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Hospitals on the Edge

A report by the Association of Salaried Medical Specialists on the precarious state of New Zealand's public hospital services and recommended actions

Acknowledgements

This publication was inspired by the report *Hospitals on the Edge? The Time for Action*, produced by the Royal College of Physicians in the United Kingdom in September 2015.

Introduction

The Association of Salaried Medical Specialists (ASMS) has been receiving reports from our members with increasing frequency expressing nothing less than desperation about the unceasing pressures to cope with hospital workloads. In the past there has been relative quiet periods to recover, but this has changed. As District Health Boards themselves are reporting, hospital bed occupancy rates are hitting record levels and many wards are operating at levels exceeding clinical safety standards for prolonged periods. There is a palpable sense of dread among our members of what's in store next winter when hospitals are at their busiest.

This is why hospitals are the focus of this report. ASMS advocates for a whole-systems approach to health, recognising that all parts of the system are inter-dependent. However, the pressures that have built in hospital services mean they are now at a dangerous tipping point. Verbatim comments from members throughout this report typify what we are hearing.

Hospitals have been ill-served by policy-makers in the past few decades, including privatisations, restructurings, amalgamations, real funding cuts, and imposing narrow, politically motivated targets without appearing to understand their consequences. The problems canvassed in this report will worsen if the mistakes of the past are repeated, and we fear this is happening.

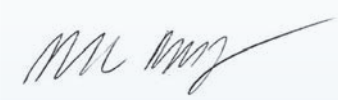
Proposals to shift resources from hospitals to the community, strongly indicated in the Health and Disability System Review's Interim Report to the Minister of Health, have happened in mental health services in this year's Budget, despite strong evidence of unmet need for specialist level services. This will create an even narrower bottleneck for accessing hospital care, which will increase the workloads for primary care practitioners, and which in turn will add to the rapidly growing number of patients turning up in hospitals needing emergency care. More resources are needed in the community but it is harmful and counterproductive to do so at the expense of hospitals.

The negative spiral of acute hospital admissions increasing at twice the rate of population growth has been caused largely by chronic under-funding. There are simply too few staff, too few acute hospital beds, too many patients discharged before they should be, too many facilities unfit for purpose, and too many patients denied access to timely treatment because hospitals lack capacity.

This report offers evidence-based solutions. The solutions involve, as indicated above, a whole-system approach. They require a change in mindset of policy-makers who appear to view hospitals mostly as an inconvenient expense instead of a core investment for improving and maintaining New Zealanders' well-being and productivity.

In May 2017 the then Labour health spokesperson Dr David Clark commented: "Waiting times and full beds across our hospitals are symptomatic of a growing crisis."[1] The content that follows, compiled from official information requests, Ministry of Health data and various DHB committee reports, represents a brief overview of that same "growing crisis". One that now needs urgent action.

We welcome feedback and discussion.



Professor Murray Barclay
ASMS National President

At a glance

- Acute hospital admissions are increasing at more than twice the rate of population growth.
- The steep rise in acute admissions appears to be displacing non-urgent admissions, which are increasing at only half the rate of population growth.
- Emergency Department use is growing more than twice the rate of population growth.
- Urgent presentation to EDs are growing at a faster rate than less urgent events.
- Unplanned acute readmission rates within 28 days of discharge from hospital averaged 12.1% of discharges for the year to December 2018. This has risen from an average 8% in 2007.
- In many hospitals, bed occupancy rates are frequently close to – and sometimes over – 100%. The widely accepted clinical safety level for bed occupancy is a maximum of 85%.
- About 4.7% of the population is estimated to have severe mental health need. Mental Health and Addiction (MHA) services for people with severe needs saw about 3.6% of the population in 2016, DHBs are funded to cover 3%.
- The number of hospital beds per head of population for people with severe psychiatric needs is among the lowest in the Organisation for Economic Cooperation and Development (OECD).
- Despite significant increases in the use of hospital services, we estimate there are potentially 430,000 children and adults with an unmet need for hospital care.
- The DHB-employed senior doctor workforce is estimated to be 24% short of what is needed to provide safe, good quality and timely health care, based on surveys of clinical leaders in 15 DHBs.
- In 2009/10 Vote Health operational expenses were 6.28% of gross domestic product (GDP), which had dropped to 5.60% of GDP by 2017/18. For Vote Health operational expenditure to match 6.28% of GDP in 2009/10, it would have needed a further $1.7 billion in this year's budget.
- **Actions for the Government:**
  - To reduce pressure on hospitals, get serious about integrating primary and secondary services
  - Support staff to flourish rather than simply survive. This requires a strong commitment to distributed clinical leadership
  - Address staff shortages to enable patient-centred care and greater efficiency
  - Adopt responsible funding policies to match policy aspirations
  - When planning to fix hospital buildings, talk with those who use them
  - More effort and urgency into addressing the determinants of ill health
  - Start measuring and monitoring unmet need for hospital care
- **What the health system does not need:**
  - Restructuring
  - Policies with 3-year focus
  - Ideas imported from overseas out of context and not transferable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EXIT

