

Clinical Training Agency Strategic Intentions

2003–2012

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MANATŪ HAUORA

Foreword

“Health board prepares to send babies to Australia in readiness for strike”¹

“Radiation therapists may be bonded to stay in New Zealand”²

“Young doctors sick of debt”³

Anyone reading the newspapers could be forgiven for thinking that all of our brightest and best are leaving the country for more lucrative careers overseas. High student debt, high workloads, and the lure of high salaries overseas all contribute to the growing shortages in many areas.

While the Clinical Training Agency (CTA) cannot address all the issues, it has a unique role and perspective through its funding of post-entry clinical training. By utilising its extensive database and relationships with many key people in the sector it is uniquely able to see the shortages – in many cases before they occur. Fixing predicted shortages is not a case of simply targeting training funds. Instead, it is vital that all parties with an interest in the health workforce pull together to address the issues as or before they arrive. The CTA will work closely with, and be guided by the Health Workforce Advisory Committee as it develops strategies and goals.

The CTA’s focus on workforce development is welcomed, and will ensure that training funds are targeted appropriately and effectively. Without the CTA many initiatives in Māori health, rural health and disability support would not have been possible. I congratulate the staff for their continued willingness to think outside the boundaries.

This plan provides a direction for the purchase of post-entry clinical training, and will allow the CTA to address workforce issues much sooner than ever before. Changes will be signalled well in advance to allow for planning to occur within service and education providers, and a more proactive approach to workforce planning will be taken.

Gordon Davies
Deputy Director-General
DHB Funding and Performance Directorate

¹ *New Zealand Herald*, 24 January 2002.

² *New Zealand Herald*, 30 January 2002.

³ *New Zealand Herald*, 27 October 2001.

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Executive Summary

The Clinical Training Agency (CTA) is responsible for purchasing post-entry clinical training.⁴ This is one form of workforce development, and is an essential component of developing an expert health and disability workforce. Previous planning completed by the CTA was on an annual basis, and provided for change at the margins. In a sector where training programmes can be five years long, and any programme of greater than six months requires substantial planning and staffing requirements, annual advice of purchasing direction can be counter-productive.

The publication in 2001 of *The Health Workforce: A training programme analysis* (Ministry of Health 2001g) provided a platform of information for the CTA, and allowed a much stronger basis for planning. The aim of the current plan is a long-term outlook for the purchase of post-entry clinical training, alongside an achievable work plan with identified projects to fill in the gaps and allow for workforce planning. The CTA will work alongside the Health Workforce Advisory Committee to ensure that scarce resources available for workforce planning are utilised in a complementary way.

The CTA's involvement in workforce analysis and development incorporates many areas, including assessment of the current capability of the workforce, working with other directorates within the Ministry of Health to identify gaps, and facilitating training development – whether funded by the CTA or through other agencies or employers. Partnership and collaboration are key features of CTA workforce projects, with strong networks necessary to ensure information is accurate and timely. While purchasing post-entry clinical training is the CTA's principal mandate, wise purchasing would be impossible without an understanding of the full workforce and the impacts of other issues such as recruitment, retention, and the role of undergraduate training and continuing education.

This plan will be implemented through a robust contracting strategy, including working from a clear purchasing strategy with enhanced stakeholder relationships. Monitoring, evaluation and audit are all components of this strategy.

The plan is:

- aligned – with the strategic priorities of the Government
- affordable – utilising existing funding streams
- achievable – within the current resources.

The CTA relies on the expertise and advice of many stakeholders, and plans to maintain strong working relationships within the sector.

⁴ Post-entry clinical training is training that is vocational, clinical, post-entry, formal, a minimum of six months and nationally recognised. A full definition is given in the Glossary.

This strategic plan provides a benchmark for planning over the next decade. The plan will be reviewed on an annual basis to ensure congruency with Government direction and service planning and also to ensure predicted workforce patterns are accurate. While indications are given on individual programme areas regarding the purchasing directions of the CTA for the next 10 years, these may change as Government direction and service planning change. However, we anticipate that the overall direction identified will remain relevant, at least in the short term.

This plan was developed with a strongly practical basis for its implementation and timeframe. The result is a focus on the highest priority training programmes, and a viable way forward.

The CTA's aim is to predict and prevent workforce shortages where they relate to a lack of post-entry clinical training.

Key changes planned for the 10 years beginning in 2003 include:

- a change in the mix of CTA funding, with more emphasis on training for primary and preventive health professionals, and allied health professionals
- targeted funding towards improving the health of Māori and Pacific populations, and rural communities
- specified training programmes for nursing, technical, and other allied health staff
- an increase in understanding of the disability support workforce, and targeted post-entry clinical training
- development of key interdisciplinary training programmes.

A number of projects will commence during 2003/4, and interested organisations and persons are encouraged to participate. Following is a brief outline of the key projects.

- *Analysis of the disability sector workforce.* This project aims to provide key information on the disability workforce in order to inform policy and planning and to assist future workforce development planning. This includes gaining a fuller understanding of the workforce that provides support and health services to people with impairments, identifying major gaps in the workforce and training, and providing recommendations to the CTA on future purchasing in this sector.
- *A cultural audit of specifications and training providers.* This will assess the CTA's training specifications for cultural safety.
- *Evaluations, including the overseas doctors training programme, the autism programme and the first year of clinical practice for nursing.* These evaluations will provide the CTA with accurate information on the effectiveness of the programmes.
- *Interdisciplinary training.* The CTA will assess the viability of introducing interdisciplinary training programmes in areas such as primary health care, rural health and health of older people. It is anticipated that pilots will be tendered in four to six years or when funding becomes available.

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 a Government committed 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 the alignment of a number of functions, including:

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

While the purchase of post-entry clinical training is only one of the tools available to ensure an adequately skilled and qualified health workforce, it plays a vital part. Funding for post-entry clinical training is approximately \$80 million, and there are significant demands on this funding – including some existing unfunded training.

This plan covers the years 2003 to 2012, and provides a benchmark for future planning. It will be revised each year to ensure congruence with current strategies and changing workforce needs.

