Costs of Implementing the Generic Public Health Competencies

1. Executive Summary

To assist the Ministry of Health with implementation planning and decision making, PHANZ, on behalf of the Core Competency Project (CCP), commissioned Strategic Policy Consulting Ltd to estimate the cost of implementing the generic public health competencies. The cost we have estimated (working collaboratively with the CCP) is necessarily of a 'ballpark' nature at this stage, because it is based on information regarding several important factors about which there is some degree of uncertainty. These factors include: the size of the existing public health workforce in different professional sub-groups; the extent to which different sub-groups in the existing public health workforce require training to achieve the generic competencies; the approach to be adopted to deliver training and assessment to those requiring it and the magnitude of costs arising from adopting that approach.

The analysis begins by exploring the possible approaches that could be adopted for implementing the generic public health competencies, and recommending a multipronged approach. The recommended primary approach is a 'sector-based in-house' model, linked to the New Zealand Qualifications Framework. A 60 credit qualification, the National Certificate in Public Health, would be registered by an ITO with NZQA, and public health personnel with relevant expertise would be trained as trainers and workplace assessors, to deliver regionally-based training in the workplace to Public Health Unit and NGO staff who required it. Complementing this, polytechnics and other tertiary providers may also choose to offer courses which enabled achievement of the National Certificate in Public Health.

The likely additional direct financial costs of implementing the primary approach over a six year time frame (2008/09 – 2013/14) are estimated at between $2.41 million - $3.67 million to provide upskilling to between 63 – 78% of the existing public health workforce. In addition, there would be reductions in public health outputs during this period as a consequence of the time involved in training by both trainers and trainees which could not be devoted to their usual work. This investment should yield benefits in subsequent years in terms of greater achievement of public health outcomes.

2. Approaches to Implementing Generic Public Health Competencies

2.1 NZQF-based

A key implementation decision is whether or not to incorporate the generic public health competencies within the New Zealand Qualifications Framework (NZQF). What this would involve, and the pros and cons of adopting this course of action are outlined below.

To achieve incorporation in the NZQF and to have access to workplace training subsidies, unit standards would need to be developed and registered with the New Zealand Qualifications Authority (NZQA) by an industry training organisation (ITO).

Of these, the Public Sector Training Organisation (PSTO) appears to be the most relevant to the public health sector. PSTO is the recognised standard setting body for the public sector and can provide subsidies to support the cost of training and development in the state sector, as well as standard setting and qualification development, assessment resource development, workplace assessment (including assessment for recognition of current competence), and brokerage of training providers. The Ministry of Health is already a member of PSTO, although none of DHBs or public health NGOs are.

The unit standards which the ITO (possibly PSTO) would register would specify learning outcomes - that is, what a learner needs to know or be able to achieve. Anyone assessed by a registered workplace asssessor as having achieved all the unit standards associated with the public health competencies could then be granted a National Certificate in Public Health. Those within the public health workforce who need to complete only some of the competencies would have their completion of unit standards for those competencies recorded on their record of learning by NZQA, but would not receive the full qualification.[1]

Clearly there are some costs involved in developing unit standards, and additional time involved in developing and registering them before training can commence. However the CCP advocates incorporating the generic public health competencies in the NZQF because this will facilitate national consistency in training standards, and will most effectively promote skill and career development in the public health sector. This is particularly important for those occupational groups within the public health workforce who currently do not have access to a specialist tertiary level qualification (such as community health workers).

2.2 National Certificate in Public Health

Analysis of the competencies in the light of knowledge about other NZQF-based qualifications leads the CCP to the view that overall the National Certificate in Public Health could constitute a qualification encompassing 60 credits at Levels 4 and 5 of the NZQF. The expected distribution of credits by competency is as summarised in Table 1.

[1] Recognition of prior learning could, ultimately, allow them to gain the full qualification.