Acute and non-acute admissions

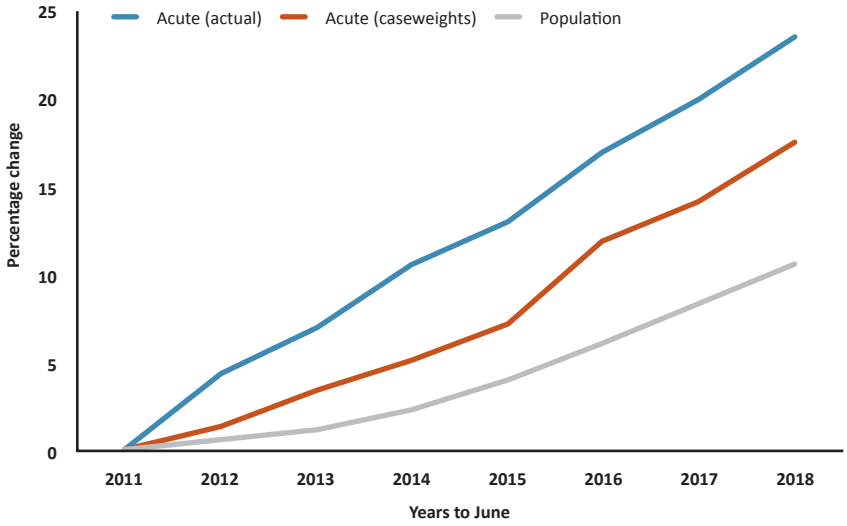


FIGURE 1: ACUTE DHB INPATIENT DISCHARGES (ACTUAL AND CASE WEIGHTED) 2010/11 TO 2017/18

Source: Ministry of Health Caseload Monitoring Reports (data extracted from Excel spreadsheets)

Notes

Figures include inpatient, surgical, medical and maternity discharges.

Case weights measure the resources needed for the treatment given to each patient during a hospital stay. For example, a cataract operation will receive a case weight of approximately 0.5 whereas a hip replacement would receive 4 case weights. Case weight measurements are occasionally adjusted to reflect changing practices and technology. These are expected to have a marginal effect on overall trends.

Acute hospital inpatient discharges increased by 23.5% between 2011 and 2018 (17.6% when case-weighted), while the population increased by 10.6% (Figure 1). On the other hand, while case-weighted non-acute discharges increased by 14.6% over the same period, the increase in actual discharges (5.3%) was lower than population growth (Figure 2).

These trends suggest non-acute patients are being displaced by a combination of budget constraints, a rise in acute cases and the increase in complexity of non-acute cases. More information is needed to properly interpret these trends, but the low growth of non-acute headcounts compared with population growth may indicate growing unmet need for elective surgery and non-urgent medical treatment.

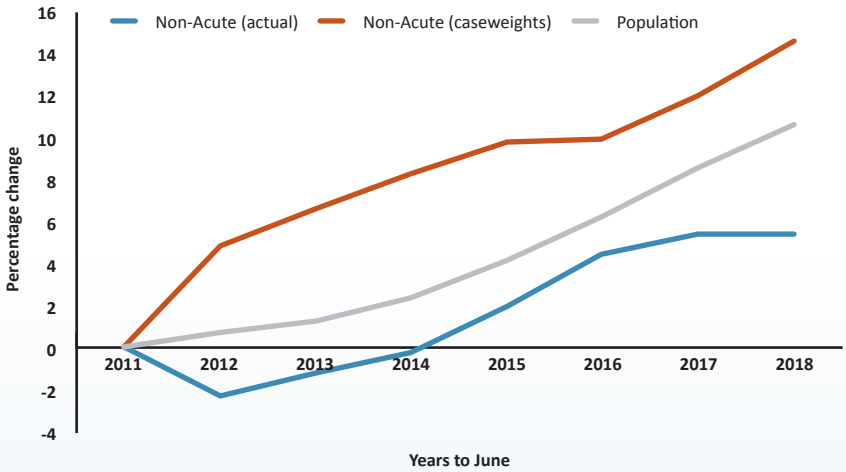


FIGURE 2: NON-ACUTE DHB INPATIENT DISCHARGES (ACTUAL AND CASE WEIGHTED) 2010/11 TO 2017/18

"This past winter is the worst we've seen. I've brought it to the attention of administration multiple times, saying I feel patient acuity and volume are unsafe given our current staffing. Someone is going to die in the ED waiting room and that's the only thing that's going to make change happen in the DHB".

Emergency medicine specialist

Emergency Department use

More than 1.2 million people attended hospital Emergency Departments (EDs) in 2018/19 – an increase of 26.4% since 2010/11 and more than twice the population growth rate of 12.2% for that period (Figure 3).

In addition, the proportion of immediately or potentially life-threatening events (triage levels 1–3) is growing. Ministry of Health data show in 2010/11 the number of triage levels 1-3 was about the same as less urgent events (triage 4-5). By 2014/15 triage levels 1-3 comprised 54% of total presentations.

