Medical generalist/specialist roles and postgraduate training for New Zealand: Does New Zealand need more generalists?

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**Council of Medical Colleges**

The Council of Medical Colleges (CMC) is the umbrella organisation for the 14 Medical Colleges in New Zealand. These Colleges train, examine, and confer specialist status for medical graduates. They also deliver continuing professional development and recertification programmes for specialist medical practitioners in specific medical disciplines. The Medical Colleges provide support to and train over 7000 medical practitioners working in 36 specialties in the New Zealand health system [http://www.cmc.org.nz/](http://www.cmc.org.nz/).

CMC’s purpose is to assist in the development of a New Zealand medical workforce that:

- Is fit for purpose.
- Is sustainable and affordable.
- Will deliver high quality health services throughout New Zealand (both in provincial and urban centres) that are accessible and safe.

**CMC Board members as at November 2012**

Australasian College for Emergency Medicine

Australia and New Zealand College of Anaesthetists

College of Intensive Care Medicine of Australia and New Zealand

College of Urgent Care Physicians (formerly AMPA)

New Zealand College of Public Health Medicine

Royal Australasian College of Medical Administrators

Royal Australasian College of Surgeons

Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Royal Australian and New Zealand College of Ophthalmologists

Royal Australasian College of Physicians

The Royal Australian and New Zealand College of Psychiatrists

Royal Australian and New Zealand College of Radiologists

Royal College of Pathologists of Australasia

Royal New Zealand College of General Practitioners

John Bonning

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Tony Williams

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Julia Peters

David Sage

Scott Stevenson

John Tait

Derek Sherwood

John O'Donnell

Rosie Edwards

Mike Baker

Richard Steele

Harry Pert
1. The context for the debate
New Zealand has a small, dispersed and diverse population. The population is ageing and there is a growing burden of chronic disease with an increasing number of patients presenting with multiple system disease. There is a limit to the financial resources available to address this demand where health spending continues to increase faster than the growth in GDP (Appendix 2).

Across the health sector, groups are looking at ways to deliver effective high quality care to more people with multiple health needs. Changes in existing models of health care delivery are needed if New Zealanders are to continue to have equity of access to a full range of affordable services. It follows that doctors, particularly at specialist level, will need to work differently within and across health settings to achieve this; particularly if they are to meet the brief for those with the most specialist training to be working at the ‘top of their licences’, most of the time (HWNZ, 2012)(Appendix 3).

The changing demographic of health need, health professionals and resourcing this has led to Health Workforce New Zealand (HWNZ), as the funder of post graduate medical training, to call for greater numbers of “generalist” doctors, along with new health professional roles (physician assistants) and expansion of non-medical health professional roles. This paper is in response to those calls that are also being echoed internationally.

The term “generalist” medical practitioner is used in the sector in several ways and this is confusing the debate.

2. What is meant by the term “generalist”?
In the sector the term “generalist” can refer to groups of doctors, for example:

- Some use it to promote the number of primary care or vocationally registered general practitioners who are trained across a broad curriculum, where they are the first point of contact with the health system for most patients. Some general practitioners may also develop their learning and practice in a “special interest” area.

- Others refer to “general specialists” as those working in the acute sector with the “undifferentiated patients.” For example vocationally trained physicians who work with a wide range of patients, some of whom may have multi system disease. These “general” physicians may also develop areas of specialist interest.

- Others mean “general” disciplines such as geriatric medicine, palliative medicine, and hospital medicine which are based on clinical needs as well as the organisation and delivery of care rather than on scientific and technical expertise in a specific organ system.¹

- The term general is also used to describe scopes of practice. An example being a “general” surgery which is a broad based surgical specialty². This area of surgery is one of twelve

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scopes of surgery \(^3\) recognised by the Medical Council of New Zealand (MCNZ) for vocational registration.

All of these groups of doctors, working across medical disciplines, have post graduate qualifications, are vocationally registered and may be referred to as “specialists”\(^4\). In contrast to this, the use of the term “general” by the Medical Council of New Zealand refers to a “generally registered doctor” i.e. a doctor who has not gained a specialist post graduate qualification.

CMC has agreed the term “generalist” to mean a **vocationally registered doctor working in primary or secondary care who works with the undifferentiated patient\(^5\)** or in an **undifferentiated practice**\(^6\) **within their particular speciality area**\(^7\) - the **“generalist specialist”**. That is, those doctors who can work with a wide range of patients or set of symptoms that are poorly defined, poorly organised, or not diagnosed or who can perform a wide range of procedures within their specialty area. More of these doctors are needed because more patients are presenting with multiple system disease, acute and chronic health problems.

