Anatomy of a health crisis

By the numbers

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Introduction

In November 2019 ASMS released a report, *Hospitals on the Edge*, a compilation of official information, mostly previously unpublished, to assess the condition of Aotearoa New Zealand's public hospital services. The findings: in short, too few staff, too few acute hospital beds, too many patients discharged before they should be, too many facilities unfit for purpose, and too many patients denied access to timely treatment because hospitals lack capacity. Actions were recommended to address these systemic failures.

Three years on, after the upheavals of the Covid pandemic and a system restructure, this report pulls together the latest data – again, mostly previously unpublished – to assess any progress or otherwise. As with the previous report, its focus is hospitals and specialist services, though the issues highlighted here are echoed throughout the system, not least because all parts of the system are interdependent.

It will come as no surprise that things have got worse in virtually all areas covered in this report. Minsters of Health of all persuasions may argue the sky hasn't fallen, there are now more doctors and nurses than ever; there is more funding than ever; hospitals are treating more patients than ever. It's easy spin, ignoring the costs of inflation and the complex needs of a growing and ageing population. In the real world, as found in the information reported here, we're going backwards.

Three years ago, ASMS warned that public hospitals' services were at a tipping point. Since then, access to general practitioners and public hospital specialists has deteriorated, resulting in an estimated third of the adult population with an unmet need for health care. That doesn't include the estimated 1.75 million adults with an unmet need for dental care due to cost – many of whom will have an overlapping unmet need for health care.[1] For those adults, and countless children, the system has well and truly tipped. For the many staff who have quit, leaving an 8,000-plus workforce shortage, according to official estimates, the system has tipped.

Adding to the barriers to GP services, timely access to non-acute hospital care, as well as some urgent time-critical care, is becoming increasingly dependent on the ability for people and whānau to pay for it out of pocket. Consequently, as ASMS found in its 2023 report *Creeping Privatisation,* growing numbers of people are turning to private health care – that is, those who can afford it.[2] While successive governments have professed commitment to the public health system, they have watched it descend over many years to the current crisis. Time and time again their stated intentions have not been backed by the necessary investment. Nor have any of them managed to shift from short-term policy approaches and recognised that fixing our broken health system requires strategic whole-of-government action.[3]

The current coalition Government's plans to reintroduce health targets (attempting to address the consequences of systemic under-resourcing rather than the cause) and reduce public services in general do not augur well for a change towards more holistic policy approaches and responsible public investment. So while ASMS has made a broad range of social and health recommendations to fix the health system in previous reports, which still stand and are summarised in this paper, we have added a further specific call for action. It is an urgent need to open an independent inquiry into how we fund our health system as a whole, and how to mitigate future health needs, including policies and investment for addressing the determinants of ill health.

Chronic workforce shortages, long waiting lists and cost-barriers to health care won't be fixed until governments widen the policy lens on health and recognise that investing in wellbeing is also an investment in the economy.

1 ASMS. *Tooth Be Told,* July 2022. https://issuu.com/associationofsalariedmedicalspecialists/docs/asms220501-tooth_be_told

2 ASMS, *Creeping Privatisation,* September 2023. https://asms.org.nz/creeping-privatisation/

3 Our analysis and recommendations for action covering a whole-of-government approach to health care are covered in other reports, including *Creating Solutions* https://issuu.com/associationofsalariedmedicalspecialists/docs/asms-creating-solutions-fa-web_-_final and Health workforce: the make or break of the health reform https://asms.org.nz/workforce-the-make-or-break-of-the-health-reform/

At a glance

Unmet need

- Well **over a third** of the adult population has an unmet need for health care, due to long waits, cost or distance to travel, which is **significantly higher than reported in 37 European countries.**
- An estimated **1.75 million adults** have an unmet need for dental care due to cost alone.
- An estimated **329,000 adults** and **55,000 children** had an unmet need for Mental Health and Addiction (MHA) services – an increase of **73 per cent** and **45 per cent** respectively since 2016/17.

Acute service overload

- People with unmet health care needs are at **higher risk of presenting at Emergency Departments** and being admitted to hospital as an acute patient.
- Almost **1.3 million people** attended public hospital Emergency Departments (EDs) in 2022/23 – an **increase of 22.5 per cent** since 2013/14.
- Compounding the ED pressures, the number of immediately or potentially life-threatening events (**triage levels 1-3**) is growing at a much higher (**51.1 per cent**) rate than less-serious events.
- Acute public hospital inpatient discharges **increased by 24 per cent between 2014 and 2023** (28 per cent when adjusted for complexity) while the population increased by 16 per cent.
- The rise in acute cases, combined with chronic staff shortages, is **displacing non-acute hospital discharges** (patients from the waiting list or 'arranged' bookings), which decreased by 1 per cent (-3 per cent when adjusted for complexity).

Chronic workforce shortages

- Clinical Directors across 15 districts surveyed in 2022 estimated a **22 per cent shortfall of Senior Medical Officers**, on average, taking into account issues of access, quality, safety, and unmet need.
- Vacancy rates for psychiatrists working in the public system hit 19% in the year to March 2023. **More psychiatrists are now leaving the public sector workforce than are entering it.**
- As of September 2023 nearly **60,000 patients were waiting more than four months** for a first specialist appointment. That's a **67 per cent increase** in 12 months and more than a four-fold increase since 2019.
- The number of patients (**currently nearly 30,000**) who are deemed unwell enough to exceed "clinical" thresholds and given a commitment to treatment but don't receive it within four months **increased six-fold between July 2019 and September 2023.**
- Government Core Health Expenditure (excluding Covid-related funding) has remained **below 7 per cent of GDP since at least 2010.** Total health expenditure (public and private), measured as a proportion of GDP, has remained well below other comparable countries for many years.

Recommended Actions

While this report focuses on hospital services, the actions needed to address our health system crisis clearly require a comprehensive whole-of-government response, including funding the public health system through an holistic lens and recognising that investing in wellbeing is also an investment in the economy.

Our recommendations to Government therefore cover a broad range of social and health actions which are summarised and updated from previous reports.

An additional call for action is an urgent need to open an independent inquiry into how we fund our health system as a whole, and how to mitigate future health needs, including policies and investment for addressing the determinants of ill health.

A note on the data used in this report: Some of the data used in the analysis in this report has been obtained through requests made via the Official Information Act to Te Whatu Ora. Previously, this data had been more readily accessible through the Ministry of Health's National Minimum Data Set data request process.

Unmet need for medical care

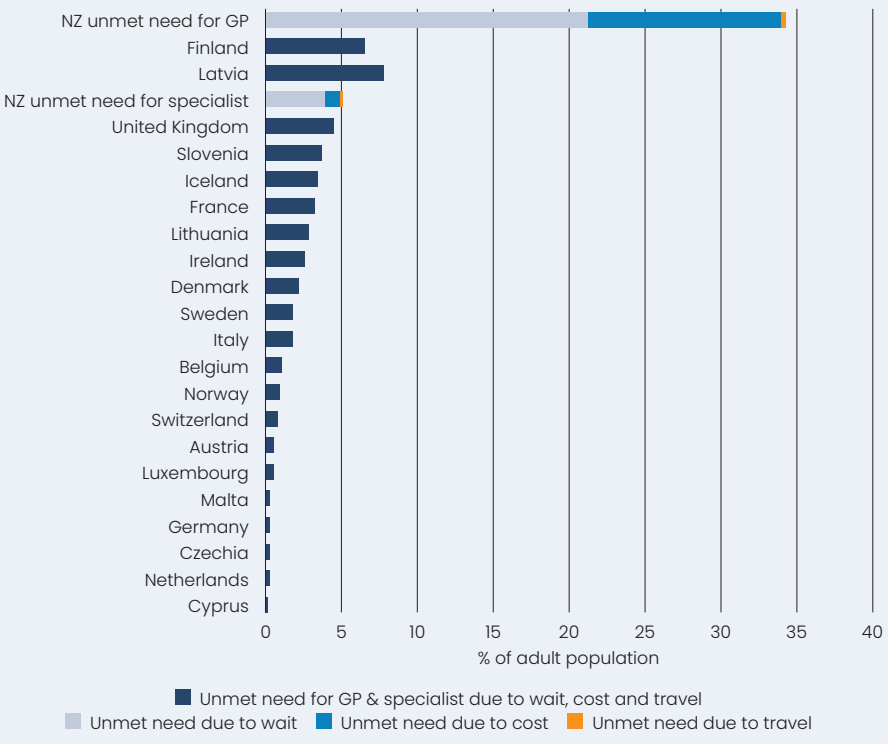
Aotearoa New Zealand's unmet need for medical care due to long waits, cost or distance to travel is significantly higher than in the United Kingdom and 20 European countries (Figure 1). Unmet need for GP services and specialists combined, for these three criteria (34.3 per cent and 5.1 per cent respectively), is likely conservative considering the factors that are not taken into account in these figures (e.g., unmet need for after-hours care, unfilled prescriptions due to cost, etc).

As always with international comparisons, caution is needed in their interpretation. This is especially so when the data is obtained from subjective, self-reported unmet health need.

