Tertiary Education Commission
Te Amorangi Mātauranga Matua

Tertiary Education Report: Next steps in the establishment of a School of Rural Medicine

Date:	21 November 2017	**TEC priority:**	Medium
Security level:	In Confidence	**Report no:**	B/17/00840
		Minister's office No:	

Action Sought

	Action sought	Deadline
Hon Chris Hipkins Minister for Education	**discuss** options regarding the School of Rural Medicine initiative with officials; **forward** this briefing to the Ministers of Health and Finance; **confirm** whether you and the Ministers of Health and Finance support continuing, deferring or stopping the tender process to establish a School of Rural Medicine.	Before Christmas
Enclosure: Yes	**Round Robin:** No	

Contact for telephone discussion (if required)

Name	Position	Telephone	1st contact
Tim Fowler	Chief Executive	s9(2)(g)(ii)	
s9(2)(a)	Special Advisor	s9(2)(a)	✓

The following departments/agencies have seen this report

☐ DPMC ☐ MPI ☐ ENZ ☐ ERO ☐ MBIE ☒ MoE ☒ MoH
☐ MPP ☐ MSD ☐ NZQA ☐ NZTE ☒ TEC ☐ TPK ☒ Treasury

Minister's Office to Complete:

- ☐ Approved
- ☐ Noted
- ☐ Seen
- ☐ See Minister's Notes
- ☐ Declined
- ☐ Needs change
- ☐ Overtaken by Events
- ☐ Withdrawn

Comments:

Recommendations

Hon Chris Hipkins, Minister for Education;

It is recommended that you:

1. **discuss** options regarding the School of Rural Medicine initiative with officials;
2. **forward** this briefing to the Minister of Health and the Minister of Finance (please circle);

   YES NO;

3. **confirm** whether you and the Ministers of Health and Finance support continuing, deferring or stopping the tender process to establish a School of Rural Medicine (please circle).

   CONTINUE DEFER STOP

Tim Fowler

Chief Executive
Tertiary Education Commission

21 November 2017

Hon Chris Hipkins

Minister for Education,

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Purpose

1. This briefing provides background information on the previous Cabinet's decision to establish a School of Rural Medicine, and outlines the next steps in the process as requested in the Cabinet decision (refer CAB-17-MIN-0464).
2. We are also seeking confirmation of whether you and your fellow Ministers are supportive of continuing with this initiative at this time. We recommend sharing this briefing with your fellow Ministers followed by discussion to determine what your next steps will be. A covering letter to provide with the briefing is provided in Appendix 1.

Executive summary

3. In August 2017, Cabinet agreed in principle to the establishment of a School of Rural Medicine though a competitive tender. This paper reports back following that decision, setting out the background to the decision and options for progression.
4. The School of Rural Medicine responds to a shortage of doctors in rural areas. Although Health Workforce NZ (HWNZ) data indicates that New Zealand's health needs will continue to be met through domestic graduates and International Medical Graduates (IMGs) through to 2026, Officials agree there is a maldistribution issue within the medical workforce with rural areas having poorer access to doctors than urban areas.
5. This issue was initially raised by the University of Waikato and Waikato DHB in their joint proposal to establish a third School of Medicine based in Hamilton. This Graduate Medical School would focus on recruiting students who are more likely to choose a rural career (those coming from rural backgrounds, and/or with an early interest in pursuing a rural career) and provide an enhanced clinical training experience through regional clinical training centres were students would complete rotations and placements.
6. This School would be innovative in that it would enrol 60 graduate students each year into a four-year graduate training programme, but would be expensive to set up.
7. In response to this, the existing medical Schools at the Universities of Auckland and Otago developed a counter proposal – a national School of Rural Health. This expands on existing initiatives to provide students with an enhanced rural training experience, which would encourage them to choose a rural career.
8. There would be no increase in the number of medical students, but other health professions such as physiotherapy, nursing, and pharmacy would be incorporated. This would support integrated learning between professions, supporting the development of alternative care models, as well as help address shortages in these professions.
9. The two existing proposals both have some merit in that they are likely to increase recruitment into rural careers and make some contribution to regional development, but there are a number of issues including that it is not clear how successful the proposals would be, or how they would address retention of the rural workforce.
10. Establishing a School of Rural Medicine through a tender process would allow these diverse proposals to be considered against common criteria, together with other ideas from other interested parties. This would allow a solution to rural health problems to be selected that is creative, innovative and provides the best solution to the problem.
11. We recommend discussing the proposal with your Ministerial colleagues before determining whether to pursue the initiative, and the priority you would give it. If the initiative is pursued, we suggest a two-stage competitive process comprising submission of expressions of interest, followed by full proposals from entrants of interest.

Medical training in New Zealand

Medical training is delivered by the Universities of Auckland and Otago

12. The Universities of Auckland and Otago both offer six-year medical programmes primarily focussed on enrolling school-leavers. At both universities, prospective medical students enrol in a Bachelor's qualification in their first year, along with students seeking admission to other aligned programmes such as pharmacy, dentistry and physiotherapy.

13. The first-year of study acts as a 'weeding-out' process to ensure students progressing to the medical programme are academically equipped. Following this, successful students continue for a further five years to complete their medical qualification, which includes several clinical placements. The final year of study is the Medical Intern year in which students complete a preparation year of clinical attachments – learning the skills to become a house surgeon.

14. There is a graduate entry pathway at both universities where those who already have an undergraduate degree start at the second year. About 30 percent of students commencing the second year of the current medical training programmes enter as graduates from another degree programme.

15. In 2016, Auckland delivered over $46.5 million (approximately 1,200 equivalent full-time Students - EFTS) and Otago delivered over $54 million (approximately 1,400 EFTS) Student Achievement Component Level 3 and above (SAC 3+) funded provision in years 2-6 of the Bachelor of Medicine and Bachelor of Surgery (MB ChB) qualification. Additional information about the number of students and SAC funding is provided in Appendix 2.

Medical provision is capped

16. Medical provision is considered high-cost and the amount of delivery is therefore capped on the first-year EFTS intake. The cap currently sits at 539 SAC 3+ funded EFTS. The Universities of Auckland and Otago work together to agree the distribution of the cap. Applications far exceed the number of places.

17. The cap has been raised from 365 SAC 3+ funded first-year EFTS in 2009, to its current level of 539 SAC 3+ funded first-year EFTS. A table illustrating the total cap and how it has been split between the Universities is provided below. It is proposed to further increase the cap to 565 EFTS.

Medical EFTS cap over time

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
First year EFTS cap (Auckland)	155	155	191	191	219	219	233	257	257	257
First year EFTS cap (Otago)	210	210	234	254	266	266	272	282	282	282
Total Cap	365	365	425	445	485	485	505	539	539	539

There is further training following medical school

18. Following graduation, students first undergo two years of prevocational medical training - postgraduate year 1 (PGY1) and postgraduate year 2 (PGY2). During this period, graduate doctors (known as interns) complete clinical attachments to gain further skills and experience.

19. Following successful completion of the PGY1 and PGY2 training, doctors who wish to specialise must undertake vocational training, usually through the relevant professional body. This allows them to gain specialist skills and those successfully completing these courses can then practice as specialists.

20. For General Practitioners, vocational training is a three year programme undertaken through the Royal New Zealand College of General Practitioners. In 2015/16, there were 183 placements in GP year one training programmes and 241 applicants.

Cabinet decisions

Cabinet agreed in principle to the establishment of a School of Rural Medicine

21. On 21 August 2017, Cabinet agreed in principle to the establishment of a School of Rural Medicine (CAB-17-MIN-0464 refers). Cabinet:

    - **noted** the Government has been considering two proposals to address the shortages of doctors in rural areas in New Zealand, put forward by the University of Waikato and the Waikato DHB, and the Universities of Auckland and Otago;
    - **noted** the Government has been considering advice from agencies on the issue and potential solutions to address the shortages of doctors in rural areas, including running a competitive process to establish a new medical school;
    - **agreed in principle** to the establishment of a School of Rural Medicine;
    - **noted** that funding would be required for the establishment of the School and its operating costs; and
    - **invited** the Tertiary Education Commission (TEC) in consultation with other agencies as appropriate, to develop a detailed plan for the competitive tender process, with a view to reporting back to the Minister for Tertiary Education Skills and Employment in October 2017 on their next steps.

22. This report back responds to the Cabinet minute. The previous Minister's press release relating to the decision is provided in Appendix 3 for your information, stating the Government's intention for the school "to be up and operating no later than 2020".

The School of Rural Medicine initiative responds to proposals to address rural health issues

23. Nationally, there is a shortage of doctors in rural areas. Although the current and projected number of New Zealand medial graduates together with International Medical Graduates (IMGs) is enough to keep pace with population growth, there is a maldistribution of the workforce arising from the recruitment and retention of doctors in rural areas.

24. Lack of access to primary care has the potential to impact significantly on the health of New Zealand's rural population. Studies from the USA indicate that primary care supply has been associated with improved health outcomes including for all-cause mortality, cancer, heart disease, stroke and infant mortality, low birth weight, life expectancy and that self-rated health is also improved.

25. Over the last 12 months, two proposals have been presented to Government, both aimed at increasing rural healthcare provision. These proposals are discussed further below. Both proposals aim to improve recruitment of the rural health workforce, but both proposals differ significantly in both scope and cost.

26. Given the differences between the existing proposals it was determined that a competitive tender process would best allow these proposals to be compared. The process could generate a wider range of options from a wider range of providers, which could generate a more innovative and cost-effective solution to be developed.