It is the CTA's aim to predict and prevent workforce deficits by the purchase of appropriate training. The nature of most health workforce training is long-term, and a number of programmes take many years to complete. Indeed, a competent workforce does not occur immediately after training is completed, but comes about through implementing this learning. The focus for the CTA, therefore, is on avoiding future – not current – crises. However, if it is within the CTA's ability to react to changing circumstances, funding will be targeted to assist short-term solutions. Note also, that a lack of training is not the only driver of workforce deficits, and issues affecting retention should not be underestimated.

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: 8–23). While there have not been any major environmental changes over this year, three factors have altered: key strategies, the education sector, and the formation of the Health Workforce Advisory Committee.

Key strategies

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

- service delivery, including:
 - Māori Health Strategy (He Korowai Oranga)
 - Disability Strategy
 - waiting times (medical/surgical/radiotherapy)
 - diabetes incidence and impact
 - inequalities
 - primary health care
 - Mental Health Blueprint implementation
- keeping infrastructure costs as low as possible
- industrial relations strategies
- innovative approaches to managing within budget.

Where training funded by the CTA is able to impact on the service delivery areas listed above, targeted funding has been identified. Infrastructure costs and managing within budget are key components of the CTA's planning for both the training and operational budgets. Industrial relations strategies, while sometimes affecting providers' ability to provide training, are not considered to be within the CTA's mandate.

Education sector

In April 2000 the Ministry of Education established the Tertiary Education Advisory Commission (TEAC). The aim was to identify how New Zealand could develop a more co-operative and collaborative tertiary education sector. TEAC produced four reports on the state of tertiary education and recommended some major changes. In 2002 the *Tertiary Education Strategy 2002/07* (Associate Minister of Education 2002) was published, outlining an explicit direction for the future of tertiary education.

One of the key proposed changes to the current tertiary education system is an improved response to the needs of business, social services and health care providers. Current discussions between the Ministry of Health and the Ministry of Education will provide a framework for the health sector to have more input into the purchase and provision of Ministry of Education-funded programmes, and hence on the number and type of trainees available for post-entry clinical training. A current project within the Ministry of Health's Sector Policy Directorate is to identify the skills required of people graduating from health education programmes.

Health Workforce Advisory Committee

The Health Workforce Advisory Committee was established in 2001 to advise the Minister of Health on health workforce issues. The CTA will continue to work with the Committee, to ensure relevant information is shared between the two organisations. It is anticipated that the work streams of the CTA and the Health Workforce Advisory Committee will be complementary as both strive to improve knowledge and understanding of the health workforce.

1.3 Planning for the future

The CTA's strategic plan will take the purchase of post-entry clinical training into the future. The plan will be revised annually, taking into account the changing environment of 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 stream for three years. Any planning outside three years is indicative only and subject to available budget.

The CTA works in a collaborative way. 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

In order to develop the strategic plan, new and proposed programmes were ranked according to each programme's relevance 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 major workforce deficit scored very high on workforce need.

Once this ranking was completed, optimal numbers of trainee full-time equivalents (FTEs) for each training programme were developed, taking into account the following principles.

- Changes are incremental rather than sudden.
- Contracted volumes are retained (as a minimum) for the term of the contracts.
- Initial estimates for optimal numbers are 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 is reasonable and achievable. (For example, where a programme is required to have accreditation, then sufficient time will be given to achieve this.)
- Planned increases are demonstrably possible, both in terms of supervised positions and placements available and/or trainee availability.
- Reductions of training funding will not leave trainees unfunded part-way through a programme.
- Any changes to volumes are on a calendar- or training-year basis, in order to reflect actual training programme intakes.

The calculated optimal numbers provide an estimate of volumes that would be purchased if the programme is considered a high priority and funding is 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.

- 1) Lower-priority programmes not currently provided/purchased.
- 2) Current programmes with a low priority ranking.
- 3) Programmes where there is more training funded than is required to meet future workforce needs.

- 4) Programmes where the current funding level is less than the ideal level to meet workforce needs, but unfunded training is occurring regardless, and there is expected to be a reduction in the training volumes required in the medium term.

There were usually a number of options for how a reduction from optimal training numbers could be carried out, 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 toward 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 budget process.

3 Implications

What are the implications of the CTA's strategic framework for the many people and organisations affected by the direction of post-entry clinical training? This chapter considers the affects on stakeholders, and outlines the work plan.

3.1 Stakeholders

Post-entry clinical training for health and disability professionals involves many different stakeholders. This plan is intended to give stakeholders direction and an understanding of the priorities for the CTA, and also a measure of certainty. Any changes to existing programmes will be signalled in advance, which should allow stakeholders to plan their own activities rather than focus on whether the CTA will reduce funding for certain programmes. The implications for some stakeholders are summarised below.

Hospitals

There will be a change in the mix of training funded, and more training opportunities for nursing and allied health staff.

Training providers

New programmes

We anticipate that new programmes will involve many established training providers. It is likely that the number of training programmes purchased by the CTA will increase.

Systems, monitoring and audit

The CTA will continue to refine systems to ensure essential monitoring is performed efficiently and effectively, with a focus on reducing the administrative burden on providers and the CTA, without compromising the quality of information sought. Providers will be encouraged to be innovative and implement progressive policies – especially in terms of programme delivery – to ensure health professionals are able to access programmes and participate fully, while working in an often busy and stressful environment. The CTA will continue to audit providers to ensure all programme components, including adequate release time and formal teaching, are provided to trainees.

Evaluation

Programmes will be evaluated on an ongoing basis.

Māori provider organisations

It is expected that there will be an increase in the number of programmes provided by Māori provider organisations.

Professional bodies

The CTA will continue to work with professional bodies to ensure that information is current and relevant, and that the needs of the profession are understood. Memoranda of understanding with professional bodies will continue to be pursued with the purpose of mutual benefit in the sharing of information.

Trainees

More funded training programmes will be available. While the traditional focus on advanced, profession-specific training will continue, the CTA will seek ways to implement interdisciplinary and multidisciplinary training, to meet the needs of the sector.

