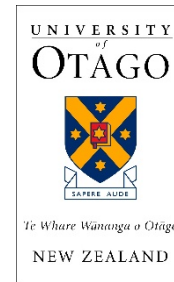




**MEDICAL AND
HEALTH SCIENCES**



26th July 2016

Hon Steven Joyce and Hon Jonathan Coleman,
Minister for Tertiary Education and Minister for Health

Dear Ministers,

We understand that the Vice Chancellor of Waikato University and the CEO of Waikato Hospital have approached you with a proposal to establish a graduate entry medical school at Waikato University and Waikato Hospital. The proposal purports to alleviate some of the difficult challenges we face with the current distribution of doctors in New Zealand. Addressing these widely known challenges has been a major priority for both our programmes for some time, so we are disappointed that this has not discussed with us prior to presentation to you. The future medical workforce of New Zealand is a matter of national importance and a renewed national strategy should be developed only after comprehensive analysis of current capabilities and alternatives along with widespread consultation. An *ad hoc* local initiative does not do justice to the complexities surrounding medical education and training. The Government's current strategy is well founded, cost effective, and on track to achieve its objectives. We therefore have major reservations about the Waikato proposal that we present here for your consideration.

1. NZ has planned for a sufficient pipeline of medical graduates

In 2008, the National government approved the funding of an additional 200 medical places to meet the predicted NZ medical workforce requirements for the next 20 years. This increase has been implemented over the past eight years and reaches steady state in 2020. The quantum was determined from future workforce planning begun in 2005 and planning continues today through Health Workforce NZ. The increase in 2008 was influenced by the assumption that NZ would continue to lose 25% of its medical graduates to Australia, a loss that has been markedly curtailed since 2008 with the massive expansion of medical programmes in Australia (1400 in 2000 versus 3672 graduates by 2018), many of whom will look to NZ when they cannot find their preferred jobs in Australia.

The introduction of a further 200 undergraduates (50 students in each of the four years of the programme) would put severe pressure on available training places in the upper North Island. It is our firm belief that additional placements will be difficult to find particularly in critical specialties such as general practice, paediatrics and obstetrics. Our two programmes are currently struggling to find additional placements to meet the increasing undergraduate numbers. Staffing of a new programme would similarly be difficult and would inevitably involve the loss of key staff from Auckland and Otago.

2. The Waikato proposal

The Waikato proposal is based on four challenges that we believe are already being proactively addressed by Otago and Auckland:

1. A relative lack of Māori and Pacific graduates
2. A relative lack of rurally-based graduates.
3. A relative lack of community-based teaching.
4. The five-year programmes fails to credit relevant prior learning for graduate entrants.

Auckland and Otago graduated 455 new doctors in 2015. By 2020, this will have increased 25% to 570 per annum. This is against an annual population growth of 1.13%. Approximately 70% of the intake are undergraduates from the pre-medical first year (1+5) and approximately 30% enter as graduates from another degree. Students are accepted from around the country and both programmes have three preferential admissions pathways (Māori, Pacific and rural).

Māori and Pacific Admissions scheme

Both Otago and Auckland are now preferentially enrolling young Māori at demographic equity, something that has taken many years and significant resources to achieve. These numbers will soon result in demographic equity of graduates with a completion rate of Māori students through our programmes of over 90%. Both Otago and Auckland are achieving similar success with Pacific medical students.

Rural and Regional Admissions scheme (RRAS)

This scheme recruits students from a rural background who are more likely to return to work there. Recent evidence indicates that 50% of students admitted under our RRAS 7-15 years ago have returned to work in regional and rural communities ¹.

	2013	2014	2015	2016
University of Auckland				
Maori and Pacific	43	53	36	52
Rural	32	39	44	48
University of Otago				
Maori & Pacific	40	45	55	69
Rural	50	50	55	55
TOTAL	165	187	190	226

Table 1. New Maori and Pacific and Regional and rural enrolments entering Y2 at Auckland and Otago Universities. NB. The total in these two categories over the 5 years of our programmes is now over 900.