Given the significant difference between Aotearoa New Zealand and other countries, details of the data presented in Figure 1, including the comparability of surveys, are provided in Appendix 1.

The data excludes unmet need for dental care, which the New Zealand Health Survey estimated to be 44 percent of the adult population in 2022/23.

Figure 1: Self-reported adult unmet need for medical care due to long waits, cost or distance to travel, Europe, UK and Aotearoa New Zealand, 2023 or nearest year



Sources: EU Statistics on Income and Living Conditions (EU-SILC) Eurostat, 2023; NZ Health Survey 2022/23; Te Whatu Ora: Elective Services Patient Flow Indicators (ESPI), 2022; *Planned Care Taskforce: Reset and Restore Plan,* 2022; data released under the Official Information Act, 2022.

An outcome of workforce shortages

The most prevalent form of unmet health need for hospital specialist or GP care in Aotearoa New Zealand is wait time.

Wait times for primary care almost doubled between 2021/22 and 2022/23, and now outpaces all other forms of unmet need combined[4]. Wait times signal the critical pressure primary care is under. It is an outcome of workforce shortages, particularly for GPs, but also for practice nurses, counsellors, and other allied professions. Whereas the barriers to care have been strongly linked to the social determinants (cost, access to transport, etc) they now also relate increasingly to barriers resulting from workforce factors within the service itself.

Increasingly, GP practices are forced to close their enrolments to new patients. Where enrolment itself is a barrier to accessing primary (and potentially secondary) health care, the New Zealand Health Surveys are likely to underestimate all forms of unmet need.[5]

Hospital workforce shortages, discussed later in this paper, are also a major cause of wait times for specialist services, which are also understated in the data presented above. The international data excludes people who are on a waiting list "for planned (non-urgent) care if the need is not seen as urgent." In order to align Aotearoa New Zealand's data with the international data, the number of people experiencing long delays on the planned care waiting lists are not included as it is assumed, by definition, that their treatment is not urgent. (Though there is growing anecdotal evidence that long delays are having a serious impact on patients' health and wellbeing.) The unmet need due to waiting time for hospital care therefore is largely related to delays in getting a first specialist appointment (FSA) or waiting to get onto a waiting list.

The data also excludes unmet need due to long delays in specialist follow-up appointments, as well as unmet need for dental care.

The impact on patients and the system

The data show the patient journey from primary care presentation and referral to diagnosis, treatment and management of a health need is neither linear nor smooth[6]. People and whānau face a kaleidoscope of barriers to accessing primary care, including access to childcare, time off work, cultural safety and, increasingly, difficulties in getting enrolled, as well as those included in the data (wait times, cost, and lack of transport). And there is no guarantee a referral from a GP will eventuate in an FSA. The chronic hospital specialist workforce shortages ensure that only the highest risk patients with the greatest acuity meet this barrier, and result in many declined referrals, meaning follow-up testing and symptom management falls back on a stretched primary care workforce. These people are also at higher risk of presenting at Emergency Departments and ending up as an acute admission.[7 8 9]

The cumulative impact of overall workforce shortages and GP clinics closing their enrolments is stark. Many are detailed in this paper, visible in clinical performance metrics tracking increases in acuity and complexity of critical and potentially life-threatening ED presentations, and acute hospital admissions surpassing population growth. Others are less apparent, and delays in access to care may take months to reveal, including more advanced cancers, worsening symptoms from chronic conditions (arthritis, autoimmune diseases). In turn, delayed care and treatment is more likely to result in increased pain, reduced mobility, time off from work, education and training and decreased quality of life.

As well as the suffering caused by unmet health need, it also impacts badly on the economy. The cost of ill health due to lost productivity was estimated by Treasury to be between 2.7 per cent to 7.6 per cent of GDP (about $10 billion to $30 billion today) with the large range due to the different methods and assumptions used.[10]

4 Manatū Hauora. Unmet need. NZ Health Survey: Update of key results 2022/23. https://www.health.govt.nz/publication/annual-update-key-results-2022-23-new-zealand-health-survey.

5 Iruzun-Lopez M, Pledger M, Mohan N, Jeffreys M, McKenzie F, Cumming J, et al. "Closed books": restrictions to primary health care access in Aotearoa New Zealand – reporting results from a survey across general practices. N Z Med J. 2024; 137(1591):11-29. Available from https://nzmj.org.nz/media/pages/journal/vol-137-no-1591/closed-books-restrictions-to-primary-healthcare-access-in-aotearoa-new-zealand-reporting-results-from-a-survey-across-general-pr/9b832b6e4d-1709520184/6347.pdf.

6 Rashbrooke M. Lightening the Load: The case for a fully-free public healthcare system. ASMS 2022. https://asms.org.nz/lightening-the-load/.

7 Penedo F, Natori A, et al. Factors Associated with Unmet Supportive Care Needs and Emergency Department Visits and Hospitalizations in Ambulatory Oncology, JAMA Network Open. 2023;6(6). 10.1001/jamanetworkopen.2023.19352.

8 Parry E; Ahmed K, et al. General practitioner assessment of unmet need in a complex multimorbid population using a data driven and clinical triage system, BJGP Open, 2023.0078. https://doi.org/10.3399/BJGPO.2023.0078

9 Beach S, Shulz R, et al. Adverse Consequences of Unmet Needs for Care in High-Need/High-Cost Older Adults, Gerontol B Psychol Sci Soc Sci, 2020, Vol. 75, No. 2, 459–470. https://doi.org/10.1093/geronb/gby021

10 Holt H. The Cost of Ill Health. New Zealand Treasury Working Paper 10/04, Wellington: NZ Treasury, November 2010.

Emergency Department use

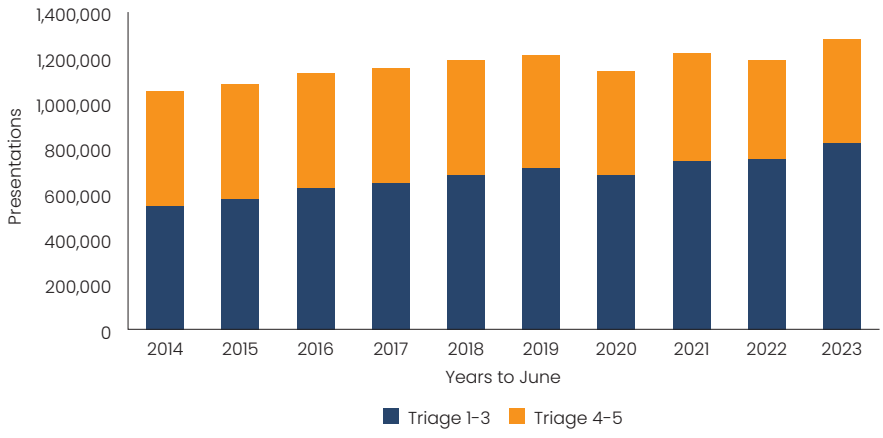
Almost 1.3 million people attended public hospital Emergency Departments (EDs) in 2022/23 – an increase of 22.5 per cent since 2013/14 compared with a 16 per cent population growth for that period.

Compounding the ED pressures, the number of immediately or potentially life-threatening events (triage levels 1-3) is growing at a much higher (51.1 per cent) rate than less-serious events. Notwithstanding some data gaps, triage levels 1-3 made up just over half of total ED presentations in 2013/14. By 2022/23 they amounted to almost two-thirds of total presentations (Fig 2). People presenting in triage 1-3 categories need to be seen by ED staff immediately (category 1) or within 30 minutes (category 3).[11]

Increases in ED presentations vary across different populations. The rates of increase for Māori, Pacific peoples and Asian patients, for example, are significantly higher than for European/Other patients (Appendix 2).

Ministry of Health assessments of 11 (nearly 50 per cent) of ED buildings nationally in 2018-19 found most scored poorly on infection control issues, privacy of patients being treated and adequate spaces for clinical work. Conditions in 70 per cent of the departments were such as to compromise patient and staff health and safety. The assessment report acknowledged, "Most departments have experienced significant increases in demand over the last five years [to 2018-19]."[12] Given the continued rise in ED presentations since then, conditions are likely to be worse today.

Figure 2: Public hospital Emergency Department presentations by Triage levels, 2014-23



Sources: Te Whatu Ora 2023
Note: The triage levels of a small number of presentations (less than 1 per cent) are unknown.