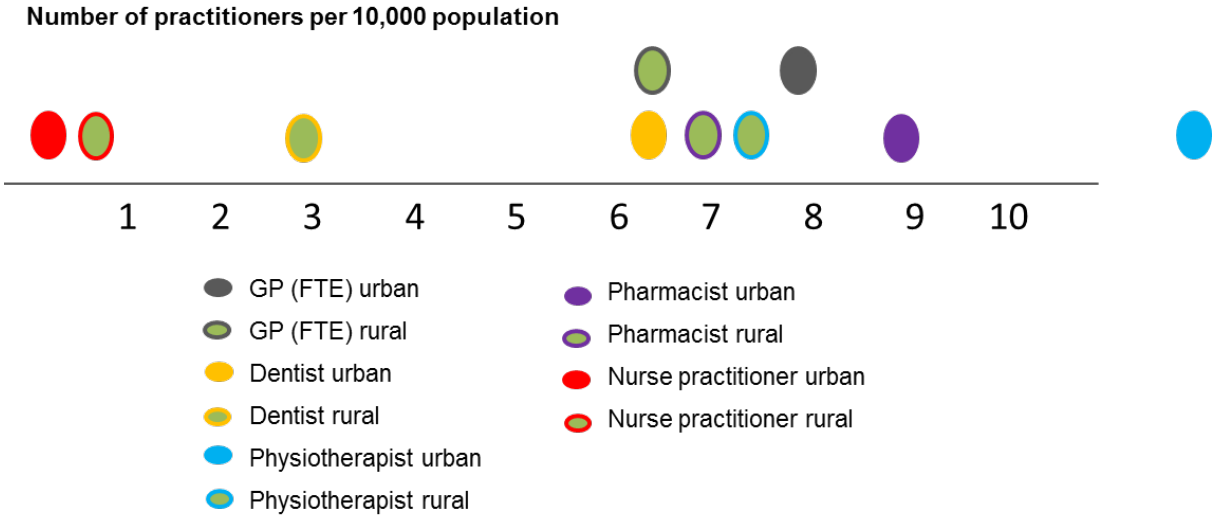
The problem…

There are fewer medical practitioners in most rural areas

27. Nationally, urban areas have on average greater access to general doctors than rural areas. The latest data we have (below and Appendix 4) is from 2014, but we understand it is soon to be updated by HWNZ.

28. The 2014 data from HWNZ illustrates that whilst mostly urban DHBs such as Capital and Coast have high numbers of general doctors (87 per 100,000 population), rural DHBs such as West Coast and Taranaki have fewer general doctors (61 and 60 per 100,000 population respectively). Full data is provided in Appendix 4, but it is noted that HWNZ has recently received data from 2016, which will be presented to the Minister of Health shortly.

29. The inequalities in the distribution of doctors also extends to other health professions as illustrated below:



30. The underlying reasons for the maldistribution are complex. Factors which contribute to difficulties in recruiting and retaining health professionals in rural locations include:

- a general lack of support, including cover for training or holidays due to overall shortage of health professionals and lack of rural staff
- perceptions of long hours and reduced down-time (particularly relevant for doctors, nurses and midwives who are often 'on-call' outside of working hours)
- practices are often located in remote areas with few facilities and few opportunities for partners and children
- geographic distance between patients (this particularly applies to midwives and other professions that undertake home visits) or practices (relevant to professions that undertake clinics at differing locations)
- lower intensity than urban practices, which leads to lower salaries for those remunerated on a per patient or per hour basis.

31. In addition the age profile of the current rural medical workforce means a significant number of existing doctors will retire in the near future. A diagram setting out the issues faced by the rural medical workforce is provided below:

International Medical Graduates (IMGs) fill the gaps

32. To mitigate the geographic and specialty maldistribution of the medical workforce, New Zealand imports approximately 1,100 IMGs per year[1]. In 2016, IMGs made up around 35 percent of the registrar workforce.

33. In 2017, IMGs made up 43 percent of the senior medical officer (SMO) workforce[2]. HWNZ estimates that 51 percent of IMG SMOs have a New Zealand or Australasian vocational qualification. This means while they may have done their basic medical training overseas, they did their specialty training in New Zealand or Australia. In the case of general practice, rural hospital medicine, and urgent care, approximately 75 percent of the IMGs practising under these specialties only have a qualification from the respective New Zealand medical college.

34. Most of these IMGs only remain in New Zealand for a short period of time and of each cohort, only around 30 percent are retained in the medium term.[3]

35. The high turnover of IMGs affects continuity of care, which is particularly important in general practice. One way of addressing this is to improve retention of IMGs to ensure their skills remain in the New Zealand health system.

36. Whilst IMGs bring diversity, which contributes to innovation, as well as addressing workforce pressures, they often have little understanding of the social and cultural context in which they practice, which can have significant impacts on some patients. This is more important in some specialties than others.

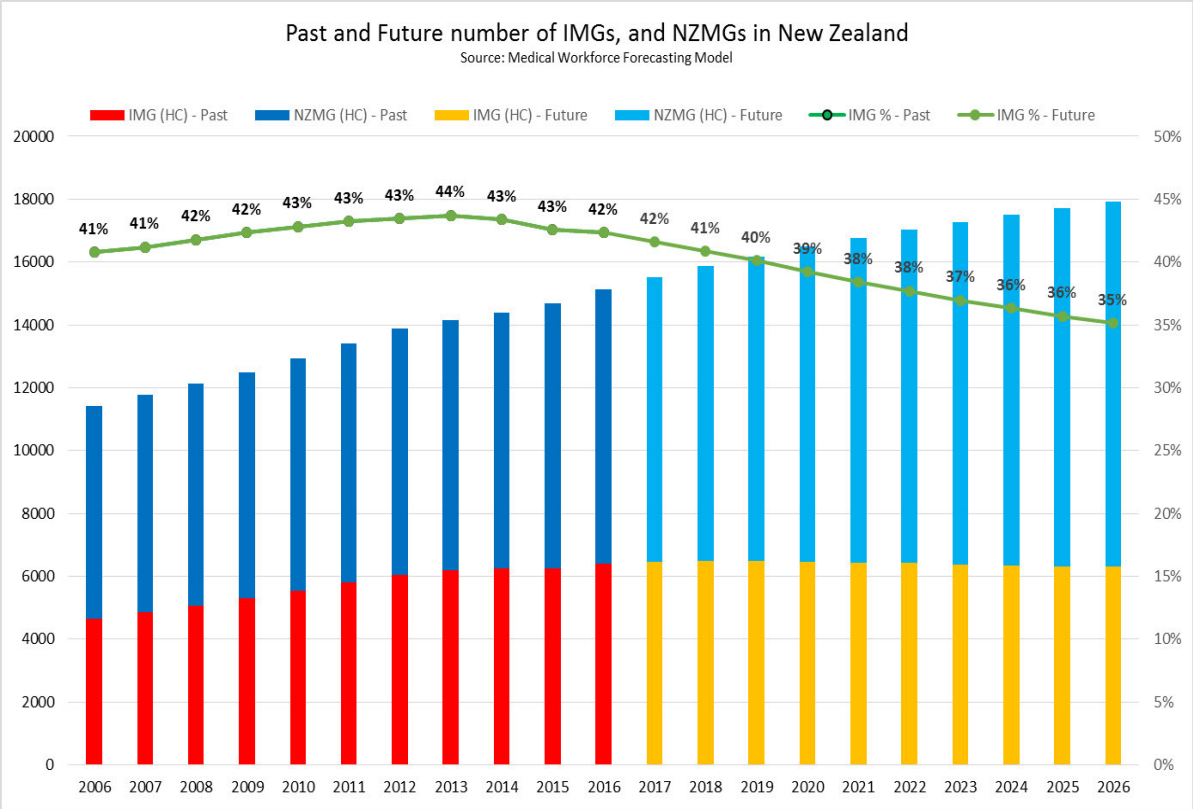
[1] Three distinct groups of IMGs come to New Zealand. Firstly, junior doctors on short term (one to two years) contracts having a working overseas holiday, who help fill a short term service need. This level of service need is reducing with the rise in the number of domestic graduates. Secondly a group of IMGs come to obtain specialist training in New Zealand's high quality training programmes and many of these are retained in New Zealand when they obtain employment as a specialist. Thirdly there are IMGs who obtained their undergraduate and specialist training overseas, or are working in New Zealand as locum generalists.

[2] Based on the number of practising SMOs as at May 2017 according to Medical Council of New Zealand data

[3] Medical Council of New Zealand. (2016). *The New Zealand medical workforce in 2013 and 2014*.

37. Importing medical graduates reduces the number of medical students that need to be educated in New Zealand. This means there are fewer opportunities available to New Zealanders to study medicine at an undergraduate level in New Zealand. However, importing SMOs assists with the ability to provide high quality specialist training programmes.

38. The chart below shows the past, current and forecast future number of IMGs and New Zealand medical graduates in the health workforce. Between 2006 and 2013, the number of IMGs employed in New Zealand rose, but reliance on IMGs from 2018 onwards is forecast to level off or slightly reduce with increased numbers of New Zealand medical graduates meeting New Zealand health needs.



There are two recent proposals to address problems in the rural medical workforce, but both have positives and negatives

39. Proposals have been received from the University of Waikato and Waikato DHB, and the Universities of Auckland and Otago. Background information about the Universities involved in each proposal is provided in Appendix 5.

40. The University of Waikato and Waikato DHB proposal was submitted as an Indicative Business Case in accordance with the Treasury's Better Business Case process. The proposal from the Universities of Auckland and Otago is a presentation accompanied by a discussion paper and has not yet been developed into a business case.

41. Officials have provided advice to Ministers on both proposals, including the steps required to produce a business case that contains enough information on which a decision can be made by Ministers. This information has also been provided to the Universities and Waikato DHB as comments.

42. The two proposals are briefly summarised below, with additional information provided in Appendix 6. A comparison between the proposals is provided in Appendix 7.