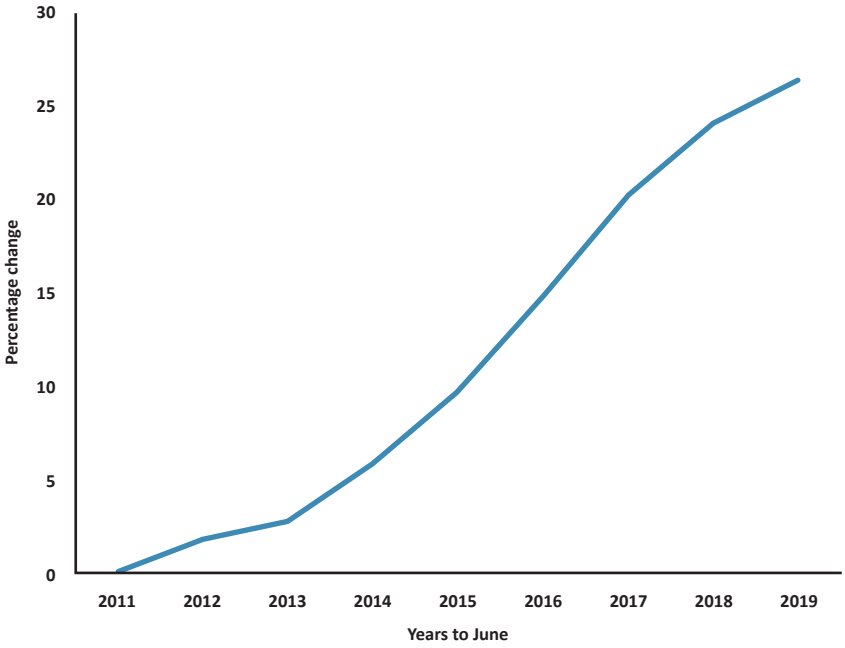


FIGURE 3: GROWTH IN HOSPITAL EMERGENCY DEPARTMENT ATTENDANCES, 2010/11 TO 2018/19

Source: Ministry of Health: 2011-2015. DHBs 2017-2019. 2016 is estimated.

Emergency readmission to hospital within 28 days of discharge

Unplanned acute 28-day readmission rates averaged 12.1% of hospital discharges for the year to December 2018, ranging from 9.9% in one DHB to 14.6% in another. This has risen from an average 8% in 2007 (Figure 4).

Unplanned readmission rates in Australia were 7.4% of acute care discharges in 2015.[2] In Britain's National Health Services, the rates were 6.7% in 2015/16.[3]

This indicator is a proxy of both the care received in hospitals and the coordination of care back to and within the outpatient setting. It may indicate a quality issue related to shortened length of stay and premature discharge, inadequate care, lack of patient adherence to the care regimen following discharge from hospital or poor integration of care.

Readmission rates are an imperfect measure of quality, however. Not all reasons for readmission are under the control of the health care service or hospital.

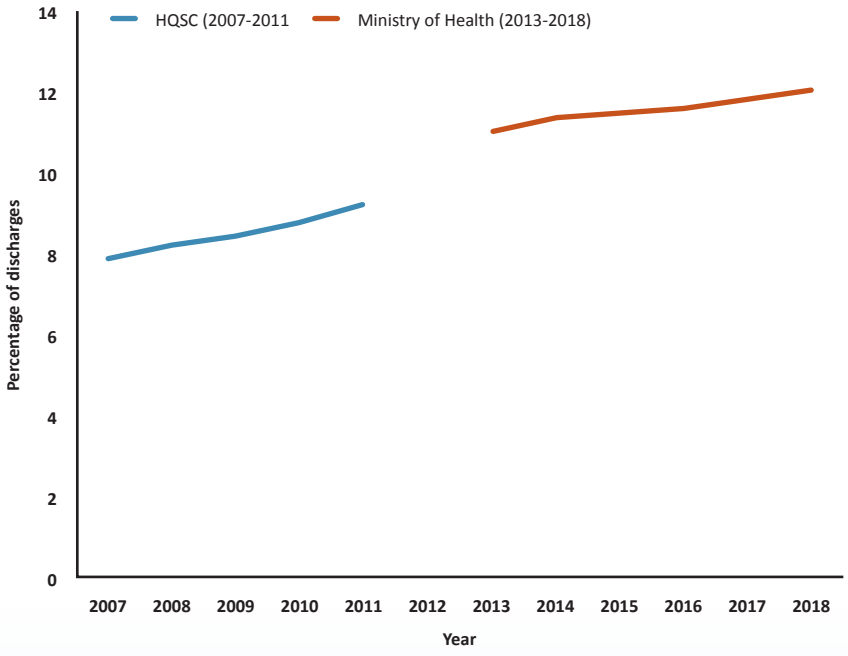


FIGURE 4: EMERGENCY READMISSION TO HOSPITAL WITHIN 28 DAYS OF DISCHARGE

Sources: HQSC (2007-2011); Ministry of Health (2013-2018). Note: Years 2013, 2014, 2015 are years to June

"There is an overall lack of clinical space and isolation facilities are insufficient to meet demand. Workflow is dictated by constraints of the existing layout and at times becomes chaotic, especially during the winter peaks when the clinical team works flat out to free up bed spaces for acute ED and GP referrals. During a recent weekend on call period, four children spent the night in ED due to lack of capacity on the ward".

Paediatrician

"Because the hospital is over-capacity with patients, the ED becomes overcrowded, with some admitted patients in ED waiting up to 16 hours for an inpatient bed to become available. All treatment spaces in ED are filled up with patients who should be on a ward, and the ED waiting room becomes an overcrowded area with undifferentiated patients whose care is delayed by insufficient treatment space in ED".

Emergency medicine specialist

Bed occupancy

In many hospitals around New Zealand, bed occupancy rates are frequently close to – and sometimes over – 100%, which is well above the widely accepted safety level.

Hospitals cannot operate at 100% occupancy, as spare bed capacity is needed to accommodate variations in demand and ensure that patients can flow through the system. A lack of available beds has widespread consequences in a health system. For example, delays in emergency departments worsen, elective procedures are cancelled, patients are placed in clinically inappropriate wards, hospital acquired infections increase, and there is greater pressure on staff to free up beds. Bed availability is also closely linked to staffing, as beds cannot be safely filled without appropriate staffing levels.[4]

A figure of 85% occupancy is often quoted as the ideal in balancing clinical safety and cost-efficiency, though the range 82% to 85% is considered by some to be the "absolute maximum occupancy (even during the winter months)" to maintain patient safety. The national average figure for Europe is around 77%.[5]

While high levels of hospital bed occupancy are an important indicator of a health system under pressure, occupancy rates are not routinely reported as key performance indicators, nor does there appear to be a standardised way of measuring occupancy rates in New Zealand. However, a variety of reports reveal not only an alarming level of occupancy rates but that they are increasing. This has been underscored to ASMS from many verbal reports from our members.