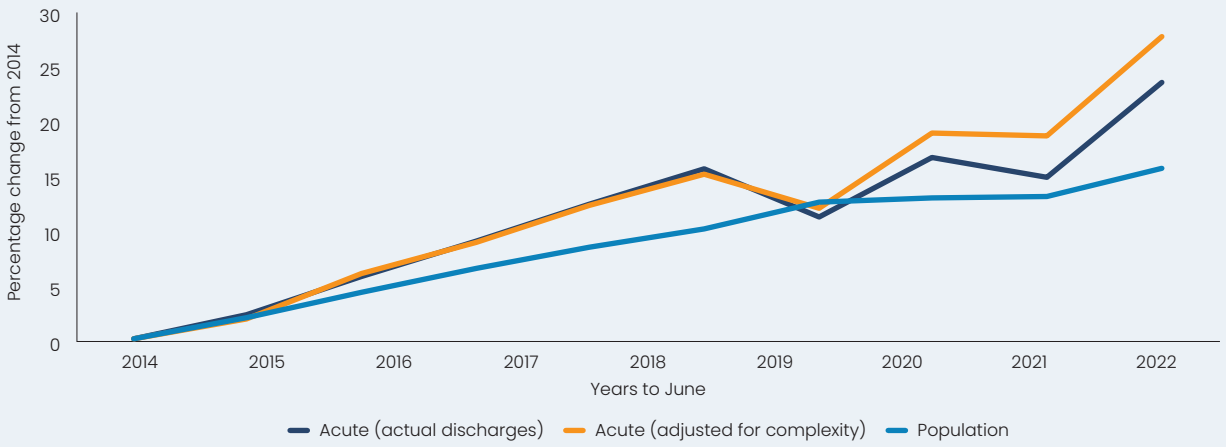
11 Te Whatu Ora. Emergency department triage. https://www.tewhatuora.govt.nz/our-health-system/hospitals-and-specialist-services/emergency-departments/emergency-department-triage/

12 Ministry of Health. *The National Asset Management Programme for district health boards. Report 1: The current-state assessment*. Wellington: Ministry of Health, June 2020.

Acute and non-acute admissions

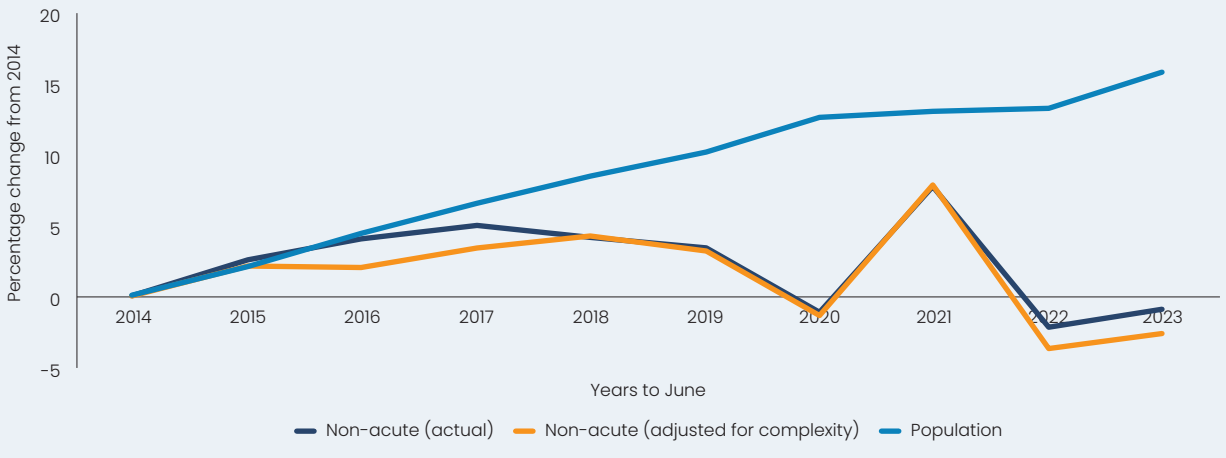
Data released to ASMS show acute hospital inpatient discharges increased by 24 per cent between 2013/14 and 2022/23 (28 per cent when adjusted for complexity) while the population increased by 15.9 per cent (Fig 3). In contrast, non-acute hospital discharges (patients from the waiting list or 'arranged' bookings) decreased by 1 per cent (-3 per cent when adjusted for complexity) (Fig 4).

Figure 3: Acute public hospital inpatient discharges (actual & adjusted for complexity) percentage change from 2014 to 2023



Sources: Te Whatu Ora 2023; Statistics NZ

Figure 4: Non-acute public hospital inpatient discharges (actual & adjusted for complexity) percentage change from 2014 to 2023



Sources: Te Whatu Ora 2023; Statistics NZ

As found in 2019, these trends indicate publicly provided 'elective' services are being displaced by a combination of budget constraints and rising, more complex acute cases.[13] Covid-related disruptions aside, the widening gap between population growth rates and public hospital discharge rates will be contributing to growing unmet need for elective treatments and, for those who can afford it, the growing use of private health care.[14]

Ministry of Health assessments of 19 ward blocks over 20 years old in 2018-19 ranked 15 of those blocks poor or very poor in terms of fitness for purpose. Similar to the findings for EDs, the assessment report recorded poor conditions for infection control and privacy of patients, and inadequate spaces for clinical work.[15]

The report commented, "All units reported excess demand, which has implications for increased staff stress and risks to the quality of care."

Notes

Figures include inpatient, surgical, medical, maternity discharges and Emergency Department 'inpatient' discharges (ie, patients whose treatment is longer than 3 hours, some of whom may be treated in short-stay unit, for example).

Adjustments for complexity: 'Caseweighted' discharges (sometimes referred to as costweights) measure the resources (costs) needed for the treatment given to each patient during a hospital stay.* For example, a cataract operation will receive a caseweight of approximately 0.5 whereas a hip replacement would receive 4 case weights. Case weight measurements are occasionally adjusted to reflect changing practices and technology.

These are expected to have a marginal effect on overall trends. Not all discharges are caseweighted – for example, where there is not a lot of distinction in cost between those done for complex cases and those done for non-complex patients. Examples are gastroscopy, colonoscopy, ENT minor procedures.

* Ministry of Health. New Zealand Casemix Framework for Publicly Funded Hospitals, Casemix Purchase Unit Allocation for the 2022/23 Financial Year.

13 ASMS. *Hospitals on the Edge,* November 2019. https://asms.org.nz/wp-content/uploads/2022/05/Hospitals-on-the-Edge.pdf

14 ASMS. *Creeping privatisation,* September 2023. https://asms.org.nz/wp-content/uploads/2023/09/Creeping-Privatisation_final-Sept-2023.pdf

15 Ministry of Health. The National Asset Management *Programme for district health boards. Report 1: The current-state assessment.* Wellington: Ministry of Health, June 2020. https://www.health.govt.nz/publication/national-asset-management-programme-district-health-boards-report-1-current-state-assessment.

Mental Health and Addiction Services

The latest release from the New Zealand Health Survey (NZHS) reveals rates of psychological distress remain persistently high for many people (11.9 per cent up from 11.2 per cent in 2021/22). This represents more than 500,000 New Zealanders.[16]

For wāhine Māori, young people aged 15-24, and disabled people, the rates are even more pronounced: for example, one in five wāhine reported high or very high levels of psychological distress in the previous four weeks, and disabled people are four times more likely to experience psychological distress than non-disabled people.

In 2022/23, an estimated 329,000 adults and 55,000 children had an unmet need for Mental Health and Addiction (MHA) services – an increase of 73 per cent and 45 per cent respectively since 2016/17.

The steep growth rate is due to several factors:

- Adults reporting high or very high psychological distress grew by 72.5 per cent between 2016/17 and 2022/23: need for MHA services is growing.
- The number of clients accessing MHA services increased by just 10.4 per cent from 2016/17 and 2021/22 (figures are not yet available for 2022/23).[17]
- The MHA workforce grew by less than half that rate (5%) from 2017/18 to 2021/22.[18]

Rates of psychological distress have nearly tripled since 2011/12 (Figure 5) and diagnosed mental health conditions have also steadily increased over this time. Unfortunately, the latest NZHS has discontinued indicators for the prevalence of depression, anxiety, and mood disorder diagnoses.

Unusually, the latest survey data shows the rate of unmet need for MHA services has fallen – from a total 429,000 adults and children in 2021/22 to 384,000 in 2022/23 (Figure 6). This is anomalous, considering the increasing prevalence of high and very high psychological distress among New Zealanders. Further, people reporting an unmet need for GP services (a major source of referrals to MHA services) due to wait times has exploded since 2021/22, from 11.6 per cent to 21.1 per cent.