A graduate-entry medical school is proposed by the University of Waikato and Waikato District Health Board (the Waikato proposal)

43. In late 2016, the University of Waikato and Waikato DHB submitted a joint proposal to establish a new graduate-entry medical school. The new medical school would be based in Hamilton and 12-15 regional clinical training facilities would be established over a ten-year period to deliver enhanced clinical training in a rural setting.

44. This proposal is estimated to require government capital expenditure of $111.7 million with an operating subsidy over its establishment phase of around $100 million.

45. Once fully established, operational funding of approximately $75 million per year would be needed. It is noted that the business case does not include the additional funding needed for vocational training of graduates. The total amount of HWNZ funding for vocational training years would depend on the graduate's choice of vocational training, but is likely to be at least $9 million per annum[4].

46. The school would provide a four-year graduate-entry medical programme for 60 students per annum beginning in year five of the establishment period. This is a model of training used commonly overseas and is one year shorter than the current graduate entry pathways at the Universities of Auckland and Otago.

47. Student selection would be based around practices shown to be effective in recruiting students who will later choose a rural career.[5,6,7,8] It will also provide an enhanced rural training experience, which has also been shown to be important in encouraging graduates to work in rural areas.

The Waikato proposal has put pressure on current medical schools to innovate

48. One significant advantage of the Waikato proposal is that it encouraged the existing medical schools to think about how they could change their current practice to address rural health needs.

49. The Universities of Otago and Auckland have both invested time and effort in developing a counter-proposal, which whilst based on international best practice, is something that both Universities could have developed much sooner.

The Universities of Auckland and Otago propose establishing a dedicated School of Rural Health (the Auckland/Otago proposal)

50. This proposal builds on the expertise that the Universities of Auckland and Otago have established through their existing medical training programmes. It is based on the existing Rural and Regional Admission Schemes, which use rural 'hubs' to train medical students. The proposal would establish additional hubs nationwide, which would be based in rural hospitals and linked to local communities.

51. The proposal does not ask for an increase in the medical EFTS cap so there will be no new doctors.

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[4] It is noted that the vocational funding is the minimum amount required and is based on all students pursuing general practice careers. If students pursue other specialties, costs will be higher.

[5] Playford DE., Evans, SF., Atkinson, DN., et al. 2014. Impact of the Rural Clinical School of Western Australia on work location of medical graduates. Medical Journal Australia 200: 104-107

[6] Poole, P., Stoner, T., Verstappen, A., and Bagg, W. (2016). Medical Students: Where have they come from and where are they going? NZ Medical Journal, 129.

[7] Shelker, W., Zaharic, T., Sijnja, B., & Glue, P. (2014). Influence of rural background and rural medical training on postgraduate medical training and location in New Zealand. *NZ Medical Journal, 127*, 12-16

[8] Matthews, C., Bagg, W., Yielder, J., Mogol, V., and Poole, P (2015). Does Pūkawakawaka (the regional-rural programme at the University of Auckland) influence workforce choice? NZ Medical Journal, 128, 35-43.

52. The proposal does incorporate vocational medical training. This allows for medical training to be vertically integrated with more advanced medical students contributing to teaching and learning experiences of newer students, and supporting other professions.

53. Although the proposal includes several options for scaling the proposal, their preferred option is to develop ten hubs over a five-year period to provide education across multiple health disciplines including medicine, nursing, midwifery, pharmacy and physiotherapy. The hubs would accommodate full-year rural immersion and short-term rural clinical placements for both undergraduate and postgraduate vocational students.

54. The hubs would address retention of the existing rural workforce by providing a focal point for networking, professional development and general support. In addition, students involved in the hub would provide support to established rural practices and help reduce pressure on the existing workforce.

55. Their preferred option seeks additional operational funding of up to approximately $13.8 million per annum from the Crown. No capital funding has been sought. Officials believe these costings to be underestimated.

Both proposals have merit

56. In addition to using student recruitment practices that are likely to encourage more medical graduates to seek a rural career, each proposal has the potential to deliver several other benefits.

57. Each has some capacity to incorporate other professions. This is stronger for the Auckland/Otago proposal where integrated learning between professions is a key feature. This facilitates closer interdisciplinary working relationships and post graduate learning opportunities, and the introduction of alternative models of care that would support existing rural general practices.

58. Both proposals could contribute to regional development goals. The Waikato proposal specifically identifies the key economic benefits that the medical school would bring to the region, including increased GDP, increased direct and indirect employment, skills and training opportunities, and increased innovation. The Auckland/Otago proposal would spread the 10 hubs and spokes in rural areas throughout New Zealand.

59. The proposals may also contribute to Crown-Māori economic growth partnership goals including growing the future Māori workforce, and strengthening the transition from education to work for Māori.

60. Additionally, each proposal indicates that it would incorporate a research component. The outputs from this research would bring benefits to DHBs, primary care providers, community groups and local iwi, as well as tertiary education providers. There is also significant opportunity for the research to contribute to the wider aims of government, including the Health Research Strategy.

61. Finally, it is noted that the Waikato proposal would provide a less costly option for graduate medical training as it is one year shorter than the current graduate entry programmes offered by the Universities of Auckland and Otago. Compared to the Waikato proposal, the graduate pathway at the Universities of Auckland and Otago involves an additional year of study at a cost of approximately $15,000 to the student (currently) and $43,000 to Government (per EFTS). However, the cost of undertaking a degree followed by medical training is likely to be higher than direct entry into a medical training programme.

But there are issues and risks associated with each of them

62. The chief concern with both proposals is that although they are based on established strategies, it is not clear how many medical graduates would enter rural practice or, how long they would be retained in the rural health workforce. They will both need to have other programmes and support measures built around them to support doctors practicing in rural and remote areas.

63. The Waikato proposal is costly. There is also potential for the costs of both proposals to increase if any of the other funding streams are unable to deliver.

64. An important concern with the Waikato proposal is Waikato DHB's ability to focus on this work when it has a number of issues to deal with, including its financial performance, updating core IT systems, leadership, relationships with Midland Health Network and performance on the 'Shorter Stays in Emergency Department' Health Target.

65. Any increase in numbers of medical students may affect the availability of clinical placements. It is noted that Waikato DHB has already informed the Auckland Medical School that if the Waikato proposal is successful, it will look to reduce the number of University of Auckland students undertaking clinical placements in its hospitals. The Universities of Auckland and Otago already report difficulties in securing enough clinical placements for their students. One of the issues behind this appears to be funding, and the demands on already busy practitioners resulting from having students in their practice. However, the Waikato proposal intends to tackle this by broadening the range of clinical placements.

66. There may also be system capacity issues associated with training additional doctors, who will need mentoring and supervision when they enter the workforce.

The tender process can be designed to ensure that the best solution to the problem is chosen

Diverse proposals from a range of providers should be encouraged to allow the best, most cost-effective proposal to be identified

67. If the initiative goes ahead, the School of Rural Medicine must provide the best available solution to the rural medical problem, addressing recruitment, distribution and retention of the rural health workforce. Recruiting students who are more likely to choose a rural career does not guarantee that they will choose or remain in a rural location. Therefore, the School of Rural Medicine could support recommendations made by the WHO to implement initiatives which would encourage retention of the existing rural medical workforce.

68. The tender process should encourage innovation and creativity in addressing rural health inequalities, as well as allow diverse proposals to be considered against a common set of goals and criteria.

69. It is important that the tender process we establish is able to accommodate both options that are already proposed. It is noted that other Universities have expressed interest in the School of Rural Medicine and may develop proposals that will address rural health issues in other new and innovative ways.

70. In addition, the School of Rural Medicine could be used to promote different models of care in rural practice outlined earlier, such as increased use of technology to address health needs, greater use of nurse practitioners etc.

A two-stage tender process will allow other parties to indicate their interest

71. If you support continuing the initiative, we suggest a two-stage process. The first stage is to seek expressions of interest (EOIs), which will be reviewed prior to inviting a more detailed proposal to be submitted in the second stage of the process. This will both allow other entrants to get up to speed without requiring significant costly work, and ensure unsuitable proposals are rejected before parties commit too much time, effort and money in developing detailed proposals.

72. Proposals would be considered in terms of their ability to address both recruitment and retention of the rural medical workforce, and provide a pipeline for rural medical provision. The cost-effectiveness of the proposals will also be considered.

73. The TEC has previously run competitive tender processes to select ICT Graduate Schools, Centres of Research Excellence, Entrepreneurial Universities and other initiatives. The documentation and standard process requirements can be adapted for the School of Rural Medicine process.

74. As both existing proposals have received advice from agencies, we will need to ensure that this does not constitute an unfair advantage to these proposals over other novel proposals. Therefore ensuring probity requirements are met will be an important consideration.

Establishment of an expert advisory group to assist in the process

75. As significant levels of funding may be required, Cabinet will need to make the final funding decision. It is suggested that this is based on advice from officials and an independent expert advisory group as this will bring credibility to the final decision and reinforce that the decision is made on merit.

76. The independent expert advisory committee would review the EOIs and provide advice on detailed proposals. This advice would then be considered by the Minister(s), then Cabinet, which would decide which final option to support.

