

Health Dialogue

A Public Hospital for 2026: Queenstown

A S M S

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A Public Hospital for 2026: Queenstown

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1 Introduction

The Southern District Health Board's management has proposed major changes to the way public health services are delivered in the Wakatipu region that would see Queenstown's Lakes District Hospital services dismantled and moved into a new facility owned by a property developer, which it would share with a private health company. Directly linked to this is the desire of the DHB's management to cut medical and nursing staff numbers at the hospital. At the same time, a Queenstown Lakes District Council-appointed health governance reference group has proposed a community trust takes charge of Lakes District Hospital.

The DHB management's rationale for the change is that in order for local public health services to be financially and clinically sustainable, hospital services need to be provided through an integrated family health centre where hospital services are delivered under the same roof as primary care and other health services. Its justification for the clinical staff cuts is that by diverting low acuity patients from the emergency department (ED) to GP practices, the ED workload would be reduced.

Few disagree that innovative planning is needed to ensure the right services are in place to meet increasing health needs effectively and efficiently into the future, no more so than in the rapidly growing Queenstown district. The DHB management's proposal, however, lacks essential details, raises many uncertainties and poses considerable risks for future delivery of public health services in the district. Aside from the proposal's shortcomings, the DHB management's handling of the emerging issues has shaped up as a good example of how *not* to manage change.

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Now the DHB has asked the National Health Board to step in to lead the review of services "as it believes an independent approach will ensure public confidence and help reach a consensus view by building on the work undertaken during the past two years."¹

The NHB has established a special three-person panel² to consider the clinical and financial sustainability of primary and secondary health services, including integrating care, supporting workforce training and development, and effective access to other hospital clinical specialties and support services.

The panel will hold a series of community and health sector meetings and workshops and, by the end of July, make recommendations to the

¹ National Health Board statement: Wakatipu Expert Panel – Community Update, 10 June 2011.

² Dr Peter Foley (chair), David Russell, Prof Mike Ardargh/Dr Angela Pitchford (sharing)

DHB Board on the desired medium-term service configuration for integrated community and hospital-based services, and how to implement this. This is likely to cover all issues relevant to the effective delivery of services, including both the optimal structure and governance of health services in the Wakatipu.

The review, unwisely, does not include Dunstan

The DHB Board will consider the recommendation at its August board meeting and implementation could begin in September, if approved.

The review, unwisely, does not include Dunstan, despite the strong professional and clinical relationships between the two hospitals and the rapidly growing need for comprehensive service planning across the region, as discussed below.

This paper examines the issues to date: the DHB’s arguments, the information on which it bases its arguments, the service implications and risks, and the way the proposal has been managed. It also discusses some of the risks involved with community governance and issues that need to be considered in deciding a future governance model. Finally,

a way forward, taking a strategically planned regional approach to developing services, rather than the somewhat ad hoc, narrowly focused proposal promoted by the DHB

the paper proposes a way forward, taking a strategically planned regional approach to developing services, rather than the somewhat ad hoc, narrowly focused proposal promoted by the DHB.

2 The future... Wakatipu, Wanaka, Central Otago, 2026

A recent media report revealed how, over a period of six months, a Queenstown woman had to make regular 400km return trips to Invercargill to receive chemotherapy when she could have been treated at Clyde's Dunstan Hospital, 90km away.³

The case was a stark illustration of the health service divide that continues to exist between Queenstown's Wakatipu district, formerly in the Southland DHB, and Wanaka⁴/Central Otago, formerly in the Otago DHB, despite the two DHBs merging in May 2010. The divide also cuts in half the region covered by the Queenstown Lakes District Council, which comprises Wakatipu and Wanaka. The DHB management has said it will give urgent attention to the obvious shortcomings in relation to some cancer treatment services of Wakatipu residents. However, it does not appear to have recognised the case raises far wider matters that also need attention.

It is clear that from a health management perspective Wakatipu and Wanaka/Central Otago continue to be seen as separate, rural neighbours. While this may be partly due to old habits established under the former DHBs, it is also partly due to their having separate funding arrangements on account of Dunstan Hospital being governed by a community trust. Nevertheless they have much in common. Both face similar, significant service implications from the growth and ageing of their resident populations, as well as growing visitor numbers. The residents (and many visitors) of both districts must travel to other public hospitals for most hospital treatments. And both districts' rural hospitals are more than a two-hour road journey from their respective base hospitals.

from a health management perspective Wakatipu and Wanaka/Central Otago continue to be seen as separate, rural neighbours

Up until now, it is probably fair to say that most residents have accepted that, by and large, a two-hour-plus drive to the base hospital is the price you pay for living in rural isolation (cases such as the above aside). However, Wakatipu and Wanaka are among the fastest growing areas in New Zealand. – to the extent that in just 15 years' time Wakatipu and Wanaka/Central Otago combined will have a resident population as big or bigger than five current DHBs (South Canterbury, West Coast, Wairarapa, Tairāwhiti and Whanganui). And that is not even taking into account the growing visitor numbers.

³ R Blackstock, "Don't let cancer patients go through my travel hell". *Mountain Scene* 31 March 2011.

⁴ Includes Wanaka, Hawea and Matukituki

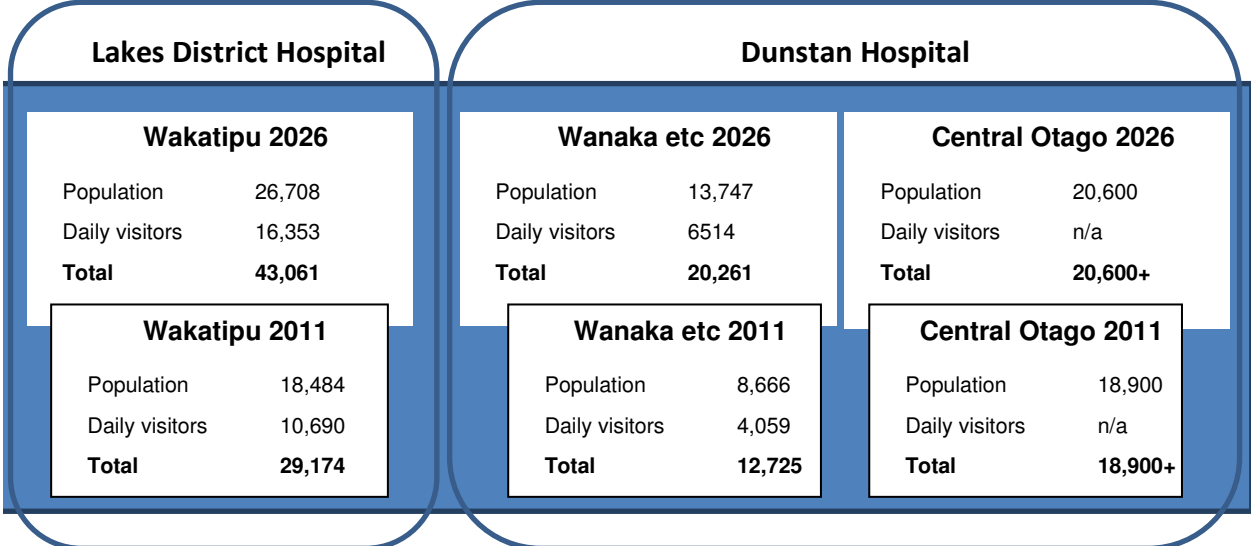
Further, the collegiality between senior doctors at both hospitals (Lakes and Dunstan) is highly professional and beneficial to both. It is reinforced by the fact that most doctors at both hospitals are registered with the relatively new rural hospital doctor vocational scope of practice.

Queenstown Lakes district’s medium population projections indicate a 36% increase over the next 15 years (from 28,200 in 2011 to 38,400 in 2026). That’s nearly three times New Zealand’s projected growth rate. While the district’s current population is relatively young, those aged 65+ are projected to increase by 115% in the same period (from 2600 to 5600). Lakes District Hospital is fundamentally different from other rural hospitals both in the Otago-Southland area and the rest of the country. Although in a rural setting it is based in one of New Zealand’s largest year-round tourist centres which gives it unique features and needs.

In neighbouring Central Otago, where Dunstan Hospital serves part of the Queenstown Lakes population (Wanaka⁵), medium population projections indicate a growth of 9% over the same period. This district’s current population is already relatively old, and those aged 65+ are projected to increase by 61%.⁶

Between them these two districts are projected to have a resident population of 61,000 by 2026, including 19% of the population aged 65+, which is the projected average for New Zealand as a whole for that year.

Figure 1: Population projections for the catchments of Lakes District Hospital and Dunstan Hospital



Sources: Wakatipu and Wanaka figures: Queenstown Lakes District Council. Central Otago: Statistics New Zealand

⁵ Including Hawera and Matukituki

⁶ Statistics New Zealand, Projected Population of Territorial Authority Areas 2006-31 (2006-base) update.

To gain an understanding of the scale of publicly funded and provided health services needed for a population of that size, one needs only to look at the South Canterbury District Health Board, which currently serves a resident population of around 55,000 (18% 65+).

If anything this is a conservative comparison because of the far greater number of visitors to the Queenstown area. (Average daily visitor numbers in the Queenstown Lakes District are projected to increase from 12,800 in 2006 to 24,900 in 2029.)^{7,8}

There are no significant differences in the ethnic or socioeconomic status between the latter population and that of South Canterbury's, especially when Queenstown's high cost of living is taken into account.^{9,10,11} The distance to a tertiary hospital is greater for Lakes/Dunstan hospitals (approximately 200km Queenstown-Invercargill and Clyde-Dunedin) than for Timaru Hospital (approximately 160km to Christchurch).

South Canterbury DHB's Timaru Hospital, which serves the whole DHB region, has 131 beds, including elective surgical services, a 24/7 district trauma service and an intensive care unit. The comparisons in Table 1 should be viewed as broadly indicative of the extent to which hospital services in the Queenstown Lakes/Central Otago districts would need to grow if they were to match current services in Timaru, although not necessarily in the same way, given new ways of providing hospital care, including changing vocational scopes of practice.

Table 1: Current comparisons of Lakes District/Dunstan Hospitals with Timaru Hospitalⁱ

	Lakes District Hospital	Dunstan Hospital	Total: Lakes/Dunstan	Timaru
Hospital beds	15	24	39	131
Inpatient discharges	1,569	1,560	3,129	12,000
Outpatient attendances	874	2,376	3,250	71,000
ED attendances	6,103	688 ⁱⁱ	6,791	15,450
FTE staff	40	61	101	650
Operating expenditure ⁱⁱⁱ	\$6 million	\$7.3 million	\$13.3 million	\$82 million
Population 2011 ^{iv}	18,484	27,566	46,050	55,000

Sources: Hospital Capacity Review (Cranleigh Health), South Canterbury DHB and Southern DHB

i. Lakes District Hospital data for the year to June 2010. Dunstan Hospital data as at 2009. Timaru data as at 2011.

ii. Presentations to the assessment unit.

iii. The Lakes District Hospital figure is for total hospital expenditure; the Dunstan Hospital figures are for total hospital funding.

iv. Queenstown Lakes District Council. Timaru: South Canterbury DHB (2011)

⁷ "Tourist numbers 'heartening'". *Timaru Herald*, 3 December 2010.

⁸ Queenstown Lakes District Council. Council Community Plan 2009-19

⁹ *Atlas of Socioeconomic Deprivation in New Zealand: NZDep2006*. Public Health Intelligence, Occasional; Bulletin No 50.

¹⁰ "Data shows S Canty to be 'very average'." *Timaru Herald* 4 July 2008

¹¹ *Queenstown Health Needs Assessment*. Fraser Group Consulting Ltd for Wakatipu Health Trust. October 2009

While the current combined population of the Lakes District Hospital/Dunstan catchments has yet to grow by approximately 19% to match that of Timaru Hospital's catchment, the gap between Lakes District Hospital/Dunstan and Timaru in terms of services provided is much greater, due in part to the fact that a large majority of residents of the former receive their hospital care in Invercargill or Dunedin hospitals.

Currently around 60% of Queenstown residents receiving inpatient or day patient services do so from other public hospitals, mostly in Invercargill and Dunedin.

Currently around 60% of Queenstown residents receiving inpatient or day patient services do so from other public hospitals, mostly in Invercargill and Dunedin. About 86% of Queenstown residents' outpatient visits are to other public hospitals, again mostly Invercargill and Dunedin. However, most Queenstown resident ED services (73%) are delivered at Lakes District Hospital. (Overseas and domestic visitors account for 21% of ED presentations annually.)¹²

High levels of transfers from small hospitals to base hospitals are the norm. However, the health needs assessment of the Queenstown area, commissioned by the Wakatipu Health Trust, suggests the level of transfers out of Queenstown "is consistent with what would be expected in a satellite hospital if there were a shortage of capacity..."