For example, the Auckland DHB's Health Advisory Committee (HAC) reports show the adult hospital has been at or near 100% capacity most days throughout July, August and September, and that: "Each month throughout winter new occupancy records have been broken." The October 2019 HAC report reveals children's hospital services have been running at 95% -105% since early May.

The 2017/18 annual reports for Waikato and Counties Manukau DHBs show acute bed occupancy averaged over 90% for the year in both DHBs.

The October Board meeting notes at Capital & Coast DHB report occupancy for adult beds remains at over 94% "which has a material impact on acute flow from ED".

Canterbury DHB's website says: "Hospital inpatient occupancy rate generally runs between 90%-95%", but papers prepared for the DHB board meeting in September indicated a record number of 709

surgical and medical patients were treated at the 540-bed hospital on one day in July.

At Waitemata DHB, where specialist Mental Health and Addiction (MHA) services have been operating at 100% bed occupancy (similar to MHA inpatient services in some other DHBs), the HAC report of June 2019 describes the effects of having brief periods of 85% occupancy:

"The Adult in-patient units have experienced 85% occupancy twice, lasting only a few days at a time. This is the first time the target has been reached in over three years. However, it is not being sustained for longer periods. The benefits have been significant over the two brief periods with improvements in the quality of care for people both in the in-patient units and in the community. Staff have reported that their ability to spend time with people and their whānau and provide a better quality of service has been significant during these brief periods of 85% occupancy." (HAC report, p64)

"Increase in acute demand over the years, largely driven by increased medical admissions to hospital, have not been matched with increased inpatient bed resources. At times there have been up to 35-40 medical inpatients above the number of permanently resourced medical beds. These patients are being managed on surgical wards or in overflow beds, leading to inefficient care, increased in-hospital length of stay, and arguably a lower than desired standard of care".

Emergency medicine specialist

"When we're all here it can be quite manageable but everyone has to have their leave so when people go on leave it can become very very hard. There was a stage earlier in the year when I cried on the way to work – I was just not looking forward to the workload I was going to face".

Pathologist/Haematologist

"There is a massive reliance on "stats" about what people are doing. A whole stream of work which seems focused on generating "stats" but which is almost entirely irrelevant in terms of the delivery of quality mental health care, and yet most people who spend their time in clinical roles can see that a good chunk of the work that gets done is not captured at all by this lumbering, blundering system".

Psychiatrist

"We've had exponential increases in patient volumes over the past five years but there's been no increase in FTE on the consultant or nursing side so effectively we're being asked to just work harder. I barely get to the bathroom. I can't work any harder safely".

Emergency medicine specialist

Hospital Mental Health and Addiction Services

An extensive Ministry of Health survey in 2006 estimated 4.7% of the adult population had severe mental health needs, and the available evidence suggests a similar need for younger people. At the time, mental health and addiction (MHA) services saw just 2.3% of the population. This had increased to 3.6% by 2016, though DHBs were funded to cover 3%.

Between 2008/09 and 2015/16 the number of MHA clients seen by DHB services increased by 28.8%. Funding has been in line with population growth, which was 9.1% for this period (Figure 5).

The funding shortfall for severe-needs clients became more acute after the 2019 Budget cut an estimated real $55 million from those services to help pay for additional community-based services for people with less severe needs.

These trends suggest there is a significant number of people with severe conditions who are not accessing appropriate services. Moves to shift resources from severe-needs clients to those with lesser needs is a longer-term plan to attempt to reduce pressure on the former. However, this will increase pressure on severe-needs services, which in turn will see more patients needing specialist treatment falling back on primary care services.

The number of hospital beds per head of population for people with severe psychiatric needs is among the lowest in the OECD (Figure 6).