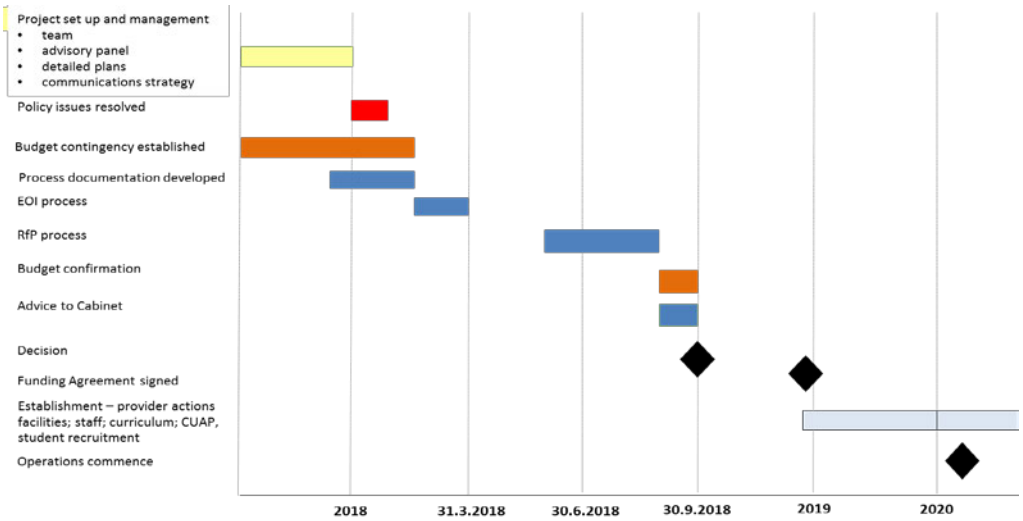
77. Care would be needed to ensure the advisory group is perceived as truly expert and independent. It is recommended that members are sought who have skills and experience with rural health, medical training, and procurement. It would also be useful to appoint some members who have international expertise in addressing rural health issues, since they would bring different knowledge and perspective.

78. It would also be important to effectively manage conflicts of interest. A large number of expert advisors have been involved in the development of the existing proposals. In addition, given New Zealand medical professionals will likely have attended the Universities of Auckland or Otago, the perception of loyalties to these institutions must be carefully managed.

Proposed timelines

Under current timelines the successful applicant would be known by 2018, and the School of Rural Medicine would be up and operating no later than 2020

79. The following timeline is proposed:



80. To meet the timeline previously announced, a public call for EOIs would be made in February 2018, closing end of March. Successful entrants would be invited to submit full in-depth proposals in June 2018.

81. It is anticipated that advice to Cabinet would be provided to enable a final decision to be made by late September/early October 2018. A period of establishment would then occur and the new School of Rural Medicine could commence operations in 2020.

There are some policy issues that need to be addressed

82. The above timeline calls for preparation and planning to be completed by early 2018. This includes resolving some policy issues and Budget contingency establishment.

83. The most pressing policy issue is whether the School of Rural Medicine will deliver additional doctors as noted in the press release (Appendix 3), or not. If so, consideration will need to be given to whether the existing model of allowing students to choose places and specialities will be followed, or whether a different model can be implemented to funnel a greater proportion of graduates into rural general practice.

84. It should also be considered whether the School of Rural Medicine should provide training and support to other professions as well as medicine.

85. As noted, there are also opportunities to design the initiative to encourage proposals to support recommendations made by the WHO to support implementation of additional strategies to mitigate rural health workforce issues.

86. If you support continuing with this initiative, we will provide a policy decision paper to you to consider these issues.

A Budget contingency would need to be established

87. If you wish to continue with the initiative, agencies, particularly Treasury, can provide advice on how to place this within the Budget process and the part of the Government's fiscal plan this should sit under.

88. If the initiative is to be funded and is a Government priority, a contingency would have to be established in Budget 2018 that would facilitate the tender process, with full cost implications to be reflected in Budget 2019 and beyond.

89. If the initiative is lower priority, a contingency would still need to be established, but costs would be reflected in later years.

Options and next steps

We recommend discussing the proposal with your Ministerial colleagues

90. We recommend discussing this issue with your Ministerial colleagues to determine whether the initiative will go ahead and, if so, what priority it has. Some initial options are presented below.

Option One: Support the initiative as a priority, and continue the process

91. If Ministers decide to continue with the School of Rural Medicine initiative on the existing timeline, the TEC will need to continue work to design the tender process.

92. If you are supportive of the School of Rural Medicine continuing, our next steps will be to:

- provide advice on the policy issues that need to be resolved;
- provide advice on the establishment of a budget contingency; and
- establish the expert advisory group for the School of Rural Medicine.

93. We will also continue to develop the tender process documentation, which will include a communications strategy to sit alongside the project, stakeholder management, engagement plan and probity rules.

Option two: Defer a decision

94. If Ministers consider the School of Rural Medicine worth further consideration, but of lower priority at this time, you could agree a timeline for revisiting the initiative and/or reviewing other options. For example, you could agree to reconsider the initiative in six months.

95. It is recommended that any timeline for revisiting the proposal is kept relatively short so as to maintain pressure for innovation and stakeholder engagement.

Option three: Decline to support the initiative

96. If Ministers are not prepared to support the School of Rural Medicine, the TEC will work with your office and relevant agencies to provide advice on alternative options. This would include preparing a communications plan, and notifying the University of Waikato and Waikato DHB, and the Universities of Auckland and Otago.

Summary of option analysis

97. The risks and benefits of these options are summarised in the table below. Each option has been assessed against the cost to government, effectiveness in addressing the lack of rural doctors, the ability to significantly improve rural health outcomes and stakeholder reaction.

Option	Cost	Ability to address the shortage of rural doctors	Change in rural health outcomes	Stakeholder reaction
1	Potentially high	Likely	Likely	Mixed
2	Potentially high	Likely	Likely	Mixed
3	Low	None	None	Mixed

Consultation

98. The TEC has prepared this briefing. The Treasury and the Ministries of Health and Education have been consulted.

Ministry of Health comment

99. The Ministry of Health's view is that rural health workforce shortages are not due to a lack of medical graduates, but rather a maldistribution of the workforce arising from the recruitment and retention of health practitioners, including doctors, in rural areas.

100. The Ministry supports increasing access to rural health services through initiatives that promote interdisciplinary ways of working and enabling health practitioners to work to the full extent of their skills and abilities. Other health professionals, including primary care nurses, midwives, pharmacists, dentists, and physiotherapists, also have a role in providing rural health services. As such, the Ministry support an interdisciplinary school rather than a medical school.

101. The Ministry supports introducing packages of initiatives to improve retention and distribution of the rural health workforce, including international health practitioners.

102. The level of funding that is required from Vote Health would need to be further clarified.

Appendix 1 – Cover note for other Ministers

Hon Grant Robertson
Minister of Finance
PARLIAMENT BUILDINGS

Hon David Clark
Minister of Health
PARLIAMENT BUILDINGS

Dear Grant and David,

Establishment of a School of Rural Medicine

I attach a briefing from the Tertiary Education Commission regarding the previous Government's proposal to establish a School of Rural Medicine. This briefing takes account of the events that led to the decision and sets out some options for our next steps. Comment from the Treasury, the Ministry of Health and Ministry of Education is also incorporated.

I look forward to discussing the options for progressing the consideration of this proposal, and the broader issues of the rural health workforce with you.

Yours sincerely

Chris Hipkins
Minister of Education

Appendix 2 – Medical provision

Value of delivery (NZ$ million) of SAC-funded^ undergraduate medical students* at the University of Auckland and the University of Otago

TEO Name	Year of study	2014	2015	2016	2017 (to-date)
University of Auckland	Medicine years 2 and 3#	$16.6	$18.2	$18.8	$22.1
	Medicine years 4, 5 and 6#	$24.9	$26.4	$27.7	$29.4
University of Otago	Medicine years 2 and 3#	$19.1	$19.4	$20.0	$23.8
	Medicine years 4, 5 and 6#	$32.0	$33.0	$34.3	$32.7

Volume of delivery (EFTS) of SAC-funded undergraduate medical students* at the University of Auckland and the University of Otago

TEO Name	Year of study	2014	2015	2016	2017 (to-date)
University of Auckland	Medicine years 2 and 3#	461	503	520	517
	Medicine years 4, 5 and 6#	583	619	651	691
University of Otago	Medicine years 2 and 3#	528	537	553	558
	Medicine years 4, 5 and 6#	750	775	805	767

Note:

*the first year of study is undertaken as a Bachelor of Science/Bachelor of Health Science before students are selected to progress to the medical programme. Information on the number of students in year one has not been provide as these students cannot be distinguished from other students undertaking the Bachelor of Science/Bachelor of Health Science.

#SAC-funding is allocated based on funding categories which group years of medical study into years 2 and 3, and years 4, 5 and 6. It is not possible to quantify the number of students in each year of study.

^Students also receive a non-SAC-funded stipend in their final year of study – the Medical Trainee Intern Grant. The grant is $26,756 (GST exempt) per equivalent full-time student (EFTS).

Appendix 3 – Press release

Paul Goldsmith **28 AUGUST, 2017**

A School of Rural Medicine to be established

The Government will establish a new School of Rural Medicine within the next three years to produce more doctors for our rural communities, Tertiary Education, Skills and Employment Minister Paul Goldsmith says.

"Every New Zealander deserves quality healthcare services, and we want to grow the number of doctors in rural and regional areas to make it easier for people in those areas to access other key health services," Mr Goldsmith says.

"The new School of Rural Medicine will be specifically geared toward meeting the challenges faced by high need and rural areas of the country, and will produce around 60 additional doctors per year.

"I want to thank the University of Waikato and the Waikato DHB for putting forward the initial proposal, and Otago and Auckland Medical Schools for their joint proposal.

"The Government will now run a contestable business case process to consider all options for delivering the new School of Rural Medicine, and ensure it meets the needs of rural New Zealand.

"It is our intention that the successful applicant will be known in 2018 with the new medical school to be up and operating no later than 2020."

The cost of the new school will be finalised through the business case process, but for example the Waikato proposal is seeking Government funding of around $300 million over ten years.

The Government's contribution will be met through a combination of existing tertiary funding streams and future operating and capital budget allowances.