Both Otago and Auckland have extensive community-based teaching with sizeable student cohorts spending full teaching years located in rural and regional settings such as Whangarei, Rotorua, Taranaki, the Bay of Plenty, Napier/Hastings, Palmerston North, Nelson, and Invercargill. There is now good research evidence emerging from both schools showing the effectiveness of these approaches in attracting graduates to work in rural settings. Such evidence is consistent with, and builds on, similar findings internationally.

We accept that a possible short-coming of the graduate entry pathway into our undergraduate programmes (3 + 5 years), is that prior graduate experience is not formally recognised (students who have a science background are credited with one year of learning and enter Year 2 of the medical programme). However, the major benefit is that graduates from any degree are accepted since they receive essential biomedical and health science training in their first two years. In contrast, a four-year graduate entry medical programme (3 + 4 years) typically expects graduates to have completed a prescribed first articulation degree to ensure they have the requisite biomedical and health science knowledge prior to undertaking clinical training. The one-year difference adds a marginal cost to overall training.

3. A third programme will present unnecessary competition for clinical placements

Auckland and Otago medical programmes collegially agree to operate on either side of a line across the North Island from Taranaki to Gisborne, thus avoiding competition for training places. The introduction of a third programme at Waikato would introduce direct competition with Auckland and possibly Otago since it is unlikely that the additional 200 Waikato students could all be accommodated within Waikato hospital and the midlands region.

4. A new programme must be considered against national medical workforce requirements

There is potential to produce an over-supply of doctors until at least 2030. This is determined from:

1. The predicted number of working practitioners over the next 20 years.
2. The increasing number of domestically trained graduates.
3. A decline to almost zero in the exodus of young doctors to work in Australia.
4. An expected increase in NZ graduates returning from training in Australian medical schools.
5. A recent survey of medical students² indicates that >90% expect to work in New Zealand (Latest MSOD survey results).

5. The shortage of General Practitioners is addressed through strategic funding

The Waikato proposal commendably focuses on producing more GPs. We acknowledge that there is a shortage of regional and rural GPs across NZ and this is being addressed through an increase in total graduate numbers coupled with increased funding for GP training through HWNZ. More NZ graduates are choosing General Practice. Most career decisions are made after graduation. We fully support the need to provide constructive and positive experiences in general practice settings within medical school, but stronger influences on career decision-making are the opportunities and incentives after graduation. The GPEP1 training programme had 183 placements in 2015/16 compared to 130 in 2012/13 (Table 2), an increase of 40%. With further strategic funding and with current expanding student numbers and shortages of hospital-specialist training places, graduates will be incentivised to consider General Practice as a career. Additional GP students from a third programme would demand increased funding for GP training, and it is not clear that there are sufficient training positions for them.

GP Training numbers (GPEP1 programme)					
Year	11-12	12-13	13-14	14-15	15-16
Applications	197	163	184	213	241
Placements	154	130	125	171	183
%	78.2	79.8	67.9	80.3	75.9
College employed					
Tax free Bursary	138				
College employed -Salary		130	118	154	155
Private employed					
Subsidy to practice	16				
Private employed		0	7	17	28
IMG vs NZ citizen					
NZ citizen		83	76	115	128
IMG		47	49	56	55
Total		130	125	171	183

Table 2: Number of graduates undertaking GP training.

6. Medical training of Māori and Pacific students is complex and resource intensive

Admitting inadequately prepared students results in high failure rates. It has taken over 20 years for Otago and Auckland to build the infrastructure, knowledge and skills necessary to achieve demographic equity in Māori and Pacific enrolments. Our programmes are comprehensive and complex and are supported with additional resources from the University, Faculty, external agencies and communities. These resources include people: Māori academic and professional staff, kaumātua, and also financial resources for events, space, basic and specialised academic support, cultural support and pastoral support. We currently meet with and accept, bridge or advise all Māori students from around the country who are seeking a medical career. The Waikato proposal is founded on the assumption that there is an untapped cohort of qualified Māori graduates who have not yet considered either Otago or Auckland – our experience tells us that this cohort does not exist.