3.2 Work plan

The CTA is committed to a strategic plan that has a practical implementation and timeframe. There is also a commitment to consistently improving quality – both of systems within the organisation and in programmes funded by the CTA.

Projects

Specific CTA projects planned to commence in 2002 include:

- development of a Māori health practitioners training plan with a 10-year outlook
- a review of the new monitoring systems implemented over the last two years
- an analysis of the PECT workforce and training needs for mental health
- an analysis of the workforce and training needs for health technicians, technologists and other technical allied health staff
- an analysis of the disability sector and the associated health and support workforce requirements
- a cultural audit of all programmes
- finalisation of specifications in:
 - rural primary health care
 - rural and provincial hospital practice
 - dentistry
- development of specifications for training in:
 - accident and medical practice
 - cardiac technology
 - dentistry
 - medical physics
 - palliative medicine
 - rehabilitation medicine
 - sexual and reproductive health

- evaluations for:
 - autism
 - overseas-trained doctors bridging programme
 - comprehensive pharmaceutical care
 - first year of clinical practice
 - high and complex needs (care management and co-ordination).

Longer-term projects include:

- evaluation of programmes including:
 - palliative care nursing
 - rural rotations for medical postgraduate year 2 (PGY2)
 - Māori child and family
 - hauora Māori
 - clinical teaching (Māori)
 - rongoa Māori
 - Māori support and access grants
 - rehabilitation
- development of new interdisciplinary training, focusing on:
 - primary health care
 - rural health
 - health of older people (especially those with multiple morbidities)
 - disability support services/health services for people with impairment.

If you are interested in providing comment on specifications, or in participating in advisory groups or assessment panels in any of these programme areas, please contact the CTA nominating the specific programme area and task.

Ongoing work

The CTA will continue to build its knowledge base through research and analysis, and by working with stakeholders to improve information and understanding. A sustainable audit programme will also continue.

Other directions the CTA will continue with include:

- purchasing all programmes (where possible) on a lead provider model
- purchasing all programmes on a national price basis (marginal costing will be implemented where appropriate)
- an increased focus on evaluation of programmes.

4 Service Plans

The CTA purchases two types of training: profession-specific and cross-profession. Profession-specific training generally leads to qualifications directly related to the trainee's profession, while cross-profession training focuses on generic skills that can be utilised by more than one profession, or on providing services to a particular population. In many cases, cross-profession training is not recognised by the profession on a career pathway. However, with the introduction of the Health Practitioners' Competence Assurance Bill we anticipate this will change as the Bill enables recognition of multidisciplinary training as a part of continuing professional development.

The service plans are presented in the following order:

Profession-specific:

- medical
- nursing
- dentistry
- pharmacy
- technician/technologist/technical allied health

Cross-profession:

- Māori
- Pacific
- mental health
- primary health care
- rural health
- disability.

Note that there are blurred boundaries between programme types. For example, much rural health is primary health care, and primary health care is also represented in medical, nursing, dentistry and pharmacy training. Programmes funded by the CTA outlined in the following sections are categorised as closely as possible to their key focus.

4.1 Profession-specific training

Medical training

Access to appropriate care is a cornerstone of the New Zealand Health and Disability Strategies, and appropriate specialist care is an essential part of providing care to many patients. Indeed, 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 funds all training years, including PGY1, PGY2, diploma programmes taken at any time, 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 by Table 1. A vocationally registered doctor may have a working life as a consultant of approximately 30 years. Conversely, this doctor is typically a registrar for a maximum of approximately 10 years.

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

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

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. Evidence suggests that the uptake of the obstetrics and gynaecology diplomas by eligible trainees is reducing, and CTA budgeting will reflect this decrease.

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

Programme area	2002 volumes contracted	2003 volumes forecast	2004 volumes forecast	Direction of future purchasing (volumes) (2002–2012)
Year 1 house surgeons	269	All eligible	All eligible	No change
PGY2	365	Subject to specification implementation		
Diploma in Obstetrics and Gynaecology	29.5	20	20	30% decrease
Diploma in Paediatrics/Child Health	40.5	42	42	5% increase

Vocational training

There are currently significant shortages in many of the medical specialties. While this situation remains CTA will continue to target funding towards the highest priority groups. Over the longer term it is anticipated that initiatives currently in train or planned will positively impact on these shortages, and numbers in training may decrease, to reduce the likelihood of oversupply in the consultant workforce. 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 purchasing and future direction

Programme area	2002 volumes contracted	2003 volumes forecast	2004 volumes forecast	Direction of future purchasing (volumes) (2002–2012)
Anaesthesia	115.5	119	112	30% decrease
Emergency medicine	57	57	57	85% decrease
General practice	50	50	50	No change
Intensive care medicine	0	7	8	50% increase
Musculoskeletal medicine	7	7	7	30% increase
Obstetrics and gynaecology	41.5	37	35	80% decrease
Ophthalmology	14	11	10	30% decrease
Pathology	43	43	43	No change
Physician training – adult medicine*	172	172	172	No change
Physician training – paediatrics	58.5	61	62	70% decrease
Public health medicine	31.5	35	35	10% increase
Radiation oncology	12	13	13	10% increase
Radiology	59.3	59	59	10% decrease
Rehabilitation medicine	3	5	7	33% increase
Surgery	192	203	196	25% decrease

* 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, cardiology, geriatric medicine, medical oncology, rheumatology and dermatology.

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

New areas of purchasing in advanced vocational training are anticipated in palliative care medicine, sexual health medicine, and accident and medical practice.

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. 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 250 placements on the programme.

The programme comprises an academic course followed by an internship, during which the doctor observes clinical practice. Placements began in February 2001 and the final cohort will complete in February 2004. Once doctors have completed the programme they are able to sit NZREX, which, if successful, leads to registration with the Medical Council of New Zealand.

There will be an evaluation of the bridging programme after the first cohort has completed and results from NZREX are known. This evaluation will assess the quality of the programme, taking into account the outcomes for trainees and stakeholders.

