Hon Dr Shane Reti

Minister of Health
Minister for Pacific Peoples

Hon David Seymour MP
Associate Minister of Health (Pharmac)
d.seymour@ministers.govt.nz

Dear David

Waikato Medical School Cost-Benefit Analysis

Thank you for your letter of 21 August 2024 responding to the Waikato Medical School cost-benefit analysis (CBA). I appreciate the time your office took to review and engage with the independent CBA provider (Sapere) and officials from the Ministry of Health (the Ministry). I welcome your questions about the CBA methodology and evidence base.

In your letter, you raised three main points which I respond to below, specifically:

1. that the quantitative analysis includes only graduates who opt to be general practitioners (GPs).

2. whether we can rely on Australian evidence establishing causation from changed medical education to increased propensity to be a GP.

3. the options considered in the CBA (which you recognise were directed by Cabinet decisions).

I also attach a memorandum from Sapere to the Ministry, which responds to these and other issues raised in your letter. In Sapere's memorandum, its Managing Director states that they stand behind the independent CBA's outcome and notes that all options have positive NPVs.

- *Including graduates who chose to work in hospitals as a qualitative benefit*

Sapere notes that they made the judgement that the non-GP graduates should be included as a qualitative benefit, to focus the quantitative analysis of the CBA on the investment objectives agreed by Cabinet. Sapere notes that they could explore monetising these benefits and the additional costs, but that it would be a very complex undertaking.

In the health sector, with complex measurement issues, economic evaluation would typically include both qualitative and quantitative benefits. While the NPV and Benefit Cost Ratio are very important, the Ministry would expect the findings to be considered wholistically, with recognition of the non-monetised benefits alongside those that have been monetised.

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand | +64 4 817 6803 | s.reti@ministers.govt.nz

The Ministry advises me that the costs associated with hospital-based doctors are often much higher than those associated with GPs since hospital-doctors usually require more support staff and substantial additional capital and equipment including, for example, theatre time for surgeons. It is also more difficult to identify the individual impact of hospital-based doctors in the complex system that is secondary and tertiary care. For example, it is difficult to isolate the impact of an emergency care clinician, relative to the other staff and facilities in the department and associated parts of a hospital.

The Ministry also note that it is not usual to apply the concept of "full" or "partial" to an economic evaluation. This is because the complexity or comprehensiveness of an analysis is generally a judgement based on factors such as information required for the decision, availability of evidence and information, complexity of the decision problem, and analytical time and resources.

In most economic evaluations, some form of "stopping rule" needs to be applied to quantifying benefits and costs. The fundamental consideration relating to "stopping" before monetising non-GP costs and benefits relates to whether this would provide substantive information and improve the decision, or whether their inclusion would introduce further uncertainty which, given the level of complexity, is very likely.

- *Whether Australian evidence is a reliable basis for assuming causality from changed medical education to increased propensity to be a GP*

I note that in their memorandum, Sapere provides substantive justification for the assumption that it is the change in the medical education model that influences propensity to be a GP, rather than there being only a "selection" effect of potential GPs into the new medical education model.

Sapere also note that given the very small evidence base they established and worked with a panel of medical education experts, whose expert judgements were brought to issues such as establishing causation. The Ministry notes that in the health sector with its many intangible variables, it is sometimes possible to use natural experiments to establish causation. But the Ministry notes that this is the gold standard, and we often have to rely on qualitative evidence combined with expert judgement.

- *Choice of options in the CBA*

As noted in your letter, the options considered in the CBA were agreed to by Cabinet earlier this year. Investing in increased medical education capacity is a Government priority, so it was appropriate to focus the analysis on viable medical education options. The options are not strictly mutually exclusive, and any investment in a new medical school does not rule out the consideration of other initiatives (both related to medical education and wider workforce initiatives) to increase the number and distribution of doctors in our workforce.

In conclusion, it is worth noting that at this point in the process of developing a business case, Treasury's Better Business Case guidelines expect only 45% of the economic case (which this CBA informs) of a project to be completed. Further testing of assumptions and strengthening of the economic case will be completed in the Detailed Business Case and will

include consideration of the points you have raised. This work remains compliant with relevant best practice and in line with expediated timeframes.

As you know, under the Coalition Government's Quarter 3 Action Plan, it is a priority to "take Cabinet decisions on the programme business case, including cost-benefit analysis, for a proposed third medical school at Waikato University." Therefore, I intend to take a paper to Cabinet on this matter, and look forward to discussing it further with our Cabinet colleagues.

Yours sincerely,

Hon Dr Shane Reti
Minister of Health

Attached: Sapere Memorandum to the Ministry of Health, 22 August 2024