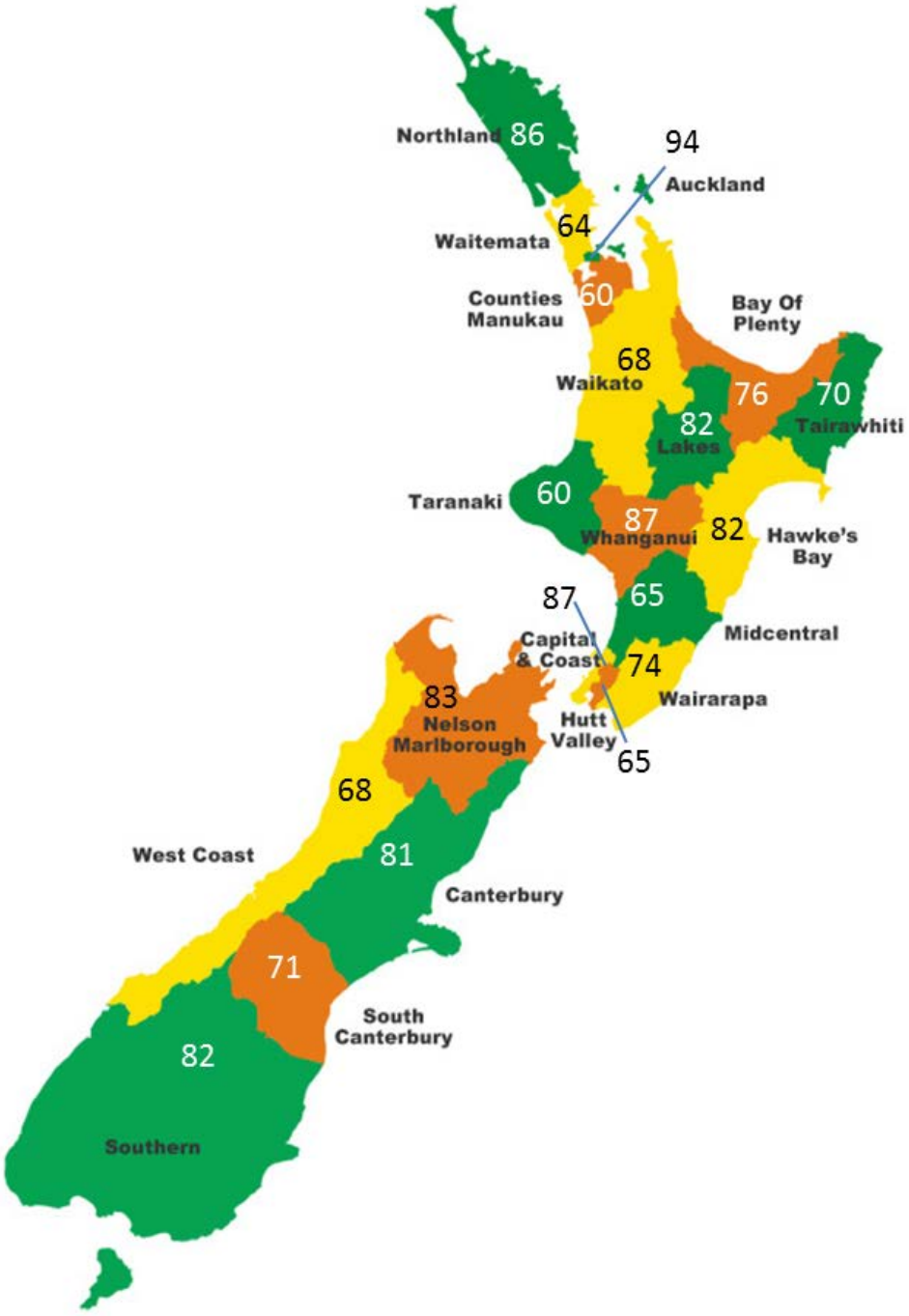
"The Government is committed to growing our medical workforce to meet the needs of a growing and ageing population," Mr Goldsmith says.

"Since 2008 this Government has increased the number of medical students by 47 per cent, with over 530 doctors now being trained annually.

"The new School of Rural Medicine will add to this number, increasing particularly the number of doctors qualified for, and committed to, serving in rural communities."

Appendix 4 – Distribution of GPs

General practitioner FTE per 100,000 population (data from 2014)



Note:

The data presented is for 2014. We understand additional data from 2016 will soon be available.

The data indicates clustering around the main training centres (Auckland, Christchurch and Dunedin). When split into regions, the distribution of GPs in the Southern DHB is 85 GPs per 100,000 in Otago and 78 GPs per 100,000 in Southland.

It is noted that health inequalities for rural populations are likely to be greater than they appear because of problems with data collection and the use of inappropriate geographic classification systems. This is particularly troublesome for Māori health as Māori are more likely to live rurally than other groups. Given issues with data collection in main centres (caused by GPs practicing across DHBs, or living in one and working in the other) it is better to view Capital and Coast and Hutt Valley as a combined entity with 80 FTE per 100,000 population and Waitemata, Auckland and Counties Manukau as a combined entity with 70 FTE per 100,000 population.

Appendix 5 – Key facts about the Universities of Auckland, Otago and Waikato

See attached A3s.

Key facts about the University of Otago (Otago)

Otago is New Zealand's oldest university. It is a high-performing university with very good educational and research performance, and is home to specialist provision through its medical school (with satellite schools in Christchurch and Wellington) and the only national dental school.

Tertiary Education Commission
Te Amorangi Mātauranga Matua

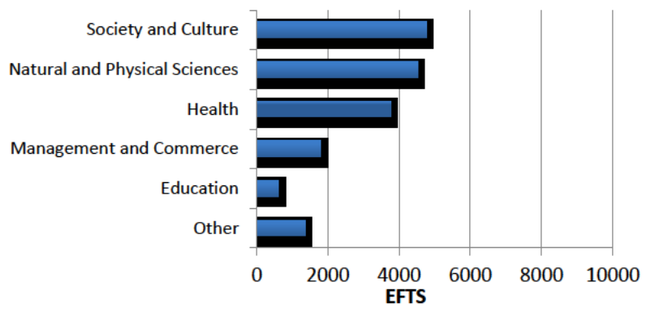
2016 Total Equivalent Full-Time Students (EFTS) = 18,505
2016 Total Student Achievement Component (SAC) EFTS = 16,836
2016 SAC delivery compared to allocation = 99.7%

	2012 actual	2013 actual	2014 actual	2015 actual	2016 actual	2016 subsector average	2016 actual to subsector average
Undergraduate SAC EFTS	83.0%	84.2%	83.8%	83.1%	83.4%	75.2%	8.1%
Postgraduate SAC EFTS	17.0%	15.8%	16.2%	16.9%	16.6%	24.8%	-8.2%
Total SAC EFTS	17,402	17,238	17,236	16,842	16,836		
International full-fee paying EFTS	8.3%	8.1%	7.7%	7.6%	8.0%	11.9%	-3.9%
Total EFTS	19,200	18,898	18,782	18,398	18,505		
% difference between EFTS delivery and allocated EFTS	-2.0%	-2.0%	-1.5%	-0.4%	-0.2%		

- Total SAC funded EFTS have declined from 17,615 in 2010 to 16,836 in 2016.
- Each year since 2011, Otago has delivered very close to the TEC minimum SAC allocation threshold.

Priority group participation rates	2012 actual	2013 actual	2014 actual	2015 actual	2016 actual	2016 subsector average	2016 actual to 2012 actual	2016 actual to subsector average
Māori (Level 4+)	8.4%	8.8%	9.3%	9.5%	10.0%	10.8%	1.6%	-0.8%
Pasifika (Level 4+)	3.2%	3.2%	3.7%	4.1%	4.4%	8.0%	1.2%	-3.6%
Under 25 (Level 4+)	81.4%	82.7%	83.4%	83.3%	82.9%	75.6%	1.5%	7.3%

EFTS delivery in top 5 subjects by Standard Classification of Education (NZSCED) broad field (2016)



Otago has a proportionately higher share of SAC delivery in Health and Natural and Physical Sciences compared to the subsector average in those fields.

Educational Performance

Pease note: Cohort measures are only available from 2015.	2013 actual	2014 actual	2015 actual	2016 actual	2016 subsector average	2016 actual to 2013 actual	2016 actual to subsector average
All students							
Course completion	89.1%	87.8%	88.5%	89.0%	86.5%	-0.1%	2.5%
Qualification completion (cohort)			70%	70%	63%	n/a	7.0%
First-year retention (cohort)			82%	84%	78%	n/a	6.0%
Māori students (Level 4+)							
Course completion	84.3%	82.2%	83.5%	84.4%	80.6%	0.2%	3.9%
Pasifika students (Level 4+)							
Course completion	76.4%	72.4%	75.0%	75.9%	71.9%	-0.5%	4.0%

- All course completion educational performance indicators (EPIs) for Otago continued to increase 2014 to 2016.
- Course completions for all students were the highest in the university subsector in 2016. Both Māori and Pasifika course completion were well above the university subsector average.
- Otago's cohort qualification completion and first year retention are well above the university subsector average. The first year retention cohort is the highest in the university subsector.
- Otago's cohort qualification completion is the highest in the university subsector. Its cohort first-year retention is on a par with Auckland University as the highest in the subsector.

Research Performance

- Ranked third in the 2012 PBRF Quality Evaluation with an Average Quality Score (AQS(N)) score of 4.96. The highest AQS(N) score by a university was 5.51.
- Otago ranked second in the 2006 and third in the 2003 Quality Evaluations (using the current reporting framework). The next quality evaluation is in 2018.
- Ranked first or second in 18 subject areas. Ranked first in four of the top 10 ranked subject areas: law; pharmacy; philosophy; and pure and applied mathematics.
- External research income for 2016 was $108.2 million. This is the highest figure in the last decade for Otago.
- PBRF indicative funding for 2018 is $63.4 million (21.0% of all PBRF funding).