Table 1: Estimates of credits and training time needed to complete the generic public health competencies

Competencies	No. of credits	Total learning time (hours)	Training time - face-to-face (hours)	Self directed - includes workplace learning and mentoring (hours)
Public Health Knowledge				
1. Health Systems	6	60	15	45
2. Public Health Science	6	60	15	45
3. Policy, Legislation, and Regulation	6	60	15	45
4. Research and Evaluation	6	60	15	45
5. Community Health Development	4	40	10	30
Public Health Practice				
6. Te Tiriti o Waitangi	6	60	10	50
7. Working Across and Understanding Cultures	6	60	10	50
8. Communication	4	40	5	35
9. Leadership, Teamwork, and Professional Liaison	4	40	5	35
10. Advocacy	4	40	5	35
11. Professional Development and Self Management	4	40	5	35
12 Planning and Administration	4	40	5	35
Total	**60**	**600**	**115 (20 days)**	**485**

2.3 Options for delivering the training

In regard to how NZQF-based training should be delivered to the public health workforce, there are a number of alternative options. The CCP has identified two broad models, which can be characterised as the 'sector-based in-house model' and the 'polytech-based tertiary model'. Their broad features are outlined below, and their pros and cons analysed.[2]

[2] University-based tertiary training in public health is not considered as an option for delivery of the foundation public health training because it is not NZQF based, and it is typically at a post-graduate level. The more research-based and higher level university training is something that some members of the public health workforce will continue to take up subsequently as they further specialize at later stages in their

In both models, a necessary prior step is ensuring that the unit standards are developed and registered by an ITO. To ensure the concentrated effort required to achieve this is applied, the CCP recommends that this work be contracted out to an organisation with specialist expertise in unit standard development, working with a public health reference group. Using the same reference group the CCP assembled to guide development of the public health competencies would ensure continuity. The objective should be to have the National Certificate in Public Health registered by an ITO with NZQA by the end of the 2008/2009 financial year.

2.2.1 The 'sector-based in-house model'

This model would involve the Ministry of Health or an organisation contracted by the Ministry of Health fostering development within the public health sector of the expertise and other infrastructure required to enable training in the public health competencies to be delivered 'in-house' on a regional basis. The training delivered would be available to staff of both Public Health Units and NGO's, environmental health staff employed by local government and other public health practitioners.

2.2.1.1 Training the trainers and assessors

To build a pool of skilled trainers who are capable of successfully delivering the courses in house requires drawing on the wealth of professional expertise already available within the public health sector, in both Public Health Units and NGO's. This professional public health expertise needs to be coupled with training expertise to ensure that learning is maximised for those who participate in training. Under this model, this could be achieved by pro-actively identifying PHU and NGO staff around the country with relevant expertise to become trainers, and sponsoring them to undertake the a qualification in adult education, such as the Open Polytechnic National Certificate in Adult Education and Training.[3] They would then need to register with an ITO as workplace assessors.

2.2.1.2 Developing Training Content

Under the 'sector-based in-house' model, there would also be a need to develop training material which the trainers could utilise. This could be incorporated in the contract for unit standard development or contracted for seperately. This contract would include reviewing the materials used in existing courses run by Public Health Units and NGO's

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career path. The CCP sees the university-based public health programmes as complementary to either of the two models for providing foundation training and development in public health outlined in this report.

[3] This workplace training and assessment pathway of the Open Polytechnic's National Certificate in Adult Education and Training constitutes 7 unit standards, taught in three modules, and constitutes a 43 credit qualification at Levels 4 and 5 in the NQF. This includes unit standard 4098 (use standards to assess candidate performance) which all workplace assessors require in order to be registered with an ITO as capable of assessing unit standards in the workplace. The National Certificate is entirely undertaken as distance learning, with an expected total learner time commitment of 430 hours.

on aspects of the competencies (e.g. on the Treaty of Waitangi, and communication skills).