Furthermore the health needs assessment estimates Queenstown residents' current access to public inpatient services – whether in Queenstown or elsewhere – is about 30% lower than the New Zealand average, after adjusting for population, gender and age.¹³

The big question that our health service planners now need to be addressing urgently is how, in 15 years' time, will the 60,000+ residents of Queenstown Lakes and Central Otago receive the level of services that is currently shown to be necessary for such a population

The significant difference in the level of services currently provided in Queenstown Lakes/Central Otago compared with South Canterbury does not appear, then, to be simply a matter of population size but also a result of a relative lack of capacity in the former.

The big question that our health service planners now need to be addressing urgently is how, in 15 years' time, will the 60,000+ residents of Queenstown Lakes and Central Otago receive the level of services that is currently shown to be necessary for such a population, and – to take account of government policy – "better, sooner and more conveniently"?

¹² Hospital Capacity Review (Cranleigh Health)

¹³ *Queenstown Health Needs Assessment*, Fraser Group Consulting Ltd for Wakatipu Health Trust, October 2009. (Socio-economic status is not taken into account in this estimation.)

The DHB management's proposal relating to Lakes District Hospital, discussed in the following sections, must be viewed in this context, as must the Wakatipu Health Trust's proposal. The above question must also be central to any consideration given to changing the current governance structure in Wakatipu, as discussed later in this paper.

3 The Past: From “health centre” to hospital

Lakes District Hospital serves one of the fastest growing populations in New Zealand and one of the busiest all-year-round tourist centres. The town’s nearest base hospital is in Invercargill, about two-and-a-half hours away by road and 45 minutes by helicopter, so its small Emergency

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Department (ED) is a vital part of the local health service, providing treatment and care for more than 6500 people last year, including stabilising the more serious cases and transporting them to larger hospitals.

Not so long ago (in 1998) the current facility was classified a “health centre”¹⁴ and Queenstown’s hospital medical services were covered by local GPs. In response to increasing demands, a permanent medical workforce was established at the hospital in December 2002 with the appointment of three medical officers (non-specialist hospital doctors), who provided a 24-hour service with support from the town’s GPs. In 2004, the GPs ceased to be involved in providing hospital cover and so the hospital’s medical staff was gradually increased to six full-time-equivalent (FTE) doctors.

By 2008, doctors were organised into a day shift and night shift so that at least one doctor was on-site 24/7. Busy periods during the day were dealt with either by the doctor who was going off shift staying on as needed or by calling back the night-shift doctor. However, it had become clear that presentations during the night had increased to the extent that day-shift doctors were reluctant to call in an exhausted colleague to help with complex or multiple cases during the day. Increasingly doctors felt patient care was unsafe. A “swing shift” was therefore introduced in 2008, initially from Monday to Thursday, to ensure another doctor was rostered between 11am and 9pm. In 2009/10 this was extended to the full week, on the recommendation of the DHB’s Medical Division, on the

Increasingly doctors felt patient care was unsafe.

grounds that the extra shift was needed as much from Friday to Sunday as it was from Monday to Thursday.¹⁵ The introduction of the

swing shift to ensure a safe 24-hour service seven days a week required medical staffing to be increased to the current eight doctors (seven FTEs), two of whom are filling temporary positions. Five are specialists (having vocational registration) in rural hospital medicine, and one is about to gain vocational registration in emergency medicine.

¹⁴ *Southland Times*. “Southern Health not perturbed by ‘health centre’ ranking”. 23 September 1998.

¹⁵ Medical Division, Southland District Health Board. “Recommendations regarding Medical and Nursing staffing at Lakes District Hospital”.

Nursing staff has also increased over recent years, to meet the increasing demand of a 24/7 service, from 22.0 FTEs in 2005/06 to 26.2 FTE nurses in 2009/10.

With these recent developments, Lakes District Hospital now has the potential to employ a registrar to train as a rural hospital specialist with funding for that position provided by the Clinical Training Agency. Having the ability to train the next generation of specialists provides an important opportunity to ensure Lakes District Hospital continues to develop so that it is able to meet the district’s increasing health needs into the future.

<u>FTEs</u>	<u>Hospital Staff</u>
7	Doctors (including two temporary)
26	Nursing staff
3	Allied health staff
4	Administration/management
40	Total FTEs

Current primary care services

There are 18 general practitioners (GPs) working in Wakatipu’s four practices, including an Accident and Medical Clinic, and who between them provide services from 8am to 8pm.¹⁶ All trauma and inpatient events present at the hospital’s ED outside those hours.

Figure 2: Lakes District Hospital Services

- ❖ Emergency Department (level 2 emergency service)*
- ❖ Inpatient acute care (10 beds)
- ❖ Maternity service - primary birthing facility (5 beds)
- ❖ Wakatipu Community Mental Health Service (across the road from the hospital)
- ❖ Diagnostics, including digital radiology, bedside ultrasound, X-ray and laboratory
- ❖ Outpatient clinics + day surgery (visiting specialists provide clinics and day surgery for minor procedures)
- ❖ Allied Health Services (physiotherapy, occupational therapy, social work, speech and language therapy)
- ❖ District nursing

Source: Southern DHB. *Officially an “Accident and Stabilisation Unit”

¹⁶ Includes a solo practice that is not a member of the Wakatipu Primary Health Organisation.

4 Now: A work in progress

Through all of the scrutiny it has had in recent times, no one has found fault with the quality of care provided at the hospital.

Health services have never been static. They are constantly developing in response to growing and changing populations, changing health needs and advances in technology. In this respect, the development of Lakes District

Hospital is work in progress. The hospital (it is invariably described as a hospital today) has grown from a GP-run “health centre” in a relatively short time.

Through all of the scrutiny it has had in recent times, no one has found fault with the quality of care provided at the hospital. It is well supported by the community, and the staff have good working relationships with the town’s GPs. As three GPs wrote in their joint-submission on the DHB management’s initial proposal, “The doctors and nurses currently working at Lakes District Hospital provide a top-level service to the community of Queenstown and their visitors”¹⁷ – a point strongly emphasised by two of those GPs at a public meeting on the proposal on 6 April 2011. One GP also pointed out that if the DHB management’s proposals were implemented we would see a reversal of the progress made over the last 10 years. The same sentiments were expressed by a Dunstan Hospital specialist to the Minister of Health at a recent conference.

*There is a fantastic team of doctors now based at that hospital. It’s taken years to build that up. Those sorts of teams are like absolute gold when it comes to generalist rural teams in New Zealand and the proposed changes will largely decimate that team.*¹⁸

“the skill set of medical, nursing and other staff is high and the service offered is exemplary”

Lakes District Hospital clinical staff have also gained respect from senior medical colleagues in the larger base hospitals where patients are frequently transferred. Dr Alasdair Millar

(Southland Hospital) has commented that “the skill set of medical, nursing and other staff is high and the service offered is exemplary”,¹⁹ while Dr John Chambers (Dunedin Hospital) has described Lakes District Hospital services as being of “a good standard and a credit to those who have worked hard in recent years”.²⁰

¹⁷ Delivering Wakatipu Health Services in the Future: Submission from Wakatipu Medical Centre (Drs Valerie Miller, Nigel Thompson and Tom Milliken)

¹⁸ G Nixon: Comment made to the Minister of Health at the New Zealand GP Rural Network Conference, Wellington, 18 March 2011.

¹⁹ JA Millar, “Discussion of ‘Option 1’”. Lakes District Hospital review Group.

²⁰ JA Chambers. “Wakatipu Health Services Submission from Emergency Clinician. 15 March 2011.

With a medical staff that includes five with vocational registration in rural hospital medicine, and the fact that Lakes District Hospital has a particularly stable medical workforce, Lakes District Hospital is in a position to which rural hospitals around New Zealand aspire. The hospital is now in a strong position to prepare for meeting the district's fast-growing future demands.

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It is worth noting here that the development of Lakes District Hospital into a rural centre of excellence has not occurred as a result of any planning or direction by the DHB management but through years of dedication and commitment by the hospital's clinical staff to aim for the best possible practice within the constraints of a rural service. Their efforts are a prime example of the benefits of clinical leadership in the planning and delivery of health services.

5 The initial proposal

The DHB management's initial proposal, released for public consultation in March 2010, was to establish an "integrated family health centre" at the site of the DHB's Lakes District Hospital, which would be redeveloped²¹

The rationale for this change was that current Lakes District Hospital services were clinically and financially unsustainable, though scarce detail was provided to support that claim. A key feature of the proposal involved bringing together various services under the roof of the redeveloped hospital, including mental health, community services and, most notably, GP services.

General Practitioners, who would provide a 24-hour service from the site, would manage the entry to the Emergency Department. Patients presenting to the ED that were assessed as non-emergency cases would no longer be treated in the ED but in an adjoining GP practice and would be charged a fee.

No explanation was given nor evidence provided to show how an integrated family health centre, as proposed, would address the claimed unsustainability of current Lakes District Hospital services

No explanation was given nor evidence provided to show how an integrated family health centre, as proposed, would address the claimed unsustainability of current Lakes District Hospital services, nor why the DHB management had such confidence in its proposal that it was prepared to make a

"significant" investment in upgrading the Lakes District Hospital site as well as promising increased levels of service in aged care beds, dementia care, palliative care, outpatient clinics, day-case elective surgery, and community nursing.

Nor is any explanation given as to why the DHB management proposed changing the governance of Lakes District Hospital, rather than addressing the community's calls for more accountability and responsiveness from the DHB. In its proposal, it would "assign the head lease of Lakes District Hospital to a new local entity", referred to as a "Local Governance Body", which in turn would sub-lease to an "operating entity". The Local Governance Body would include representatives from service providers, the DHB and the community.

²¹ Southern DHB. *Public Consultation: Hospital Capacity Review. Delivering Wakatipu Health Services in the Future.* March 2010

The DHB management’s proposal was in part a response to a “Hospital Capacity Review”,²² which it commissioned to provide information on the current capacity and future health and disability needs of the rural Otago and Southland DHB regions, and in part “the DHB’s [unexplained] wish to focus in the Wakatipu Basin area”.²³

The review, which has been criticised by clinicians for “significant gaps in the report data and a number of erroneous assumptions”,²⁴ found that of the Queenstown residents requiring ED services, 73% received them at Lakes District Hospital with the remainder attending EDs at Invercargill, Dunedin or other public hospitals. Overseas and domestic visitors account for 21% of ED presentations annually at Lakes District Hospital. The review suggested many people attending the ED could be treated by GPs – eg triage categories 4 and 5,²⁵ and utilisation of inpatient beds, according to the review, is just 52% and maternity 19%.

The review, has been criticised by clinicians for “significant gaps in the report data and a number of erroneous assumptions”

Around 60% of Queenstown residents receiving inpatient or day patient services do so from other public hospitals, mostly in Invercargill and Dunedin. About 86% of Queenstown residents’ outpatient visits are to other public hospitals, again mostly Invercargill and Dunedin.

²² Otago Southland District health Boards Hospital Capacity Review: Current state Analysis, Draft 4.1. Cranleigh Health, December 2009.

²³ Southern DHB. *Public Consultation: Hospital Capacity Review. Delivering Wakatipu Health Services in the Future.* March 2010

²⁴ *Report of the Wakatipu Models of Care Clinical Advisory Group.* December 2010.

²⁵ Triage category 4: 70% of these patients should be seen within one hour. Category 5: 70% of these patients should be seen within two hours.

6 Clinician and public response to management's proposal

A submission representing the unified views of medical staff at Lakes District Hospital, agreed there was a need to make changes to enable services to meet future demands, but strongly opposed the DHB management's proposal. The staff raised a number of significant concerns, including:

- The model had been presented hastily
- It had not been strategically planned
- It was vague
- It was presented in isolation of other services in the district
- It had not been costed, and
- There had been no opportunity for informed debate before the model had been presented.

Of the total 266 submissions received by the DHB, many had serious concerns about the proposal to make GPs the gatekeepers of the hospital's ED; a third of respondents supported such a move. There had been some support for the concept of an integrated family health centre at Lakes District Hospital (49%) but this was heavily qualified, being dependent upon there being no moves towards privatisation, no ED user charges, and no adverse impact on both hospital and GP services. Many questioned whether the integrated family health centre model had been researched and proven to be cost effective and beneficial to patients. Nearly 60% of respondents supported an IHFC being located at the Lakes District Hospital site. A similar number supported the establishment of a local body governance structure.

Emails obtained by the ASMS under the Official Information Act reveal that DHB management did, however, engage in discussions with some Queenstown Medical Centre GPs during 2009 about aspects of Lakes District Hospital services and the development of a Queenstown integrated family health centre.

The ASMS expressed deep concern about the proposal and took issue with the exclusion of the hospital's clinical leaders in the development of the proposal. Emails obtained by the ASMS under the Official Information Act reveal that DHB management did, however, engage in discussions with some Queenstown Medical Centre GPs

during 2009 about aspects of Lakes District Hospital services and the development of a Queenstown integrated family health centre. In relation to this, on 31 May 2009, Queenstown Medical Centre's Dr Hans Raetz contacted the DHB's Regional Primary Care Advisor, Dr Roy Morris, and Chief Executive Brian Rousseau seeking "a bit more from

OSDHB than a secret ‘commitment’” to support Queenstown Medical Centre’s integrated family health centre project, to which Mr Rousseau responded by suggesting further discussion on the phone.