It is the doctors’ **“unique training in diagnosis and managing probability and risk in the context of changing medical knowledge”**\(^8\) that makes involvement of the generalist doctor essential in the delivery of good medical care. These skills are fundamental to being a doctor both individually and collectively and cannot be substituted by other health professionals.

In practice, both in New Zealand and elsewhere, many doctors develop specific areas of interest or move into areas of sub specialisation. It is too simple to label vocational registered doctors either generalist or specialist\(^9\). It is more appropriate to see all doctors as working across a continuum; where some work across the breadth of a speciality and others work in depth in one sub speciality area, some to the significant exclusion of general practice in their specialty\(^10\).

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\(^2\) This includes the diagnosis and treatment (operative and non-operative) of patients with disorders of the colon and rectum, upper gastro-intestinal organs, breasts, endocrine organs, skin and subcutaneous structures, blood vessels (including varicose veins) and the head and neck region and the early and ongoing management of trauma.

\(^3\) Cardiothoracic surgery, General surgery, Neurosurgery, Obstetrics and Gynecology, Ophthalmology, Oral & maxillofacial surgery, Orthopaedic surgery, Otolaryngology, Paediatric surgery, Plastic and reconstructive surgery and Vascular surgery.

\(^4\) A specialist is a vocationally registered doctor.

\(^5\) An undifferentiated patient is one where a health related problem or set of symptoms are poorly defined, organised and/or diagnosed.

\(^6\) In procedural specialties the generalist is one who can perform a wide range of procedures within that speciality. This practice includes seeing the undifferentiated patient and performing undifferentiated procedural work.

\(^7\) As in surgery where there are 12 broad areas of surgical practice.

\(^8\) Independent Commission for the Royal College of General Practitioners and the Health Foundation. “Guiding Patients through Complexity Modern Medical Generalism”. 2011

\(^9\) Ibid.

\(^10\) Based on the model by Gerald Biala (Biala 2008)
In New Zealand, to be able to meet the needs of patients particularly in provincial and rural areas and to deliver acute and out of hours care, the majority of doctors need to be able to work in the centre of the continuum be a “generalist specialist” for at least some of the time.

This means for example:

- The surgeon on the acute on call roster, who may also specialise in breast surgery, will be able to assess and initiate or deliver management across the scope of practice of general surgery which includes disorders of the colon and rectum, upper gastro-intestinal organs, breasts and endocrine organs.
- The psychiatrist on the acute on call roster, who may also specialise in old age, or forensic psychiatry, will be able to assess and initiate management to the person presenting acutely across the age range and diagnostic spectrum.
- The vocationally registered general practitioner is able to assess and initiate management to the undifferentiated patient presenting with any medical or surgical symptoms.
- The physician on the acute on call roster may specialise in diabetes and endocrinology, but will be able to assess and initiate management to the patient presenting acutely with respiratory failure.

3. The development of specialism and sub specialism

For over 100 years, there has been increasing specialisation in medicine as doctors and other scientists have devoted their energies to knowing more and more about narrower topic areas\(^\text{11}\).

Specialisation has been driven by:

- Advances in medical science and technology
- Personal preferences
- Economic considerations\(^\text{12}\)
- Community and consumer expectations.

There is also the drive from regulators to ensure competency across all areas of the practitioner’s work and therefore it may be “less risky” to work in a narrow area of practice.

The concern is that, if this direction of increasing subspecialism continues and doctors concentrate on smaller and smaller areas of practice, this will “fragment an already over fragmented system” and result in a “silo approach” to health care that is more expensive, less efficient and that does not accurately reflect patient need, nor benefit patients.

The Royal Australasian College of Physicians (RACP) paper *Restoring the balance*\(^\text{13}\) lists concerns about increasing sub specialisation as leading to compartmentalisation of care, possible misdiagnosis


\(^{12}\) Allan, S., Gautheir, S., Fuchs, V. “Specialization in Medicine, How much is Appropriate?” 2012
and inappropriately managed care for patients with significant co-morbidities. It can also result in increased cost of care, discontinuity of care, resource intense practice, increased cross-referral, and reduce access for patients - especially in provincial and rural areas.

4. What sort of doctor do patients need?

Patients prefer quality care close to home, with timely access, with continuity of care where possible; they also want ease of access to necessary specialist and subspecialist services in a timely manner.

Specific people at specific times will benefit from the highly focused knowledge and skill from sub specialists. Some commentators note that patients do benefit from seeing “an appropriately trained doctor who has a high level of expertise” as early in their care as possible and that “patients have increased morbidity and mortality when the involvement of specialists is delayed, particularly in acute surgery and emergency medicine.” Once a definitive diagnosis has been made, research indicates that there is a better quality of care and better outcomes if a patient is treated by a sub specialist.