2.2.2 The 'polytechnic-based tertiary' model

This model would involve one or more polytechnics or wananga choosing to deliver the National Certificate or to develop their own certificates. This could arise from their own assessment of a potential market, or through the Ministry pro-actively encouraging polytechs and wananga to develop programmes.

An example of polytech-based training which has developed in another part of the health sector is the National Certificate in Mental Health Support Work, a 122 credit qualification offered by Nelson Malborough Polytechnic and aproximately 20 other tertiary providers around the country – in conjunction with Careerforce, the Community Support Services ITO.

Having developed course materials and content and contracted in staff with relevant expertise to utilise it to provide training, the polytechnic provider(s) would then advertise the availability of their courses. PHU, NGO and relevant local government public-health related staff would then opt to register with them to undertake training as they saw fit.

2.2.3 Pros and cons of the alternative models for delivering training

On the cost side, the 'sector-based in-house model' requires investment in training expertise and in the internal administration associated with running courses, organising course assessment etc which tertiary sector organisations already have in place.

The CCP considers, however, that this investment is likely to pay dividends in terms of overall improved capability to foster skill development within the public health sector which would spill-over outside of explicit 'course delivery' times. The stronger overall internal focus on building a community of learning in the workplace is likely to enhance the motivation and capability of public health staff in an ongoing way. This in turn may improve staff satisfaction (of both trainers and others), and improve staff retention – which the Phoenix Research report on the public health workforce[4] identified was an issue. This should improve public health outcomes, as staff have a clearer idea of what they should be achieving, and of the most effective ways of achieving it and ongoing internal support for doing so. Regional provision of training around the country would also reduce travel and accomodation costs relative to the alternative polytechnic model.

For the tertiary-based polytechnic model, polytechnics or wananga providers would be drawing on their existing expertise in and infrastructure for training delivery. This may mean that the public health sector would benefit from some economies of scale in the cost of training delivery. However they would need to draw expertise out of the public health sector to deliver some of the course content, particularly for the public health

[4] Phoenix Research (2004), Public Health Workforce Development Research – Surveys of Organisations and Individuals, 2003/04, p 98 – 103,

knowledge competencies. It is likely a lower proportion of the content would be delivered by those with public health sector expertise than in the 'in-house' model, which may reduce the relevance and ease of applicability in a work setting of what is learned. As it is likely training would be available in a limited number of the larger centres, the overall costs of travel and accomodation of trainees would be higher under the tertiary model.

In light of this analysis of the pros and cons of the different models for implementing the generic public health competencies, the CCP recommends that the primary approach adopted be the 'sector-based in-house' model. This is the model for which cost estimates have been undertaken in the following section. However it would be a good outcome if some polytechs also chose to offer the National Certificate in Public Health, once it is registered on the Qualifications Framework. The continuing existence of the university-based degree programmes in public health will continue to provide a valuable source of public health knowledge and expertise. The CCP sees these as complementary rather than competing endeavours.

3. Costs of implementing the 'sector-based in-house' model.

The costs of implementing the generic public health competencies via a 'sector-based in-house' model for the costs have been estimated over a six year time-frame, from 2008/09 to 2013/14 financial years. This time frame is recommended by the CCP because given the estimated volume of training provided, the impacts on public health sector outputs from having so many people occupied in training would be too great if a shorter time frame was adopted.

The sequence of events involved over this time frame would be as outlined in Table 3.

Table 3: Key activities and milestones in implementing generic public health competencies, 2008/09 to 2013/14