The lack of consultation with the hospital’s clinical leaders conflicted with the requirements for clinical leadership in the national collective agreement covering senior doctors employed by DHBs, in the *Time for Quality* national agreement between the ASMS and the DHBs, and the government’s own policy requiring DHBs to implement genuine clinical leadership. As a result the DHB set up a Clinical Advisory Group in August 2010 to undertake a “Wakatipu Models of Care Review”, including examining possible governance models and a clinical service models for the Wakatipu Basin.

The advisory group’s report included a long list of factors limiting the ability to reach sound conclusions, including absence of strategic planning and lack of sound financial information

The advisory group’s report²⁶ included a long list of factors limiting the ability to reach sound conclusions, including:

- The absence of any strategic planning
- Lack of sound financial information, including that relating to unfunded costs to cover tourists
- Inconsistent population data
- Unavailability of a clear funding entitlement for the Wakatipu Basin
- Unclear information on the cost of providing services for local people at Dunedin and Invercargill
- Evidence of a lack of trust between service providers that has occurred as a result of the process used by the DHB to develop its proposal.

On the matter of governance, a Queenstown Lakes/Central Otago regional governance approach was recommended, but with considerable caution. The Clinical Advisory Group was “very concerned about the vulnerability of this model in relation to funding restrictions that may place a service at risk, as demonstrated in other facilities in Otago and Southland operated by a community health trust”. Its recommendation therefore came with a list of provisos designed to ensure any new arrangements were able to deliver adequate and equitable services into the future. If those provisos could not be met, the group recommended Lakes District Hospital remained under the governance of the DHB.

²⁶ Report of the Wakatipu Models of Care Clinical Advisory Group. December 2010.

With regards to clinical services, the majority recommendation (nine of 12) of the group was to keep the current health service model but with incremental improvements and innovations – most notably a regional approach to delivering services with Lakes District Hospital and Dunstan Hospital clinicians working collaboratively. This recommendation was dependent on a whole of Queenstown Lakes/Central Otago governance and management structure, either within the DHB or a combined community governance model.

The group also recommended, among other things, that the DHB hold off making any further decisions until research into population needs and tourist impact on services is undertaken, as well as strategic planning, and a fully worked up business case is developed with robust financial and population information, supporting the recommended model.

Dr Raetz's letter prompted the *Southland Times* to publish a scathing editorial suggesting that "commercialism, perhaps even greed, has helped shape medical services in Queenstown"

A minority (three of 12) of the group, including Queenstown Medical Centre GP Dr Hans Raetz, recommended shifting Lakes District Hospital's emergency department to Queenstown Medical Centre's Remarkable Parks site under a new community trust.

Dr Raetz, as some in the community will recall, is the same person that in 2004 suggested in a letter to his GP colleagues that they adopt a "dirty tricks campaign" to put pressure on the former Southland District Health Board to give up its control of Lakes District Hospital.²⁷ Dr Raetz's letter prompted the *Southland Times* to publish a scathing editorial suggesting that "commercialism, perhaps even greed, has helped shape medical services in Queenstown".²⁸

Subsequent emails obtained by the ASMS under the Official Information Act show Dr Raetz trying to undermine last year's consultation exercise undertaken by the Clinical Advisory Group by attempting to set up an alternative group, and then attempting to influence who the ASMS was authorised to represent.

After he eventually agreed to join the Clinical Advisory Group, emails between him and DHB chief executive Brian Rousseau suggest a degree of collusion, including making arrangements for a phone discussion about options the Clinical Advisory Group was currently considering, as well as discussion on an alternative option, which featured key aspects

²⁷ *Southland Times*. "Plots by doctors typical: English". 14 October 2004.

²⁸ *The Southland Times*, Editorial: "Close scrutiny required", page 6, 20 October 2004.

of the minority-supported option later put up by Dr Raetz and which was subsequently supported by DHB management.²⁹

Other emails from Dr Raetz reveal attacks on those who disagreed with him (including Lakes District Hospital doctors, the Wakatipu Health Trust and the ASMS) and accusations of Lakes District Hospital doctors manipulating data. There appears to be no evidence in the emails of any attempt by Chief Executive Brian Rousseau to defend his staff.

emails between him and DHB chief executive Brian Rousseau suggest a degree of collusion

In the meantime, in September 2010, the DHB had released its District Annual Plan 2010/11. It states that finding \$8 million new capital funding for Lake District Hospital's redevelopment, given the DHB's overall financial position, "is likely to be a challenge". It adds:

It is important to note that capital approval from the Minister is yet to be obtained for this project and this will be required before it can proceed.

Annual District Plan 2010/11 (p 50)

If the Clinical Advisory Group was frustrated by the lack of information to make sound decisions, it is inconceivable that the Minister of Health would approve spending \$8 million on a project based on the same inadequate information. This raises questions as to the DHB's commitment to developing the hospital as proposed, particularly given the Minister's evident desire to see an early decision on the DHB management's proposal. At a recent conference³⁰, after hearing of the negative impact of proposed staffing cuts in Queenstown, the Minister (revealing a poor understanding of local community feeling) simply commented "...they have spent far too much time consulting and talking to everyone about this thing for years. It is time they actually got on with it."

In summary, the feedback gave several clear messages to the DHB:

- The community mistrusted the DHB (this appears to be the basis for the support for "local governance").
- Robust data and information was needed to justify the proposal (the lack of detail raised the level of mistrust).
- The DHB had alienated GPs, as well as clinical staff at the hospital.
- The community backed its hospital (support for any development to be on the Lakes District Hospital site).

²⁹ Emails dated 6 September 2010 to 11 October 2010.

³⁰ New Zealand Rural GP Network Conference, Wellington, 18 March 2011.

- In whatever model was developed the community wanted the line between public and private services to remain distinct.

The lesson to be drawn from this is the compelling need for Southern DHB to repair its relationships and improve its trust and confidence with the community, general practitioners and its own health professional employees.

The lesson to be drawn from this is the compelling need for Southern DHB to repair its relationships and improve its trust and confidence with the community, general practitioners and its own health professional employees. This poor relationship and lack of sufficient trust and confidence would also negatively impact on the DHB's relationship

with any new governance structure because, if this structure were separate from the DHB, the DHB as the funder only would have a perverse combination of increased negotiating leverage (over funding) and reduced responsibility and accountability (over provision). Unhappiness and discontent would blur the relationship whether Lakes District Hospital was run by a Queenstown Medical Centre-led or community/local government-led trust. The solution rests with improving the quality of the DHB's relationships rather than structural changes that merely leave the problem intact.

7 DHB management's revised proposal

On 3 March 2011 the DHB management unveiled a revised proposal for an integrated family health centre, which it intended to present to the board for consideration.³¹ It had rejected the Clinical Advisory Group's recommendation, saying the group "was silent on how to address the fundamental concerns about ensuring clinical and financial sustainability at Lakes District Hospital..." This in fact misrepresented the group's report. The DHB failed to acknowledge the group's concerns about the lack of reliable data to reach sound conclusions. Nor did it acknowledge the group's recommendation that the DHB address the information shortcomings and work up a full business case before advancing its proposal any further.

On the other hand, the DHB management claimed that the minority recommendation, based on Dr Raetz's proposal to co-locate services at Queenstown Medical Centre, *had* addressed the sustainability issues, despite the advisory group stating it "did not have sufficient information to determine the viability or clinical impact of the model".

Remarkables Park Ltd, developer of Frankton's main retail and residential hub, and Queenstown Medical Centre unveiled plans for an integrated medical services facility just hours after the DHB's announcement

So while the DHB management's initial proposal was solely to co-locate services at the Lakes District Hospital site, its revised proposal emphasised a new option to co-locate services, via a private-public partnership, in a new health centre development in Remarkables Park.

Remarkables Park Ltd, developer of Frankton's main retail and residential hub, and Queenstown Medical Centre unveiled plans for an integrated medical services facility just hours after the DHB's announcement - a coincidence not lost on the local media.

On paper at least, the option to co-locate services at Lakes District Hospital remains on the table, but its genuineness looks questionable in view of Dr Raetz's email to DHB CEO Brian Rousseau in October 2010 pointing out that: "*Co-location at Lakes District Hospital is not seen as an option by my colleagues and joint venture partners.*"³²

The Minister has yet to publicly reveal whether he has decided to fund the Lakes District Hospital redevelopment. Whether the DHB's new option is in anticipation of a negative decision from the Minister, or whether it's an option the DHB has always intended, the community's and clinicians' response to the two announcements, widely reported in

³¹ Southern DHB: *Wakatipu Health Services* (Recommendations to the DHB Board)

³² Email from Dr Hans Raetz to Brian Rousseau, 9 October 2010.

the media, reflect suspicion of an unspoken agenda to increase private influence and control of public services in the district.

Indeed, when the revised DHB management proposal states,

There now exists a window of opportunity for the Southern DHB to support current primary care providers and broaden the proposed Queenstown Medical Centre development to establish an IFHC....,

that “window” looks to have appeared more by design than by accident.

As Queenstown Medical Centre explained in a “special newsletter” published on its website, the Remarkables Park health centre development has been waiting in the wings for some time. After it was granted resource consent in 2009, **the DHB approached Queenstown Medical Centre** “and asked them to suspend further progress until the DHB could evaluate and assess the future provision of public health services in Queenstown”.³³ That work was to include a possible private-public partnership.³⁴

Remarkably, no mention is made of the Remarkables Park option in the DHB management’s original proposal of March 2010, so the public were denied an opportunity to comment on the matter.

In the meantime, in November 2009, an email from Queenstown Medical Centre’s CEO Richard Macharg to DHB chief executive Brian Rousseau suggested an option involving GPs in the provision of all ED first presentations, including –

“the fully equipped A&M facility at Queenstown Medical Centre 9 Isle Street and perhaps enhanced facilities at Queenstown Medical Centre Remarkables Park and Wakatipu Medical Centre...”

Remarkably, no mention is made of the Remarkables Park option in the DHB management’s original proposal of March 2010, so the public were denied an opportunity to comment on the matter. Nor did there appear to be any intention of consulting the community on the revised proposal focusing on a Remarkables Park option.

However, just as the DHB was obliged to consult with the ASMS and its Lakes District Hospital members on the initial proposal, which led to the establishment of the Clinical Advisory Group, the DHB was also obliged to consult with the ASMS and its Lakes District Hospital members on the revised proposal.

The ASMS-DHB national collective agreement acknowledges that, when significant services changes are being considered, involvement of employees will help to improve decision-making and lead to a more

³³ Queenstown Medical Centre Ltd. *Special Newsletter*, 4 April 2011. Available at www.qmc.co.nz/specialNewsletter.html

³⁴ Email from Dr Hans Raetz to Dr Richard Macharg, forwarded to the DHB, 25 November 2010.

effective and efficient workplace. The document therefore requires the DHB to engage with employees and support clinical leadership in “service design, configuration and best practice service delivery”, as part of a specific *Time for Quality* agreement. The national agreement also requires the DHB to consult with staff and the ASMS on any review which might impact on the delivery or quality of clinical services. In particular, the agreement includes a specific clause requiring the DHB to engage with the ASMS and its affected members to resolve “any serious professional or clinical concerns” they may have with regard to the recommendations of any review.

A list of serious professional and clinical concerns that were identified as a result of that consultation is currently being discussed between the ASMS and the DHB. Had those serious professional clinical concerns not been raised by the ASMS, NZNO and other unions, the DHB management intended the proposal to go to the DHB board for consideration and, if approved, was to enter early implementation stages. There appeared to be no initial intention to consult with the public.

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It was also proposed that, while an integrated family health centre was being established, and “given the DHB’s financial position”, an immediate “interim” measure was needed to cut costs at Lakes District Hospital. It involved reducing senior doctor staffing by 25% (from 8 to 6) and cutting nursing staff by 0.8FTE. Chief Executive Brian Rousseau justified this by saying that a 2009 “desktop review” by a former chief medical officer had concluded that the “majority of attendances at the hospital could have been safely dealt with in primary care”, thus reducing the ED workload and the need for the current medical and nursing staff levels.

The DHB had estimated a saving of \$500,000 per year, minus an unknown portion that would be set aside “to assist those people who truly cannot afford primary care”.

Curiously, no mention was made of a “desk top review” in the final draft of “Hospital Capacity Review”, published in December of that year. Nor was such a document able to be located when sought by the Clinical Advisory Group.

After persistent enquires by the ASMS, it was revealed that the “review” did not actually exist in written form, as explained later in this paper, and

the claim only served to heighten clinicians' concern about the integrity of the proposal and the process used to develop it.