7. The postgraduate training pipeline is currently bottlenecked

Postgraduate medical training is bottlenecked at PGY1 & 2. The current graduating cohorts can only find pre-registration positions because DHBs are being required to create new positions for them. Producing further graduates who are unable to obtain the positions they need to become registered will not meet workforce shortages. The numbers of medical graduates exiting Otago and Auckland will not reach steady state until 2020, so accommodating an additional 50 graduates a year at Waikato will put added pressure on this pipeline. The Waikato programme proposes to focus on the training of rural General Practitioners. This is commendable, but unrealistic given the difficulty both Auckland and Otago are currently experiencing, even with significant investment in rural and regional admission and training schemes, to encourage graduates to return to their regions and work as GPs. Currently only half of those students admitted under existing rural and regional admissions scheme return to the regions¹. Unless

there is a bonding scheme or a more attractive pathway for rural and regional general practice, the Waikato programme will very likely produce a similar ratio of urban/rural practitioners as the two existing programmes.

There is a shortage of GP training places nation-wide and the Auckland medical programme in particular is struggling to find sufficient GP placements for its expanding student numbers. This is further compounded by the new requirements for PGY community based attachments (CBA) which further compete for limited GP resources.

8. The growing Auckland programme is reliant on Waikato DHB and surrounding regional hospitals

The Auckland medical programme is a partner with Waikato DHB for medical student training. The 120 Auckland students currently at Waikato is planned to grow to about 150. Auckland also relies on mid-North Island regional hospitals such as Tauranga, Whakatane and Rotorua and further expansion across the mid North Island has been planned for 2017 and 2018. A graduate entry medical school at Waikato could place up to 200 new students (50 x 4 years) into these hospitals and general practices. The obvious consequence would be the displacement of the Auckland programme from the Waikato region, a situation that is completely unacceptable. If this were to happen, Auckland students would no longer be exposed to regional and rural Waikato and midlands, thus worsening the problem it attempts to address and further strengthening the unfounded accusation that University of Auckland Medical Programme only trains doctors for Auckland. The reality is that graduates from Otago and Auckland are working from Cape Reinga to Bluff.

9. There would be confusion with running two distinct medical programmes within the same hospitals

If the intention of Waikato DHB is to accommodate two medical programmes running simultaneously in the same hospital, we cannot support this. Students will be at different levels of competency and readiness and likely have curricula frameworks that will not be aligned. This would be confusing to clinical teaching staff.

10. Conclusions

We believe there are two major issues conflated into a single proposal that should be addressed separately and sequentially. The first is whether a separate 4-year graduate programme specialising in rural GPs is right for New Zealand, and the second is whether and to what extent, a 3rd programme of the type proposed is likely to destabilize or undermine the currently funded model.

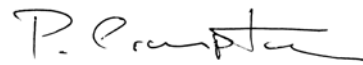
We acknowledge that there will be a need for a third medical programme at some time in the future. However, with the current expansion in student numbers putting significant pressure on the training pipeline, and the very considerable disruption to Auckland's medical programme that would result from a new programme in Waikato, we believe now is not the time to be considering an additional 200 new medical students.

We would welcome the opportunity to meet with you to discuss this matter in more detail.

Yours sincerely,



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Pro-Vice Chancellor, Health Sciences
Dean, University of Otago Medical School
University of Otago

1. Poole, P, Stoner T., Verstappen, A. and W. Bagg (2016) Medical students: Where have they come from and where are they going? NZ Med J 129 1435
2. Latest Medical Deans of Australis and New Zealand (MDANZ) survey results.