Year	Activities Undertaken & Milestones Achieved
2008/09	• Identify preferred standard setting body (e.g PSTO or other ITO) • Let contract(s) for development of unit standards for National Certificate in Public Health and for development of course materials • Potential trainers within the public health sector identified
2009/10	• National Certificate in Public Health registered by NZQA • Trainers commence National Certificate in Adult Education and Training • Training material developed is workshopped with and disseminated to trainers • Managers in PHU's, NGO's and in local government assess staff during performance assessment process against unit standards to identify who needs training in what
2010/11	• Trainers complete National Certificate in Adult Education and Training or equivalent (including elements that require having students

	undertaking courses to assess) • Trainers register with ITO as workplace assessers • Sufficient courses run to meet first quarter of assessed training needs • Staff who undertake courses are assessed and outcomes achieved are registered on individuals' record of learning
2011/12	• Trainers renew registration with ITO as workplace assessers • Sufficient course run to meet second quarter of assessed training needs • Staff who undertake courses are assessed and outcomes achieved are registered on individual's record of learning
2012/13	• Trainers renew registration with ITO as workplace assessers • Sufficient course run to meet third quarter of assessed training needs • Staff who undertake courses are assessed and outcomes achieved are registered on individual's record of learning
2013/14	• Trainers renew registration with ITO as workplace assessers • Sufficient course run to meet final quarter of assessed training needs • Staff who undertake courses are assessed and outcomes achieved are registered on individual's record of learning

The following costing is undertaken on the assumption that, once trained in adult training and education, workplace-baseed training providers only require registration as assessors with PSTO (or whichever ITO the unit standards are registered through), and the courses they run do not require registration with NZQA. The focus is on costing elements of expenditure that are 'additional' to business as usual, and would require specific funding approval outside existing budgets. Where existing internal resources would be drawn on, the likely person-time involved is estimated, but the financial value of the resource has not been estimated.

3.1 2008/2009 and 2009/10 costs

Based on feedback from a standards development contractor regarding the costs associated with developing and registering unit standards in other areas of public sector activity, it is likely that provision needs to be made for between $8,000 - $10,000 for the public health unit standards development. This would include checking the public health competencies against the unit standards already registered with NZQA to identify if any existing unit standards cover the required learning outcomes, and developing unit standards for all learning outcomes not already incorporated in the Qualifications Framework. This contract or a separate contract should include a further $8,000 - $10,000 for a survey of existing course materials and the development of new course materials.

Possibly the ITO may be able to contribute to or cover the costs of the unit standard development within their budget. Should the ITO be PSTO, they have indicated that this would depend on the degree of Ministerial priority associated with this project, relative to those required for other parts of the public sector workforce. Should it be necessary for

the Ministry to fund unit standard development, it is assumed that the contract could be developed and monitored within the Public Health Directorate of the Ministry of Health by existing personnel hence no additional funding would be required for that. At most this is expected to occupy 2 - 3 working days of Public Health Directorate personnel time.

The costs to identify potential trainers within the public health sector should also be able to be incorporated inside existing budgets.

Estimates of the cost of training trainers are based on the costs associated with undertaking the Open Polytechnic National Certificate in Adult Education and Training. This costs $1001.65 for the full 7 unit standard 60 credit programme, assuming all the unit standards are completed within one year. An additional administration fee of $45 per year is charged if a candidate takes more than one year to undertake the qualification. The number of senior public health practitioners who need to undertake this programme of study to become qualified trainers is dependent on how many people in the wider public health workforce require training to achieve what proportion of the public health competencies (which is estimated in section 3.2 below). The CCP considers that in the order of 20 – 25 trainers would be required[5], which means an estimated cost of between $20,033 and $25,041.25 in course and administration fees split between 2009/10 and 20010/11 financial years.

Training materials developed as part of the contract let in 2008/09 need to be disseminated to trainers in 2009/10. It would be beneficial if they could meet as a group, and 'workshop' the materials with the contractor. Assuming 20-25 trainers, two thirds of whom have to fly to Wellington for the one-day workshop which is delivered in Ministry off Health premises where catering is the only additional delivery cost, funding of between $6,000 and $7,500 would be required.

To enable public health training to be properly targeted, managers need to assess their staff's knowledge and capabilities against the performance criteria specified in the public health unit standards (once they have been developed). This will enable them to identify which staff need training to achieve which unit standards. While this will take manager and staff time to achieve, it is assumed this can be undertaken as part of the annual performance review process, and that no additional resources are required to fund it.