A frequent question raised during 2001/02 was regarding 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 high cost to hospitals, and once the specification for training in PGY2 has been implemented the CTA will assess the potential for specifying and funding training and supervision for NZREX doctors.

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.

Initial training for nurses was originally hospital-based, under an apprenticeship model. More recently, training transferred to the polytechnics and a diploma was awarded. In 1991 three-year bachelor degrees were established. Currently, 19.4 percent of the nursing workforce holds an undergraduate degree (Nursing Council of New Zealand 2002). Due to the level of initial training, there is increasing demand for postgraduate (level 800) nursing education programmes. The emerging nurse practitioner role has also created a demand for higher education.

The initial unbundling of post-entry clinical training 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 national need. Additional funding from the base CTA budget and the Mason⁵ allocation has also been directed towards nursing training.

This process left the CTA with three streams of funding for nurse training:

- the 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 national, post-entry clinical training programmes
- the ex-Mason funding, with two programmes purchased in mental health nursing - the CTA administers these programmes in line with the *Mental Health Directorate 2002–2005 Purchasing Plan* (Ministry of Health 2002a).

⁵ In 1996 a review team led by 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.

The recent development of a framework for the nurse practitioner has highlighted the need for post-entry clinical training 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)

The CTA has identified a need to provide training that is well-organised, transferable, meets the health needs of New Zealanders and is at an advanced level. The Nursing Council of New Zealand has developed a framework for post-registration nursing practice education which outlines a pathway of educational preparation for registered nurses, extending from the first year of clinical practice through to advanced nursing practice.

A sector reference group⁶ identified key areas where nursing training is required:

- first year of clinical practice
- primary health care
- mental health
- intensive/emergency care.

Accordingly, the CTA is piloting a first year of clinical practice programme. This programme will be evaluated at the end of 2002. Current funding would enable a subsidy of between 10 percent and 30 percent of the total cost to support national first year of clinical practice programmes in future years. The results from the evaluation of the pilot programmes will provide District Health Boards with information on 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.

Within the next 10 years the sector will move towards providing programmes under the four areas named above. Each area will include different scopes of practice; for example, primary health care may include child health, rural health, Māori health and Pacific health streams. These programmes may lead to master's level education to support the development of nurse practitioner roles. This may require a transfer of CTA funding from the ex-deficit, local-need programmes to nationally specified programmes that enable nurses to better meet population health needs. The focus will be on supporting nursing in advanced training at a level equivalent to 800 on the New Zealand Qualifications Framework, and will be congruent with the proposed *National Strategy for Purchasing Post Entry Clinical Nurse Training Programmes* report, which has yet to be consulted on.

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.

⁶ The sector reference group comprises representatives from District Health Boards, the education sector, Māori and Pacific communities, and the Ministry of Health.

Table 4: Nursing training: current purchasing and future direction

Programme area	2002 volumes contracted	2003 volumes forecast	2004 volumes forecast	Direction of future purchasing (volumes)
Child and family nursing	93	100	100	Subject to evaluation and sector reference group report
Emergency nursing	40	40	40	
Specialty nursing practice	44	44	0	
Palliative care nursing	40	40	40	
First year of clinical practice	139	Subject to evaluation and sector reference group report		
Ex-deficit nursing	630*	485	Subject to evaluation and sector reference group report	

* Additional funding was applied during the 2002 training year as a result of the late start of pilot programmes.

Dentistry training

The career pathway for dentists involves an undergraduate degree, followed by optional specialist postgraduate training. Dentists may choose to work as general dentists, therefore not requiring postgraduate training (approximately 79 percent of dentists worked in this capacity in 2000).⁷ Funding of training for dentistry is split between the Ministry of Education and the CTA, with the responsibilities identified in Table 5.

Table 5: Dentistry training: funding responsibilities

Qualification	Funder
<i>Undergraduate training</i>	
Bachelor of Dental Surgery	Ministry of Education
<i>Postgraduate training</i>	
Postgraduate Diploma in Clinical Dentistry	CTA
Postgraduate Diploma in Community Dentistry	Ministry of Education
Oral and Maxillofacial Surgery	CTA
Master of Dental Surgery	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. The training funding for oral and maxillofacial surgery will be reviewed, with separate specifications developed during 2002. Also to be assessed is training in special-needs dentistry.

⁷ NZHIS, <http://www.nzhis.govt.nz/stats/dentstats.html>.

Table 6: Dentistry training: current purchasing and future direction

Programme name	2002 volumes contracted	2003 volumes forecast	2004 volumes forecast	Direction of future purchasing (volumes) (2002–2012)
Postgraduate Diploma in Clinical Dentistry	5	4	4	No change
Master of Dental Surgery	14	14	14	No change
Oral and Maxillofacial Surgery	9	10	12	20% increase

Pharmacist training

The role of the pharmacist is evolving, and the focus is more on providing primary health care services rather than on counting and dispensing drugs.⁸ There are also wider employment opportunities, including key roles within Independent Practitioner Associations (IPAs) and, probably, Primary Health Organisations (PHOs). The CTA funds two areas of training for pharmacists: the pharmacy intern year (immediately after completion of the undergraduate pharmacy degree), and training in Comprehensive Pharmaceutical Care®.

By 2004 an increase in numbers into the undergraduate degree will impact on the number of internships required in New Zealand. Accordingly, the CTA will increase funding to ensure all eligible trainees are supported during their intern year.

Training in Comprehensive Pharmaceutical Care® leads to the ability to perform drug reviews and associated services. We anticipate that funding allocated to training in this area in 2001/2 will provide a core number of pharmacists qualified in this area. Subsequent funding will be targeted at maintaining this core number of pharmacists, and therefore will be aimed at replacement level only.

Table 7: Pharmacy training: current purchasing and future direction

Programme area	2002 volumes contracted	2003 volumes forecast	2004 volumes forecast	Direction of future purchasing (volumes) (2002–2012)
Comprehensive pharmaceutical care®	250	5	5	95% decrease
Pharmacy intern training	86	120	184	150% increase

Technician, technologist and physicist training

There is increasing awareness of the importance of appropriately trained health technicians and technologists in the health workforce. The ongoing discussion around the Health Practitioners' Competence Assurance Bill has led to a number of the professions with voluntary registration to call for compulsory registration. We anticipate that compulsory registration would raise the quality of services within the profession, and also raise the profile of technicians and technologists.