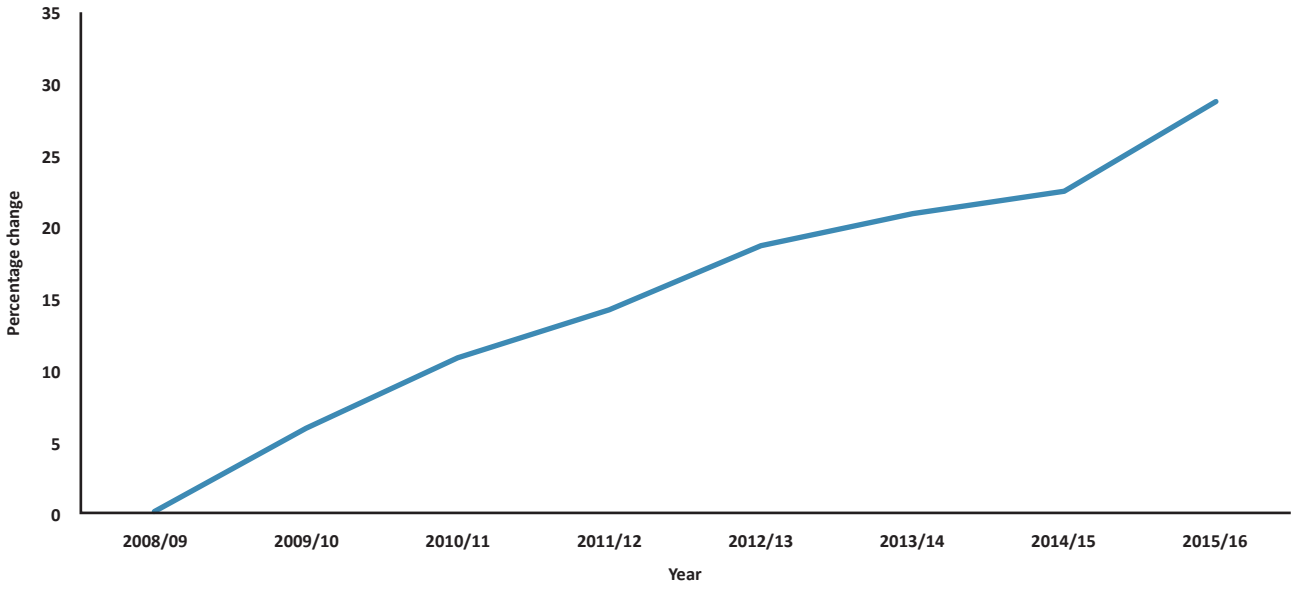


FIGURE 5: MENTAL HEALTH AND ADDICTION CLIENTS SEEN BY DHBS - PERCENTAGE CHANGE 2008/09 TO 2015/16

Source: Ministry of Health

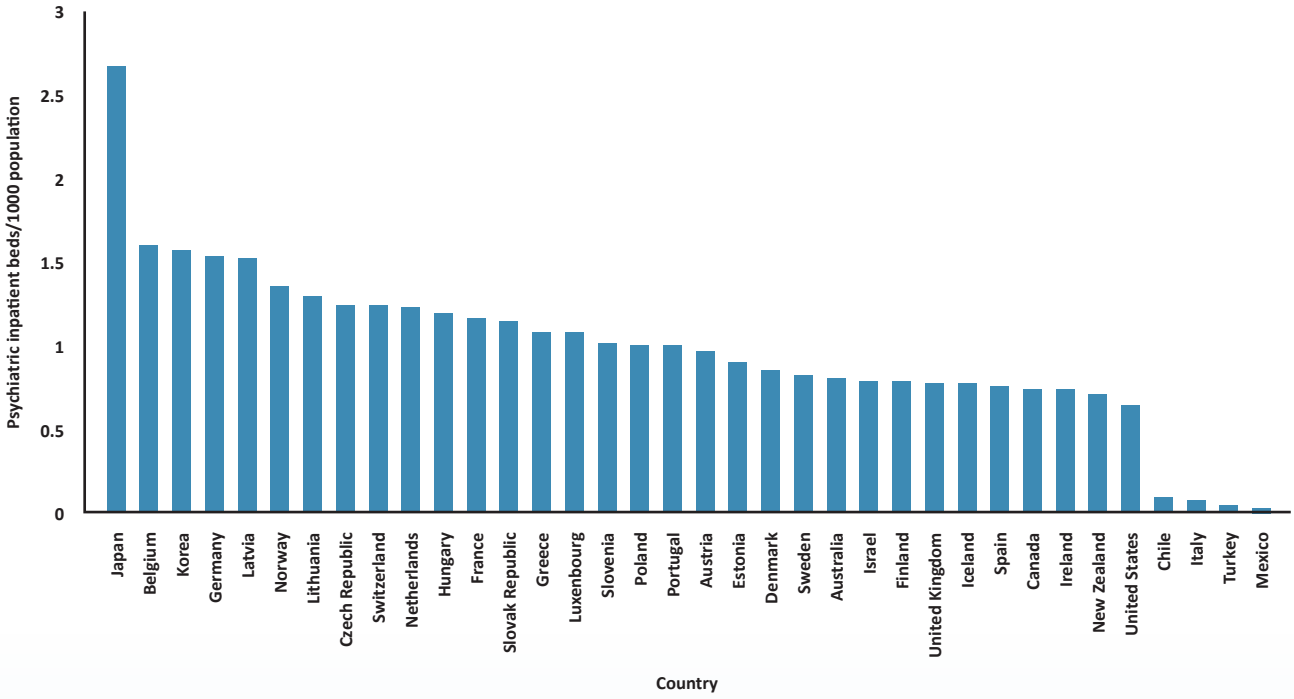


FIGURE 6: PSYCHIATRIC INPATIENT BEDS/1000 POPULATION – 2018 OR NEAREST YEAR

Source: OECD Health Data 2019

"We're hundreds of patients behind in our clinic [first specialist assessments]. Some clinics are cancelled due to [high acute demand]. We're not meeting our cancer targets in terms of operation dates. We're cancelling theatre lists routinely due to lack of staff and bed capacity. We are running about two months behind target for semi-urgent colonoscopies and are struggling to keep up with the demands of the bowel screening project. Short notice stress leave has become more frequent".

Surgeon

Unmet need for hospital care

Despite significant increases in the use of hospital services, we estimate there are potentially 430,000 children and adults with an unmet need for hospital care.

Unmet need for hospital care is not routinely measured in New Zealand. Ministry of Health data captures only a part of it. For example, data show more than 30,000 patients a year are rejected for hospital treatment, despite being assessed by a medical specialist as needing it. These patients are turned away because the hospital has insufficient capacity. Instead they are referred back to the general practitioner for monitoring. They may receive treatment later but only when their condition has deteriorated sufficiently. A further 14,000 patients assessed by hospital specialists are sent back to their GP because they have insufficient information about the patient. And another 1,200 patients are deemed "not eligible" for treatment. But these are incomplete figures as there are gaps in data from some DHBs; GPs may be reluctant to refer patients due to the high threshold of acceptance for treatment; and many people, especially the poor and Māori and Pasifica, for various reasons cannot access GP services in the first place. Nor is there any information on how long patients who are deemed not unwell enough for treatment remain in limbo.