However for the undifferentiated condition early referral or presentation to a sub specialist is likely to waste resources; and may risk premature closure on diagnosis and treatment that will disadvantage the patient. Also, as the population ages and more people present multiple system disease, highly skilled sub specialists may lack the currency to accurately diagnose and manage important co-morbidities.

Therefore today with this aging population there are greater numbers of patients, presenting with undifferentiated conditions, accurate diagnosis and management of their care in the context of other conditions they may have and the lifestyle they lead is central to their care. Overall there is a need to increase the number of generalists to manage growing patient need.

The Royal Australasian College of Physician’s Māori Health Committee also has considered the issue of generalism versus specialism. For Māori, generalism is a preferred patient pathway because sub specialism requires multiple interactions with health professionals. Māori patients in particular, do not react positively to this approach as rapport must be established with each individual health professional. Experience with Māori patients has shown that referring Māori patients on to sub specialist care may result in Māori not presenting at the clinic and consequently not receiving ongoing care.

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15 The RACP note that generalism is focusing on ‘the patient not the disease’ and viewing the patient’s health, as encompassing physical, mental and social aspects of the patient’s life as referenced in Doctors in Society: Medical professionalism in a changing world (2005) The Royal college of Physicians, London UK.
Effective management of patients requires good communication between all involved in the patient’s care. Generalists also ideally/should act as the coordinator of further care, acting as the “gate-opener”17 to other clinical services; avoiding multiple referrals and unnecessary investigations. For example general specialist physicians and general paediatricians work with a wide range of patients presenting acutely to hospitals or at clinics through referral from primary care. They clarify diagnosis and treatment options which may then include onward referral to other specific subspecialties such as endocrinology and neurology.

This gives the generalist specialist a “unique responsibility for promoting integration of care, support for people in need and for achieving optimal cost-effective use of services18.”

5. Does New Zealand need more generalists?
This debate is not a New Zealand specific one and has been raised in Australia, the United Kingdom and the USA. The paper Restoring the balance: An action plan for ensuring the equitable delivery of consultant services in general medicine in Australia and New Zealand, 2005-2008 by the Royal Australasian Colleges of Physicians noted that the “current position of general medicine in Australia and New Zealand in the context of increasing levels of subspecialisation which may not be appropriate for meeting the health care needs of populations in the 21st century”19.

Health Workforce Australia has noted in its Strategic Framework for Action that there needs to be a concerted effort to “reinforce generalists practice in all (health) professionals with more relevant skill mix20”. However the specialist/generalist balance is changing. Statistics indicate that in New Zealand the trend to doctors practising as “generalist specialists” is already increasing:

- Currently in Royal Australasian College of Physicians (RACP) in New Zealand, the biggest single group of Advanced Trainees are those completing training in General and Acute Care Medicine, followed by those training in General Paediatrics. There are currently about 180 NZ trainees under the General Medicine Special Advisory Committee and 307 Fellows who are trained in general and acute care medicine many of whom (212) are trained in more than two sub specialities.

- The 2011 Medical Council workforce survey notes that there were 2700 specialist general practitioners, about a third of the vocationally trained workforce.

- 242 surgeons noted their practice was in general surgery and 248 work in orthopaedics of the total of 1333 surgeons.

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17 Independent Commission for the Royal College of General Practitioners and the Health Foundation “Guiding Patients through Complexity Modern Medical Generalism.” 2011.
18 Ibid.
This trend needs to be encouraged in New Zealand with the need to deliver acute care and care out of normal working hours and in provincial and rural areas of the country with limited resources and numbers of doctors. This is in part to adequately meet the health need of most of the population most of the time and in part to support integrated medical care at both primary and secondary health service level.

There is a risk of limiting the already small pool of doctors willing to work in provincial areas. So the composition of local teams, and local needs should be taken into account and generalism should also be valued as a characteristic of a service, department or team.

6. Who is being trained in New Zealand now?
The Medical Council of New Zealand has actively encouraged general medical education at post graduate year one (PGY1) level. The current training system in New Zealand values this approach and this must continue. It is now also being recognised and desired in Australia. The Medical Council is currently reviewing pre-vocational training and it is understood that there will be an emphasis on broad general training and acquisition of competencies across inpatient, outpatient, and community-based settings both in PGY1 and 2.

Currently most College training programmes emphasise the need for a broad experience of training across the range of the specialty at least in the early years of registrar training. For example:

- The RACP training includes a broad base of experience in the first three years of vocational training. In the final three years a significant proportion of RACP trainees choose dual specialties to complete training. Usually this dual training includes either General and Acute Care Medicine or General Paediatrics with a second specialty, thus strengthening numbers of consultants with generalism\(^{21}\) expertise.