⁸ Cabinet Minute EHC (01) 15/6, Direction of Pharmacy Services.

Terminology

There is often confusion regarding the difference between a technician and a technologist. For the purposes of this document, the following terminology will be 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 who are neither technicians nor technologists performing both roles.

Current programmes

The CTA currently funds training for anaesthetic technicians, cardiopulmonary technicians, physiology technicians and sonographers. Cardiopulmonary and physiology technician funding is currently being assessed, and specifications will be circulated for consultation later this year. It is anticipated that the training specifications and funding will be grouped under the title 'cardiac technician/technologist training'.

Table 8: Technician/technologist training: current purchasing and future direction

Programme area	2002 volumes contracted	2003 volumes forecast	2004 volumes forecast	Direction of future purchasing (volumes) (2002–2012)
Anaesthetic technicians	48	50	50	5% increase
Ultrasonography	25	20	25	No change

Other technician workforces

In 2001 the CTA identified (Ministry of Health 2001g) a lack of collated information on the health technician workforce, and early in 2002 commissioned an analysis of the sector. Key findings included a severe shortage in many areas, and low morale among staff. It was also found that in some areas there is a lack of co-ordinated nationally recognised training for staff, and no identified career pathways, which exacerbates the low morale.

The report identified that post-entry clinical training for the technician workforce is necessary in the short term. The following roles will be individually scoped, and the CTA will work towards specifying and funding nationally recognised post-entry clinical training programmes in:

- cardiovascular perfusion
- neurophysiology
- nuclear medicine.

The National Screening Unit (NSU) of the Ministry of Health has also identified a lack of training opportunities for cytotechnicians (Ministry of Health 2001a). The CTA will work with the NSU and the sector to identify and plan for training, subject to funding being made available.

Medical physicist training

It has been identified that a suitable postgraduate training programme for medical physicists in New Zealand needs to be re-established (Ministry of Health 2001c: 30). The CTA is currently working with the sector towards this goal.

4.2 Cross-profession training

Areas that do not fall neatly into vocational professional training include providers of health services for specific population groups, and training for specific services or communities. Training in these areas can be multidisciplinary, interdisciplinary or profession-specific.

The New Zealand Health Strategy (Minister of Health 2000: 27) identifies that:

... for health services to address the needs of local communities and individuals, more co-ordinated and complementary ways of working across the sector need to be established.

Further:

Most of the progress will come from the teams of health professionals working and learning together ...

The CTA currently funds training programmes in Māori health, mental health and rural health, and for professionals working in disability support services. We anticipate that new training programmes will be developed in the areas noted above, in addition to programmes in Pacific health and public health. The initial focus on new interdisciplinary training will be in the primary health care sector, although the potential for interdisciplinary training within hospital settings will be explored.

There are currently issues around the recognition of multidisciplinary training in vocational pathways. The CTA expects that regulatory and accrediting agencies will move to recognise such programmes in the short term, as the Health Practitioners' Competence Assurance Bill enables recognition of these programmes as a part of maintaining competency.

The Health and Independence Report (Ministry of Health 2001f) notes that services delivered by workers from relevant communities are more likely to be effective than services provided by workers from other communities. The under-representation of Māori and Pacific peoples, particularly at the advanced levels in the health workforce, has led to the CTA targeting funding towards recruitment and retention of Māori and Pacific health professionals, including providing specific support for trainees in mainstream programmes, and developing specific programmes for Māori health professionals who intend to practise

in Māori health. It is also acknowledged that all health professionals should provide services that are both culturally and clinically effective.

Māori health

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 that:

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 identifies the need for the Ministry of Health to continue to identify barriers to participation in the health and disability workforce, identify workforce development needs, and continue to 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, including mainstream enhancement and Māori development. A scoping report to the CTA in 2000 (Hodges and MacDonald 2000) identified an increasing number of Māori participating in post-entry clinical training, 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 clinical 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 development of:

- a 10-year strategic plan for Māori health practitioner training
- a training and accreditation pathway for Māori community health and Māori personal care workers.

Future CTA purchasing will focus on sustainable post-entry clinical training programmes.

Current programmes in Māori health will continue to be funded subject to evaluation. These include hauora Māori, rongoa 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.

Table 9: Training in Māori health: current purchasing and future direction

Programme area	2002 volumes contracted	Direction of future purchasing (volumes)
Clinical teaching	32	To be evaluated
Hauora Māori	109	Entry-level training, CTA funding expected to cease
Child and family	40	
Rongoa Māori	16	

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-ordination for Māori trainees in the general practice and public health medical programmes.

An audit of all current CTA-contracted providers will be conducted to ascertain the level of compliance with cultural expectations outlined in CTA contracts. This will ensure that responsiveness to Māori is maintained in training, and provide information to allow for further planning of Māori health initiatives.

Pacific health

The *Pacific Health and Disability Action Plan* (Ministry of Health 2002c) identifies a paucity of Pacific health and disability professionals and by-Pacific-for-Pacific services in the health sector. In 2002 the CTA commissioned a report (Jansen 2002) to identify where best to target funding to address these issues.

This report identifies two programmes where funding could be targeted.

- First year of clinical practice – to assist new graduate Pacific nurses in consolidating their academic knowledge, and to provide a structured entry to practice in primary health care settings.
- Nurse practitioner – to develop a postgraduate certificate to assist advanced-level nurses on the pathway towards becoming nurse practitioners.

The CTA will assess the viability of these recommendations, and work towards implementing programmes targeted to Pacific health practitioners. Further recommendations identify that research into the training and education needs of the workforce required by specialty nursing, midwifery and mental health services is required. This will be completed as time permits.

Mental health

The vision for mental health workforce development is:

A workforce sustained to respond to the needs of mental health consumers, confident in their positive and unique contribution to the journey of recovery, with District Health Boards 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* (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 workforce capacity deficits that need to be addressed.