After they have accessed a GP, more than one in four under-25s are unable to access specialist mental health services within three weeks of referral.[19]

It is well understood that access to MHA services is limited by insufficient funded staff positions, made worse by growing vacancy rates, which more than doubled from 2018 to 2022 (from 597 to 1,383).[20]

16 New Zealand Health Survey 2022/23. https://www.health.govt.nz/publication/annual-update-key-results-2022-23-new-zealand-health-survey

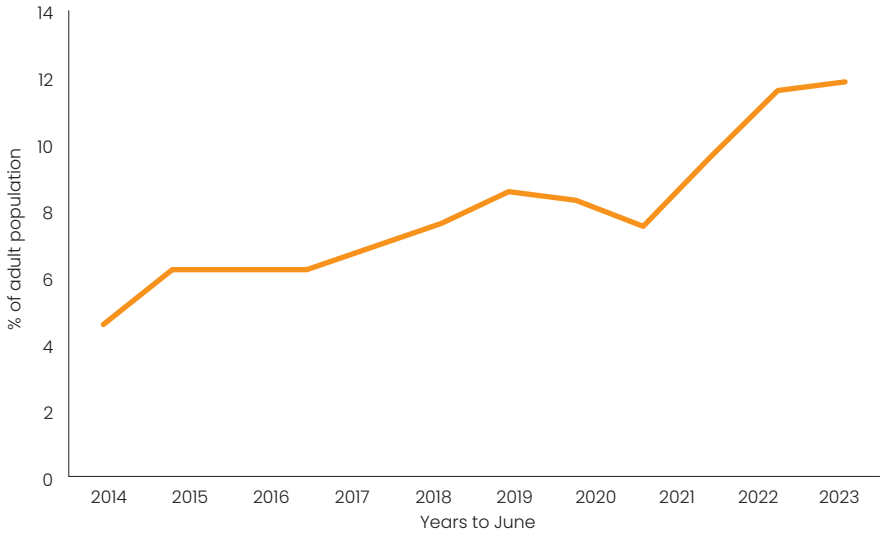
17 Te Whatu Ora. Mental Health and Addiction: Service Use Webtool. https://tewhatuora.shinyapps.io/mental-health-and-addiction-web-tool/ *Note: 2021/22 figure is based on 2020/21 estimates as data for 2021/22 are incomplete; Te Whatu Ora explain that *"it is likely that overall, there has been a net increase in access to services and support [from 2020/21]."*

18 Te Pou. *Adult mental health and addiction workforce: 2018 secondary care health services (2019); Te Whatu Ora adult mental health and addiction workforce: 2022 alcohol and drug, forensic, and mental health services* (2022); *NGO workforce estimates: 2022 survey of adult alcohol and drug and mental health services* (2023). Auckland. *Note: Data for 2016/17 is not available.

19 Te Whatu Ora. Clinical Performance Metrics, June 2022 to September 2023.

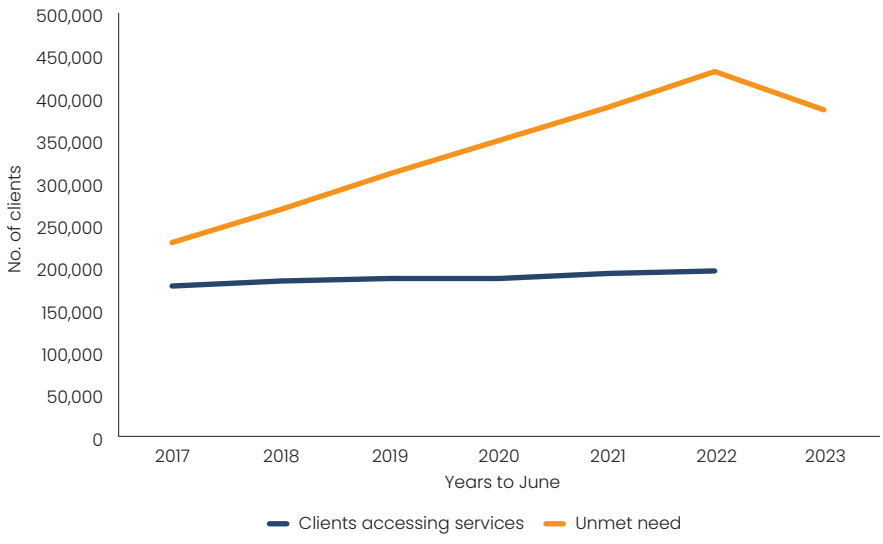
20 Ibid

Figure 5: Growth in psychological distress – adults (high and very high) 2012 to 2023



Source: NZ Health Survey 2022/23

Figure 6: Growth in unmet need for MHA services and growth in clients accessing services, 2012 to 2023



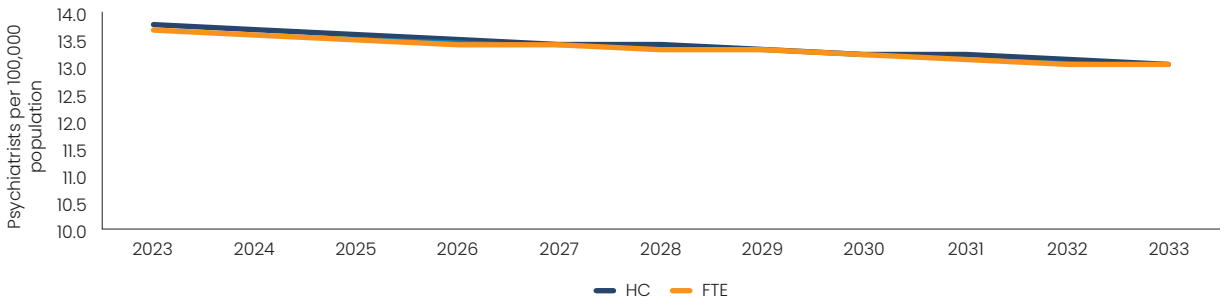
Sources: Te Whatu Ora, MHA Service Use data, 2024
* Estimate based on average annual growth in previous five years

Reduced access to psychiatrists

As the workload is increasing at a higher rate than workforce growth, Te Whatu Ora forecasts show pressures continuing to mount for psychiatrists over the coming years unless recruitment and retention improve significantly.

The forecasts in Figure 7 are projected from workforce entry and exit trends over the five years to 2023 for public and private sectors combined.[21] Other data also show workforce movement from the public to the private sector. Unpublished Medical Council figures show a 61 per cent increase in the number of full-time-equivalent (FTE) psychiatrists working privately from 2019 to 2022 (from 52.5 FTE to 84.3 FTE). On average, more than a quarter of psychiatrists' time is now spent in the private sector or in other non-public health service employment. FTE to 84.3 FTE).[22]

Figure 7: Forecast psychiatrist workforce (public and private) by headcounts and full-time equivalent numbers, 2023-2033



Source: Te Whatu Ora 2023

The trend towards more private work in psychiatry is reinforced by the results of a national survey of ASMS members on the reasons behind decisions to work part-time outside of the public system.

34 per cent of psychiatrist respondents said they were thinking about working part-time in other employment. Combined with the 41 per cent already working privately in addition to their public roles, three out of every four psychiatrists employed by Te Whatu Ora either work privately or are thinking about doing so.[23]

The public-to-private shift, along with the effects of an ageing workforce (nearly 20 per cent of psychiatrists are aged 65 or older) has resulted in more psychiatrists leaving the public sector workforce than are entering it.

In the year to March 2022, 12.9 per cent of the Te Whatu Ora psychiatrist workforce resigned while recruitment totalled 9.1 per cent. Nearly one in five Te Whatu Ora psychiatrist positions were vacant in 2022 (Table 1).[24]

21 Ministry of Health, 2021.

22 MCNZ. Unpublished medical workforce data, 2023.

23 ASMS. *A less public place: A survey of ASMS members on reasons for working part time outside the public health system.* August 2023. https://asms.org.nz/wp-content/uploads/2023/08/A-Less-Public-Place-FINAL-1.0.pdf

24 Te Pou. *Te Whatu Ora adult mental health and addiction workforce: 2022 alcohol and drug, forensic, and mental health services.* Auckland, April 2023. https://www.tepou.co.nz/resources/te-whatu-ora-adult-mental-health-and-addictionworkforce-2022-adult-alcohol-and-drug-and-mental-health-services-report

> “There has been nil increase in FTEs at the [mental health centre] I worked at in the past 8 years in spite of 20% increase in referrals.” - PSYCHIATRIST

Table 1: Te Whatu Ora psychiatrist workforce, year to 31 March 2022

Psychiatrists	FTE employed	FTE vacant	Vacancy rate (%)
Adult Mental Health	303.2	74.2	19.7
Adults Forensic Mental Health	33.4	4.2	11.3
Adults Addiction	28	5.4	16.1
Total	**364.6**	**83.8**	**18.7**

Source: Te Pou 2023

The poor condition of many mental health facilities adds further service challenges. Ministry of Health assessments of 24 mental health units in 2018-19 found 70 per cent did not provide adequate privacy, safety or therapeutic space. The assessment report commented: “Managing patients with different needs in a poorly designed unit is difficult for staff and challenging for patients. The problem is exacerbated in the units with fewer beds and fewer options to separate patients.”[25]

25 Ministry of Health. *The National Asset Management Programme for district health boards. Report 1: The current-state assessment.* Wellington: Ministry of Health, June 2020. https://www.health.govt.nz/publication/national-assetmanagement-programme-district-health-boards-report-1-current-state-assessment