- In ophthalmology, most trainees start with broad general training and continue to work across the range of eye care. The Royal Australian and New Zealand College of Ophthalmology (RANZCO) remains committed to providing a General (Comprehensive) Ophthalmology training which includes but is not limited to Surgical Retina, Medical Retina, Paediatric Ophthalmology, Ocular Plastics, Uveitis, and Glaucoma. RANZCO has no plans at present to accredit fellowship training in sub specialities.

- In psychiatry all prospective fellows are in a generalist pathway until the final two years where trainees can select subspecialisation. A number of the subspecialties in psychiatry maintain a generalist focus. Also, like many other specialist, it is not uncommon for psychiatrist to work in both generalist and subspecialty settings simultaneously. Currently over 50% of trainees are undertaking training in generalist and adult psychiatry.

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\(^{21}\) RACP define “generalism” is an approach to the practice of health care in all disciplines that provides holistic care of a person over time; managing a range of conditions, mindful of the impact of external and societal factors on health and referring to a specialist or other services as and when required.
• A revised curriculum for anaesthetists is being implemented in New Zealand from December 2012, which is geared toward generalist training. Sub-specialty training is only available in the last year of training.

• In surgery all trainees have general training prior to entry to one of nine broad speciality areas\textsuperscript{22} in PGY3 or 4. There is an expectation that all registrars have part of their training in a regional hospital. All surgeons that work in the public system are able to work across the spectrum of broad specialist area. Any sub-specialty training occurs after registrars have gained their fellowship.

Therefore most vocationally registered or “specialist” doctors in New Zealand already have a broad generalist training in their area of speciality during their training. So that this trend continues CMC recommends that the emphasis remains on broad generalist training in the early years (i.e. PGY1 and 2), that trainees should not enter specialist training too early and that College post graduate training and recertification programmes continue to emphasise generalist competencies.

7. The impact of International Medical Graduates on the generalist/sub specialist balance

New Zealand has a high International Medical Graduates (IMGs) workforce – up to 48% in some specialities. Many IMGs specialise narrowly and early in their training, in places where there is a greater emphasis on sub specialisation (for example as seen in Germany)\textsuperscript{23}. Due to the number of IMGs in New Zealand this may impact on the generalist/specialist skill balance across NZ health services. This is of particular concern when such IMGs are more likely to work in provincial and rural areas. Places where good generalist and generalist specialist skills are most needed.

CMC recommends that the assessment of IMGs should include assessment of sound general medical knowledge, especially for doctors who trained in countries that do not have the equivalent of PGY1 and PGY2 years - and the same as applied to their specialist training.

8. Implications for sub specialists

The call for more “generalist specialists” does not alter the need for sub specialist doctors who only work in highly specialised areas or practice. These doctors require moderate-high patient volumes to maintain their skills; therefore they need to be based where they can gain referrals from throughout a region and to deliver care across District Health Board (DHB) boundaries.

Some sub specialists working in tertiary hospitals are practising in sub speciality areas with very small groups of colleagues. These individuals need increased collegial support which may be possible via managed care networks (MCNs). Where MCNs are “linked groups of health professionals and organisations from primary, secondary and tertiary care working in a co-ordinated manner

\textsuperscript{22} Cardiothoracic surgery, General surgery, Neurosurgery, Oral & maxillofacial surgery, Orthopaedic surgery, Otolaryngology, Paediatric surgery, Plastic and reconstructive surgery, Vascular surgery.

\textsuperscript{23} Powell, I., Our Health System. The Specialist.
unconstrained by existing professional and DHB boundaries to ensure the equitable provision of high quality clinically effective services”

Well designed, clinically-led networks can enhance health service delivery, performance and support for those in the network. By definition these networks must operate across DHB and regional boundaries. Adjustments will need to be made to existing budgetary flows to enable and support greater mobility of key clinical staff.

To achieve change in the way care is organised, CMC suggests that the need for sub specialists should be driven locally, with a regional and national overview from the DHBs and Ministry of Health.

9. Increasing sector support for generalists
Currently government policy is focused on the delivery of “better, sooner, more convenient care” with an emphasis on:
- Home-based delivery of services.
- Better integration of community-based services and the development of integrated family health centres.
- Secondary hospitals focusing on enhancing core clinically viable services.
- Increasing reliance on partnerships between neighbouring hospitals.
- Managed specialisation and consolidation into a smaller number of centres/hubs.

These ways of working require generalist specialist doctors and therefore young doctors need to be encouraged to see these areas of practice as valued and rewarding - a valid career choice. With the increase in sub specialisation, medical students have formed the impression that general disciplines are “less intellectually exciting”. The term generalist was considered by some to be pejorative. Graduates need to be persuaded that this type of care is held in high regard by the profession and employers; that the role is pivotal, can facilitate good patient care and be interesting and challenging.