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The revised proposal also angered many in the community. The Wakatipu Health Trust, an independent charitable organisation, called it "a total disregard for the wishes of this community", citing the views expressed at a series of health forums where there was strong opposition to any suggestion of allowing private company involvement in current public hospital services.³⁵

Following extensive media coverage in which community representatives, clinicians and unions (including the ASMS) continued to raise concerns about the lack of information, lack of responsiveness to clinician and community feedback and the impact of staff cuts on patient safety, Mr Rousseau organised a public meeting so the community could "hear the facts".

Prior to that meeting, the ASMS, the Nurses' Organisation (NZNO) and Lakes District Hospital staff representatives met with Mr Rousseau to discuss concerns about the proposed staff cuts. An agreement was reached between the ASMS, NZNO and DHB to set up a working group to "to recommend on innovative models of care, quality improvement initiatives and cost saving initiatives to enhance the effectiveness of the medical and nursing workforce employed by the DHB at Lakes District Hospital". The group, which is made up of ASMS, NZNO and management nominees, largely comprises Lakes District Hospital health professionals. However, given the subsequent announcement of a broader review by the National Health Board, it has been agreed that the working group's review will be put on hold and reappraised after the NHB has completed its work.

Later that same day, at the 500-strong public meeting to "hear the facts", many vented anger, frustration and distrust of the DHB management's intent.

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The people were expecting to hear details about the structure and make-up of the integrated facility. Instead Mr Rousseau asked for support for the concept and suggested the details could be worked out later. The crowd were clearly uneasy about that and the DHB announced its plan to vote on new health services in the Wakatipu region would be delayed.

Radio New Zealand reporter – *Insight*, 10 April 2011

³⁵ Wakatipu Health Trust. "Latest DHB proposal". Available at www.whtrust.co.nz

DHB chair Joe Butterfield's announcement that the board would not be making a decision on the proposal at its next meeting followed a somewhat confusing presentation by the CEO, Mr Rousseau.

In contrast to statements from the Wakitipu Health Trust and the obvious anxiety expressed by many at the meeting, Mr Rousseau claimed concerns raised through the earlier public consultation had been addressed in the revised proposal. He also emphasised the proposal was directed at ASMS and staff (ie not the public) as part of contractual consultation requirements.

He explained that pending resolution of professional concerns raised by the ASMS and staff, the DHB would start a process to determine:

- Where the integrated family health centre is best located (if not Lakes District Hospital, then Lakes District Hospital is surplus to requirements)
- What services will be provided
- Who the providers will be
- Who the governors will be
- Who the integrated family health centre owners will be

He also indicated a business case would be drawn up that would look at what benefits would accrue from co-location of services, such as the possible reduction of overheads of a single facility. Whether this is intended as "a fully worked up business case with robust financial and population information", as recommended by the Clinical Advisory Group, remains to be seen.

Under a banner, "Let's be clear!!" Mr Rousseau stated:

The DHB is currently the governor of public hospital services. The DHB is currently the provider of public hospital services. If there are any recommendations to significantly change the DHB governance or provision, the DHB will first need to consult the public and staff.

The exact meaning of that statement is not clear on the matter of DHB provision, however. A reasonable interpretation is that any decision to co-locate DHB-provided services to the Remarkables Park development would be deemed a "significant change" to DHB provision and would therefore be subject to consultation.

the approach Mr Rousseau had taken in his revised proposal to the board lacked any hint of further public consultation being necessary, regardless of whether the board decided upon redevelopment at the Lakes District Hospital site or a shift to the commercial site.

The statement may also mean that moving services to the Remarkables Park development would not constitute a significant change to DHB

provision if the DHB services themselves remained more-or-less the same. That would be consistent with the approach Mr Rousseau had taken in his revised proposal to the board, which lacked any hint of further public consultation being necessary, regardless of whether the board decided upon redevelopment at the Lakes District Hospital site or a shift to the commercial site. The “implementation next steps” were:

Following resolution of any serious professional or clinical concerns (if any are raised by ASMS), if the Board approves the recommendations in this paper, the likely next steps will comprise:

- *A procurement process/integrated family health centre development workstream*
- *A working group to set up clinical pathways*
- *Change management consultation with Lakes District Hospital staff and unions*
- *Funding and public service configuration (following the clinical pathways being established).*

As far as Mr Rousseau was concerned – despite the many concerns raised by those at the public meeting – his proposal had addressed all the issues raised in the public consultation. As he told the meeting: “You told us in March 2010 that you conditionally supported the idea of an integrated family health centre, [you] want hospital services retained, [you] want a free emergency department. All of these issues are addressed in the March 2011 proposal to staff and ASMS.”

a proposal to develop the Lakes District Hospital site at a cost of \$8 million, as well as provide a raft of new services, however much needed, simply does not fit with the DHB’s position of being strapped for money

In the final analysis, a proposal to develop the Lakes District Hospital site at a cost of \$8 million, as well as provide a raft of new services, however much needed, simply does not fit with the DHB’s position of being strapped for money. There is a distinct ring of truth, however, contained in the option submitted to the Clinical Advisory Group by Queenstown Medical Centre:

Southern District Health Board would abandon expansion plans for Frankton’s Lakes District Hospital – the DHB won’t have the dough. Southern DHB would sell the \$18 million Lakes District Hospital complex, pocket some money and put the rest into a public-private partnership with Queenstown Medical Centre for a new hospital...³⁶

³⁶ F Marvin, “Queenstown doctors hatch plan to scrap Frankton hospital”. *Mountain Scene*, 25 November 2010.

Following the community and clinician backlash, the DHB has wisely taken a pause, but its revised proposal is still largely intact. The key issues and concerns are not yet resolved. They include a number of serious concerns the ASMS has raised with the DHB. These and other issues are discussed in the next section.

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professional and clinical
These and other issues

8 Issues raised by the DHB management's proposals

Integrated Family Health Centres

First, the DHB management has produced no evidence to support its rather obliquely expressed claim that the particular integrated family health centre model in its proposal has been shown “internationally and nationally” to be more clinically and financially sustainable than the current health service model. The existence of such evidence sounds as doubtful as the claimed “evidence” supporting the idea of turning away patients from ED.

The DHB management's proposal implies that it is faithfully and fully consistent with government policy. This is misleading, however, because it ignores the fact that integrated family health centres may take various forms. In Auckland, for example, the Greater Auckland Integrated Health Network business case, which has been approved by government, envisages integrated service “hubs” involving more than one site. Likewise, in Hamilton, three pilot sites are being used, connected by a centralised phone and online contact centre.³⁷

The government has a policy on clinical leadership, for example, which the DHB has disregarded in the development of this proposal.

Given that in Queenstown the primary care and hospital sites are reasonably proximate, there is no reason why clinically appropriate models of care might not be developed with an appropriate level of professional and clinical collaboration. Further, basing a proposal on a

narrow application of only one strand of government policy, while ignoring others of arguably more importance, is unlikely to achieve greater sustainability. Achieving sustainability requires vision, including implementing a broader range of government policy in an integrated way.

The government has a policy on clinical leadership, for example, which the DHB has disregarded in the development of this proposal. The Minister of Health could not have emphasised the importance of this policy more clearly when he stated in a major address outlining the government's health agenda:

*This failure to engage the very people with the right expertise – doctors and nurses who know the patients' needs best – is seriously eroding our ability to provide patients with the care they need.*³⁸

³⁷ New Zealand Doctor, 20 April 2011.

³⁸ Hon Tony Ryall. “The Government's Health Agenda.” Address for the Dean's Winter Lecture Series, AUT, 15 October 2009.

The government also has a policy on strengthening and enhancing public hospital capacity which, again, the DHB management proposal ignored. It has further policy to improve regional coordination and sharing of services (as proposed in a number of submissions to the DHB). To quote the Minister:

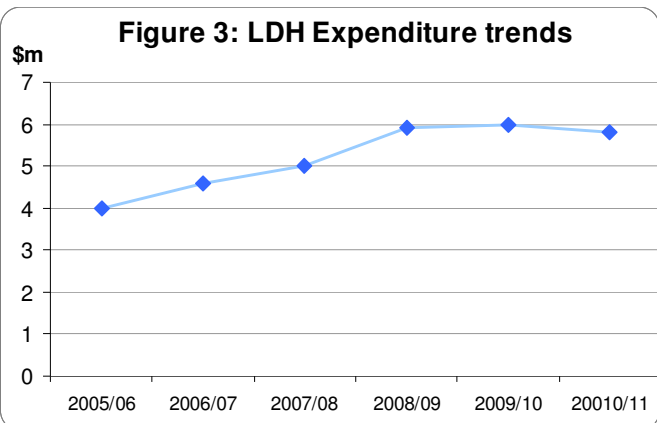
*The government is seeking better coordinated and integrated planning and decision making across all levels of the health services, to deliver better services at district, regional and national levels. This will be done working in partnership with health professionals to harness clinical expertise to improve service planning and quality.*³⁹

Yet again, however, the policy has been ignored in the DHB management’s proposal.

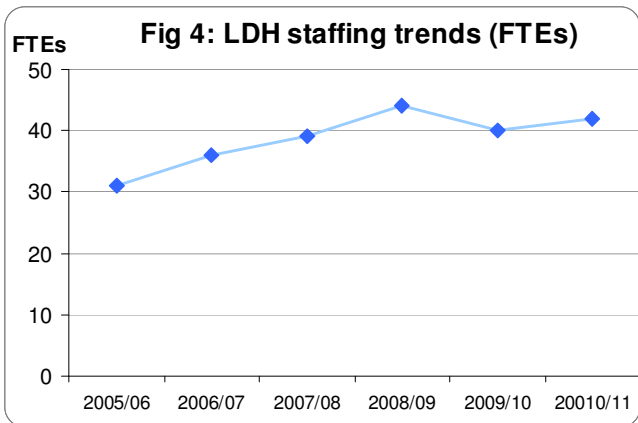
“Financial unsustainability”

The DHB management’s claim that Lakes District Hospital is financially unsustainable does not bear scrutiny. It is based on expenditure increases between 2005/06 to 2008/09 when the hospital was undergoing a much-needed expansion of its clinical staff – largely for safety reasons – which has now stabilised.

From 2008/09 to 2009/10 costs increased by just 2%, and when adjusted for inflation there was virtually no change. Financial data provided by the DHB shows estimated expenditure for 2010/11 (based on the first 10 months’ expenditure) will actually drop by approximately \$150,000, as indicated in Figure 3. (More explanation of the staffing increases is provided below.)



Source: Lakes District Hospital
 2010/11 estimate based on first 10 months’ expenditure
 Expenditure increase = 47% (2005/06 to est. 2010/11)
 Inflation = 14.6% (June 2006 to March 2011)



Source: Lakes District Hospital
 2010/11 - as at April 2011
 Staff increase = 35% (2005/06 to est. 2010/11)

³⁹ Ibid

Caution is needed when comparing expenditure levels across hospitals, given no two hospitals are the same, even if their populations are broadly similar. A hospital's proximity to its base hospital, and whether a hospital provides a 24/7 ED, for example, will impact on medical and nursing requirements, especially if there is no after-hours GP cover, such as in Queenstown (and especially in a town with the unique characteristics of being a major year-round tourist centre in a wider rural setting).

With that caveat, the DHB-commissioned Hospital Capacity Review shows Lakes District Hospital's total hospital expenditure per head of population falls in the middle of a selected group of rural hospitals (Balclutha, Gore, Lakes District, Dunstan, Oamaru, Tokoroa and Taumaraunui).⁴⁰ Expenditure per head of population ranges from \$295 in Balclutha to \$577 in Taumaraunui, with Lakes District sitting at \$395.

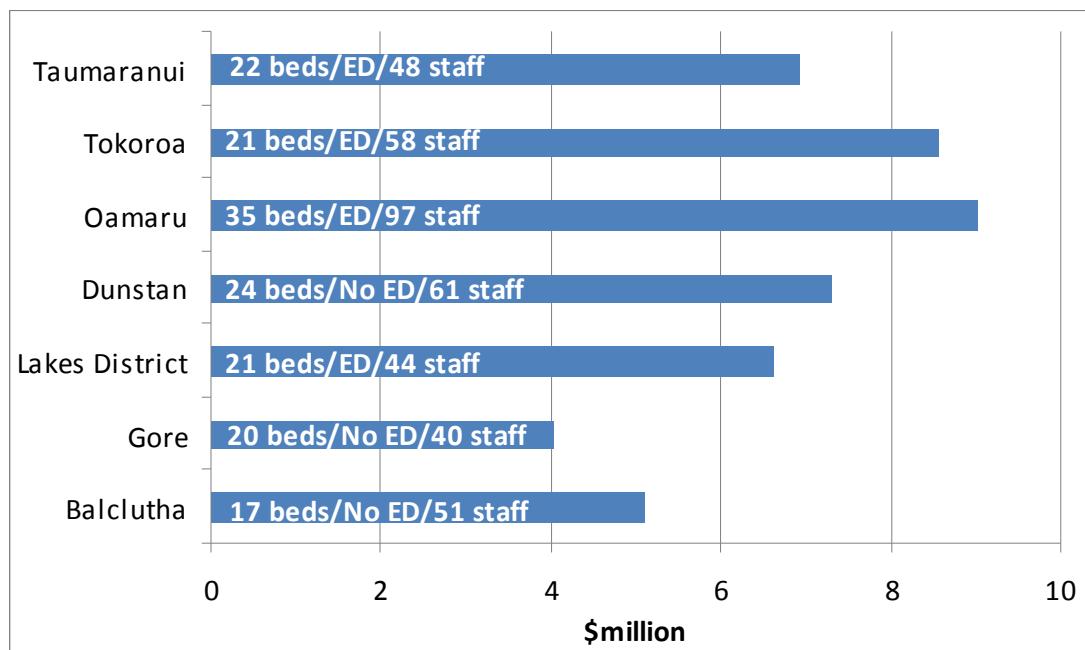
That calculation, however, takes no account of visitors to the region.