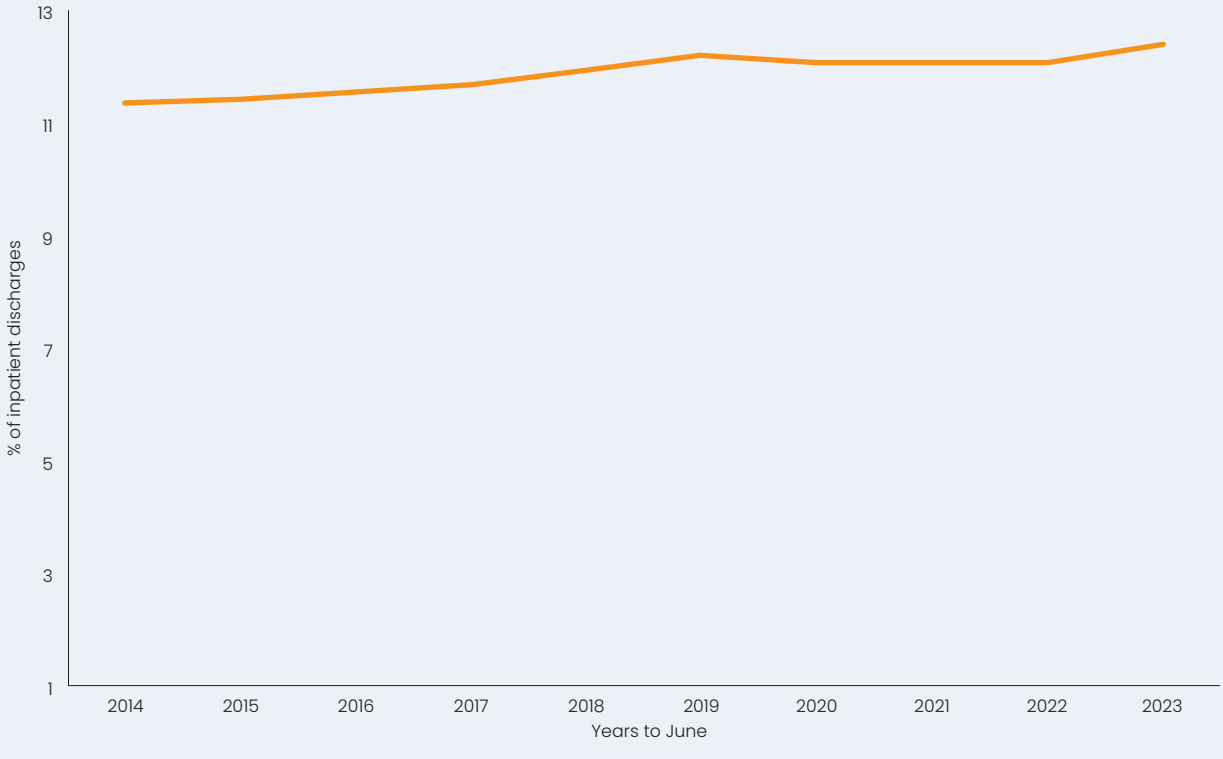
Emergency readmission to hospital within 28 days of discharge

One in eight public hospital patients (12.4 per cent) had to be readmitted within 28 days for the year to March 2023. For patients aged 65 or over, the average national readmission rate was 15.4 per cent within 28 days and 18.1 per cent within six months.

This indicator is a proxy of both the care received in hospitals and the coordination of care back to and within the outpatient setting. It may indicate a quality issue related to shortened length of stay and premature discharge, inadequate care, lack of patient adherence to the care regimen following discharge from hospital or poor integration of care. It may also be due to patients being discharged to the same conditions (eg, a cold, damp house) that may have led to the hospital admission in the first place. Te Whatu Ora data shows those patients from the most deprived communities were more likely to be readmitted (20.4 per cent) than those in the least deprived communities (15.9%).

Since not all of the reasons for readmission are under the control of the health care service or hospital, readmission rates are an imperfect measure of service quality. Addressing the social determinant of ill health is critical for reducing readmission rates.

Figure 8: Public hospital acute readmission rates 2014 to 2023



Sources: National Minimum Dataset 2023 (2019/20 onwards year to March)

Bed occupancy rates

In many hospitals around New Zealand, bed occupancy rates are frequently close to – and regularly over – 100 per cent, when the widely accepted safety limit is about 85 per cent occupancy.[26] [27]

Data provided by Te Whatu Ora under the Official Information Act shows only the percentage of times per week that hospitals exceed 90 per cent occupancy. The figures show that in one week last winter, for example, a third of the country's hospitals were operating above that level 100 per cent of the time. Half of the country's hospitals exceeded that level more than 90 percent of the time. Only two hospitals (Taranaki and Wairarapa) reported no times when the 90 percent occupancy level was reached, though Te Whatu Ora cautions: "Compliance and quality with this data submission was clearly variable by hospital".

Summer provides little respite, with all 29 hospitals for which data was available exceeding 90 percent occupancy at some point during most summer weeks.

Hospitals cannot operate safely and effectively at such high occupancy rates as spare bed capacity is needed to accommodate variations in demand and ensure that patients can flow through the system.[28] A lack of available beds has widespread consequences in a health system. It lengthens delays in emergency departments, causes elective procedures to e be cancelled, places patients in clinically inappropriate wards, increases rates of hospital acquired infections and puts added pressure on staff. Bed availability is also closely linked to staffing, as beds cannot be safely filled without appropriate staffing levels.[29]

The national average figure for 28 OECD countries in 2021 was 70 per cent, including private hospitals.[30]

> "When there's not enough beds our patients queue. They queue in our hallways, they queue in our ambulance bays, they queue in ambulances and they don't get seen in a timely manner." – EMERGENCY MEDICINE SPECIALIST

26 Roden J. Hospitals hit 100% occupancy more than 600 times lasT year, *OneNews*, 9 February 2023. https://www.1news.co.nz/2023/02/09/hospitals-hit-100-occupancy-more-than-600-times-last-year/.

27 *O'Dowd A.* Hospital bed occupancy rates in England reach dangerously high levels, *BMJ* 2021;374:n2079. https://www.bmj.com/content/374/bmj.n2079.

28 Australasian College for Emergency Medicine. Position Statement. https://acem.org.au/getmedia/c0bf8984-56f3-4b78-8849-442feaca8ca6/Statement on Access Block

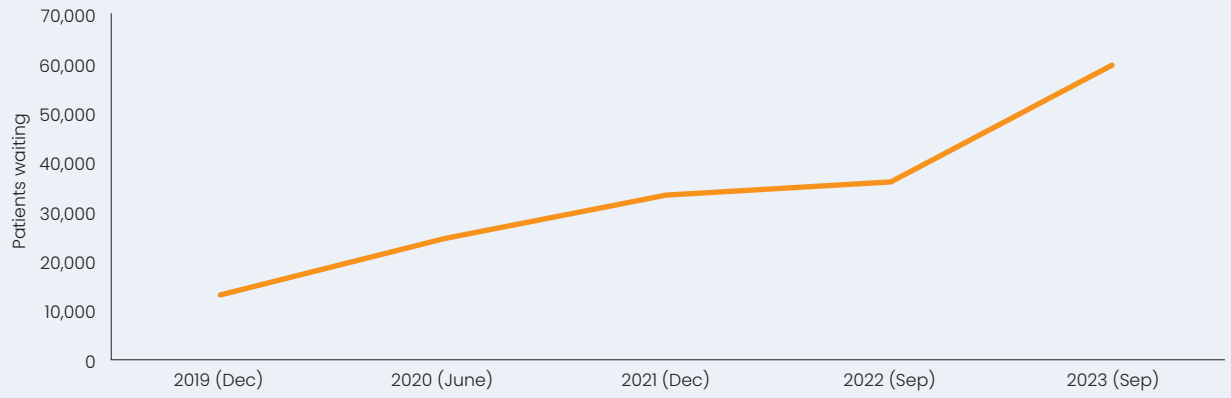
29 Nuffield Trust. *Hospital Bed Occupancy*, updated 26 April 2019. https://www.nuffieldtrust.org.uk/resource/hospital-bed-occupancy

30 Jones R. Hospital bed occupancy demystified. *British Journal of Healthcare Management*, 17(6): 242-248, 2011.

Access to hospital specialists

Te Whatu Ora data show nearly 60,000 patients were waiting more than four months for a first specialist assessment as of September 2023. That's a 67 per cent increase in 12 months and more than a four-fold increase since pre-Covid 2019 data reported by the Planned Care Taskforce (Fig 9).[31]

Figure 9: Patients waiting longer than 4 months for a first specialist assessment (FSA)

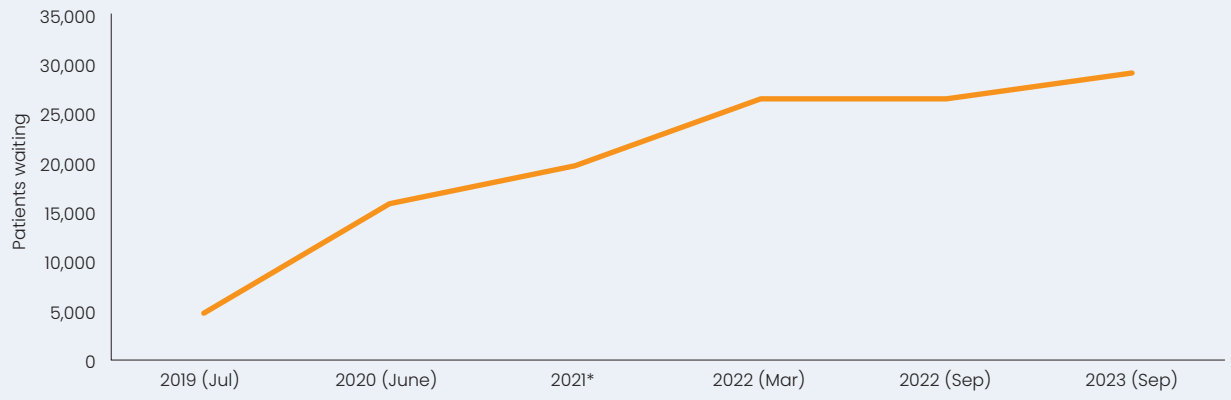


Sources: Planned Care Taskforce, Manatū Hauora and Te Whatu Ora
Note: Some quarterly data is not readily available. Te Whatu Ora has been requested for the full data.