Financial Performance

($ million)	2008	2013	2014	2015	2016	2008-2016 change (percentage point or $)
Total revenue	519.8	629.1	629 6	656.2	682.5	162.7
Total Government funding	233.8	270.9	275 5	282.6	297.3	63.5
Net surplus/deficit (after unusual items)	18 5	45.9	33.6	32.6	27.8	9.3
Net surplus/deficit as % of total revenue	3.6%	7.3%	5.3%	5.0%	4.1%	0 5%
Total assets	1411.6	1661	1879.8	1922 2	1950.8	539.2
Net cashflow from operations	90 5	81.7	79.9	87.9	88.2	-2.3
Cashflow from operations (%)	120 5%	115 2%	114.7%	115.5%	114 9%	-5 6%

Revenue source as a % of total revenue	2008	2016	2016 subsector average
Government income (including PBRF)	45.0%	43.6%	41.5%
Domestic tuition fees	14.7%	16.0%	17.8%
International tuition fees	6.6%	6.6%	10.6%
Other	33.7%	33.9%	30.1%

Audited figures

Funding

($ million)	2010	2015	2016	2017	2018	2010-2018 % change
Total TEC funding allocation	263.5	294.4	300.8	305.9	316.9	20.3%
SAC funding	197.1	223.3	227.1	232.6	235.6	19.5%
PBRF funding	51.7	58.1	60.1	60.1	63.4	22.6%

- There were no specific SAC allocations for Māori and Pasifika, regional provision, or priority engineering places in 2013 to 2017.
- For the past 5 years Otago's SAC funded enrolments have fallen below allocation. This resulted in small recoveries in 2013 and 2014 and an in-year plan amendment in 2015. Otago delivered 99.7% in 2016. Otago is determined not to compromise high standards and quality provision to lift enrolments.

Otago is the second-ranked New Zealand university in the annual Quacquarelli Symonds (QS) and Times Higher Education Supplement (THES) world university rankings for 2016.

World Rankings

	2010 (2010/11 THES)	2013 (2013/14 THES)	2014	2015	2016	2017	2016-2017 change
THES ranking	226-250	226-250	251-275	201-250	201-250	201-250	n/c
QS ranking	135	155	159	173=	169	151	up 18

TEC-funded initiatives

- Otago's Graduate Longitudinal Study New Zealand (GLSNZ) was funded by the TEC as a Priority for Focus project. GLSNZ commenced in 2011 and aims to determine the ongoing impact of a tertiary education on 8700 graduate's lives over a 10 year timeline.
- Otago hosts the Dodd-Walls Centre for Research Excellence (CORE). Otago and the University of Auckland are co-hosting the Brain Research NZ CoRE.
- Otago is partnering with other Universities to establish the three Centres of Asia Pacific Excellence.

Current Issues

- Otago is planning to build a $14.7 million specialist dental teaching campus in South Auckland in a joint initiative with Counties Manukau DHB. This would enable Otago to take on approximately another 30 foreign students and service a region that has well-known high unmet dental needs. Otago is seeking government co-investment for this $30 million initiative.
- A new $126 million state-of-the-art Dental School is currently being built on Otago's Dunedin campus. Completion is expected in September 2019.
- Otago experienced a drop in both domestic and international students in 2015 with a 9.2% drop in first year enrolments. 2016 first year enrolments improved, but it's unlikely that this improvement will apply to 2017.

Key University and TEC personnel

- Chancellor: John Ward (Retiring Dec. 2017)
- Vice-Chancellor: Professor Harlene Hayne

TEC Contacts

- University Team Manager: Dr Dafydd Davies
- Investment Manager: Dr Bronwen Kelly

Last updated: 15/11/17 PG

Key facts about the University of Waikato (Waikato)

Waikato was founded in 1964 and is the second smallest New Zealand university by EFTS and has the highest proportion of Māori EFTS. Waikato has recently revised its areas of distinction to include civil and environmental engineering, freshwater, health and sports science.

Tertiary Education Commission
Te Amorangi Mātauranga Matua

2016 Total Equivalent Full-Time Students (EFTS) = 9,805
2016 Total Student Achievement Component (SAC) EFTS = 8,250
2016 SAC delivery compared to allocation = 99.1%

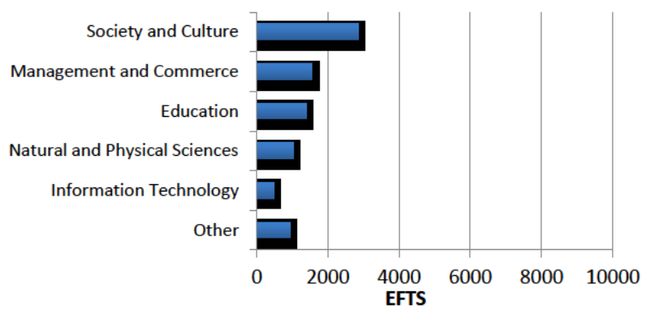
	2012 actual	2013 actual	2014 actual	2015 actual	2016 actual	2016 subsector average	2016 actual to subsector average
Undergraduate SAC EFTS	82.9%	79.5%	78.4%	78.6%	77.7%	75.2%	2.4%
Postgraduate SAC EFTS	17.1%	20.5%	21.6%	21.4%	22.5%	24.8%	-2.3%
Total SAC EFTS	8,776	8,726	8,473	8,451	8,250		
International full-fee paying EFTS	14.1%	13.9%	14.1%	15.3%	15.4%	11.9%	3.5%
Total EFTS	10,370	10,157	9,904	10,018	9,805		
% difference between EFTS delivery and allocated EFTS	2.6%	-0.9%	-0.5%	2.1%	0.0%		

- Total domestic EFTS have decreased from 8,546 in 2010 to 8,253 in 2016.

- Māori student participation rates are the highest in the subsector with 22.6% of Waikato's total EFTS being Māori compared to the subsector average of 10.8% in 2016.

Priority group participation rates	2012 actual	2013 actual	2014 actual	2015 actual	2016 actual	2016 subsector average	2016 actual to 2012 actual	2016 actual to subsector average
Māori (Level 4+)	21.8%	21.4%	22.0%	22.1%	22.6%	10.8%	0.7%	11.7%
Pasifika (Level 4+)	5.6%	6.1%	6.0%	6.7%	6.8%	8.0%	1.2%	-1.3%
Under 25 (Level 4+)	67.0%	68.6%	68.9%	70.5%	70.8%	75.6%	3.8%	-4.8%

EFTS delivery in top 5 subjects by Standard Classification of Education (NZSCED) broad field (2016)



Waikato has a proportionately higher share of SAC delivery in Education and in Society and Culture compared to those fields' share as a total of subsector delivery.

Educational Performance

Pease note: Cohort measures are only available from 2015.	2013 actual	2014 actual	2015 actual	2016 actual	2016 subsector average	2016 actual to 2013 actual	2016 actual to subsector average
All students							
Course completion	85.2%	84.7%	84.3%	85.1%	86.5%	-0.1%	-1.4%
Qualification completion (cohort)			67%	67%	63%	n/a	4.0%
First-year retention (cohort)			74%	75%	78%	n/a	-3.0%
Māori students (Level 4+)							
Course completion	80.2%	78.9%	78.3%	78.8%	80.6%	-1.4%	-1.8%
Pasifika students (Level 4+)							
Course completion	65.1%	69.4%	67.1%	70.7%	71.9%	5.6%	-1.2%

- Waikato's course completion educational performance indicators (EPIs) for all students and Māori increased in 2016, although results are still slightly below the sub-sector average.
- Pasifika course completion rate increased in 2016 although still slightly below the sub-sector average.
- Waikato's cohort first year retention is below the university subsector average however its cohort qualification completion rate exceeds the university subsector average.

Research Performance

- Ranked fifth in the 2012 PBRF Quality Evaluation with an AQS(N) score of 4.53. Its AQS(N) score is essentially unchanged compared to 2006. The highest AQS(N) score by a university was 5.51.
- By subject in the 2012 PBRF evaluation, Waikato ranked second in economics; education; marketing and tourism; and music.
- PBRF indicative funding for 2018 is $16.6 million (5% of all PBRF funding).

Financial Performance

($ million)	2008	2013	2014	2015	2016	2008-2016 change (percentage point or $)
Total revenue	188.5	228.9	229 5	241.8	251.2	62.7
Total Government funding	86 6	101.6	99.8	101.8	103.1	16.5
Net surplus/deficit (after unusual items)	-1.7	9.7	11.6	9.5	12.3	14.0
Net surplus/deficit as % of total revenue	-0.9%	4.2%	5.0%	3.9%	4.9%	5 8%
Total assets	355.5	423	457 5	473.9	485.9	130.4
Net cashflow from operations	23 3	24.2	39.6	36.5	37.8	14.5
Cashflow from operations (%)	113 2%	112 0%	120.2%	117.3%	117 2%	4 0%

Revenue source as a % of total revenue	2008	2016	2016 subsector average
Government income (including PBRF)	45.9%	41.1%	41.5%
Domestic tuition fees	17.8%	18.7%	17.8%
International tuition fees	12.5%	12.5%	10.6%
Other	23.8%	27.8%	30.1%

Audited figures

Funding

($ million)	2010	2015	2016	2017	2018	2010-2018 % change
Total TEC funding allocation	86.2	88.1	88.5	89.4	91	5.6%
SAC funding	65.1	71.1	71.7	72.6	73.3	12.6%
PBRF funding	15.5	15.9	15.8	15.8	16.6	7.1%

- Waikato successfully delivered 36 more undergraduate EFTS for Priority Engineering in 2015 compared to 2014.

