From: s9(2)(a)
To: s9(2)(a)
Cc: s9(2)(a)
Subject: From teh productivity Commission report
Date: Friday, 24 March 2017 9:34:57 am
Attachments: image003.png

Hi,

The Waikato med school proposal has been noted in the PC report (see below). This extract (report pages 427-429) is from the section on 'Pricing that rewards providers for delivering what government seeks to purchase'. This section talks about government adjusting process based on performance and using price to intervene in supply/demand mismatches.

Kind regards
Angela

What about high-cost courses?

Some courses have very high delivery costs, and high public and private benefits, for example medicine or dentistry. To make these affordable for itself and for students, government currently offers a high per student tuition subsidy but limits student volumes.

A better approach would use price, not volume, to achieve the same goals. On this model, government would:

1. pay a low tuition subsidy;
2. allow providers to charge high fees that, in addition to the tuition subsidy, fully covered their costs of delivery;
3. allocate to providers (to allocate onward to students, subject to any conditions about student eligibility133) a set number of fee scholarships to maintain the desired level of access for students; and
4. let additional domestic students "buy their way in" if they want to.134

This approach enables domestic students and providers to contract for high-cost delivery where students are willing to pay for it, but allows government to ensure that it maintains participation by students with particular characteristics – for example, Māori and Pasifika students in medicine, or rural-background students in veterinary studies. Scholarships are a better fit for this kind of targeting than volume caps. Government could seek employer co-funding of scholarships (including where government is the employer, as with existing Ministry of Health scholarships for Māori and Pasifika health sciences students, described in Chapter 11). The approach would avoid the current situation where high-cost fields of study are dominated by incumbent providers with little scope for new entrants (Box 15.8).

Depending on student loan settings, and on how many students chose to self-fund their studies via government-administered student loans, this approach could be fiscally neutral, a saving, or a small additional expense.

Recommendation: Government should use price, not volume, to maintain its desired level of delivery (and where relevant its desired level of participation by students with particular characteristics) in any given location or field of study, including high-cost fields of study. Price

levers available to government include tuition subsidies, fee regulation and scholarships. Any changes government makes to prices should be transparent, and based on a good understanding of why government has chosen to intervene and the outcomes it expects from its intervention.

Box 15.8 The University of Waikato bid for a medical school

New Zealand currently has two medical schools, at the University of Auckland and the University of Otago. These two institutions share between them the 539 government-subsidised places for first-year medical students.

The University of Waikato, partnering with Waikato District Health Board, would like to establish a third medical school, in Hamilton, providing a new model of medical education: a community-engaged four-year programme for graduates of any three-year undergraduate degree (in contrast to six-year programmes at Auckland and Otago). The proposed new school would have a focus on community health and primary healthcare, selecting graduates who are "willing to serve high-needs communities and meet the health care needs of the population that lives outside the main centres (i.e. small cities, provincial towns and rural areas)" – an area of labour market shortage in New Zealand (University of Waikato, 2017).

Because government currently controls medical student places with a hard volume cap, and there is no practical way for students to self-fund their study, Waikato cannot establish its proposed school unless either the Minister for Tertiary Education, Skills & Employment increases the number of funded places through his or her funding determination, or TEC decides to shift funded volume away from Auckland and/or Otago. Both universities are lobbying to prevent the latter from happening.

If a price lever were in place instead, then Waikato, Auckland and Otago could share TEC-funded scholarships (with the Ministry of Health having some say in what kinds of programmes and students best met their workforce needs), and students who missed out on these scholarships could self-fund their study if they so desired, borrowing from the Student Loan Scheme. Each medical school could then enrol as many willing-to-pay domestic students as it chose within its overall TEC funding allocation, in addition to its scholarship-supported students. The only costs to government would be any tuition subsidy it chose to pay for medicine (which it could reduce to zero if it so desired, raising scholarship funding commensurately), and the cost of any subsidy inherent in student loans if they remained interest-free.

Under these settings, the Otago and Auckland medical schools may still be disadvantaged compared to the status quo if they were unable to attract sufficient numbers of fee-paying students to maintain their enrolments – but they would still be better off than if they lost student places to Waikato and had no means of enrolling any additional domestic students in compensation. The Commission has not assessed Waikato's proposal, but providing that the proposed school delivered on its commitment to train doctors willing to work in primary healthcare in regional areas, the gains to New Zealand of the new model of medical education may be significant.

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