The number of patients who are deemed unwell enough to exceed "clinical" thresholds and given a commitment to treatment but don't receive it within four months increased six-fold between July 2019 and September 2023 – from 4,685 reported by the Planned Care Taskforce, to 29,266 reported by Te Whatu Ora's Clinical Performance Metrics (Fig 10).

Note: *Data accuracy in Figures 9 & 10 is doubtful, as noted by the Planned Care Taskforce in its report of September 2022.*

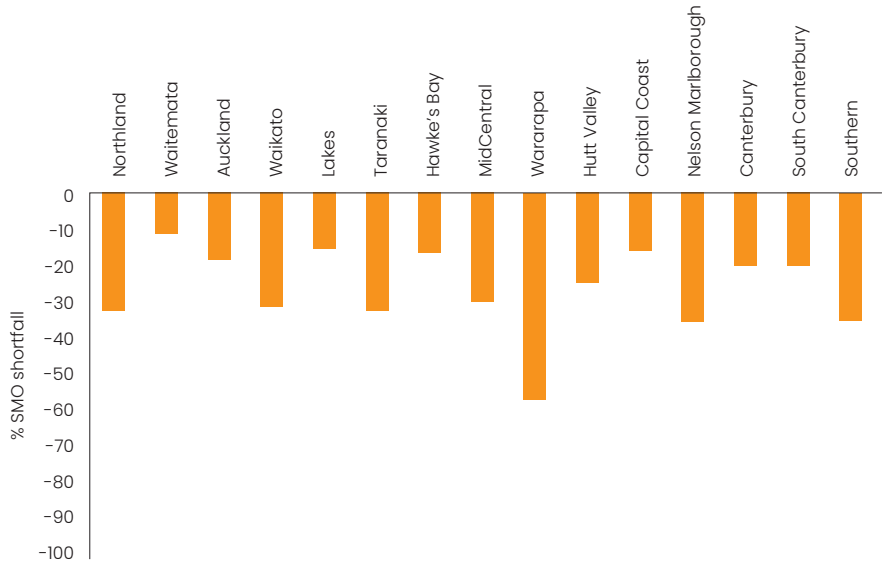
Figure 10: Patients given a commitment to treatment but not treated within 4 months



Sources: Planned Care Taskforce and Te Whatu Ora
* Estimate based on 2020 and 2022 data.

Continuing specialist workforce shortages

Figure 11: Estimated public shortage of full-time equivalent senior medical officers (SMOs) employed in public hospitals



Source: ASMS 2022

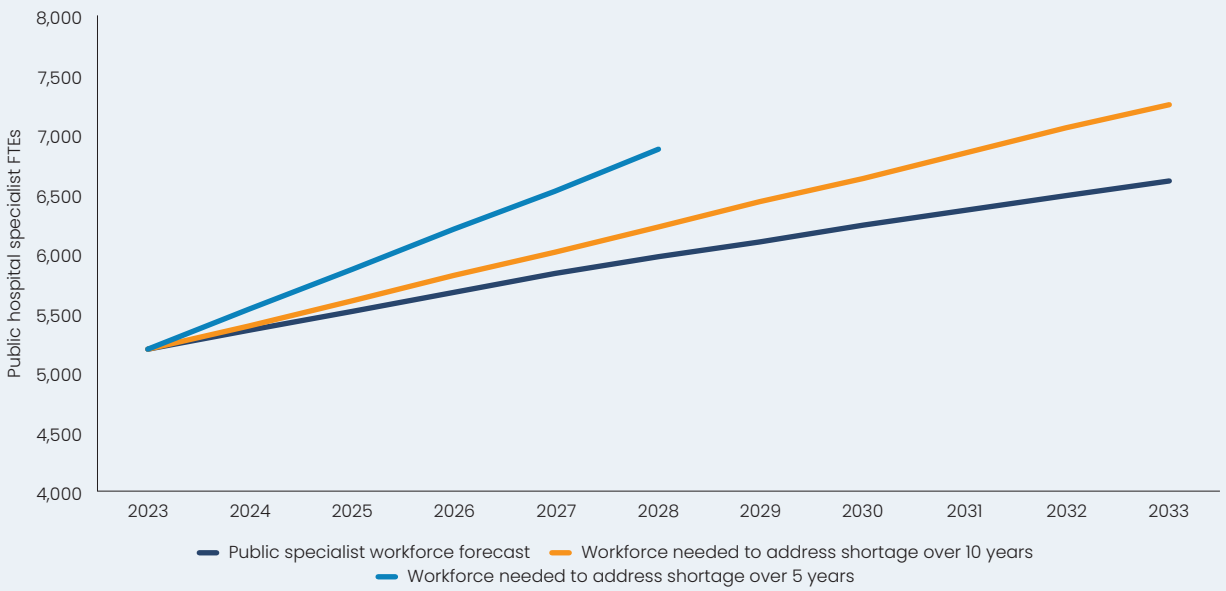
Clinical Directors across 15 districts were surveyed in early 2022 to establish their assessments of safe staffing levels in their departments, taking into account access, quality, safety, and unmet need. The surveys found an average 22% shortfall of senior medical officers (SMOs) across all departments (Figure 11).[32] Extrapolating those results to the total national workforce, this would amount to a shortfall of approximately 1,140 full-time equivalent (FTE) SMOs.

Te Whatu Ora has projected the combined public and private medical specialist workforce to increase by 13.5 per cent/100,000 population between 2023 and 2033.[33] Assuming public FTEs remains about 70 percent of the total workforce, the forecast net growth in the public sector is just over 125 FTEs per year on average. In order to address the estimated 22 per cent shortfall over 10 years would require public sector specialist workforce net growth to average approximately 180 FTEs per year. In order to address the shortfall over 5 years would require net growth to average about 300 FTEs per year (Figure 12).

32 Chambers C. Exposing the gaps. The Specialist. Issue 131, June 2022. https://issuu.com/associationofsalariedmedicalspecialists/docs/13598_the_specialist_issue_131_final.

33 Te Whatu Ora. Unpublished medical specialist workforce projections (5-year model), 2023-2033.

Figure 12: Public sector specialist workforce forecasts and workforce needed to address an estimated 22% shortages over 5 years and 10 years



Sources: Te Whatu Ora 2024; ASMS 2022

In other words, SMO workloads will continue at current levels unless there is substantial improvement in recruiting and retaining more public hospital SMOs. This assumes, also, that the proportion of specialists working full-time or part-time in the private sector remain constant,[34] but various indicators show the under-investment in the public sector is leading to a workforce shift towards the private sector.

> "It has been really difficult to recruit and retain staff, as the work hours and expectations have remained unsustainable."
>
> – ANAESTHETIST

34 It also assumes that the proportion of specialists to medical officers remains constant.

> “Engagement with the sector has highlighted that workforce shortages, maldistribution, poor workforce wellbeing, inconsistent cultural safety and under representation are the key challenges which have created barriers for achieving the health workforce we need.”
>
> – MINISTRY OF HEALTH - BRIEFING TO THE INCOMING MINISTER OF HEALTH, NOVEMBER 2023

A 2023 ‘exit’ survey of ASMS members leaving their employment during that year showed that while leaving for work overseas is a major reason for leaving (26.5 per cent), those leaving to take up private practice or increase their hours in private practice was also significant (15.2 per cent), while 16.7% were retiring from medicine altogether.[35]

Working conditions and poor relationships with management were cited as the main reasons for leaving.

The rate of employment exit in psychiatry, emergency medicine and anaesthesia were disproportionately high, with most leaving to either go work overseas or take up/increase private practice.

The survey results echo similar findings from a 2022 survey.

A 2022 survey on ASMS members’ career intentions within the next five years found 42 per cent of over 1,600 respondents intend to reduce their hours in the public system, with many indicating a move to the private sector.[36]

Unpublished Medical Council data show in 2022, 30 per cent of medical specialists’ full-time-equivalent (FTE) working hours were spent outside of the public system. In surgical specialties the figure is 35 per cent, including four specialties with over 40 per cent non-public FTEs. In nearly a quarter of specialties and sub-specialties, more than 50 per cent are non-public FTEs.

35 ASMS. *Exit Survey 2023*. Finding from the annual survey of doctors and dentists exiting employment in Aotearoa New Zealand’s public hospital system, 2023.