That calculation, however, takes no account of visitors to the region. The catchment of Lakes District Hospital's resident population is given as 16,780 (the report was published in 2009). Queenstown Lakes District Council has estimated the average daily visitors numbered at almost 10,700, making a total of around 27,500. If Lakes District Hospital's spending per head of population were based on that figure, it would be approximately \$240.

Total hospital spending across the selected rural hospitals, taking into account bed numbers and total (rounded) FTE staff numbers, again shows Lakes District Hospital's expenditure is by no means high, especially compared to other hospitals with an ED (Figure 5). (Note: Lakes District Hospital's bed number is higher than the more recent figure quoted in Figure 2 due to the loss of aged care beds to another provider. Figure 5 expenditure figures include capital charges, putting LDH's 2008/09 expenditure higher than the 2009/10 expenditure quoted elsewhere in this paper, which excludes capital charges.)

⁴⁰ Two North Island hospitals (Tokoroa and Taumaraunui) were added to "to ensure the comparative analysis is robust as possible". These hospitals "have similar population volumes, ED and secondary service configurations, and are of similar distances from their base/tertiary hospital". (However, Taumaraunui Hospital serves a resident population less than half that of LDH and Tokoroa Hospital is about half the distance from its base hospital than LDH.)

Figure 5: Total rural hospital expenditures, bed numbers and FTE staff (2008/09)



Source: Cranleigh Health, Hospital Capacity Review

The Hospital Capacity Review also compares rural hospitals by applying a case weighted discharge (CWD) methodology to hospital outputs to arrive at an average cost per CWD, which suggests Lakes District Hospital’s cost per output is second-highest of Southern DHB’s rural hospitals, behind Balclutha.⁴¹

However, the report does not explain why, logically, some rural hospitals will have higher CWDs than others. Lakes District Hospital, for example, is more isolated than other rural hospitals in the region, increasing the costs of transfers and outpatient clinics. This is especially so considering there are no commercial flights between Invercargill and Queenstown, which means non-emergency transfers, and specialists visiting from Invercargill, have a 2.5-hour road trip, one way. Lakes District Hospital’s provision of a 24/7 ED will also push up its operational costs, compared to most other rural hospitals.

Also significantly, Lakes District Hospital’s average bed occupancy rate – officially 52% – is understated. There is no recognition that many of the hospital’s inpatient cases are transferred within a 24-hour period and therefore are not counted in the bed occupancy statistics.⁴² For example, Lakes District Hospital bed occupancy data showing daily bed occupancies as at 11am and midnight indicate many days when

⁴¹ Case weighted discharge (CWD): Common currency in which hospital service delivery is described. CWDs are applied to discharges based on clinical coding and represent the average level of resources used in treating cases classified under diagnostic related groups.

⁴² Bed occupancy is based on counts as at midnight

occupancy rates are higher in the morning than at midnight. In the busiest months during 2010, occupancy rates (as at 11am, midnight, or both) frequently reached 70% and over, including some days with rates from 90% to 100%.⁴³ A recent media report indicates the average (midnight) occupancy rate in March 2011 was 80%.⁴⁴

Understatement of Lakes District Hospital's bed occupancy rates will have the effect of inflating Lakes District Hospital's real cost per hospital output.

Understatement of Lakes District Hospital's bed occupancy rates will have the effect of inflating Lakes District Hospital's real cost per hospital output. Emergency department attendances have also risen by about a third since the figures used in the report.

The DHB's funding of rural hospitals is actually based on the volumes of patients treated against a rural medical "bed day rate", calculated by the DHB and, for hospitals with EDs, a nationally set average price for patients attending level 2-4 EDs. The volumes are budgeted according to current trends.⁴⁵ It is on this basis that DHB Chief Executive Brian Rousseau claimed at a public meeting in Queenstown on 6 April 2011 that had hospitals Lakes District Hospital been "funded on the same basis as other rural hospitals, its 2009/10 funding should have been \$3.6 million when its actual expenditure was \$5.99 million".

the fact that Lakes District Hospital's expenditure is greater than its budget is not in itself an argument for "financial unsustainability"

In fact Lakes District Hospital's budget was \$3.6 million in 2009/10 (clearly inadequate, given its actual expenditure).⁴⁶ The DHB has not released information to enable any

verification that other rural hospitals were indeed funded on the same basis. Moreover, the DHB's budget appears not to tally with information in the Hospital Capacity Review, which indicates, Lakes District Hospital funding based on "rural hospital activity volumes by national pricing" would have amounted to \$4.4 million in 2008/09.⁴⁷

Regardless of questions about the appropriateness of comparisons with other hospitals, the fact that Lakes District Hospital's expenditure is greater than its budget is not in itself an argument for "financial unsustainability". As Dr Alasdair Millar, the Chief Executive's own nominee on the Clinical Advisory Group has commented:

It is said that Lakes District Hospital runs at a substantial deficit financed by financial top-ups that are necessarily sourced from other Board areas of operation, ie other areas subsidise Lakes District Hospital. However,

⁴³ Lakes District Hospital: Monthly Inpatient Census

⁴⁴ *Otago Daily Times*, 6 May 2011.

⁴⁵ Communication with the DHB's Chief Financial Officer, May 2011.

⁴⁶ Southern DHB Lakes Hospital Service statement of Financial Performance

⁴⁷ Hospital Capacity Review. Appendix 7, page xxvii.

*this point of view ignores the possibilities that the base funding is unreasonably low or that the operational environment at Lakes District Hospital is special and different from other areas within the Board's jurisdiction, such that costs are necessarily greater. A claim of financial non-sustainability justified solely by reference to a funding deficit is inadequate.*⁴⁸

Mr Rousseau has not presented expenditures of other DHB hospitals in relation to their budgets. However, the estimated DHB deficit for this year is approximately \$15 million.

Further comments from Dr Alasdair Millar summarise many of the points made above:

The claim that current operations at Lakes District Hospital are “financially unsustainable” is an ambit claim not supported by evidence. It appears to be based on an uncritical view of the existence of a deficit at Lakes District Hospital that is high relative to the base funding, along with a general unwillingness to spend the resources required to achieve clinical sustainability.

*The Board has not established that the total cost of Lakes District Hospital is unreasonable by New Zealand standards for a hospital of Lakes District Hospital's size and service structure....*⁴⁹

“Clinical unsustainability”

The New Zealand Rural Hospital Doctors Working Party, which was formed in 2005 to examine the vocational issues faced by doctors working in small rural hospitals, found a key issue for clinical sustainability in rural hospitals is medical staff recruitment and retention.⁵⁰

Their work led to the establishment of rural hospital medicine as a new speciality, which is the first concrete progress in the endeavour to provide a tier of medical specialists with the ability to deal with a wide range of presentations. This is crucial for attracting and retaining specialists in New Zealand's rural hospitals at a time of growing international shortages. The new specialty provides a career pathway for rural hospital specialists and will help to provide some balance to the tendency to increased sub-specialisation which usually requires specialists to be based in larger urban hospitals.

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⁴⁸ JA Millar, “Discussion of ‘Option 1’”. Lakes District Hospital review Group.

⁴⁹ Ibid

⁵⁰ G Nixon, K Blattner, “Rural hospital medicine in New Zealand: vocational registration and the recognition of a new scope of practice,” NZMJ, Vol 120 No 1259, 10 August 2007.

As noted earlier, Lakes District Hospital happens to be in a strong position in this respect, with five of the hospital's eight specialists holding vocational registration in rural hospital medicine, and with another specialist about to gain vocational registration in emergency medicine. This, and the fact that Lakes District Hospital has a particularly stable medical workforce, is a position to which rural hospitals around New Zealand aspire. There is no evidence indicating the hospital is clinically unsustainable; quite the contrary.

Having the ability to train the next generation of specialists will help to ensure the hospital continues to develop the capacity to meet the district's future health needs

With a specialist workforce and – since the introduction of the swing shift – having an ED staffed by two doctors during the daytime shifts, means Lakes District Hospital now has an opportunity to employ a registrar to train as

a specialist in rural hospital medicine with funding for that position provided by the Clinical Training Agency. Having the ability to train the next generation of specialists will help to ensure the hospital continues to develop the capacity to meet the district's future health needs.

As the DHB-commissioned *Hospital Capacity Review* states:

Unless there is a sustained effort on rural-focused training, the rural health workforce is unlikely to grow in significant numbers. Therefore, careful utilisation of an already scarce medical resource and the development of new roles and responsibilities for both nurses (nurse practitioner) and doctors (RHD) is most likely to lead to a sustainable service.

Ironically, the biggest current threats to Lakes District Hospital's clinical sustainability are DHB management decisions. First, the Australasian College of Emergency Medicine was due to undertake an inspection of Lakes District Hospital in September 2010 as part of the process towards having the hospital accredited for the purpose of training new specialists. For reasons not explained at the time and still unknown, that visit was cancelled by the Chief Executive a week before it was to take place. Although the reasons remain unexplained, it may have been linked to the discussions between the Chief Executive and Queenstown Medical Centre in their email correspondence.

Ironically, the biggest current threats to Lakes District Hospital's clinical sustainability are DHB management decisions

Dunedin emergency medicine specialist John Chambers, who is also a member of the New Zealand Faculty Board of the Australasian College for Emergency Medicine (ACEM) and an experienced college accreditation inspector, had this to say in his submission to the DHB:

It is my opinion that the current developments have undermined a lot of good work undertaken by the rural hospital medicine specialists and

previously supported by the Southland DHB. The training of our ACEM trainees has been disadvantaged by the process.

There is an impression that the current proposal is attempting to fix a system which is not broken from a clinical perspective. In fact the service as it has developed is of a good standard and a credit to those who have worked hard in recent years.⁵¹

After receiving much criticism from clinicians about the cancellation of the college inspection, the DHB rescheduled a visit from the college, which occurred on 19 May 2011. This is a more positive sign of the DHB's commitment to the future development of Lakes District Hospital, though questions remain about that commitment, particularly in view of the DHB management's proposal to do away with the ED's "swing shift" and by the way in which the justification for the proposal was contrived.

The proposal to cut staff

Some DHB managers, faced with tight budgets and government pressure to reduce emergency department waiting times, have taken a view that ED workloads can be reduced (and therefore money can be saved and waiting times reduced) by diverting patients that appear to be of low acuity to a GP. Mr Rousseau is among those who see this as the answer to reducing ED workloads. This, he claims, will render Lakes District Hospital's swing shift and the employment of two doctors unnecessary.

That assumption, however, lacks evidence to sustain it. It has been shown to be overly simplistic, unsafe and, at best, would result in only marginally reducing the ED workload^{52,53}

Patients presenting at emergency departments are normally triaged by a nurse on presentation into triage categories. The categories are based on those present at any given time and the urgency of their condition; a category is assigned after a relatively cursory examination. For example, on a recent weekend at Lakes District Hospital there were two triage four patients; one had a sprained ankle, the other a broken back. Moreover, as the hospital's clinical nurse coordinator points out in her submission to the DHB, many of the lower triage patients are actually referred to the ED by their GPs!⁵⁴

many of the lower triage patients are actually referred to the ED by their GPs

⁵¹ JA Chambers. "Wakatipu Health Services Submission from Emergency Clinician. 15 March 2011.

⁵² M Ardagh. "How to achieve New Zealand's shorter stays in emergency departments health target" *NZMJ* 11 June 2010, Vol 123 No 1316; ISSN 1175 8716

⁵³ Australasian College for Emergency Medicine. *Access Block and Overcrowding in Emergency Departments*, April 2004

⁵⁴ KT Paa, clinical nurse coordinator. Wakatipu Health Services – Submission, 17 March 2011.