3.2 2010/11 to 2013/14

[5] If there were 20 trainers, and the numbers requiring training were the equivalent of 1190 people undertaking a full 60 credits of training (the upper range estimated later in this report), and the training was spread over four years, then each trainer would be responsible for the equivalent of 15 people studying for 60 credits per year. For 25 trainers, it is the equivalent of 12 people. This seems a reasonable level of part-time commitment for senior public health practitioners who still need to undertake their other public health responsibilities during the year.

The bulk of the costs of implementing the generic public health competencies will fall in these four financial years, as those identified as requiring training undertake courses and assessment delivered by the sector-based trainers. The objective would be to bring all existing public health sector staff up to 100% competency in all generic public health competencies by the end of the four year period.

In order to estimate these costs, the CCP has asked members of the CCP reference group for this project with a good understanding of both the public health competencies and the specific professional groups involved, to provide a broad assessment of the extent to which training is required by each group . Those providing the assessments warned, however, that these are at best 'informed guesses'. The size of the public health workforce is also not known with certainty. Table 4 summarises the currently available workforce data and these 'informed guesses' by sector experts, and the consequent implications for how many people need training in how many credits.

Table 4: Training requirements of public health workforce to achieve all generic public health competencies

Professional Group	Number employed [6]	Percentage of the workforce requiring training[7]	Percentage of the competencies needing to be addressed by training[8]	Number requiring training[9]	Average number of credits required [10]	Numbers requiring the equivalent of '60 credit' units of training[11]

[6] For all but public health nurses and environmental health officers, the overall size of each professional group is based on information in the report by Phoenix Research ,'Public Health Workforce Development Research – Surveys of Organisations and Individuals, 2003/04'. Specifically, the breakdown by professional group for 133 of 207 organisations funded by the Public Health Directorate of the Ministry of Health in the table on pages 26 to 27 of the Phoenix Research Report have been multiplied by 1.21. This is the factor that Phoenix Research estimated (after undertaking follow-up phone calls to organizations who had not completed the survey) should be applied to the surveyed total public health workforce to derive the size for all 207 organisations. For public health nurses, the estimated number (509) is sourced from Nursing Council of New Zealand registration data for 2004 regarding the number of registered nurses who stated their area of practice was public health nursing For environmental health officers the estimated numbers (158) were provided by the Environmental Health Institute. Where professional groups have been divided into two sub-groups, the allocation of the total numbers between the two groups is based on 'informed guesses' undertaken by relevant people on the CCP reference group.

[7] 'Informed guess' undertaken by relevant people on the CCP reference group.

[8] 'Informed guess' undertaken by relevant people on the CCP reference group. Differences in views of different CCP reference group members are represented by a range (e.g. 50% - 60%).

[9] The numbers requiring training are derived by multiplying column 2 by column 4.

[10] The average number of credits required is derived by multiplying column 3 by 60, which is the estimated number of credits for all public health competencies.

[11] The number requiring the equivalent of '60 credit' units of training' is derived as (column 5 x column 6)/60.

NGO managers/advisers	307	70%	50%	214.9	30	107.5
Public health nurses with signif. qual and/or experience	356	60% -100%	50%	213.6 - 356.0	30	106.8 -178.0
Public health nurses (other)	153	80% -100%	80%	122.4 - 153.0	48	97.9 -122.4
Health promoters with signif, qual. and/or experience	66	5% - 30%	30% - 40%	3.3 - 19.8	18 - 24	1.0 – 7.92
Health promoters (other)	593	60% -75%	50%- 80%	355.8 - 444.7	30 - 48	177.9 -355.8
Health protection officers (recent graduates)	46	70%	25%	32.2	15	8.1
Health protection officers (others)	104	50%	35%	52.5	21	18.2
Environmental Health Officers	158	90%	50%	142.2	30	71.1
Community Health Workers	348	60% - 95%	50% - 75%	208.8 - 330.6	30 - 45	104.4 - 250.0
Policy analysts	61	50%	30%	30.5	18	9.2
Allied Health (discipline specific e.g. dietitians)	35	30%	20%	10.5	12	2.1
Allied Health (non-specific)	137	70%	70%	95.9	42	67.1
Total	**2,364**			**1,499.1-1,866.3**		**778.3 – 1,190.5**