World Rankings

Waikato has typically been in the lower band of New Zealand universities featured in the Times Higher Education Supplement (THES). For 2018 Waikato is up 32 places in the Quacquarelli Symonds (QS) world university rankings, placing at 292 out of the top 500.

	2010 (2010/11 THES)	2013 (2013/14 THES)	2014	2015	2016	2017	2016-2017 change
THES ranking	401+	301-350	351-400	401-500	401-500	351-400	up
QS ranking	316=	405=	405	338=	324	292	up 32

TEC-funded initiatives

- Waikato is a consortium member along with three other universities that will run the Centres for Asia Pacific Excellence. This was a competitive process run in early 2017.
- Waikato has partnered with the University of Auckland to host an ICT Graduate School based in Auckland, with satellite locations in Hamilton and Tauranga.

Current Issues

- In May 2017 Waikato was the first NZ University authorised to offer degrees at a joint institute with Zhejian University City College in Hangzhou, China. Approval was granted to enrol almost 1000 students to the NZ designed, purpose built institute which will be staffed by University of Waikato academics delivering degrees in Finance, Computer Graphic Design and Design Media.
- In August 2016 Waikato and the Waikato District Health Board proposed establishing a third Medical School in the Waikato region. The proposal is for a 4-year graduate entry programme focussed on encouraging more students to train as GPs for rural practice, and aims to encourage more Māori into medical studies. The previous government announced a contestable business case process to establish a new school of rural medicine which the new Labour-led government may take into consideration.

Key University and TEC personnel

- Chancellor: Rt Hon Jim Bolger
- Vice-Chancellor: Professor Neil Quigley

TEC Contacts

- University Team Manager: Dr Dafydd Davies
- Investment Manager: Dr Bronwen Kelly

Last updated: 15/11/2017 PG

Key facts about the University of Auckland (Auckland)

Auckland is New Zealand's largest university by EFTS and offers a comprehensive range of programmes, with particular strengths in its education, business, science, and engineering faculties and one of New Zealand's two medical schools. Its educational and research performance has been consistently strong.

Tertiary Education Commission
Te Amorangi Mātauranga Matua

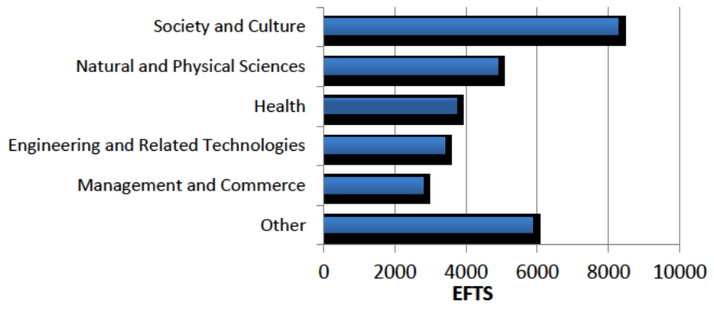
2016 Total Equivalent Full-Time Students (EFTS) = 33,102
2016 Total Student Achievement Component (SAC) EFTS = 28,935
2016 SAC delivery compared to allocation = 100.0%

	2012 actual	2013 actual	2014 actual	2015 actual	2016 actual	2016 subsector average	2016 actual to subsector average
Undergraduate SAC EFTS	72.8%	72.2%	71.2%	70.2%	69.1%	75.2%	-6.1%
Postgraduate SAC EFTS	27.2%	27.8%	28.8%	29.8%	30.9%	24.8%	6.1%
Total SAC EFTS	29,090	29,380	29,711	29,435	28,935		
International full-fee paying EFTS	9.6%	9.8%	10.3%	11.1%	11.6%	11.9%	-0.3%
Total EFTS	32,657	33,050	33,468	33,472	33,102		
% difference between EFTS delivery and allocated EFTS	1.5%	2.1%	2.6%	0.3%	-0.3%		

- One of the objectives of Auckland's strategic plan is to increase its proportion of international, postgraduate taught, and postgraduate research students to 20% by 2020.
- There is still a need for improvement in participation and particularly achievement rates for both Māori and Pasifika students.

Priority group participation rates	2012 actual	2013 actual	2014 actual	2015 actual	2016 actual	2016 subsector average	2016 actual to 2012 actual	2016 actual to subsector average
Māori (Level 4+)	7.5%	7.6%	7.7%	8.4%	8.4%	10.8%	0.9%	-2.4%
Pasifika (Level 4+)	9.2%	9.6%	10.0%	10.4%	10.6%	8.0%	1.5%	2.6%
Under 25 (Level 4+)	77.6%	78.3%	78.7%	79.2%	79.4%	75.6%	1.7%	3.8%

EFTS delivery in top 5 subjects by Standard Classification of Education (NZSCED) broad field (2016)



Auckland has a proportionately higher share of SAC delivery in Engineering, and in the Natural and Physical Sciences compared to those fields' share as a total of subsector delivery.

Educational Performance

Pease note: Cohort measures are only available from 2015.	2013 actual	2014 actual	2015 actual	2016 actual	2016 subsector average	2016 actual to 2013 actual	2016 actual to subsector average
All students							
Course completion	88.2%	88.1%	87.8%	88.7%	86.5%	0.5%	2.2%
Qualification completion (cohort)			69%	71%	63%	n/a	8.0%
First-year retention (cohort)			82%	83%	78%	n/a	5.0%
Māori students (Level 4+)							
Course completion	83.3%	83.9%	84.1%	85.2%	80.6%	1.9%	4.6%
Pasifika students (Level 4+)							
Course completion	74.0%	72.4%	73.7%	74.8%	71.9%	0.8%	2.9%

- Auckland's educational performance is consistently above the sub-sector average.
- Auckland and Otago achieved the highest EFTS-weighted course completion rates in the University sub-sector in 2016.
- Auckland's cohort qualification completion and its cohort first-year retention for 2016 are second only to Otago which is the highest in the subsector.

Research Performance

- Research performance is an area of particular strength. The 2012 PBRF Quality Evaluation confirmed that Auckland has the greatest depth and breadth of research activity. Auckland employs a greater number of research active academic staff than any other tertiary institution.
- Ranked second in the 2012 PBRF Quality Evaluation with an AQS(N) score of 5.12. The highest AQS(N) score by a university was 5.51. It would have ranked first in the 2003 and 2006 Evaluations.
- Ranked first or second in 17 subject areas. Ranked first in anthropology and archaeology; clinical medicine; and human geography, all of which are ranked in the top 10 subject areas.
- PBRF funding for 2018 is $94.2million (30% of all PBRF funding)
- Auckland has consistently earned around 30% of the total PBRF funding available, the highest proportion of any individual institution.
- Generated $163.4 million of PBRF external research income (ERI) in 2016. This is the highest amount of ERI earned by any NZ university by a considerable margin.

Financial Performance

($ million)	2008	2013	2014	2015	2016	2008-2016 change (percentage point or $)
Total revenue	788.9	973.5	1012.8	1087.7	1092.6	303.7
Total Government funding	319.5	388.8	399 3	416.4	418.6	99.1
Net surplus/deficit (after unusual items)	24 9	29.5	44.6	79.1	75.3	50.4
Net surplus/deficit as % of total revenue	3.2%	3.0%	4.4%	7.3%	6.9%	3.7%
Total assets	1574.4	1924.9	1962.8	2341 5	3243.9	1669 5
Net cashflow from operations	130.8	148.5	182 8	197.3	213.3	82.5
Cashflow from operations (%)	120 0%	118 3%	122.2%	122.2%	123.4%	3.4%

Revenue source as a % of total revenue	2008	2016	2016 subsector average
Government income (including PBRF)	40.5%	38.3%	41.5%
Domestic tuition fees	14.5%	16.0%	17.8%
International tuition fees	7.2%	7.2%	10.6%
Other	37.9%	38.6%	30.1%

Audited figures

Funding

($ million)	2010	2015	2016	2017	2018	2010-2018 % change
Total TEC funding allocation	372.4	436	441.9	448.5	457.6	22.9%
SAC funding	267.3	312.1	319.1	325.5	330.3	23.6%
PBRF funding	73.8	86.4	89.6	89.8	94.2	27.6%

- Almost $3 million of SAC funding was allocated over 2013 and 2014 to support increases in Māori and Pasifika participation.

World Rankings

Auckland is the top-ranked New Zealand university at 192 in the Times Higher Education Supplement (THES) and 82 in the Quacquarelli Symonds (QS) world university rankings. Auckland's QS ranking has remained largely steady since 2015.

	2010 (2010/11 THES)	2013 (2013/14 THES)	2014	2015	2016	2017	2016-2017 change
THES ranking	145=	164=	175=	172=	165=	192	down 27
QS ranking	68	94	92=	82=	81	82=	down 1

TEC-funded initiatives

- Auckland hosts five of the Centres of Research Excellence (CoREs): the Maurice Wilkins Centre for Molecular Biodiscovery; Te Pūnaha Matatini; Medical Technologies; Brain Research New Zealand (co-hosted with the University of Otago) and Ngā Pae o Te Māramatanga.
- Auckland is leading the Auckland ICT Graduate School consortium with Waikato University. Schools are located in Auckland, Hamilton and Tauranga.
- Auckland hosts the North Asia Centre of Asia Pacific Excellence (CAPE).
- Auckland was successful in the first funding round for the Entrepreneurial Universities initiative.

Current Issues

- Auckland is well advanced in its 20-year $2 billion facilities upgrade.
- Auckland is consolidating its activities over its Grafton, Newmarket and City campuses.
- Auckland is shifting provision to postgraduate delivery - particularly research based qualifications, boosting research output, attracting more international students, and increasing its national and international collaborations
- Auckland is focused on increasing its share of New Zealand's international EFTS.
- Auckland is reviewing its programme to support Maori and Pasifika achievement. An early result is the development of a student retention policy for implementation in 2018.