There is ... a persistent line from management that patients in triage categories 4 and 5 (or those who are not admitted from ED) are patients who should have been seen by GPs. Although the initial nurse triaging process can identify certain patients who are safe to wait for over an hour, this does not in fact imply they are 'inappropriate attendees'. A patient with an ankle fracture can safely wait for several hours for their plaster (given adequate pain relief), but their treatment is best done in ED, and they will not be admitted for further care.⁵⁵

Hamish Wilson (Senior Lecturer, Dept of General Practice),
University of Otago

Lowering barriers to more appropriate care is a better solution than raising barriers to perceived inappropriate care

A common and unfortunate response to a perceived excess of [ED] preload has been to deny or obstruct care to those considered inappropriate for presentation at the ED. The assessment of 'appropriateness' at triage has consistently been shown to be inaccurate and, in addition to potentially contravening rights of access to care, 'triaging' patients out of the ED is dangerous and does not reduce costs. Lowering barriers to more appropriate care is a better solution than raising barriers to perceived inappropriate care.⁵⁶

Prof Mike Ardagh (Professor of Emergency Medicine)
and Sandra Richardson (Emergency Nurse Researcher)

General practice-type patients attending emergency departments represent the low-end of complexity and cost. Significant reductions in this type of patient, if they are capable of being identified, will have marginal impact on emergency department workloads.⁵⁷

Australasian College for Emergency Medicine

The evidence gathered by a Ministry of Health literature search states:

"While EDs will often see patients with primary care problems, particularly after hours, the evidence for having primary care practitioners in the ED, or for redirecting patients to a primary care facility, is poor."⁵⁸

⁵⁵ H Wilson. "Co-locating primary care facilities within emergency departments: brilliant innovation or unwelcome intervention into clinical care? *NZMJ*, Vol 118 No 1221, 26 August 2005.

⁵⁶ M Ardagh and S Richardson. "Emergency Department Overcrowding – can we fix it? *NZMJ*, Vol 117, No 1189, 20 February 2004

⁵⁷ Australasian College for Emergency Medicine. *Access Block and Overcrowding in Emergency Departments*, April 2004

⁵⁸ Ministry of Health. "Solutions to emergency department (ED) overcrowding: a literature review, March 2009.

Despite perceptions that EDs see a large number of primary care patients, numbers of primary care presentations at EDs were found to be surprisingly small. Only three percent of primary care patients attended an ED in preference to visiting their GP (Eagar K, 2005). It has been proven that general practice (GP) patients do not cause access block or ED overcrowding and persistence of this belief is detrimental to finding real solutions (Sprivulus PC, 2004).

Ministry of Health literature review

The advice from both the director of Southland Hospital's Medical Services Division (whose responsibilities at the time included Lakes District Hospital) and the doctors at Lakes District Hospital is consistent with the literature: that while some presentations might be dealt with more effectively in general practice, there are not sufficient of these to materially affect the medical staffing needs of Lakes District Hospital.

However, Mr Rousseau appears not to have been convinced by this body of research and experience and attempted to produce his own "evidence", through a "desk top review" by a former Chief Medical Officer (who was not an emergency medicine specialist and who no longer practices clinical medicine). This review concluded that the "majority of attendances" at Lakes District Hospital could have been safely dealt with in primary care.

while some presentations might be dealt with more effectively in general practice, there are not sufficient of these to materially affect the medical staffing needs of Lakes District Hospital

The Clinical Advisory Group had asked for a copy of the "review" but was advised that the DHB was unable to locate it. In fact it did not exist; after an enquiry from the ASMS, the Chief Executive revealed that this review was not in writing and he undertook to obtain a letter from Dr Pim Allen, who had undertaken the exercise. Subsequently he forwarded to the ASMS a letter from Dr Allen, dated 11 March 2011, which refers to an exercise she undertook in 2007 and early 2008 (not 2009 as asserted in the DHB management's proposal).

Dr Allen's letter does not say what the proposal alleged it said; Dr Allen gives no information on the number of presentations which form the population from which she has selected, and there is no clear indication from her letter as to what she considers an inappropriate presentation to an emergency department. Dr Allen's "desk top review" is essentially a casual report that lacks credibility and cannot be relied on.

Even if low acuity patients could be safely diverted from ED to GP practices, it is hard to see how this would mean a swing shift is not needed

Even if low acuity patients could be safely diverted from ED to GP practices, it is hard to see how this would mean a swing shift is not

needed. Before the swing shift was introduced, it was not the low acuity patients that caused the night-shift doctor to be called in during the day, because low acuity patients wait until staff become available. It was the number of *complex high-acuity patients* that created the need for the swing shift.

No GP service in Queenstown has an after-hours' service that extends beyond 8.00pm,⁵⁹ so the hospital's night-shift doctors would continue to deal with the same work-load. Daytime presentations would have the same high acuity patients as at present. Even if an efficient method were found to identify and divert the low acuity patients to GPs, this would have little or no effect on the need for an additional doctor to deal with the high acuity patients during the busiest part of the day.

The proposed solution would be unsafe for ED patients in the opinion of the senior doctors working at Lakes District Hospital

Furthermore, since the DHB's Medical Division recommended employment of two additional doctors and a 0.8 FTE nurse in 2009 to ensure safe staffing in the 24/7 ED, presentations have continued to increase.

The proposed solution would be unsafe for ED patients in the opinion of the senior doctors working at Lakes District Hospital. It would also put at risk those patients who are diverted to GPs, as pointed out by a number of staff submissions to the DHB and as recognised in the literature.

*Redirecting them is seen as risky, especially if serious cases such as meningitis could be missed. Redirecting is also time-consuming, and not always in the patients' best interest.*⁶⁰

It is likely that both nursing and medical staff would not wish to continue employment if they were put in the position of having to provide a service in a clinically unsafe environment, thus the proposal undermines the future viability of the hospital.

*None of the nurses or doctors who previously worked in the pre-swing shift environment are willing to go back to the same safety-compromising situation which existed previously. The night doctor is now too busy to provide a day-time call-back option.*⁶¹

Hospital clinical staff submission

As well as being clinically unsafe, the DHB management's proposed cuts would almost certainly lead to increased service costs, contrary to the

⁵⁹ The Queenstown Medical Centre formally has a GP on call after this but the doctors at Lakes have never to date been able to obtain a response from the designated GP.

⁶⁰ Elley CR, Randall P-J, Bratt D, Freeman P (2007) Can primary care patients be identified within an emergency department workload? *NZ Med J* 120(1256):U2583

⁶¹ Clinical staff, Lakes District Hospital. *Wakatipu Health Services*. "Communication to SDHB board from medical and nursing staff at Lakes District Hospital with regard to Brian Rousseau's paper (dated 2 March 2011)", 7 March 2011.

DHB management's unsubstantiated claim of making a saving of \$500,000. As a number of staff have explained in submissions to the DHB, cutting the hospital's medical and nursing capacity will simply mean more patients are transferred to the larger base hospitals, often at great expense.

Procedures which require significant sedation, which by international standards requires two doctors to be present, would no longer be possible at the hospital and would certainly have to be transferred. Not least, a single sentinel event resulting from the loss of clinical safety could have potentially huge cost implications.

The long-term "solution" to providing a clinically and financially viable service in the DHB management's proposal is essentially to disaggregate the functions that constitute Lakes District Hospital and co-locate the emergency department with private specialist functions and the after-hours service and GP practice run by the Queenstown Medical Centre.

Such an emergency service will still need to have two doctors on duty during the afternoon in order to be clinically safe. The suggestion is that one of these could be a GP "on call". Such a GP would need to be either at home and called back, in which case they would require payment; scheduled to see patients with appointments which they then abandon because of emergency service requirements, which would again require funding because of foregone co-payments; or require the GP practice to run with an extra GP with no scheduled appointments available to the emergency department if required, which again would require funding.

There is no reason to believe this funding will come from anywhere other than the funding provided by the DHB. Even in the proposed integrated family health centre, the costs to the DHB of staffing an emergency department on a 24/7 basis will be similar.

In summary, the "swing shift" is necessary in some form or other to ensure the safe provision of a 24-hour, seven-day a week service. The DHB's options are to provide this service and pay for it (one way or another) or not to provide a 24/7 emergency service in the area of its greatest population growth.

the "swing shift" is necessary in some form or other to ensure the safe provision of a 24-hour, seven-day a week service

Maintaining free access to hospital services

One of the concerns of the doctors at Lakes District Hospital has been the low number of clinics held by Southland DHB specialists at the hospital. This is in contrast to Dunstan Hospital, which has had more

outpatient clinics held by Dunedin Hospital specialists. This is in part because of the historic specialist workforce shortages at Southland. The merging of the two DHBs is an opportunity to rectify this and provide more free secondary services at Lakes District Hospital.

If all the promises made to the community are implemented, the costs will make the price of a swing shift at Lakes District Hospital seem insignificant

The DHB management's proposal suggests a different model. Specialist services at the Remarkables Park development can be provided either in the private system, where they are charged by the service provider, or be

funded by the DHB. It is unclear from the proposal what mix is proposed. Certainly the impression given is that there will be an expansion of services; that was a key part of the DHB management's original proposal. No costings have been put forward for these extra services. If all the promises made to the community are implemented, the costs will make the price of a swing shift at Lakes District Hospital seem insignificant.

The government has been very clear that anything that is currently funded as a secondary service through the public hospital system will not be charged for as part of their initiatives to integrate primary and secondary care.

Maintaining sufficient hospital capacity to meet increasing needs

A DHB-commissioned "Clinical Services Plan" for the Queenstown Lakes District suggests that since the reported bed occupancy rate is low (52% at Lakes District Hospital), and assuming the number of preventable hospital admissions can be reduced, current bed numbers should be adequate until 2026.⁶² This is reflected in the DHB management's proposal, described in one hospital staff submission as

*...a larger Queenstown Medical Centre, on a new site with a downsized hospital wing attached, and no emergency department.*⁶³

However, as pointed out earlier and in several staff submissions, the bed occupancy rate, which is recorded as at midnight, fails to recognise the number of patients using the beds within a 24-hour period. In 2010 an average of 56 patients per month were transferred from the hospital, which may significantly alter the true inpatient volume, depending on times of admission and discharge.

⁶² Cranleigh Health. *Models of Care: A clinical services plan for Queenstown Lakes District*, 15 January 2010.

⁶³ KT Paa, clinical nurse coordinator. Wakatipu Health Services – Submission, 17 March 2011.

projections for Queenstown Lakes/Central Otago in 15 years' time suggest future bed numbers in the district may need to be higher still

A health needs assessment of the Queenstown area, commissioned by the Wakatipu Health Trust, concludes that up to 33 beds will be required in Queenstown in the next 20 years.⁶⁴ As discussed in section one, comparisons with other hospitals currently providing services for populations such as that projected for Queenstown Lakes/Central Otago in 15 years' time suggest future bed numbers in the district may need to be higher still.

Subsidising GP after-hours' services

There is a long history to the problems over the funding of GP after-hours services. In common with much of the rest of the country, GPs in Queenstown do not provide such a service over night. Staffing for Lakes District Hospital overnight would be very different if they did. As fewer and fewer GPs are prepared to provide 24-hour primary care the burden of primary care from 11pm and increasingly from 8pm will fall on hospitals. Much of this burden will be diagnosis. There appears to be no suggestion by the Queenstown Medical Centre that their after-hours responsibilities continue overnight.

Emails between the Chief Executive and Queenstown Medical Centre's Dr Macharg and Dr Raetz, between March 2009 and February 2010 (provided to the ASMS under the Official Information Act), suggest much of their concern was that their after-hours service was not as profitable as projected and they concluded this was a consequence of the hospital treating patients that they could reasonably expect to be able to charge. An entrepreneurial practice, such as the Queenstown Medical Centre (despite their respected professionalism and standards of care), has powerful incentives to maximise their own return by cherry-picking those services which generate a profit, leaving the public services to continue providing the more expensive services. It is not at all clear, given the difficulty the DHB management had in providing good information to the Clinical Advisory Group, that the DHB is resourced and adequately geared for this level of vigilance.

An entrepreneurial practice has powerful incentives to maximise their own return by cherry-picking those services which generate a profit, leaving the public services to continue providing the more expensive services

⁶⁴ Queenstown Health Needs Assessment, Fraser Group Consulting Ltd for Wakatipu Health Trust, October 2009.