In a specific example where accurate levels of unmet need are obscured, Ministry of Health figures show that in Canterbury in 2016 only 0.6% of patients were waiting longer than the government target for first specialist assessments for hip and knee surgery. But a study for determining the 'real' unmet need related to the implementation of a triage system for elective hip and knee referrals in Canterbury found that 43% of hip and 54% of knee patients were not able to move beyond the initial triage process, which rations access to specialist appointments.[6]

A comprehensive national survey to measure unmet need for hospital care has never been undertaken. However, a 2015/16 pilot study of methods for undertaking such an exercise, including interviews with over 1200 adults in Auckland and Christchurch, estimated a total unmet need for hospital care of about 9% of the population. This included unmet need for surgical, non-surgical, dental, and psychiatric care.[7]

This was broadly consistent with studies commissioned by the Health Funds Association of New Zealand and New Zealand Private Surgical Hospitals, in 2013 and 2016, each based on surveys of 1800 adults (aged 18 and over), which found that 5% on both occasions had been advised they required some form of elective surgery but were not on a waiting list because they were not deemed unwell enough to qualify

for one. For those accepted for surgery, the study found average waiting times of 304 days (measured from the time of first GP referral) – up by 80 days on the 2013 study.[8]

Information from our members, frequent media reports concerning difficulties in patients accessing timely treatment, and continuing real-term cuts to DHB budgets, strongly suggest the situation has not got better in the past three years.

A 9% rate of unmet need, assuming rates are similar for the under 18s, equates to about 430,000 people in 2019.

Unmet need for hospital care is a cost to the economy—rather than being a saving it shifts costs to other parts of the health system. It imposes a heavy burden on primary care and patients.

"SMOs are voting with their feet, they're leaving not because they want to, but because for many they end up finding themselves in an impossible position, forced to choose between caring for patients in an obviously unsustainable system, and where no clear solutions to the issues faced are being presented, or stepping away so that they can look after their own personal health and well-being as well as that of their family".

Psychiatrist

"I wake up in the middle of the night and can't get back to sleep while I think: Oh my goodness I haven't seen this person in ages, or oh my goodness I've got these investigations to follow up and when am I going to get to this stuff".

Geriatrician

"Our colleagues come to work each day trying to do their best but are continuously exposed to a toxic, underfunded environment that leaves many demoralised and burnt out. Knowing that we could do so much better if only we had enough staff and decent facilities to work in, is heart-breaking at best and soul-destroying at worst".

General medicine specialist

Specialist shortages

The extent of DHB-employed senior medical officer (SMO) shortages in New Zealand has been well documented by ASMS.[9] The latest assessment of shortages, based on surveys of clinical heads of departments in 15 DHBs, indicates an average workforce shortfall of 24%, or 555.6 specialist FTE (Figure 7).

But while workforce shortages affect access to health care, as well as the quality, safety and efficiency of public hospital services, they go largely unnoticed by the general public, in part because the shortages are so entrenched. Coping with shortages has become the norm for many public hospital departments, though it comes at a cost of doctors' own health and well-being, as illustrated in peer-reviewed ASMS studies which found 88% of SMOs routinely go to work when they are ill[10] and 50% report symptoms of burnout.[11]

We acknowledge that shortages are also entrenched in other areas of the health sector. The Government has high policy expectations for more effective services and improved well-being for all, but falls well short of recognising the resources needed to achieve its ambitions.

For example, in Scandinavian countries, Finland and the Netherlands – all countries with policy emphases on promoting wellbeing – the proportion of the health and social care* workforce ranged from 15%-20% of the total workforce in 2015, compared to New Zealand's 10.8%.[12] The advice to the Minister of Health in the Health and Disability System Review *Interim Report* is that workforce growth trends are already at 'unsustainable' levels.

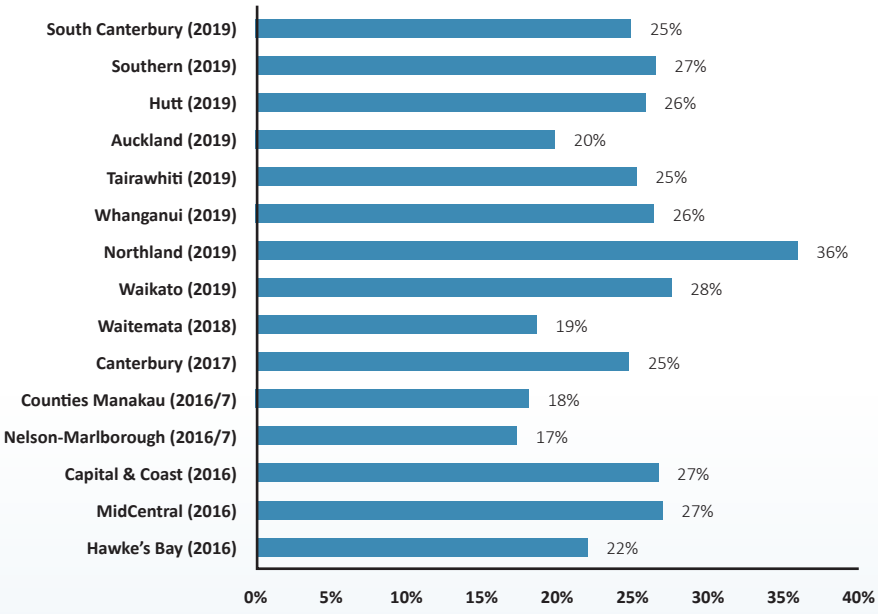


FIGURE 7: ESTIMATED SMO STAFFING SHORTFALL AS A PERCENTAGE OF CURRENT STAFFING ALLOCATIONS IN 15 DHBS

* Defined as a composite of human health activities, residential care activities (including long-term care), and social work activities without accommodation