Ministry of Health contracts for mental health workforce development are managed by the CTA on behalf of the Mental Health Directorate. A separate purchasing plan is being developed for this area (Ministry of Health 2002a).

Psychiatry

General

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.

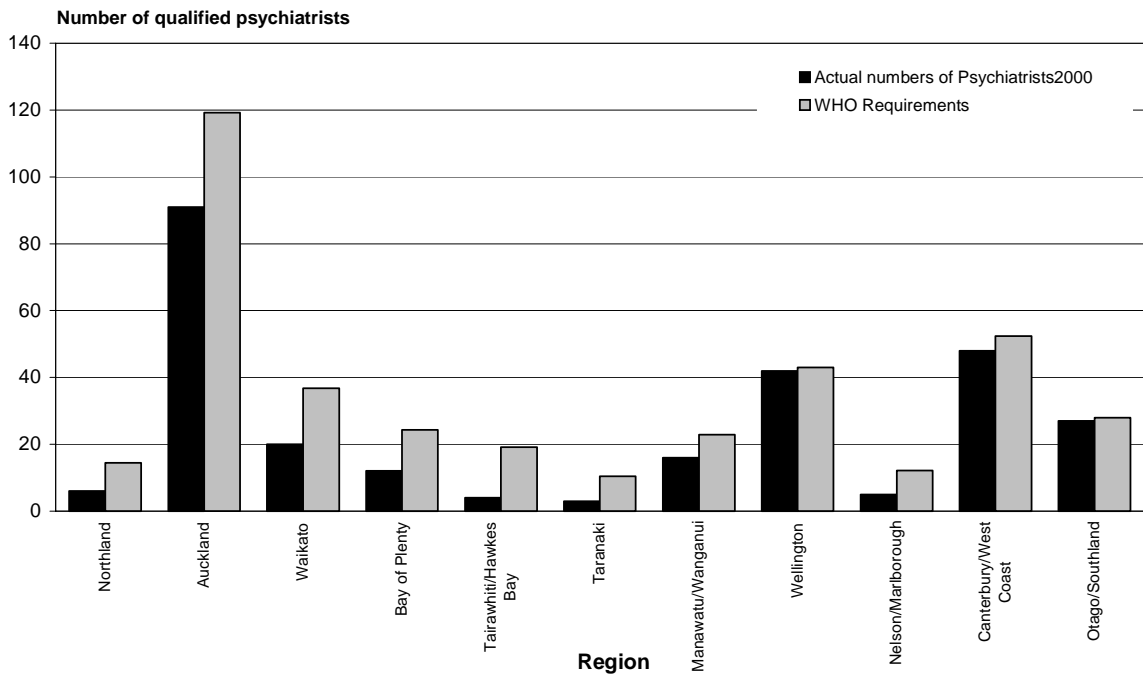
There appears to be a decreasing number of qualified psychiatrists practising in New Zealand. The New Zealand Medical Council's annual workforce survey shows that there were 274 psychiatrists practising in New Zealand as at March 2000. This represented a ratio of approximately one psychiatrist for every 14,000 people. The New Zealand Medical Register at March 2002 indicated that the number of psychiatrists who held current annual practising certificates was 261. This represented a ratio of approximately one psychiatrist for every 15,000 people.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) recommends 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 of 1:10,000 (Andrews 1991) is acknowledged as appropriate for this plan. This indicates that New Zealand has a current workforce deficit of approximately 128 qualified psychiatrists. As shown in Figure 1, the deficit was unevenly spread throughout New Zealand in 2000.

Figure 1: Number of qualified psychiatrists to population versus number required, by region, 2000



The reasons for the decreasing numbers of psychiatrists could be attrition related to retirement and local graduates finding employment overseas. Based on RANZCP data it is assumed that the attrition rate due to retirement of active psychiatrists will be around 10 percent during the period 2002 to 2007. Attrition of local graduates due to emigration within five years of qualifying is expected to be approximately 20 percent. In most years only one New Zealand-trained psychiatrist returns from overseas to work in New Zealand.

The New Zealand psychiatry workforce is heavily reliant on overseas-trained psychiatrists. The RANZCP reports that in 2002 half of the active psychiatrist workforce in New Zealand was trained overseas. *The Health and Independence Report* (Ministry of Health 2001f: 140) states that 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. Thus it is desirable to increase the number of New Zealand-trained psychiatrists in the workforce.

The Advanced Vocational Training in Psychiatry programme is a five-year registrar programme that takes most trainees between six and seven years to complete. Attrition during the programme is estimated at approximately 15 percent per annum. Half of the CTA-funded trainees on the 2001 psychiatry registrar programme were previously graduates of overseas general medical training programmes, and this is representative of other training years.

The focus for 2003 to 2012 will be on attracting, training and retaining medical health professionals in the field of psychiatry. Specific attention needs to be on reducing training programme and specialist attrition.

Table 10: General psychiatry: current purchasing and future direction

Programme area	2002 volumes contracted	2003 volumes forecast	2004 volumes forecast	Direction of future purchasing (volumes) (2002–2012)
Psychiatry	145	161	178	12% increase

Child and adolescent psychiatry

The advanced training in child and adolescent psychiatry programme is technically a two-year post-fellowship programme. Two pathways are available for trainees: they may either enter following completion of the five-year psychiatry programme, or in the fifth (elective) year of the general psychiatry programme.

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. This represents a ratio of approximately one psychiatrist for every 156,000 people. Recent work undertaken by the Ministry of Health and District Health Boards of New Zealand suggests that 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).

Table 11: Child and adolescent psychiatry: current purchasing and future direction

Programme area	2002 volumes contracted	2003 volumes forecast	2004 volumes forecast	Direction of future purchasing (volumes) (2002–2012)
Psychiatry (child and adolescent)	4	8	10	150% increase

Other mental health

A number of workforce projects currently being undertaken will provide valuable information to enable robust analysis of the workforce. Unfortunately, this information is not available early enough to guide this plan for 2003.