Public-private partnerships

Providing the same services at a private facility is likely to involve costs such as rent and charges for services that the DHB (or community trust) will find itself locked into far into the future. Public-private partnerships such as this have not proved cost-effective in the long term for the public system in overseas experiences. In Britain, a recent report has revealed that private “independent treatment centres” (ITCs), contracted by the National Health Service to provide additional service capacity, have not actually been doing all the work they have been paid to do. The Department of Health has admitted that between 2003 and 2010 the NHS lost NZ\$523 million to ITCs for services that they failed to deliver.⁶⁵

The British Medical Association has been particularly scathing of the Private Finance Initiative (PFI) which is the main form of public-private partnerships in Britain’s NHS:

*PFI [private finance initiative] has proved a long-term millstone around the neck of the NHS, dragging down otherwise good organisations. Many of the contracts were poorly set up, biased towards the private sector providers and inflexible, leaving NHS trusts struggling to meet repayments and facing decades of debts. Money that trusts needed for patient care has been diverted away from the frontline, and into the hands of private companies. It is time for the NHS to move away from this detrimental funding system and towards one that is more cost effective and allows vital funds to get to patients.*⁶⁶

It is worth noting that, while the PFI is used extensively in England, the devolved governments in Scotland (especially), Wales and Northern Ireland do not (or at least do what they can to minimise its application).

public-private partnership further complicates the already difficult task of building and operating a hospital (W H O)

A World Health Organisation Bulletin on public-private partnerships for hospitals says:

*...such projects are extremely, and in some cases prohibitively, complex. While it is premature to say whether the problems experienced relate to the underlying model or to their implementation, it does seem that a public-private partnership further complicates the already difficult task of building and operating a hospital.*⁶⁷

The DHB appears to be embarking on a process without a clear indication of risks, costs or impacts over the long term. If its proposals are implemented, with a decision to change the governance arrangement

⁶⁵ A Moore, “NHS loses £252m on work not done”, *Health Service Journal*, 24 March 2011.

⁶⁶ British Medical Association, “PFI a millstone for NHS, BMA says”. Media release, 2 September 2008.

⁶⁷ M McKee, N Edwards, R Atun. “Private-Public Partnerships for Hospitals”. *Bulletin of the World Health Organization* 2006;84:890-896.

of current public services, the DHB will have in effect shifted the management of such problems to another organisation.

Governance

There is no doubt that many people in the Wakatipu community support the idea of establishing a community trust to take control of the delivery of local health services. Nearly 60% of submissions to the DHB management's first proposal supported the establishment of a local body governance structure. This is effectively a no-confidence vote in the senior management of the DHB and has come about because of long-standing frustrations with DHB decisions (or lack of them) about the level of services provided in the district.

The Wakatipu Health Trust points to a history of ad hoc decision-making (which characterises the DHB management's current proposal) and a "planning vacuum that has existed for Queenstown for many years, together with a low appreciation of the local issues in Queenstown".⁶⁸

while the community desire to take over local services is understandable, the issues with the DHB won't disappear by forming a community trust

But while the community desire to take over local services is understandable, the issues with the DHB won't disappear by forming a community trust.

Most rural hospitals in Southland and Otago are not run directly by the DHB. They have a variety of governance structures because, in contrast to the rest of the country, the predecessors to the Southern DHB were successful in divesting themselves of the direct burden of providing rural hospital services and instead merely funded them. This occurred in the 1990s when there was a determined but unsuccessful attempt to restructure the public health system based on competitive market forces. This attempt failed and is something both main political parties now distance themselves from.

What this has meant for Central Otago, for example, is that while the DHB continues to own the buildings, the community owns the company that provides the services – and has the responsibility for providing all the fittings for the hospital (Dunstan), all the beds, and all the equipment.⁶⁹ Community trusts are still left to struggle with the arbitrary funding decisions of a distant DHB.

Community trusts are still left to struggle with the arbitrary funding decisions of a distant DHB

In 2009/10 Otago and Southland DHBs decided to leave the funding of rural hospitals at their 2008/09 level, leading to a decrease in real funding. All of the rural hospitals in the region, with the exception of

⁶⁸ Wakatipu Health trust. "The DHB is not accountable to anyone". Lakes District Hospital: Background. Available at <http://www.whtrust.co.nz/background.html>

⁶⁹ Radio New Zealand, *Insight*, 10 April 2011.

The situation becomes considerably murkier when a community trust has the responsibility of governing a private-public partnership involving a property developer and commercial health provider which clearly considers currently publicly provided and funded ED services as a competitor

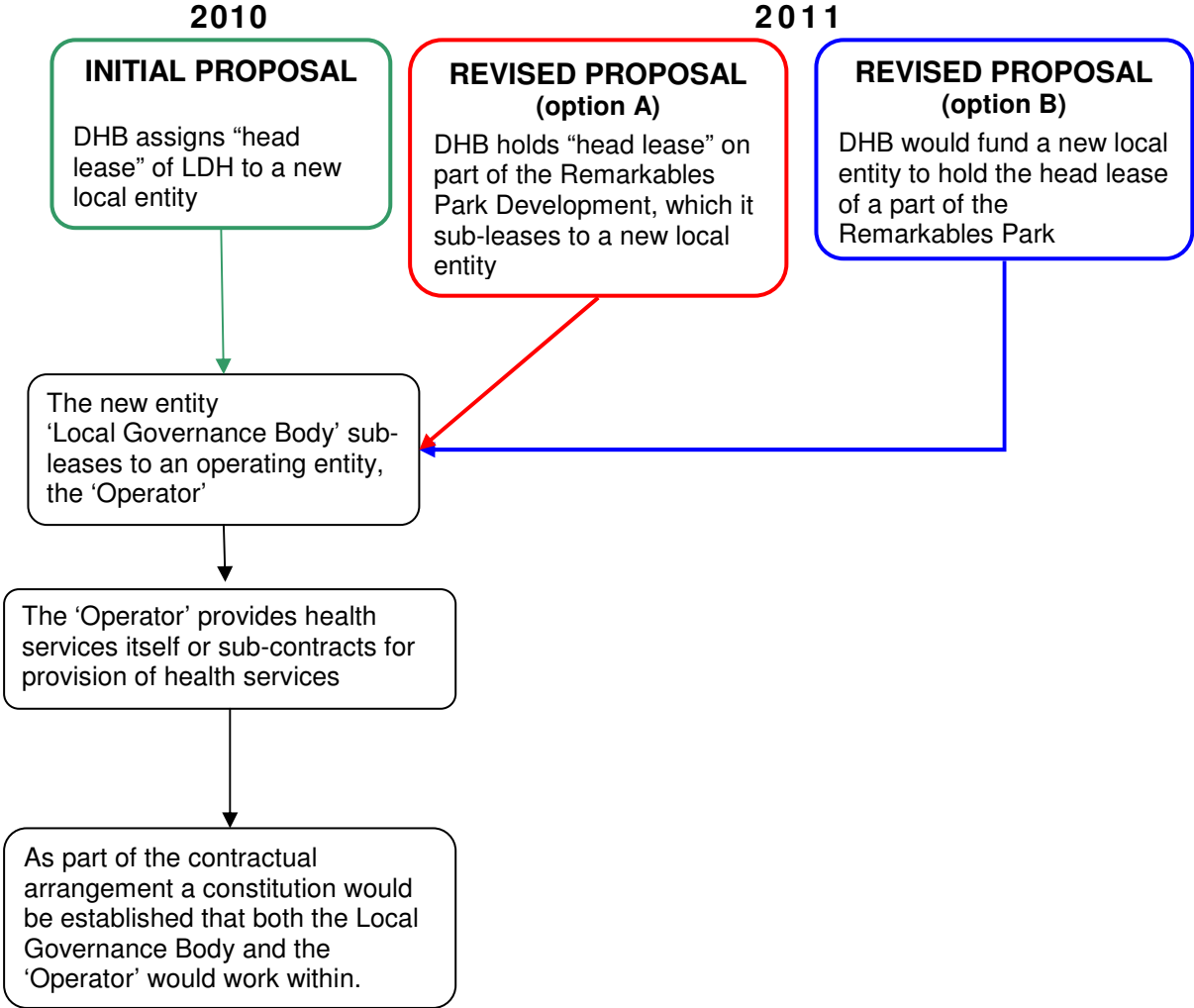
Lakes District Hospital, had to bear these costs themselves. Central Otago Health Services, which had received no funding adjustments for population growth (estimated at 13%) over the previous four years, went so

far as to say that they would no longer provide services if the price were as suggested by the DHB. It required this level of stand-off to get an increase in funding for the community trust.

Such a stand-off has obvious risks, however, particularly when there is a private provider on the doorstep more than willing to accept DHB contracts for services, and with the ability to pass some of the costs onto patients.

The situation becomes considerably murkier when a community trust has the responsibility of governing a private-public partnership involving a property developer (owner of the building) and commercial health provider (Queenstown Medical Centre Ltd) which clearly considers currently publicly provided and funded ED services as a competitor. It is incentivised to establish and strengthen a competitive business edge.

The DHB management’s revised proposal is silent on the matter of governance. If the governance arrangement, as described in their initial proposal, is amended to fit the public-private partnership arrangement loosely described in the revised proposal, it could be read as set out below:



Note there is no limit on what services might be contracted out, nor any requirement for the “operator” to be a public provider.

The Wakatipu Health Governance Reference Group, established by the District Council’s Mayor to investigate a potential community governance model, has sought community feedback on a number of questions, including whether it supported Lakes District Hospital being managed by a community board, and the means by which members would be appointed or elected.

However, it is unclear at this stage as to what its functions would be. As reference group chairperson Graeme Todd said in a letter to the Mayor in August 2010, the group’s work “is only the first step in what would have to be a detailed analysis as to whether any such recommended organisation took on the responsibility of provision of health care and/or

ownership and/or management of public health facilities in the Wakatipu.”⁷⁰

The experiences of other locally run health services in the region should certainly form part of that analysis, as well as the DHB’s position with regards to funding. Would, for example, the DHB approach be based on its rural funding formula or on actual service costs? If the former, then Lakes District Hospital would currently receive around \$3.6 million, as suggested by DHB CEO Brian Rousseau at a public meeting in Queenstown of 6 April 2011. If the latter, Lakes District Hospital would receive around \$6 million, reflecting its actual costs.

The Clinical Advisory Group identified a number of potential limitations for community governance of Lakes District Hospital, including:

- *There are potentially large additional costs to the community, ie Dunstan Hospital was developed with a substantial amount of community funds as well as a DHB contribution.*
- *The community will expect more services, or at least some service increase. However, the reality may actually be the opposite.*
- *Setting up and developing additional services may actually be difficult.*
- *There is a potential for increase in management and administration costs.*

Consideration is also needed on whether a local community trust for Wakatipu would be the appropriate governance model when it is clear substantial planning and development of services is needed across the region, including potentially substantial capital investments. As discussed earlier, within the next 15 years the two interior districts of Queenstown Lakes and Central Otago, when combined, are projected to have a population as large as or larger than five current DHBs,⁷¹ without taking account of visitors.

whether a local community trust for Wakatipu would be the appropriate governance model when it is clear substantial planning and development of services is needed across the region, including potentially substantial capital investments

Services will need to grow in a much more collaborative way, across the districts and throughout the whole DHB’s region, including investment in multidisciplinary clinical networks to enable more sharing of services between larger and smaller hospitals. Such developments require a

⁷⁰ The reference group’s “Proposal for a governance model for delivery of health care and public health facility” suggests the new entity would be a charitable trust known as Wakatipu Community Health Board. It also proposes two board members are elected at local body elections, which do not include elections for charitable trust boards. Members of Council Community Boards may be elected at the triennial elections, though a minimum of four elected members is required.

⁷¹ By 2026 the population of Lakes District and Central Otago combined will be close to the current population of Whanganui DHB and larger than the current populations of Tairāwhiti, Wairarapa, West Coast and South Canterbury DHBs.

more cohesive governance arrangement covering the region rather than fragmenting into more local community trusts. The well-founded community concern about the DHB's lack of attention to local service needs would be better addressed by exploring better ways to ensure the DHB is more accountable and responsive.

From the DHB's perspective, it is easy to see how deeply tempting it must be for a cash-strapped organisation to mitigate risk by off-loading its responsibilities to third parties, such as community trusts and commercial providers

From the DHB's perspective, it is easy to see how deeply tempting it must be for a cash-strapped organisation to mitigate risk by off-loading its responsibilities to third parties, such as community trusts and commercial providers. In the short term at least, the DHB might be able to achieve a certain amount of

cost shifting onto the community, as it has in Central Otago. Ultimately, however, the responsibility for ensuring the full range of publicly funded services are provided to the local population remains with the DHB, as the Health and Disability Commissioner has made clear:

*The DHB is funded both to provide and contract for health and disability support services to its population, ... These duties do not cease when the DHB makes an arrangement with another provider to provide services. The DHB has a statutory duty to ensure the provision of services for its resident population and to monitor the delivery and performance of services by it and by persons engaged by it to provide services.*⁷²

The DHB is also responsible for ensuring full emergency services are provided for visitors as well as other services for overseas visitors who come from countries that have reciprocal health service agreements with New Zealand.⁷³

If some DHB services were contracted to private providers at the Remarkables Park Development, it is highly unlikely that they would simply absorb costs in the way so many of the community trusts and organisations have. The DHB would find itself with a responsibility to provide the service and no option but to meet the costs generated by the commercial provider.