In summary: for a total estimated public health workforce of 2,364 people, it is estimated that between 1499 and 1866 (63% - 78%) will need some degree of training to achieve competence in all the public health competences. The total volume of training they are estimated to require is the equivalent of between 778 and 1190 people requiring training in all 60 credits of the proposed National Certificate in Public Health.

Delivery of training and assessment will give rise to a variety of different types of costs, which are summarised in Table 5. This is based on a model of 5 day block courses each constituting 15 credits, with two trainers and 20 trainees per course. Some types of costs will require 'in kind' donations of resources from employing organisations, while others will require additional expenditures that require new funding. The table distinguishes each, with 'in kind' contributions identified in volume terms, and an estimate of financial costs provided for those where additional funding will be required. Note that it is assumed that as training is delivered regionally, half the trainers and trainees do not require any travel or accomodation costs to be met.

Table 5: Elements of costs in delivering training courses and assessment

Item	'In kind' contributions	Cost
Enrolment brochure printing		$200
Mailout to course participants		$80
Trainers time (preparation and course contact time)	5 days contact and 1.7 days preparation per trainer	
Trainers travel costs		$100 (1 trainer x $100 airfare or vehicle costs)
Trainers accomodation		$520 (1 x 4nights x $130 per night)
Trainees time	5 days per trainee	
Trainees travel		$1,000 (10 x $100 air fare or vehicle costs)
Trainees accomodation		$5,200 (10 x 4 nights x $130 per night
Training rooms	Free if provided 'in-house'	$750 ($150 per day x 5 days)
Training equipment (OHP/projector and laptop/TV and video	Free if provided 'in-house'	$1000 ($200 per day)
Catering		$3,500 (20 people x 5 days x $35 per day)
Course materials (folder, paper, copying)		$500 (20 x $25 per person)
Post-course follow-up	20 hours (20 people x half hr per trainer x 2 trainers)	
Post course assessment	40 hours (20 people x 1 hr per trainer x 2 trainers)	
NZQA student registration record of learning		$500 ($25 per student x 20)
Unit standard credit fee		$1800 ($6 per credit x 15 credits x 20 students)
Total		**$15,150**

On a worst case scenario (where training rooms and training equipment must be hired), on a per-person basis, it would therefore cost $757.50 per 15 credit course per person ($15,150 divided by 20), and four times that, or $3,030 per person, to undertake the equivalent of 60 credits. For between 778 and 1190 people requiring the equivalent of 60 credits, the total estimated cost would therefore be in the range $2,358,855 - $3,605,700.

A further assumption is that during this period, when both trainers and trainees are required to devote quite a lot of work-time to training (both in classroom and outside of it), the contracted deliverables required by the Ministry of Health from PHUs and NGOs are correspondingly reduced.

The final cost falling in the 20010/11 to 2013/14 financial years is registration of workplace assessors with NZQA. This is free for staff of member organisations, but for staff employed by non-members (like DHBs and NGOs) costs $281.25 initially and $125 per year thereafter with PSTO. These costs are taken as being representative of ITOs in general. In the initial year, for 20 – 25 workplace assessors, this would require funding of $5,626 - $7,031. In subsequent years it would cost between $2,500 and $3,125.

