *six months:* the training programme is equivalent to a minimum of six full-time months in length
- *nationally recognised:* recognised by the profession and/or health sector and meeting a national health service skill requirement rather than a local employer need.

If the training meets these criteria, then the proposal is ranked against the CTA prioritisation framework and the availability of funds is ascertained. The proposal is then tabled to the CTA Purchase Board. The proposer is sent a letter indicating the Purchase Board's decision concerning the funding of the initiative.

If there is potential competition for the programme proposed, or a similar programme is to be provided by at least one other provider, then the CTA is required to initiate a contestable process. The CTA uses an open tender process.

Developing the specification

Any new purchase must be described by a training specification. Specifications can be developed initially by CTA staff, an interested stakeholder, or a group of stakeholders. The specification is then circulated to the wider sector to ensure the identified training is appropriate for the purpose and is described correctly. Once the specifications are confirmed by the sector, an analysis of the pricing range expected is completed by the CTA.

Tender process

The tender process usually begins with an advertisement in the four main national newspapers seeking expressions of interest. Where there is only a limited number of possible providers, interested parties are sometimes advised of the tender directly. The specifications, along with any other relevant documentation, are sent to respondents along with a template that outlines how the proposal should be submitted.

The CTA can make no assumption that a proposer has specific programme components in place, and will not provide additional information for assessment. It is important, therefore, that the template is followed exactly. If requested information is not provided it is less likely that a proposal will be successful. Submitters of proposals may be contacted to clarify specific items within the proposal, but feedback on the quality of the proposal or whether information is incomplete is not provided at this stage.

An independent panel drawn from the sector assesses and ranks the proposals from a clinical perspective. Panels are usually made up of:

- clinical practitioners
- education providers
- Māori
- Ministry of Health representatives
- other relevant groups.

The panel is sent copies of all eligible proposals, with all identifying information and price/ cost information removed. A meeting (usually a teleconference) is held for the panel to feed back their analysis of the proposals and recommendations to the CTA portfolio manager. The CTA portfolio manager relays the panel's recommendations to the CTA Purchase Board, along with recommendations taking into account any previous history of the providers selected and price information. The Purchase Board considers the recommendations of the panel and the portfolio manager, and authorises expenditure on the programme accordingly.

Timeframes

Specification development and consultation requires a minimum of two months – longer if there is little information available – and meetings with stakeholders are required. If a CTA staff member is needed for the work of writing the specification, this must be planned in advance. The sector is usually given four to six weeks to comment on the draft specification to allow adequate time for consideration.

The *Request for Proposal process* requires a minimum of two months. Potential providers are allowed four to six weeks to develop the submission. The panel then considers the submissions over a two-week period (minimum). Recommendations are made to the CTA's Purchase Board at the next monthly meeting.

Once a preferred provider has been selected, then *development and accreditation of the programme*, if required, may take 12 months, and sometimes longer.

There can be exceptions to this timeframe, such as where a suitable programme is already established and accredited, thus avoiding the development and accreditation stages. However, this is the exception rather than the rule, and accordingly it is anticipated that there is a minimum of 18 months from conception to implementation of any new programme.

Piloting of a programme is implemented for a minimum of one year. Once the pilot period is completed, an independent evaluation of the programme will be completed. This evaluation assesses the effectiveness of the programme to meet its objectives, and may suggest areas of concern that require remedial action.

The results of the evaluation are provided to the CTA Purchase Board for consideration. There are three possible outcomes:

- wider purchasing recommended (and funding made available)
- purchasing at the same level to continue
- purchasing to be exited.

The first two options may be subject to changes in the delivery of the programme.

If continued purchasing is recommended (subject to any agreed changes to the delivery of the programme), then the CTA will continue to purchase the originally negotiated volumes with the provider of the current pilot programme. If wider purchasing is recommended, the CTA will assess with the pilot provider the ability of that provider to meet additional numbers. If the ability does not exist to the extent required, then a further tender process for the provision of the additional volumes will be initiated.