The system and funding models need to incentivise generalist training. There is an opportunity to ensure this happens as an increased number of medical graduates (resulting from the increase in Government funded medical student by 200 places from 2009) now enter vocational training.

In addition, models of care that recognises the importance of vocationally trained doctors delivering acute care and out of hours, in primary and secondary care, need to be fostered.

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26 In written evidence the Association of Surgeons stated that “the term generalist is now pejorative’. This would not change, it added, unless the general surgeon, general physician and GP were rewarded for their holistic approach to medical care”. Ref (Independent Commission for the Royal College of General Practitioners and the Health Foundation, 2011).
Generalists working in provincial areas need easy access to support from sub specialists via regional care networks, shared IT systems, and communication systems including teleconferencing and video conferencing.

While CMC does see the need for the generalist specialist training focus, possibly with a slower growth of subspecialists to meet health demand, CMC has not been able to access any research on the “appropriate” ratio of generalists to sub specialists. Initiatives designed to increase the generalist medical capacity in New Zealand’s hospitals should be based on robust analysis of the prevalence of disease/condition within a population, requirements by specialty, geographical area, and the composition of the local multi-disciplinary team(s).

10. What is the Colleges’ role in supporting generalists?
There is a need to include both “generalist specialists” and sub specialists in the health system, with an appropriate balance that best serves the community.

It is the Colleges’ responsibility to:
- Train generalists in the first instance.
- Require and support the maintenance of generalist skills through continuing professional development and recertification programmes.
- Support generalists at provincial and rural hospitals so there is adequate generalist cover.
- Train and support sufficient numbers of sub specialist trained doctors, describe pathways of care, and support MCNs.

There should also be orientation, training and support for doctors going to work in smaller centres so they have and maintain, the breadth of skills needed. For example, generalists may need to have exposure to the other specialities or scopes of practice. This could be facilitated through cross College training - where one College may take the lead or the Colleges could work together to coordinate training and/or continuing professional development in an area or a Colleges may request their trainees attend others training programme.

For example:
- Having one lead college deliver some parts of the curriculum for example the Australian and New Zealand College of Anaesthesia (ANZCA) could take a lead role in training in airway management and resuscitation training. These are skills that every doctor should have and are areas where anaesthetists have specialist skills.

- It could be possible to develop a joint curriculum and shared training modules for some professional skills across a variety of domains; this would decrease duplication of training, increase the sustainability of training, take the pressure off SMO time needed to deliver training and better utilise training funding available from HWNZ

- Royal New Zealand College of General Practice (RNZCGP) has noted that all GPs will have some training under other vocational scopes such as psychiatry and that this may be done in conjunction with other Colleges.
Colleges should actively look for areas where they can build on shared training and learning while accepting the differing needs of each speciality area.

**Conclusions**

CMC has concluded that in New Zealand the majority of doctors need to be able to work as “generalist specialists” who can work with a wide range of patients or set of symptoms that are poorly defined, poorly organised or not diagnosed or who can perform a wide range of procedures within their speciality area. This group of doctors are more able to deliver acute and out of hours care and work in provincial and rural areas. More “generalist specialists” will mean that the health needs of most of the population can be adequately met most of the time. Also these doctors can better support good integrated medical care at both primary and secondary health service level.

Sub specialists will primarily work at tertiary hospitals or settings, in urban centres, creating centres of excellence. They will need to be able to work across DHB and regional boundaries.

New Zealand doctors already have “generalist” training in prevocational and specialist training programmes. This focus needs to be maintained and increased.

**The Council of Medical Colleges supports the following three broad principles:**

1. **New Zealand requires its senior specialist medical workforce to have a high degree of specialist training and to be able to work across the spectrum of their speciality i.e. to be generalist capable specialists.**
   
   Most specialists (vocationally registered SMOs) need to be able to work with the undifferentiated patient or in an undifferentiated practice (primary care, ED and outpatient specialist consultation and referrals) within their particular speciality area and be able to refer on for sub specialist care appropriately, where clinically indicated and in a timely manner. This will facilitate the delivery of acute care, care out of normal working hours and in all areas of the country including in provincial and rural areas.

   Generalists working in provincial areas need to be able to access timely advice and support from sub specialists through regional networks; shared IT and communication systems including teleconferencing and video conferencing. Models of care need to recognise the importance of keeping vocationally trained doctors delivering acute and out of hours in primary and secondary care.