Source: ASMS surveys of clinical leaders. Full reports available: https://www.asms.org.nz/publications/researchbrief/

Poorly maintained buildings

The now well-reported gross neglect of hospital buildings illustrates how the health system has suffered from short-sighted policies. The poor maintenance of buildings is due in large part to prolonged funding constraint forcing DHBs to divert budgeted capital expenditure to operational expenditure to cope with immediate service needs.

The impact of poor building quality on services is costly in terms of the quality and safety of health care. As a Sapere report on the condition of Dunedin Hospital found, the "deteriorating physical environment is eroding quality of care, creating safety risks, and causing distress to patients and staff", as well as causing delays and "leading to an increased likelihood of adverse events for both staff and patients".[13] Poor maintenance of hospital buildings has been cited as a serious health and safety hazard in the United States and Britain's National Health Service (NHS).

That the negligence has been so bad that an estimated $14 billion ($9.2 billion requiring Crown funding) is needed over the next 10 years to put things right reflects not only poor DHB oversight and accountability but also a poor duty of care and a head-in-the-sand mentality at government level.

The 2019 Budget for 2019/20 included $1.5 billion for infrastructure but, as the Vote Health documents explain, this includes funding for multi-year projects and provision for some future expenses or risks. New capital funding of a similar magnitude will be needed in each Budget for years to come to cover what is needed over the next decade.

The hospital essentially requires a complete rebuild with the tower block (where inpatient wards are located) aging, and without air conditioning which is a significant issue over summer months. Essentially predictable increases in both acute and elective demand have not been matched by investment in infrastructure. Funding for infrastructure, which should be a basic component of the Ministry of Health's responsibility to fund hospital-based care, is a significant issue with DHBs essentially being required to borrow funds for infrastructure investment.

Emergency medicine specialist

"We send emails, we attend meetings, we write business cases. We get our hopes up that this time we will be heard and then our hopes are dashed by another directive to do more with less, become more efficient and raise the bar at which you will see patients to make it look like we are keeping up with demand. Despite all of this, we will get up tomorrow and come back to work – and the system knows that we will – because we put the care of our patients before ourselves, even if that will eventually break us".

General medicine specialist

The funding slide

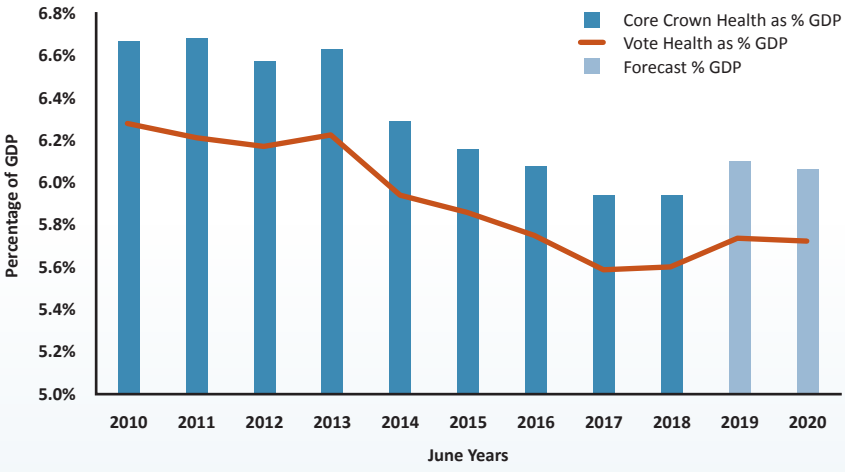
The Government's Health and Disability System Review *Interim Report* claims Core Crown Health expenditure has recently gone through "a sustained period of little real growth", referring to "real" per capita funding trends, using a GDP deflator. This does not take account of the additional needs of an aging population or the accumulating additional costs of new initiatives introduced each year.

In contrast, an Infometrics analysis of Core Crown Health expenditure (which includes some other health expenditure such as part of ACC's funding), commissioned by the Labour Party in 2017, showed a $2.3 billion gap in real Core Crown Health expenditure between 2009/10 and 2017/18. Infometrics used Treasury's modelling for calculating real health costs.[14]

Successive years of funding shortfalls specifically for Vote Health have been well documented in the annual analyses of the Government's Health Budget undertaken by the Council of Trade Unions and ASMS.[15]

In 2009/10 Vote Health operational expenses were 6.28% of gross domestic product (GDP), which had dropped to 5.60% of GDP by 2017/18 and are forecast to be 5.73% (of forecast GDP) in 2018/19 and again in 2019/20 (Figure 8). For Vote Health operational expenditure to match 6.28% of GDP in 2019/10, it would have needed a further $1.7 billion in this year's budget.

When total public health expenditure is considered, including health-related expenditure by local government and all central government agencies such as Corrections, Education, Social Development etc, total health expenditure was 7.8% of GDP in 2009/10, dropping to 7.4% in 2017/18. This is the figure for total government health expenditure reported by the OECD. Total government health spending in countries with traditionally strong policies supporting well-being (eg, Denmark, Norway and Sweden) averaged just under 9% of GDP in 2018.