36 ASMS. Over the Edge: Findings of the 2022 survey of the future intentions of senior doctors and dentists, 2023. https://asms.org.nz/wp-content/uploads/2023/03/Over-the-Edge-Future-Intentions-of-the-SMO-Workforce-March-2023.pdf

Neglect of buildings and equipment, and future risks

There is perhaps no clearer example of how the public health system has been a casualty of political short-termism than in the decades of under-investment that has led to the multitude of dilapidated hospital buildings with an estimated $14 billion repair and construction bill over 10 years.

That figure, a Treasury estimate made in 2018, would be well over $17 billion in 2023 dollars, and doesn't include the costs of ongoing repair and maintenance. In addition, nearly $3 billion (in current dollars) is estimated to be needed for upgrading information technology.[37] And while more than $4.5 billion has been injected into capital spending since then, much of that will have been swallowed up by increased costs over that time, as evidenced by large cost blow-outs of hospital building projects around the country.[38]

The poor state of many hospital buildings is not only a consequence of penny-pinching on capital spending over many years. As the Ministry of Health put it in 2020, it's "a result of prolonged under-investment in health operating expenditure, which has placed considerable constraints on [district health services] to prioritise immediate service delivery and defer investment in facilities, maintenance and remediation".[39]

Developing and maintaining good quality buildings and equipment is therefore not only dependent on adequate, ongoing capital investment but is also inextricably linked to the adequacy and management of operational funding.

Public-private partnerships?

The government has signalled it will be looking for third-party funding to make up the infrastructure shortfall, with the National-Act coalition deal committing the government to investigate "build and lease-back arrangements" for new hospitals.

Globally, the merits or otherwise of third-party funding, such as private-public partnerships (PPPs), are hotly debated. There is, however, strong agreement – including among proponents of PPPs – that they carry substantial risks.

An International Monetary Fund (IMF) publication warns: "Budgeting and accounting practices that allow governments to increase infrastructure without an immediate impact on public-sector deficits or debt are a large source of fiscal illusion."[40] In the current balance sheets can be made to look good, but the question is whether the less-visible private debt produces better outcomes than projects funded from public debt.

PPP financing costs are usually higher than those for financing traditional public investment, in part because governments can borrow at lower costs than the private sector. PPPs also require more complex and costly administration, both in tendering and contract management. And private profit margins must be added to the mix.

For PPPs to benefit those who pay for them – ultimately the public, in one form or another – the higher costs of PPPs must be more than compensated by the ability of the private partner to manage the project and its risks and to deliver greater efficiency gains than if the project were financed publicly.

These issues will be examined in a further report should the Government decide to resort to third-party funding for infrastructure developments in the public health sector.

37 Ministry of Health. *The National Asset Management Programme for district health boards. Report 1: The current-state assessment.* Wellington: Ministry of Health, June 2020. https://www.health.govt.nz/publication/national-assetmanagement-programme-district-health-boards-report-1-current-state-assessment

38 Pennington P. Construction inflation, insufficient planning adds to hospital project cost blow-outs, *Morning Report*, Radio New Zealand, 29 June 2023. https://www.rnz.co.nz/news/national/492829/construction-inflation-insufficient-planning-addto-hospital-project-cost-blow-outs

39 Ministry of Health. *District Health Board Sector Asset Management Framework: Strategy 2020-2030*, October 2020. https://www.health.govt.nz/system/files/documents/publications/district-health-board-sector-asset-managementframework-strategy-2020-2030-nov20.pdf

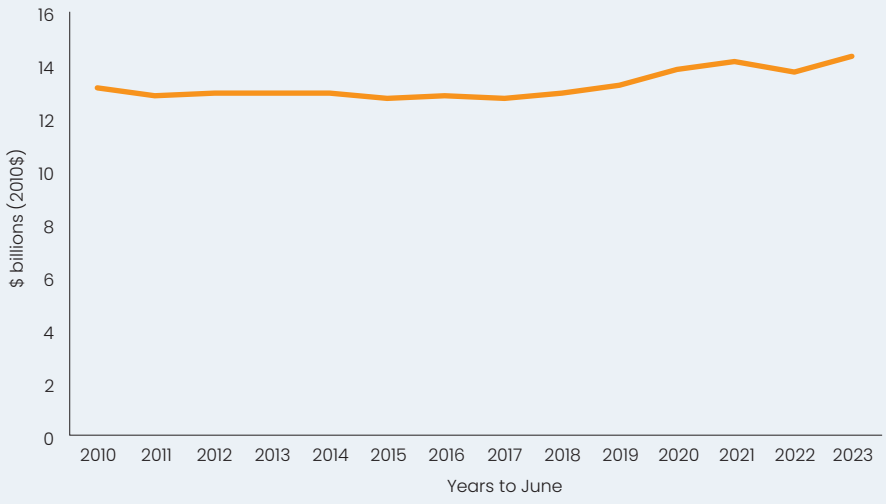
40 Fouad M, Chishiro M, et al (eds). Mastering the Risky Business of Public-Private Partnerships, International Monetary Fund, May 2021. https://www.imf.org/en/Publications/Departmental-Papers-Policy-Papers/Issues/2021/05/10/Masteringthe-Risky-Business-of-Public-Private-Partnerships-in-Infrastructure-50335

Unravelling the spin: health funding in reality

It's customary every year around Budget time, or whenever health system failings hit the news, for Ministers of Health to magnify the latest government allocations of health funding, often multiplying annual increases over four or five years and ignoring inflation and demographic growth.

In reality, budgets have not allowed workforce growth over and above that needed to keep up with demographic growth and ageing (Fig 13). In short, budgets are being set to maintain a virtual status quo in terms of service capacity versus service need.

Figure 13: Core Health Expenses in constant dollars (2010) adjusted for demographic changes*



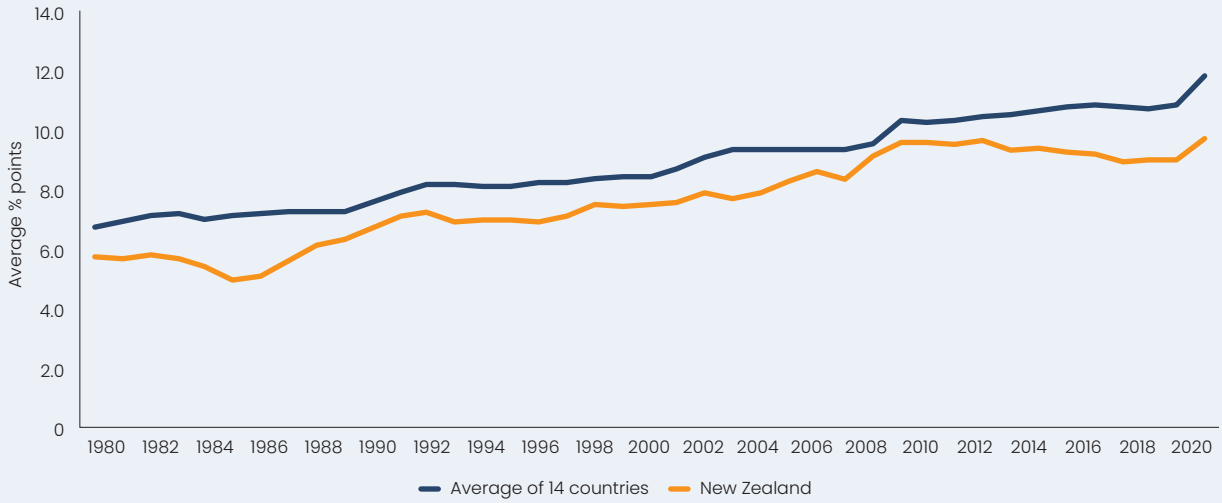
Sources: Treasury, Budget Economic and Fiscal Updates 2023 and historical; Pre-Election Economic and Fiscal Update 2023

* **For consistency across the period, data excludes:**

- Funding for the Government's response to the Covid pandemic from the year to June 2021.
- Estimated $520 million contingency funding from the year to June 2023 to frontload historical deficits which were not included in Core Health Expenses.