Community trust governance would also presents potential risks to the medical workforce in the event that Lakes District Hospital medical staff no longer had their wages and conditions of employment covered by the multi-employer collective agreement (MECA) for DHB-employed senior doctors. Doctors who are not employed by a DHB would not be entitled to improvements negotiated in subsequent collective agreements (depending on timing, possibly even the negotiations currently underway)

⁷² Health and Disability Commissioner. Decision 07HDC11548

⁷³ Minister of Health. Health and Disability Services Eligibility Direction 2011.

and most likely the conditions would fall behind their DHB employed colleagues. This would pose a serious threat to the retention of the current medical staff at Lakes District Hospital and also to future recruitment.

Clinical leadership

What is often overlooked in planning the delivery of health services is that clinicians (whether doctors, nurses or other health professionals) usually have a long-term commitment to the welfare of their patients and the community from whence they come. Sadly this long-term commitment is often at odds with the short-term views of managers who come and go and, as it seems to the ASMS and its members, may have been captured by the latest management fad or theory or the next passing management consultant.

This has led to too much change in the past with the only constant appearing to be the dedicated health professionals who soldier on in fractured or poorly functioning services left by departing managers. Senior doctors and other health professionals are left to deal with the consequences of decisions made on the basis of short-term fiscal pressures.

Sadly this long-term commitment is often at odds with the short-term views of managers who come and go

Fortunately, the current and the previous governments have recognised this problem by adopting very clear policies that require DHBs to promote and develop clinician-led and clinician-developed health services through such agreements and policies as *Time for Quality* (2008) and *In Good Hands* (2009). The board of Waitemata DHB, for example, has determined that no decisions affecting services will be made that do not have the support of the affected clinical staff.

the Minister of Health's requirement that clinical leadership in DHBs be from "bedside to boardroom". This proposal restricts clinical leadership simply to the bedside.

The principles of *Time for Quality* are incorporated in the ASMS/DHB MECA. This states that "managers will support employees to provide leadership in service design, configuration and best practice service delivery". Moreover the government has

repeatedly asked DHBs (recently, for instance, in the Minister of Health's "Letter of Expectations" to DHBs) to be led by their clinicians. In particular, he stated the requirement that clinical leadership in DHBs be from "bedside to boardroom". This proposal restricts clinical leadership simply to the bedside.

The DHB belatedly established a Clinical Advisory Group reporting to the Chief Executive, but only after the ASMS protested that there had been

no consultation with clinicians in the development of the DHB management's original proposal. The DHB management's revised proposal seems to have ignored the Clinical Advisory Group's advice, the advice of emergency medicine specialists, the local medical officer of health, the medical director responsible for Lakes District Hospital, and the senior doctors and nurses at Lakes District Hospital, the senior doctors at Dunstan Hospital, and one of the GP practices in Queenstown.

The reasons for doing so appear to be that the proposal for a private facility at Remarkables Park is more financially sustainable than continuing a clinically safe operation at Lakes District Hospital. There is no evidence provided to sustain this assertion. No costing is available on how to means test presentations after hours or how much that would cost and there are no figures on any capital costs that will have to be met by the DHB.

Senior doctors are concerned that the degree of disruption that patients will experience under this proposal will not improve their care.

Senior doctors are concerned that the degree of disruption that patients will experience under this proposal will not improve their care. The proposal is poorly thought through and ignores the advice of any clinician other than those who have an interest in drawing in the DHB to mitigating the risk of a very costly investment.

Divisiveness in community

The proposal has proven already to be highly controversial and this can only be expected to increase. It is based in part on favouring one general practice over another. It has alienated the Wakatipu Health Trust which has earned a significant following in Queenstown. Further, it has been disempowering of the DHB's own health professional staff in Queenstown. It is difficult to envisage how one might undermine further public confidence in Southern DHB and those who work for it.

It is difficult to envisage how one might undermine further public confidence in Southern DHB and those who work for it

With regards to Queenstown, one of the things that is clearly very important when it comes to integrating primary and secondary care is relationships between providers. It is very obvious standing on the sidelines that that's the one thing that's taken a real hammering in Queenstown over this process and it will take many years to repair those relationships, I think, and a lot of harm unfortunately has been done in that regard.⁷⁴

Rural hospital medicine specialist, Dunstan Hospital

⁷⁴ G Nixon: Comment made to the Minister of Health at the New Zealand GP Rural Network Conference, Wellington, 18 March 2011.

9 A way ahead

An integrated rural health strategy for the Southern DHB

a holistic review of service funding and provision is now required

In August 2009 the DHB sent the ASMS a copy of the project scope document of the DHB's Hospital Capacity and Health Services Review, fulfilling its obligations under the ASMS-DHB national collective agreement (MECA). This project was

presented as follows:

Although isolated reviews of services' funding and provision have occurred from time to time, a holistic review of service funding and provision is now required to ensure OSDHB can effectively plan given the health care challenges ahead.

This review was presented as having five phases:

- *development of a health service planning tool or model to identify future health needs*
- *identify current hospital and health service configuration (this was the Current State Analysis done by Cranleigh Health);*
- *identify health service needs to 2025 and current gap analysis using data from phase one and two;*
- *development of a range of rural hospital delivery models, solutions and scenarios. This phase was to include a cooperative approach including OSDHB staff and clinicians. Preferred options were to be peer reviewed; and*
- *a recommendation of the most viable service configuration, including an overview of factors, including hospital and service configurations, primary health care, maternity care, aged care, ambulance and transport services, relationship and service integration with base hospitals, workforce management and configuration, medical imaging and testing technologies, financial analysis, funding contracting and service measurement and the opportunity for public/private cooperation.*

The project terms of reference promised that clinicians (senior doctors and other health professionals) would then be involved in the gaps analysis and the production of the “models, solutions and scenarios” which would lead to a recommended scenario for stakeholder consultation.

The Clinical Advisory Group advised the DHB that an integrated approach, as promised in that project brief, was a necessary pre-condition to a sound decision-making process that did not risk losing a clinically sustainable service at Lakes District Hospital over unsubstantiated financial concerns. The ASMS agrees.

But, in contrast, the DHB management's proposal amounts to yet another of the *"isolated reviews of services' funding and provision"* acknowledged in the project brief (and reiterated in the Hospital Capacity Review). *"A holistic review of service funding and provision is now required."*

The Clinical Advisory Group noted that the DHB has not undertaken any long-term strategic planning for the Wakatipu Basin, and in fact: "The Rural Strategic Plan planned for 2007 was either never done or never published and the DHB continues to develop rural service models in isolation across the region."

the DHB has not undertaken any long-term strategic planning for the Wakatipu Basin

In particular, the Clinical Advisory Group's majority recommendation was to adopt a local regional approach involving collaboration between Wakatipu and Central Otago services. This is consistent with the government's approach to mitigate pressures on the health workforce as a whole and with its aim of providing services "better, sooner, more convenient".

Such an approach also makes sense considering both districts share common challenges, as discussed earlier, and together will have a population estimated at 60,000-plus in 15 years' time (equivalent to, or larger than five current DHBs).

This paper has posed a question: how, in 15 years' time, will the 60,000+ residents of Queenstown Lakes and Central Otago receive the level of services that is currently shown to be necessary for such a population – and better, sooner and more conveniently?

The answer is not to be found in the present DHB's ad hoc and narrowly focused proposals but in a much better prepared regional strategic plan and process, as recommended by the Clinical Advisory Group and the Wakatipu Community Trust.

Other ministries like education seem to understand strategic planning and have been building new schools to cope with Queenstown's huge growth. How can the health ministry run a hospital in the fastest growing region of New Zealand with the complete absence of a strategic plan and lack of accountability to the community?⁷⁵

⁷⁵ *Mountain Scene*. "Together we'll overcome DHB stonewalling", 21 October 2010.

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government policy (not just a narrow inflexible interpretation of one particular policy – ie development of integrated family health centres).

This point was made in a number of submissions on the DHB management's initial proposal, including that from Lakes District Hospital's medical staff:

Increased thought should be given to health care in the region as a whole, rather than the Wakatipu in isolation. Queenstown would be well positioned to provide more trauma care for those from Wanaka, reducing transport to Dunedin. Lakes District Hospital and Dunstan Hospital provide services which may be considered complementary, and further consideration could be given to service sharing, such as maternity services, paediatrics or diagnostic radiology. Savings can be made by keeping appropriate patients out of base and tertiary hospitals, and these savings should be taken into account when service budgets are considered.

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achieved using clinical leadership to establish innovative models of care. Some of the kinds of changes that are occurring internationally to help meet future health challenges involve smaller hospitals using clinical partnerships with neighbouring hospitals, and base hospitals, to expand their critical mass, and new regionally focused collaborative models of service involving multidisciplinary clinical networks across organisations.⁷⁶ Some of these networks may be based in integrated family health centres linked across a number of sites.

Vital to all of this is the fostering of a trusting, collaborative culture. As the DHB's own commissioned research has pointed out, "common characteristics of integrated organisations include shared goals, high trust, close networks and shared processes..."⁷⁷

⁷⁶ Hon T Ryall. "Improving the Health System: Decisions in Response to Health Ministerial Review Group's Recommendations." Cabinet Paper, released 21 October 2009.

⁷⁷ Cranleigh Health. Models of Care: A clinical services plan for Queenstown Lakes District, 15 January 2010.

Not least, given the projected growth in Queenstown Lakes/Central Otago detailed above, there will need to be well-considered investments in staffing, facilities, technology and transport systems.

The Queenstown Lakes District Council points out that a 20-year plan for infrastructure “is considered to be best practice and essential in such a high growth area as the Queenstown Lakes District”.⁷⁸ On that basis, the DHB is already well behind time to ensure adequate health services are in place for residents of the Queenstown Lakes/Central Otago districts by 2026.

⁷⁸ Queenstown Lakes District Council. *Council Community Plan 2009-19*

10 Conclusion

The DHB has produced no clear evidence to support its proposal

The DHB has produced no clear evidence to support its proposal. On the contrary most of the available evidence does not support the proposal and suggests its implementation would lead to negative longer-term consequences. The DHB has produced no clear evidence that the current service needs to be “fixed”. On the contrary feedback from clinicians and the community is positive.

There is broad consensus that the proposal lacks organisational, financial and clinical robustness and is not the sort of document upon which important decisions such as the future of Lakes District Hospital and the services it provides should be based.

This is such a poor quality document that it risks bringing our whole organisation into disrepute.⁷⁹

Lakes District Hospital clinical staff

At best, the proposal reflects incompetence. At worst the proposal, and the process of managing it, reflects a predetermined decision to sell Lakes District Hospital, shift services to a privately owned site and to shift the provision of some services to private providers. At the very least the process has been damaging on relationships, including trust and confidence.

Either way, it is clear that both hospital staff and the community have lost confidence in the DHB’s decision-making processes.

The proposal has been a costly distraction – costly in terms of time, and in staff and community relations, and no doubt costly in terms of spending, which has never been revealed.

The proposal has been a costly distraction

Meanwhile, the DHB appears to have lost sight of the rapidly increasing health demand in the wider Wakatipu/Central Otago region, which requires urgent and substantial planning and development of services, including potentially substantial capital investments.

Meeting increasing health service demand will require continual improvements in quality and cost-effectiveness of services. Services will need to grow in a much more collaborative way, not only across the Wakatipu/Central Otago region but throughout the whole DHB’s region, including investment in multidisciplinary clinical networks to enable more

⁷⁹ Clinical staff, Lakes District Hospital. *Wakatipu Health Services*. “Communication to SDHB board from medical and nursing staff at Lakes District Hospital with regard to Brian Rousseau’s paper (dated 2 March 2011)”, 7 March 2011.

sharing of services between small hospitals and between small and larger hospitals. Services will also need to be organised to enable flexibility to take into account the changing demographics throughout the DHB region, advancing technology, increasing workforce pressures, and development of new models of practice.

To achieve a more regionally integrated service, and to manage the potential financial risks of meeting increasing demands in a rapidly changing environment, it makes sense to have regionally cohesive governance and a large pool for sharing financial risk, rather than fragmenting into more local community trusts. The well-founded community concern about the DHB's lack of attention to local service needs would be better addressed by exploring better ways to ensure the DHB is more accountable and responsive, including processes for better community engagement.

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It would be a great mistake for this narrowly focused and ill-considered proposal to be progressed and further.

The National Health Board would be doing the Otago and Southland public, and the DHB, a great favour if it were to recommend the DHB now gives some priority to working on restoring public and clinical confidence in its ability to properly plan and manage the region's health services, and be more responsive to community needs. The DHB can best do this by preparing, as a matter of urgency, a regional health plan, using an inclusive, systematic process, as previously indicated, and a far more thorough analysis of today's and tomorrow's health needs than has been seen to date.

To succeed this must be led by health professionals consistent with the expectation of clinical leadership by the government in its annual "Letter of Expectations" to DHBs (2011/12), which requires clinical leadership from "bedside to boardroom", and Southern DHB's own obligations and agreements, which to date have not been respected.

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