Source: Treasury

FIGURE 8: CORE CROWN EXPENSES AND HEALTH VOTE AS % OF GDP

Actions for the Government

• To reduce pressure on hospitals, get serious about integrating care

To reduce pressure on hospitals, a 'systems approach' is needed, as well functioning community-based services are dependent on well functioning hospital services and vice versa. Strong integration between hospital services, primary care and social services, is urgently needed to provide a good patient-centred continuum of care. The 'Canterbury Initiative', which includes many of the features considered important to integration, has been recognised internationally as a rare example of how to successfully implement changes to achieve better community-hospital care integration. Look no further.

For further information on integration visit: https://www.asms.org.nz/wp-content/uploads/2019/08/Research-Brief-on-integrated-care_172441.2.pdf

https://www.asms.org.nz/wp-content/uploads/2019/03/Research-Brief-on-primary-prevention_170857.2.pdf

• Support staff to flourish rather than simply survive each day

The Health and Disability System Review Interim Report, quoting W Edwards Deming, acknowledges: *Nobody goes to work to do a bad job … Put a good person in a bad system and the bad system wins, no contest.* It adds: "The New Zealand health system is full of passionate and caring 'good people' who are doing the best work they can within the constraints and challenges the system presents to them daily." In order to "unlock and unleash the capabilities of all those good people to improve the health and wellbeing of all New Zealanders", it suggests improvements in digital technologies are needed. Inadequate digital technology is a major frustration that needs addressing but an even more important need is to unleash the health system's considerable 'intellectual capital' - to support staff to use their skills, knowledge and experience to drive innovation, efficiency and collaborative working. This requires a strong commitment to distributed clinical leadership that passes control from one to many. This is widely seen as more effective than traditional, top-down, hierarchical ways of operating.

For more on collective leadership, visit: https://www.asms.org.nz/wp-content/uploads/2019/08/Research-Brief-Distributed-clinical-leadership_172592.2.pdf

"Some days it is really hard. Some days you can see the exhaustion in your colleagues' eyes, they are near tears but hold it together until they can escape the building. Sometimes they hide in their office until they can compose themselves to face the next patient, the next student or the next colleague who has a question. You want to be able to tell them to go home, take some time, rest. But there is no-one to do their work and so many are in the same position we can't afford for anyone to drop their load".

General medicine specialist

"We come to work because we have made a commitment to keep the system going for those patients who can't afford any other option. We come to work because we have to believe that it might get better, that someone will eventually start to listen to us and that health care access for all has to be provided."

General medicine specialist

• Address staff shortages to enable genuine patient-centred care

If the goals are to provide the most efficient and cost-effective health service based on the principles of high-quality patient-centred care, this will not happen while frontline staff are expected to work continuously in a pressure-cooker environment, burnt out. The capacity for innovative change, to take on distributed leadership roles, and to engage with patients and families and whānau as genuine partners in care is severely limited in current conditions. Addressing specialist shortages requires an extensive recruitment campaign for overseas specialists and trainees, based on an assessment of trends in domestic supply of new specialists and rates of retirement.

For more on specialist workforce shortages visit: https://www.asms.org.nz/wp-content/uploads/2019/01/Research-Brief-on-SMO-workforce-needs-171201.2.pdf

https://www.asms.org.nz/wp-content/uploads/2019/06/Research-Brief-specialist-workforce-projections-_172060.2.pdf

• Adopt responsible funding policies to match policy aspirations

After two Budgets from this Government there is no real progress towards restoring health funding to previous levels (which were themselves far from adequate). Resources will always be limited, but the Government is trying to do more with essentially the same level of funding as the previous government, creating huge gaps in health, education, welfare and conservation, among others. The 'Well-being Budget' may be a worthy enterprise but it is wracked by under-funding. The New Zealand economy is in good shape but the Government's Budget Responsibility Rules, which severely limit what can be spent on public services, need to be replaced with principles consistent with improving wellbeing.

For more on funding, visit: https://www.asms.org.nz/wp-content/uploads/2019/06/How-much-funding-is-needed-to-avoid-the-condition-of-the-Health-System-worsening-2019.pdf

When planning to fix hospital buildings, talk with those who use them

There have been suggestions that a central Crown agency with capital management expertise is needed to overcome the problem of skills shortage in this area. Whatever approach is adopted, a process of thorough and robust engagement is needed with clinical staff and the community, as well as with DHB Boards.

More effort and urgency into addressing the determinants of ill health

We support the Government's aims to reduce poverty and improve access to affordable housing. However, the wait for a state house is reported to be at a record high and homelessness figures continue to climb around the country. We note the latest statistics on childhood poverty suggest that on some key measures things are worse than previously estimated. Substantial further initiatives will be needed to achieve significant and sustainable reductions in child poverty. The evidence shows policies with the greatest impact on reducing the need for hospital services relate to tax and regulation aimed at reducing smoking and consumption of alcohol and unhealthy foods.

Start measuring and monitoring unmet need for hospital care

As researchers have commented, if unmet need is not a measure of the effectiveness of a health system, how do we really know how well it is doing and how to improve it? Including relevant questions on unmet need for hospital care in the New Zealand Health Surveys would be a good start.

What the health system does not need

- Restructuring
- Policies with 3-year focus
- Ideas imported from overseas out of context and not transferable

"Two weeks ago, and I've been working in DHBs all my life – for the first time in a management meeting – I actually found myself welling up with tears and I walked out. I just thought I can't do this anymore because we're just not moving forward".

Geriatrician

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