2. **New Zealand requires its senior medical workforce to have an appropriate number of highly trained and well supported sub specialists.**
   
   These doctors need to be able to work across regional boundaries as they will usually work in larger centres and in tertiary hospitals. They will gain professional support through international, national and regional managed clinical networks. The need for these sub specialists should be driven locally, with a regional and national over view by the DHBs and Ministry of Health with regards to need, and equity of access to the full range of health services for all New Zealanders.
3. **The training system, vocational funding streams and models of care need to support generalist training.**
   The emphasis of medical training in New Zealand must remain on broad generalist medical knowledge in the early post graduate years and trainees should not enter vocational training too early. College training programmes and curricula should continue to emphasise generalist knowledge and skill through ‘basic’ specialist training within their field. The system (training sites, training hubs, College curricula and examinations) and funding models need to facilitate and incentivise this generalist training.

**Therefore CMC recommends:**

**That Health Workforce New Zealand:**
- Incentivises generalist streams in specialist training as an increased number of medical graduates enter vocational training.
- Develop models of care that support vocationally trained doctors to continue to deliver acute and out of hours care.
- Works with the Colleges to align generalist, specialist and sub speciality training numbers with workforce need.
- Facilitates cross College training where appropriate.

**That Health Workforce New Zealand, the Medical Council of New Zealand and the Australian Medical Council collaborate to:**
- Ensure that trainees receive generalist training, through their involvement in funding and accreditation of training programmes.
- Ensure that the assessment of sound general medical knowledge of IMGs is a priority especially for doctors from countries that do not have the equivalent of post graduate years 1 and 2.
- Ensure that the assessment of specialist training of IMG’s entering New Zealand seeking vocational registration at specialist level includes their capacity to work across their specialty, in acute and out of hours settings.

**In turn the Colleges will:**
- Continue to train competent generalists in the first instance.
- Require and support the maintenance of generalist specialist skills through continuing professional development.
- Support Fellows to deliver acute and out of hours care and in provincial and rural, as well as urban hospitals and community settings.
Appendix 1 - Definitions

**Generalist**  CMC uses the term “generalist” to mean a vocationally registered doctor working in primary or secondary care who works with the undifferentiated patient\(^{27}\) or in an undifferentiated practice\(^{28}\) within their particular specialty area\(^{29}\) - the generalist specialist. That is, those doctors who can work with a wide range of patients or set of symptoms that are poorly defined, poorly organised or not diagnosed or who can perform a wide range of procedures within their specialty area.

**Specialist**  A specialist is a vocationally registered doctor.

**A sub specialist**  A sub specialist is a vocationally registered doctor who, within a vocational scope, focuses narrowly on specific health problems conditions or parts of the body.

**Disruptive change**  This term is used by the Minister and HWNZ to mean the development of a change, for example in service delivery, that disrupts or changes the current way of doing thing or delivering a health services as has been promoted in the workforce services forecasts/reviews.

**Extenders**  This is defined as decisions that enable expanded services by groups such as nurse practitioners and pharmacists: these can be interpreted as “medical practitioner extenders” and use delegation or a collaborative agreement, granted at the discretion of the highest regulated professional in the team.

**Innovation**  Innovation is the use of a new method or way of doing things.

**Integrated care**  Most definitions of integrated care include references to coordination, complementarity, seamlessness and continuity for the client\(^{30}\). That is “bringing together of inputs, delivery, management and organisation of services as a means of improving access, quality, user satisfaction and efficiency.”\(^{31}\) Other writers have noted that it is “joining the patient’s journey” or clinical pathways or care networks. The aim is to reduce costs and improve the quality of care.\(^{32}\)

**“Top of scope”**  Working at “top of scope” is doing what the health professional is qualified to do and doing those tasks they are uniquely qualified to do, and delegate the

\(^{27}\) An undifferentiated patient is one where a health related problem or set of symptoms are poorly defined, organized and/or diagnosed.

\(^{28}\) In procedural specialties the generalist is one who can perform a wide range of procedures within that specialty. This practice includes seeing the undifferentiated patient and performing undifferentiated procedural work.

\(^{29}\) As in surgery where there are 12 broad areas of surgical practice.


rest. In New Zealand the concept has been used to argue that if clinicians are a “scarce resource” then they should focus their workload only on the work only they are able to do, and delegate work to other health professionals that can do it competently.

**Shared care**

Shared care has been described as a person-centric approach which involves all health professionals that have a role in the patient’s care working to a common care plan and sharing information between them.

**Substitution**

Substitution is replacing (some of the work) by one health professional with the work of another.

**Managed care networks (MCNs)**

Managed care networks are defined as “linked groups of health professionals and organisations from primary, secondary and tertiary care working in a coordinated manner unconstrained by existing professional and DHB boundaries to ensure the equitable provision of high quality clinically effective services.” These can cover an individual specialty or area of care (e.g. palliative care) or disease (e.g. cancer). In NZ there are four regional cancer networks. They can be local (DHB) regional or national.