Abbreviations

CTA	Clinical Training Agency
DHB	District Health Board
DHBNZ	District Health Boards New Zealand
TEC	Tertiary Education Commission
HPCA	Health Practitioners Competence Assurance Bill
NSU	National Screening Unit
NZREX	New Zealand Registration Examination
PECT	Post-entry clinical training
PGY1	Postgraduate year one
PGY2	Postgraduate year two
RANZCP	Royal Australian and New Zealand College of Psychiatrists
WHO	World Health Organization

Glossary

Clinical component	The component of a training programme that is substantially clinical (hands-on, occurs in a clinical setting).
Consultant	A specialist; a vocationally registered doctor.
Dual diagnosis	Where a person has two separate but interrelated diagnoses. The programmes currently funded by the CTA relate to diagnoses of mental health illness and drug or alcohol addiction.
Ex-deficit funds	The deficit switch funding allocated to the CTA has been progressively specified and/or targeted to identify areas of under-pricing, or where there were more trainees required than funded. A small pool of funding remains in the nursing area, which is not yet specified or priced. These funds are referred to as 'ex-deficit'.
In-service training	A short course related to the person's work area (eg, cardiopulmonary resuscitation).
Interdisciplinary training	Training that occurs when two or more professions learn with, from, and about one another to facilitate collaboration in practice. This is a subset of multidisciplinary training.
Intern	A health professional in his or her first year of practice who is not yet registered (or is provisionally registered, or holds probationary registration), and works under the supervision of a qualified practitioner.
Lead provider	A lead provider holds the main contract with the CTA, and sub-contracts portions of the training (eg, the clinical component) to other providers.
Mainstream programme	A training programme that leads to a vocational qualification (eg, general practice vocational training), as opposed to a programme that is specifically targeting one population, such as Māori.
Multidisciplinary training	Training where professions learn side by side.
National programme	A programme that is available nationally.
Nationally recognised programme	A programme that is available nationally and is formally recognised by an accrediting body.
Nurse Practitioner™	A registered nurse recognised and approved by the Nursing Council of New Zealand as practising at an advanced level in a specific scope of practice.
Ongoing professional development	Sometimes known as continuing medical/nursing education. This is training and learning that is required in order to remain current in the profession.
Optimal numbers	The number required to maintain an appropriately qualified workforce in New Zealand. These numbers were estimated after analysis of a range of variables, including the age of the current workforce and the numbers expected to immigrate into New Zealand. They do not include an estimate of the number of trainees required to perform service while they are in training.

Overseas trained	The professional holds an initial qualification from a country that is not New Zealand.
Post-entry clinical training	Post-entry clinical training is training that is: • *vocational:* rather than academic or research-based • *clinical:* clinically based, with a substantial clinical component where employment in a clinical setting is integral to completion of the qualification • *post-entry:* occurs after entry to a health profession so that a person is eligible to practise in a particular occupation • *formal:* a trainee is formally enrolled in a training programme that leads to a recognised qualification • *six months:* the training programme is equivalent to a minimum of six full-time months in length • *nationally recognised:* recognised by the profession and/or health sector and meeting a national health service skill requirement rather than a local employer need.
Post-fellowship	After the trainee has been made a fellow of a particular college (usually used in medical training).
Pre-vocational training	Training that occurs prior to specialisation (usually used in medical training to describe the general training immediately after graduation).
Profession-specific training	Training that leads to qualifications recognised by the profession. This often results in advancement within that profession.
Registrar	A medical trainee involved in a specialist training programme.
Replacement-level training	Training of sufficient numbers to ensure the workforce is maintained (ie, does not provide for an increase in numbers practising in the workforce).
Specialist	A consultant; a vocationally registered health professional.
Sustainable training programme	A training programme that can be continued over an unspecified period of time. This usually refers to a programme that attracts a sufficient number of trainees to maintain viability.
Technicians/ technologists	There is often confusion over the difference between a technician and a technologist. For the purposes of this document, the following terminology is used. • Technicians hold a certificate-level qualification, and much of their work consists of completing tests under supervision. • Technologists hold a degree-level qualification and work independently. Their role is to interpret, analyse, and diagnose information, and they also complete more complex procedures. It is important to note that this terminology is currently not used consistently in the workplace: many people who would be deemed technicians hold the job title 'technologist', and vice versa. There is also a crossover in work, with some centres having technicians performing technologist roles, and others having staff that are neither technicians nor technologists performing both roles.

Theoretical component	The component of the training programme that is theoretical or academic in nature.
Unbundling	The process that occurred in 1994 whereby post-entry training that was significantly clinical in nature was identified, and funds previously allocated to education (Ministry of Education) and hospitals were allocated to the initial CTA budget.
Workforce deficit	The gap between the numbers of health professionals required to perform a service, and the number currently available to provide the service. This may be international, national or local.

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