Until more robust data on the workforce is available, we will assume that purchasing of post-entry clinical training over the next eight to ten years will need to increase in proportion to the increase in clinical workforce numbers, in line with Blueprint benchmarks to ensure that the capability requirements of the expanded clinical mental health workforce are met. An increase of 41 percent based on current FTEs in the workforce is therefore required.

Estimated mental health clinical workforce requirements to meet Blueprint benchmarks are given in Table 12.

Table 12: Mental health clinical workforce requirements

	Current FTEs	Blueprint benchmark FTEs	Clinical FTE deficit	Percentage increase
Community clinical FTEs *	3240	4950	1710	52%
Inpatient clinical FTEs **	2020	2489	469	23%
Total clinical FTEs	5260	7439	2179	41%

* Source: Ministry of Health 2002a.

** Source: Ministry of Health 2002b, and Ministry of Health Blueprint tables.

In line with the Ministry's mental health purchasing plan, the CTA will continue to focus on consolidating existing post-entry clinical training programmes, including advanced mental health nursing, dual diagnosis and forensic. In addition, the emphasis of any expansion of post-entry clinical training programmes will centre on new graduate mental health nursing, child and adolescent, and Māori mental health programmes.

Table 13: Multidisciplinary and nursing mental health training: current purchasing and future direction

Programme area	2002 volumes budgeted	2003 volumes forecast	2004 volumes forecast	Direction of future purchasing (volumes) (2002–2012)
CTA funded	53	53	55	41% increase
Mental Health Directorate funded	492	492	514	41% increase

Primary health care

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: vii). 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.

The CTA notes the need for primary health care nurses to develop advanced skills in particular areas of professional practice, and will work with the sector to develop appropriate post-entry clinical training 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 sections.

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 issues around providing services in rural areas. One important issue is a maldistribution of the workforce. Other issues include the long hours on-call professionals are expected to work, and low morale among many rural practitioners.

While the CTA is focused on training for national rather than local requirements, there are initiatives targeted specifically towards health professionals practising in a rural setting, such as the postgraduate certificate and diploma in rural primary health care, and postgraduate diploma in rural and provincial hospital practice. Funding will continue to be targeted towards these programmes, although a review of the pricing structure will be completed later in 2002.

Table 14: Rural health: current purchasing and future direction

Programme area	2002 volumes contracted	Direction of future purchasing (volumes)
Rural and provincial hospital practice	5	To be evaluated
Rural primary health care	20	
PGY2 rural rotations	10	

Another initiative is rotation into a general practice based in a rural area for doctors in their second postgraduate year (PGY2). These rotations are designed to encourage doctors to view rural practice as a rewarding and viable career option, and to provide new doctors with greater awareness of the primary–secondary interface.

As rural health is a high-priority area, the CTA will continue to assess the requirements of training for those health professionals working in a rural setting, and target any available funding appropriately.

Disability issues

The New Zealand Disability Strategy is mainly focused on creating an inclusive society, where people with impairment can say they participate in:

A society that highly values our lives and continually enhances our full participation ... (Minister for Disability Issues 2001)

One goal within the strategy (p.21) is to:

Develop a highly skilled workforce to support disabled people.

The first goal – for an inclusive society – includes health professionals themselves, and therefore one challenge for the CTA in implementing this strategy is to ensure disabled people have access to and are encouraged to participate in post-entry clinical training. 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 post-entry clinical training for health professionals with a disability

The CTA expects that providers of programmes are aware of the New Zealand Disability Strategy and ensures that there are no barriers to people with disabling conditions participating fully in post-entry clinical training programmes. There will be a review of specifications, beginning in 2003, to ensure programmes meet these standards.

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 quality health services. This is especially relevant for health professionals working in primary health care. Other professionals working in 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 for workers ranges from unqualified support worker to medical specialist with an advanced vocational qualification. A large number of workers in the current workforce may not require or be able to participate in advanced training.

Three post-entry clinical training 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 to 2004.

Table 15: Disability services: current purchasing and future direction

Programme area	2002 volumes contracted	Direction of future purchasing (volumes)
Autism	20	To be evaluated
High and complex (care management and co-ordination)	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 post-entry clinical training programmes.

It is anticipated that purchasing for training in disability support services will increase over the next 10 years. Areas to be considered include programmes in continence management, and interdisciplinary training focusing on support for older people. Research into the disability workforce is currently being undertaken, and a report will be issued for consultation later this year. The aim of the research is to identify major gaps in the workforce and training currently available, and to provide recommendations to the CTA on future planning and purchasing.

Appendix A:

Financial Position 2002–2005

The CTA financial position for 2002/05 is shown below. This covers a financial year – not a training year. 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 have to reduce the training it is currently funding.

Budget figures are GST exclusive.

	2002/03 budget \$000	2003/04 budget \$000	2004/05 budget \$000
Nursing	6,590	6,601	7,181
Medical pre-vocational	16,676	16,665	16,837
Medical vocational	41,539	40,554	39,382
Technician/technologist	2,583	2,795	2,959
Mental health	1,150	1,150	1,150
Psychiatry	6,368	6,947	7,034
Disability services	441	523	693
Māori health	3,000	3,000	3,000
Pacific health	500	500	500
Rural health	762	762	762
Pharmacy	322	388	404
Dentistry	662	710	693
Price path adjuster	306	306	306
Total provider expenditure (excluding ex-Mason and overseas doctors)	80,900	80,900	80,900
Overseas-trained doctors ¹	4,170	789	0
Ex-Mason ²	5,806	5,806	5,806
Total provider expenditure	85,070	81,689	80,900

Notes:

- 1) The CTA has received additional funding for three years to administer academic and clinical refresher training programmes.
- 2) The amount of \$5,806 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 anticipated purchasing in currently defined programmes. Note that these volumes are the minimum purchases anticipated as new purchasing is indicated in most areas, particularly advanced vocational medical training.