**Regional hubs**

Regional hubs cover the four DHB regions, each with a population of approximately one million people. The key functions of the training hubs include:

- Standardising training programmes using educational principles and assessments in collaboration with the various professional colleges, educational providers, professional associations, DHBs, PHOs, private sector and HWNZ.
- Coordinating clinical placements to support vocational training programmes.
- Supporting trainees to develop and implement career plans and provision of mentoring services.
- Providing peer reviewing learning opportunities.
- Sourcing traditional and non-traditional accredited student placements.
- Ensuring workforce training aligns with national service delivery needs and regional clinical service plans.
- Administering workforce initiatives, such as the Voluntary Bonding Scheme, leadership development, Advanced Trainee Fellowship Scheme and support for HWNZ innovations such as the Diabetes Nurse Specialist prescriber role.
- Implementing and overseeing a national skills and simulation based education strategy.

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33 American College of Physicians
Appendix 2  Background to and drivers of the changes taking place in the health sector

In 2009, several reports\(^{34}\) were produced about the health and disability workforce and the recommendations from these reports continue to impact on the sector.

Prior to this, for several years there had been little coordinated workforce planning and no cohesive retention or development strategy for the medical workforce and gaps in the medical workforce were filled by IMG, many of whom came to NZ for short periods.

In terms of the structure of the sector, the impact of the Report “Meeting the Challenge: Enhancing Sustainability and the Patient and Consumer Experience within the Current Legislative Framework for Health and Disability Services in New Zealand” by the ‘Ministerial Review Group’ was far reaching. It recommended:

- Health professional led clinical networks.
- Strengthening national and regional collaboration between DHBs.
- Rationalisation of various support services.
- Downsizing the Ministry of Health.
- Creating a new National Health Board (NHB) with powers in the funding and running of DHBs.

These organisational changes have been put in place and are now impacting on the delivery of care.

Drivers causing the changes

2.1  Demographics

In New Zealand the population is growing slowly as shown in figure 1.

People in New Zealand are living longer. There will be increasing demand on health services due to the increases in the ageing population and burden of chronic disease. Currently life expectancy is 78 years for males and 82 years for females\(^{35}\). New Zealand’s population aged 65 years and over (65+) is projected to exceed one million in the late 2020’s\(^{36}\). Those aged 65+ will comprise one in five New Zealanders and exceed the number of children aged less than 15 years.

The Māori population overall will become older, but will continue to have a much younger age structure than the total New Zealand population because of higher Māori birth rates. Half of the Māori population will be older than 26.8 years by 2021; in 2001 the median age was 22.1 years. The

\(^{34}\) Ministerial Task Group on Postgraduate Training and Education “A review of how the training of the New Zealand health workforce is planned and funded: a proposal for a reconfiguration of the Clinical Training Agency”.

\(^{35}\) Medical Training Board “Foundations of Excellence: Building Infrastructure for Medical Education and Training”

\(^{36}\) Resident Medical Officer (RMO) Commission “Treating People Well: Report of the Director-General of Health’s Commission on the Resident Medical Officer Workforce”.

\(^{35}\) Senior Medical and Dental Officer (SMO) Commission “Senior Doctors in New Zealand: Securing the Future”.

\(^{36}\) Nursing Education “A Nursing Education and Training Board for New Zealand”

\(^{35}\) Ministry of Health briefing to incoming Minster

\(^{36}\) Statistics New Zealand
median age of the New Zealand population will rise from 34.7 to 39.8 years over the same period as shown in figure 2.

As figure 3 shows, the population is also growing unevenly across the country with increases in urban centres - especially metropolitan Auckland. There will be less growth in some smaller centres and rural areas.
Ethnic diversity will increase in the future, particularly in urban areas. Non-Europeans will make up 31% of the total NZ population by 2026 compared to 23% in 2006. Maori will make up 16.6% of the population by 2026, Asians 16% and Pacific populations 9.8% because of their higher growth rates.

There is also wider diversity of need for health services within the New Zealand population in relation to:

- The poor health and lower access rates of Māori and Pacific peoples.
- The rising number of older people with multiple conditions i.e. cardio vascular disease (CVD), cancer and increasing dementia.
- The need to focus on prevention and early intervention - 80% of disease burden is from non-communicable disease (NCDs); CVD, diabetes, cancers and chronic respiratory diseases.

2.2 Availability of funding

At present, confidence in the world economy is uncertain and this is impacting on New Zealand economy. The government is not predicting a return to budget surpluses until 2014/15 or 2015/16. Health is the second largest area of government spending and changes in technology, wages, capital availability and increasing public expectation will continue to increase the demand for health care.

However health spending growth will be constrained as the Vote Health has grown faster than Gross Domestic Product (GDP) over the last decade as shown in figure 4.