3.3 Summary of financial costs

Across the six fiscal years, the estimated costs requiring additional funding to bring all public health staff up to 100% competence in all generic public health competencies are:

Financial year	Source of costs	Amount (lower range)	Amount (upper range)
2008/09	Contract to develop unit standards and training materials	$16,000	$20,000
	Sub-total	***$11,000***	***$20,000***
2009/10	Trainers enrolled in National Certificate in Adult Education and Training	$10,016	$10,016
	National workshop on training materials and course delivery	$6,000	$7,500
	Sub-total	***$16,016***	***$17,516***
2010/11	Trainers enrolled in National Certificate in Adult Education and Training	$10,016	$10,016
	Training delivery and assessment of quarter of workforce requiring training	$589,714	$901,425
	Workplace assessor registration fees with ITO	$5,626	$7,031
	Sub-total	***$605,356***	***$918,472***
2011/12	Training delivery and assessment of quarter of workforce requiring training	$589,714	$901,425
	Workplace assessor registration fees with ITO	$2,500	$3,125
	Sub-total	***$592,214***	***$904,550***

2012/13	Training delivery and assessment of quarter of workforce requiring training	$589,714	$901,425
	Workplace assessor registration fees with PSTO	$2,500	$3,125
	Sub-total	***$592,214***	***$904,550***
2013/14	Training delivery and assessment of quarter of workforce requiring training	$589,714	$901,425
	Workplace assessor registration fees with PSTO	$2,500	$3,125
	Sub-total	***$592,214***	***$904,550***
All years	**Total**	**$2,414,014**	**$3,669,638**

Decisions would need to be reached about how the these costs were financed. Possible funding sources include the Ministry of Health, with additional government funding obtained for this purpose, existing training and development budgets of PHUs and NGOs, and government training subsidies via an ITO.

In the case of PSTO, where it provides public sector employers with training subsidies these are at a rate of $15.50 per credit where training contracts are registered with PSTO - although once credit administration fees, NZQA registration and NZQA certification fees are netted off, this is in the order of $12.80 per credit. If PSTO was the preferred ITO, there is still the question of whether these subsidies would be available when the main employers (DHBs and NGOs) are not members of PSTO - even though the funding comes from the Public Health Directorate of the Ministry of Health ,which is a PSTO member. Even if they were eligible for subsidies, informal feedback from PSTO is that the volume of trainees envisaged would significantly exceed the likely volume of subsidy funding available. For this reason, no subsidies have been included in the costings above.

An alternative funding mechanism model could be a variant of that already adopted in the mental health area, whereby a training grant of $2000 per employee/trainee is provided for up to 450 staff of mental health organisations registered with an NZQA registered training provider to undertake the National Health Certificate in Mental Health Support Work. The mental health worker training grants are funded by the Ministry of Health, and administered by Careerforce, the ITO with whom the unit standards are registered. It should be noted that the total costs for the qualification in question, a 122 credit qualification requiring one day (9am -3pm) of classroom time for 36 weeks, costs $3080[12] – so the subsidy amounts to two thirds of the course costs.

4. Conclusion

Implementing the generic public health competencies will require an investment by the government in improving the public health knowledge and practice of staff of a significant proportion of the staff of PHUs, NGOs and local government. The CCP

[12] This amount appears cheaper than the sector-based approach costed in this report but it must be remembered that tertiary providers receive EFT's funding from government via Vote:Education as well as student fee funding. In other words the student fees do not cover all the costs of running the courses.

recommends the Ministry of Health adopt a 'sector-based in-house model of delivering training and assessment within the National Qualifications Framework. This is recommended because it will foster a workplace community of learning that is most likely to foster the achievement of better public health outcomes.

The one-off investment required to adopt this course of action is estimated to constitute additional funding of between $2.41million and $3.67 million between 2008/09 and 2013/14. In addition, reduced public health outputs should be contracted for during the last four years of this period, so that public health staff have the time available to undertake what is required of them as trainers or trainees respectively.

The CCP expects this investment will pay significant dividends in later years, as public health agency managers, public health nurses, health promoters, health protection officers, environmental health officers, community health workers, policy analysts and allied health workers individually and collectively are able to work much more effectively to achieve population health outcomes.

Diane Salter
Managing Director
Strategic Policy Consulting

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