Key University and TEC personnel

- Chancellor: Mr Scott St. John
- Vice-Chancellor: Professor Stuart McCutcheon

s9(2)(a) [redacted]

Last updated: 15/11/17 PG

Appendix 6 – Summaries of each proposal

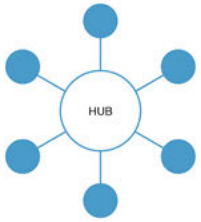
Joint proposal from the University of Auckland and the University of Otago to establish a School of Rural Health

August 2017

The problem

What is proposed?

- A National School of Rural Health (NSRH) comprising a network of up to 10 'hubs' established between 2018 and 2022.

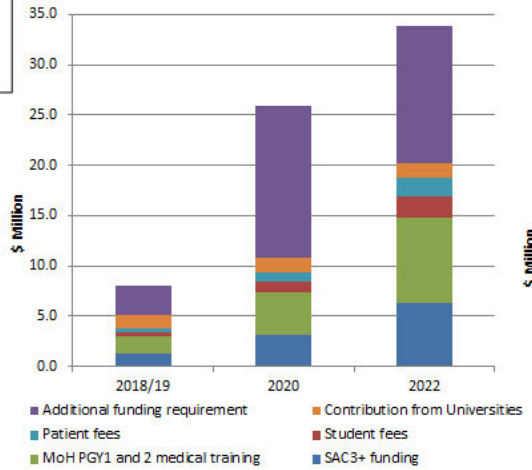


Disciplines include:
Medicine
Nursing
Physiotherapy
Pharmacy
Midwifery

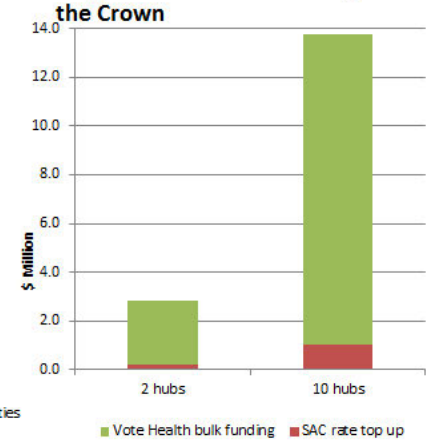
- Three options for the education on offer
  - Option 1: undergraduate, postgraduate and vocational training for medical and other health disciplines.
  - Option 2: undergraduate, postgraduate and vocational medical training.
  - Option 3: undergraduate medical training only
- The multi-discipline, multi-level option will provide the greatest benefits.

Cost: Approximately **$13.8 million additional funding per annum.** Funding will also come from existing SAC and MoH allocations, as well as student fees and fees from patients accessing healthcare at the hubs.

Sources of funding



Proposed additional funding from the Crown



Main benefits of the multi-discipline, multi-level option:

- Increased recruitment for the future workforce.
- Improved retention of the existing workforce.
- Improved rural care.
- Integrated teaching and learning.
- Partnership between multiple providers.

Main Risks:

- Evidence for long-term impact is weak.
- Unsure if it will serve greatest areas of rural need.
- Uncertain if rural practices have capacity.
- Costs may change or escalate.

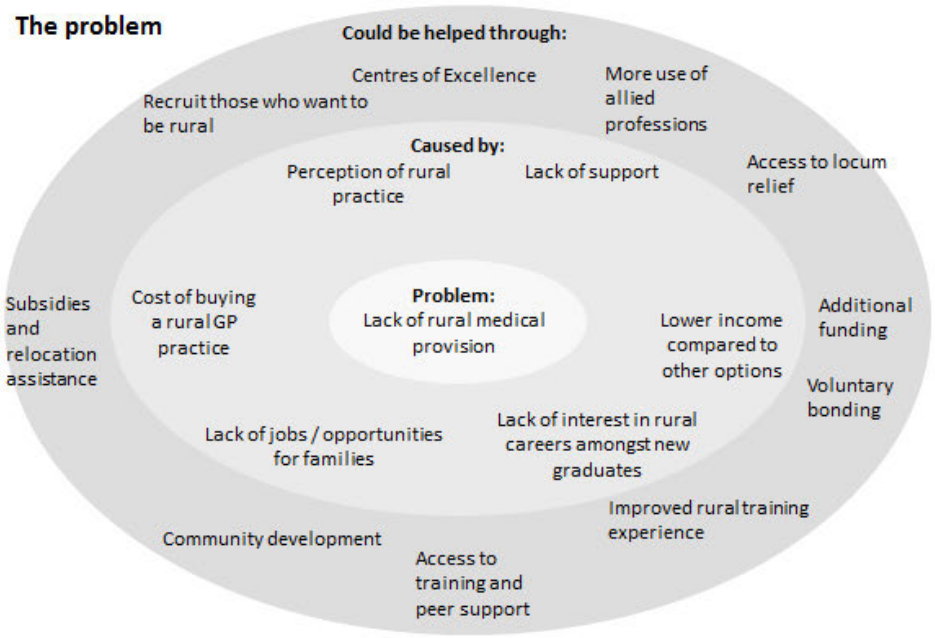
We recommend:

- The proposal to establish a multi-discipline, multi-level National SRH has several potential benefits and should be given further consideration.
- The Universities of Auckland and Otago should be asked to provide a Business Case and an Independent Quality Audit.

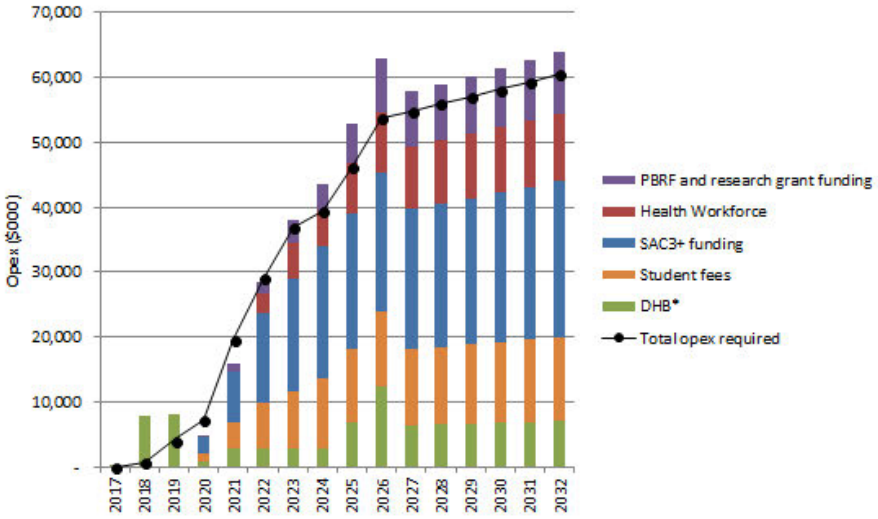
Joint proposal from The University of Waikato and Waikato DHB to establish a graduate medical school

30 June 2017

The problem



Opex requirement ($000) by source (excludes funding for vocational training)



What is proposed?

- 4-year graduate entry programme (requiring an undergraduate degree from any university in any subject)
- Training of 60 students per year from 2021
- Based in Hamilton, but incorporating 12-15 rural training centres

Capex funding required by source 2017-2026

Capex	Total 2017-2026 ($ million)
Medical School Facilities	$70.0
Rural Health Centres	$40.0
Programme/curriculum development	$21.7
Total capex	$131.7
Capex sought from government	**$111.7**
Philanthropic capital funding	$20.0

Main benefits of the proposal

- Based on successful international models
- Recruitment model shown to build interest in rural careers
- Enhanced rural training experience

Main Risks:

- Significant investment required – seeks government capital funding of $111.7 million and operational expenditure would largely come from government sources (SAC, DHB, Health Workforce NZ)
- Costs could significantly escalate
- Benefits may be overstated/not delivered

Options:

- Support and fund proposal – either in full or in part
- Support in principle, but request more information
- Defer decision
- Decline

Appendix 7 – Comparison of existing proposals

	Waikato Proposal	Auckland/Otago proposal
Proposing consortium	University of Waikato, Waikato DHB.	University of Auckland, University of Otago.
Estimated cost	*Capital expenditure:* $111.7 million. *Operational expenditure:* $100 million during establishment phase. $75 million approximately per year on-going when fully established.	*Capital expenditure:* Uncertain. *Operational expenditure:* $13.8 million per year ongoing.
Location and model	Based at Waikato Hospital in Hamilton with rural clinical training centres established at other locations throughout the 'midlands' of New Zealand (the area covered by Waikato, Bay of Plenty, Lakes, Tairawhiti and Taranaki DHBs).	National network of 10 'hubs' linked to the existing University of Auckland and Otago medical schools.
Scalable	No.	Yes – in terms of number of hubs and breadth of provision.
Provision	Four-year graduate-entry medical programme.	Clerkships and rotations for existing medical students.
Number of students	60 additional per annum.	310 students from within existing cap comprising six full-year clerkships per hub and 25 students on rotation per hub.
Type of students	Medical students.	Medical undergraduate, postgraduate and vocational training. Undergraduate and postgraduate allied health professions.
How it addresses maldistribution of doctors	Delivering medical graduates that are more likely to choose a rural career.	Delivering medical graduates that are more likely to choose a rural career. Supports alternative models of care through provision for other health professions. Improved retention of the existing workforce through professional development, networking and support opportunities.
Supporting evidence for success	Based on models used in Canada (Northern Ontario School of Medicine) and Flinders University (South Australia).	Based on regional and rural admission schemes currently in place at the Universities of Auckland and Otago, the Rural Clinical School of Western Australia and on models used in Canada e.g. the Northern Ontario School of Medicine.