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	% change
Prevocational medical	687	687	687	687	687	687	687	687	687	687	0%
Vocational medical	1,097	1,080	1,034	979	928	892	874	860	859	863	-21%
Nursing	1,174	1,194	1,214	1,234	1,234	1,259	1,259	1,259	1,269	1,299	11%
Dentistry	28	30	29	29	28	29	29	30	29	28	0%
Pharmacy	125	189	205	215	225	225	225	225	225	225	80%
Technical	94	112	124	137	148	160	159	153	151	152	62%
Māori	197	197	197	197	197	197	197	197	197	197	0%
Mental health	53	55	58	60	63	66	69	72	75	75	42%
Rural health	40	40	40	40	40	40	40	40	40	40	0%
Disability	80	80	80	80	80	80	80	80	80	80	0%

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. A programme with a high score is more likely to be purchased. If purchasing is advised (and funding is available), the proposal is then assessed for potential competition. 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 training specifications. 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
- other relevant groups.

The panel is sent copies of all eligible proposals, with all identifying information and price/cost information removed. A meeting (usually teleconference) is held for the panel to feed back their analysis of the proposals and recommendations to the CTA portfolio manager. Based on the outcome of the teleconference, 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 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
FTE	Full-time equivalent
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).
Comprehensive pharmaceutical care®	A service that focuses on patients and outcomes. It requires the pharmacist to work in concert with the patient and the patient's other health care providers to promote health, prevent disease and monitor and modify medication use to assure drug therapy regimens are safe and effective (New Zealand College of Pharmacists 2001).
Consultant	A specialist; a vocationally registered doctor.
Cross-profession training	Training that is provided across professions, or that focuses on a population group rather than specific professional training. This training can be multidisciplinary or interdisciplinary.
Deficit switch	Prior to the 1998/99 fiscal year, Crown Health Enterprises' operating deficits were funded through the appropriation of Vote: Crown Health Enterprises. In 1998/99 the part of the deficits attributed to under-pricing and over-provision was funded by Vote: Health. This led to an additional \$17.78 million for the CTA budget in 1998/99.
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 identified 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'.

Health technician	Someone who holds a certificate-level qualification, much of whose work consists of completing tests under supervision.
Health technologist	Someone who holds a degree-level qualification and works independently, whose role is to interpret, analyse, and diagnose information, and to complete more complex procedures.
In-service training	A short course related to the person's work area (for example, 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 (for example, the clinical component) to other providers.
Mainstream programme	A training programme that leads to a vocational qualification, for example, 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	<ul style="list-style-type: none"> • <i>Vocational</i>: rather than academic or research-based. • <i>Clinical</i>: clinically based, with a substantial clinical component where employment in a clinical setting is integral to completion of the qualification. • <i>Post-entry</i>: occurs after entry to a health profession so that a person is eligible to practise in a particular occupation. • <i>Formal</i>: a trainee is formally enrolled in a training programme that leads to a recognised qualification. • <i>Six months</i>: the training programme is equivalent to a minimum of six full-time months in length. • <i>Nationally recognised</i>: 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 (that is, 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.
Theoretical component	The component of the training programme that is theoretical, or academic, in nature.
Unbundling	The process that occurred in 1994 where 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.

References

- Andrews G. 1991. *The Tolkein Report: A description of a model mental health service*. Sydney: University of New South Wales at St Vincent's Hospital.
- Associate Minister of Education (Tertiary Education). 2002. *Tertiary Education Strategy 2002/07*. Wellington: Ministry of Education.
- Hodges T, MacDonald K. 2000. *A Scoping Report for a way forward in Māori Post Entry Clinical Training*. Unpublished report for the Clinical Training Agency.
- Jansen S. 2002. *Pacific Health Training and Education Funding Priorities*. Unpublished report for the Clinical Training Agency.
- Lawson-Te Aho K. 1997. *A Strategic Plan for Post Entry Clinical Training for Māori*. Unpublished report for the Clinical Training Agency.
- Mental Health Commission. 1998. *Blueprint for Mental Health Services in New Zealand*. Wellington: Mental Health Commission.
- Minister for Disability Issues. 2001. *New Zealand Disability Strategy: Making a world of difference*. Wellington: Ministry of Health.
- Minister of Health. 2000. *New Zealand Health Strategy*. Wellington: Ministry of Health.
- Ministry of Health. 2001a. *Cancer Screening Programmes: Workforce development strategy 2001–2006*. Wellington: Ministry of Health.
- Ministry of Health. 2001b. *He Korowai Oranga: The Māori Health Strategy*. Wellington: Ministry of Health.
- Ministry of Health. 2001c. *Improving Non-Surgical Cancer Treatment Services in New Zealand*. Wellington: Ministry of Health.
- Ministry of Health. 2001d. *Primary Health Care Strategy*. Wellington: Ministry of Health.
- Ministry of Health. 2001e. *Purchasing Intentions Plan 2001/02: Clinical Training Agency*. Wellington: Ministry of Health.
- Ministry of Health. 2001f. *The Health and Independence Report: Director-General's annual report on the state of the public health*. Wellington: Ministry of Health.
- Ministry of Health. 2001g. *The Health Workforce: A training programme analysis*. Wellington: Ministry of Health.
- Ministry of Health. 2002a. *Mental Health Directorate 2002–2005 Purchasing Plan*. Wellington: Ministry of Health.
- Ministry of Health. 2002b. *Mental Health Service Plan Templates 2001/02*. Wellington: Ministry of Health.
- Ministry of Health. 2002c. *Pacific Health and Disability Action Plan*. Wellington: Ministry of Health.
- National Child and Adolescent Psychiatry Task Force. 2002. *Progress Report*. Wellington: National Child and Adolescent Psychiatry Task Force.

New Zealand College of Pharmacists. 2001. *Comprehensive Pharmaceutical Care® and Pharmaceutical Review Services Support Agreement*. Wellington: New Zealand College of Pharmacists.

Nursing Council of New Zealand. 2001. *The Nurse Practitioner: Responding to health needs in New Zealand*. Wellington: Nursing Council of New Zealand.

Nursing Council of New Zealand. 2002. *Annual Practising Certificate Data*. Wellington: Nursing Council of New Zealand.