Figure 4 Health expenditure as a percentage of GDP

Source: Ministry of Health's Health & Disability Intelligence Team

37 Treasury 2010 Challenges and Choices: Modelling NZ long term fiscal Position.
2.3  Funding for training for next generation of medical specialists

Health Workforce New Zealand (HWNZ) has developed a matrix that gives the overall scoring of the disciplines and noting those disciplines that were most vulnerable and that contributed most to the current health sector priorities. This will be used to allocate funding for vocational training and ranking of medical disciplines. It is accepted that this matrix was not perfect and it had been though several iterations but it gives a methodology that will be used to decide which disciplines should be funded.

HWNZ has raised the idea that “critical disciplines” may be funded at a higher rate than others or if the health need in some areas of practice decreases, those disciplines may not be funded at all.

HWNZ is also promoting an increase in “generalists” (though it is not always clear what is meant by this term) and other ways of training, acceptance of common modules of training deliver across medical specialities, even common modules of training with other health professionals, and increased recognition of prior of learning.

2.4  Changes taking place in health care delivery

In New Zealand, health care delivery is changing at an increasing rate and in a manner that many consider to be uncoordinated. Policy makers and others in the sector are also encouraging change at an ever increasing rate, with limited cross-sector coordination.

The National government policy and groups like HWNZ have noted that most of the current services are configured around “historical patterns of demand” and there is a strong push for change across the sector, to deliver “better, sooner and more convenient care”.

Current trends worldwide include:

- Emphasis on home-based delivery of services.
- Better integrated community-based services and the development of integrated family health centres.
- Secondary hospitals focusing on enhancing core clinically viable services and increasing their reliance on broader partnerships with larger neighbouring hospitals.
- Managed specialisation and consolidation into a smaller number of centres/ hubs.

Several groups in New Zealand are encouraging and promoting similar solutions. For example, in 2010 the National Health Board noted the government’s desire to have “better, sooner and more convenient care” and worked with Synergia to produce a report on “Trends in service design and new models of care”.

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38 This gave scoring related to the age of those in the discipline and trainee numbers, dependence on general registrants, dependence on IMGs and level of DHB vacancies.
39 The contribution ranking related to five health domains, the community health based aggregate, the efficient hospital aggregate, the population and preventative health measures aggregate, the older care measure aggregates and habilitation and rehabilitation health aggregates.
40 Better, Sooner, More Convenient Health Care in the Community- Ministry of Health
41 National Party Policy.
42 Trends in Service Design and New Models of Care: A Review for the Ministry of Health.
3. Policy drivers

3.1 National government policy commitments in health care

The Minister is committed to ensuring that the pledges made before the last election are acted on. These are to:

- Increase the number of elective operations by at least 4000 per annum and ensure wait times are less than four months by 2014.
- Have no more than four months waiting for specialist appointments.
- Insulate State houses built before 1978 by the end of 2013.
- Expand voluntary bonding scheme – in relation to more health professional groups and hard to staff regions.
- Work with local primary care networks to provide free after hours GP care for children less than six months.
- Have a comprehensive after hour’s health telephone service with access to GPs, nurses and pharmacists.
- Deliver a $12 million dollar rheumatic fever programme targeting vulnerable communities.
- Add 800 doctors and 2000 nurses in 2011 election policy.
- Decrease back office bureaucracy.
- Expand the role of other health professionals, nurses and pharmacists.
- Support for rural health care.
- Expand clinical leadership, clinical networks led by doctors and others.

3.2 Ministry of Health Statement of intent

The Ministry of Health’s Statement of Intent 2012–2015 identifies key outcomes for the health system and the Ministry itself:

- New Zealanders live longer, healthier and more independent lives.
- The health system is cost-effective and supports a productive economy.

In addition, the Ministry has a focus on ensuring health services are clinically integrated, more convenient and people-centred.

The Ministry’s priorities are:

- **Lifting health sector performance through greater clinical integration**
  The Ministry will drive greater integration of services across the health system, to achieve improvements in health care and patient experience.

- **Shorter waiting times**
  The Ministry will work with district health boards to reduce waiting times for specialist appointments, diagnostic tests and emergency department admissions.

- **Ensuring the health sector delivers on the health targets**
  The Ministry will ensure the health targets are achieved.

- **Improving the health of older people**
The Ministry’s work in this area includes providing more and better services to support older people to remain in their homes, better wrap-around care for older people and stronger monitoring of the aged residential care sector.

- **Whānau Ora**
  The Ministry supports Te Puni Kōkiri and the Ministry of Social Development in rolling out the Whānau Ora approach across the country, and supports district health boards to implement Whānau Ora in their regions.

Appendix 3 References


Colwell, J. “ Teamwork is the new mantra for quality improvement getting staff working to the 'top of their license' can make or break quality and pay-for-performance projects.” 2006.


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