



# **The Waikato Medical School**

The Case For A Community-Engaged Graduate  
Entry Medical School in New Zealand

# Why Are We Discussing a Third Medical School?



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- There is no shortage of doctors in most OECD countries. NZ is unusual –
  - In 2014, 43.4% of medical workforce was trained outside NZ
  - Ongoing reliance on IMGs for 30% of workforce
- We have critical health workforce shortages in primary care, and outside the main centres
  - A looming crisis in general practice.
- How could it be that in the long term New Zealand cannot train enough doctors to meet its workforce needs, including areas of workforce shortage?

- Total doctor numbers increase year by year in response to:
  - Population growth – including net migration which at present is adding a requirement for 50 extra doctors each year
  - Increasing demand due to ageing population
  - Increasing interventions
  - Reduction of doctor's hours worked
- Failure to meet the demand for doctors in provincial and rural communities contributes to a disparity in health outcomes, and additional health system costs
  - For example, patients do not seek treatment early, have more advanced conditions requiring more medical intervention and use the emergency department as a general practice.

# Rationale for a third Medical School



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- Only a third medical school can address the problem, and even then, only if it is as different as possible from Otago and Auckland.
  - Proposal assumes that Auckland and Otago will continue to do what they do now, and what they do well.
  - The point of more medical education places has to be different workforce outcomes
- The cost of a third medical school *per se* is not high. The vast majority of the cost of the proposal is the cost of addressing the health workforce problems that we have:
  - 60 extra places,
  - the facilities to train in different locations in different ways, and
  - the postgraduate training funding.

Will offer a medical degree programme which reflects international best practice. Specifically it will be:

1. Graduate entry only (requiring an undergraduate degree from any university in any subject)
2. Four years in length rather than the five years
3. Community engaged, involving communities outside the tertiary hospital centres in the design of the programme, selection of students, and training of students
4. Proactive in adding to rather than utilising existing clinical placement opportunities for medical students
5. Built in partnership with the DHBs from the central North Island
6. An opportunity to build a new medical school in genuine partnership with Māori and with other high health needs communities.

# General Undergraduate Degree Pathways



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International evidence suggests that In problem-based graduate entry programmes,

- Students from non-science undergraduate degrees do as well as students from science degrees
- Different workforce outcomes are obtained when medical schools accept students from general backgrounds.
- Different learning dynamics are created in medical classrooms where science and humanities students are mixed together and bring different perspectives to their work.

Long experience of taking students from generalist backgrounds, and of the results. Mount Sinai Medical School, New York:

- HuMed students are more likely to choose primary care (49.4% vs 39%), and more likely to choose Psychiatry (13% vs 7%).

Key elements benchmarked against best practice internationally are:

- A student selection and admissions process that reflects engagement with communities
- A substantial proportion of clinical learning occurring in community clinical settings in which the doctors would undertake postgraduate training and be expected to practice after graduation
- An ethos focussed on provincial and community-based care and on a duty to serve these populations

Aims: 50% of graduates choosing general practice as a specialty with a commitment to practise outside the main centres,

High proportion of the remaining 50% choosing a specialty and sub-specialty relevant to provincial and rural workforce needs (including psychiatry).

# What will Waikato graduates look like?



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- Graduates who are different in kind but not in quality from those whom the University of Auckland and the University of Otago produce.
- Waikato CEGEM graduates will:
  - Have personal characteristics that are a good fit for front-line clinical care, especially where excellent empathy, communication skills and capacity for inter-professional teamwork are key attributes
  - Have a passion for community-based primary care
  - Have a deep understanding of the needs of rural and provincial high needs communities and be willing to serve those communities and meet the needs of the populations living outside the main centres
  - Be technology savvy and able to integrate new virtual health care technologies with the cultural knowledge appropriate to the communities they serve.



# Mix and match approaches do not work



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- The factors associated with high proportions of students electing specialties and locations that meet rural and provincial workforce needs identified in the literature need to be integrated into a holistic medical education approach.
- They will not work when instituted in isolation
  - rural background recruitment in a traditional undergraduate programme does not significantly change workforce outcomes.

The Waikato Medical School proposal offers

- Student selection processes, an ethos and clinical experience that focuses 100% of each student cohort on primary care
- The development of regional health centres supporting sustained student and postgraduate learning in inter-disciplinary learning and culturally responsive regional centres



# End of Presentation