As previously reported, Aotearoa New Zealand's total health expenditure (public and private), measured as a proportion of GDP, has remained well below other comparable countries for many years (Figure 14).[41]

Figure 14: Total health expenditure as a percentage of GDP – Aotearoa New Zealand and the average of 14 comparable countries, 1990-2020



Comparable countries: Australia, Belgium, Canada, Denmark, Finland, France, Germany, Italy, Netherlands, Norway, Sweden, Switzerland, UK, USA

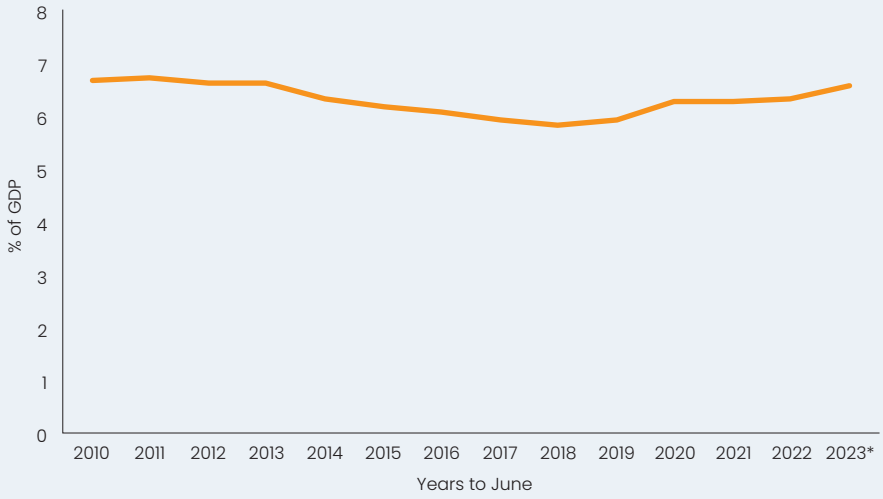
Source: OECD Health Data 2022

The effects of the Covid pandemic have hindered meaningful comparisons in the most recent years. According to the OECD Aotearoa New Zealand's total health expenditure (public and private) in the year ending June 2022 amounted to 11.2% of gross domestic product (GDP), which equates to $44 billion - 70% higher than government Core Health Expenditure, excluding Covid-related funding. The Ministry of Health, which usually supplies the data to the OECD, was unable to explain the figure as it did not provide the data that year. It was estimated by the OECD and is clearly a long way over the mark.

41 ASMS. *Workforce: The Make or Break of the Health Reform*, p42, November 2022. https://asms.org.nz/workforce-the-make-or-break-of-the-health-reform/

As shown in Figure 15, government Core Health Expenditure (excluding Covid-related funding) has remained below 7 per cent of GDP since at least 2010.

Figure 15: Aotearoa New Zealand's Core Health Expenditure as a percentage of GDP, 2010-2023



Sources: Treasury, Budget Economic and Fiscal Updates 2023 and historical; Pre-Election Economic and Fiscal Update 2023

* **For consistency across the period, data excludes:**

- Funding for the Government's response to the Covid pandemic from the year to June 2021.
- Estimated $520 million contingency funding from the year to June 2023 to frontload historical deficits which were not included in Core Health Expenses.

Concluding comment

To a large extent our public hospitals are having to cope with the policy failures – or policy implementation failures – in other sectors, as well the shortcomings within the health sector itself. Socioeconomic deprivation leads to inequitable health outcomes. Access barriers to primary care leads to poorer health and increasing need for hospital care. Poor access to hospital care leads to poorer health, reduced quality of life, need for primary care, and ultimately increasing need for more acute hospital care. Those who can afford it will escape this negative spiral by going private.

Today, our public health system is the culmination of successive government failures to take coordinated and sustained action across the whole of government. Policies are fragmented. Government sectors have operated in silos and focused on the short term.

Even within the health system, primary care and hospital care are treated like separate departments and little has been done to integrate them. Resources are targeted at containing pressure points, often at the expense of other parts of the system. Framing action to support good health as a cost to society rather than an investment continues to entrench thinking.

Health system restructurings on their own won't solve this. A real game-changer that recognises the urgent need for sustained, coordinated whole-of-government action matched by the necessary investment is required.

Our recommendations to government aim to close the growing gap of unmet need for health care by focusing on actions that reduce that need while simultaneously increasing the health capacity of the health system to meet it. To break the rut described above, these recommendations include an urgent need to open an independent inquiry into how we fund our health system as a whole, and how to mitigate future health needs, including policies and investment for addressing the determinants of ill health.

Actions needed

While this report focuses on hospital services, the actions needed to address our health system crisis clearly require a comprehensive whole-of-government response. On the one hand our health workforce is chronically under-staffed and exhausted; on the other, the health needs of our communities are growing faster than our health services can keep up, creating a growing gap of unmet health need.

These recommendations to Government are summarised and updated from previous reports and aim to close that gap by focusing on actions that simultaneously reduce the need for hospital services while increasing the health workforce capacity.

An additional recommendation for this report calls for an independent inquiry into the options for funding a properly functioning public health system.

Reducing the need for hospital services

- **Reduce potentially avoidable hospitalisations** by strengthening public health policy implementation and addressing the social and commercial determinants of ill health such as substandard housing, poverty, and the harmful effects of tobacco, alcohol and unhealthy foods.
- **Achieve health equity by 2040** by adopting proportionate universalism across all relevant government sectors and improving cultural safety.
- **Remove the barriers to primary health care and dental care** by incrementally removing user charges and reforming primary health and dental care services to enable fair distribution and availability of services.
- **Prioritise strategies to integrate hospital and community-based care**, including upfront and long-term investment, recognising that it takes time to produce measurable and sustainable benefits, and collective leadership that taps into the knowledge and experience of frontline staff.

Increasing hospital service capacity

- **Develop a complete understanding of workforce capacity constraints** by undertaking a regular Health Workforce Census to support strategic planning across all health professional groups.
- **Develop a complete understanding of unmet need for hospital care**, as well as for primary care, through regular population surveys.
- **Develop a comprehensive Health and Disability Workforce Plan** and Implementation Plan to address work-force shortages, based on a gap analysis from the Workforce Census and unmet need data.
- **Match investment to health needs** using the gap analysis from the Workforce Census and unmet need data.

Commission an independent inquiry into health funding

- That the Government commissions an independent inquiry into the options for funding a public health system that is sufficient to ensure all New Zealanders have timely access to quality health care when they need it.
- That the inquiry's terms of reference include but are not limited to:
  - Listening to communities
  - Commissioning an independent comprehensive assessment of unmet need for primary and secondary health care
  - Commissioning an independent gap analysis of health system capacity against health need, including the resources and costs needed to close the gap
  - Commissioning an economic and social analysis of unmet health need and the economic and social benefits of good health
  - Providing analysis of historical funding of the public health system
  - Considering policies and investment for mitigating future health needs, including those addressing the determinants of ill health
  - Considering international reports and research where they are applicable to Aotearoa New Zealand
  - Publishing its findings in full, with recommendations to the Government.

Appendix 1: A deeper dive into unmet need data

European data

The European data are from the European Union's Statistics on Income and Living Conditions (EU-SILC) survey compiled by Eurostat. People (aged 16 and over) are asked whether there was a time in the previous 12 months when they felt they needed medical care (primary and secondary care) but did not receive it, followed, where relevant, by a question on why the need for care was unmet. The data is commonly presented with a focus on three reasons (from eight options): health care was too expensive, the distance to travel was too far or waiting times were too long.

The latter includes "people who were actually on a waiting list [for urgent care] and, at the same time, were not helped"; for respondents experiencing delay in getting an appointment soon enough to meet their need of care; as well as for respondents who were discouraged from seeking care because of perceptions of the long waiting times." It excludes "waiting time to see a doctor on day of appointment (the time spent in the waiting room), being on waiting list for planned (non-urgent) care if the need is not seen as urgent," and dental care. The unmet need due to waiting time for hospital care therefore is largely related to delays in getting a specialist appointment or waiting to get onto a waiting list.

Aotearoa New Zealand data

The Aotearoa New Zealand data are from New Zealand Health Surveys (NZHS) of adult unmet need for general practitioner services using the three criteria above, and unmet need for specialist services due to cost or distance to travel/no transport. Additional data include the number of adults whose referrals to a specialist were declined; waits for first specialist assessments of four months or more; and waits for radiology and endoscopy treatments/tests beyond national targets. People on planned care waiting lists are not included.

Comparability

The OECD explains that some surveys of unmet needs – notably the European Health Interview Survey – report much higher rates on unmet needs than the EU-SILC survey. "This is because these exclude people without health care needs, while the EU-SILC survey considers the total [adult] population surveyed."[43] The New Zealand data is also based on estimated percentages of the total adult population.

The EU-SILC survey asks respondents for the main reason for not having a medical examination or treatment; unmet need is then calculated as a combined total of the three categories. NZHS respondents can name one or more reasons for unmet need. There may therefore be some double or triple counting across the three categories, though this may have only a marginal effect. Those with an unmet need due to cost, for example, are not likely to have an unmet need due to long waits or transport issues. Some double-ups may occur, however, if there is more than one episode for non-use or delay in receiving care during the year. Similarly, double-ups may occur between GP and specialist unmet needs but again one would expect this to be marginal. It is more likely that some unmet need for specialist services is not measured as it sits in the unmet need figures for GP services.

As always with large-scale international comparisons, caution is needed in their interpretation.

The subjectivity of self-reported unmet need measures means individuals who value health more or who have higher expectations towards health services might be more prone to report unmet needs.[44] Conversely, lower prevalence of subjective unmet need might be due to individuals not acknowledging their poor health or not realising that their poor health is amenable to healthcare interventions. Further, the World Health Organisation notes that poor people may have fewer expectations than rich

43 OECD Health At A Glance, 2021.

44 Ko H. Unmet healthcare needs and health status: panel evidence from Korea. *Health Policy* 120:646–653, 2016.

and be "accommodative to unresponsive services".[45] Unmet health need in poorer countries therefore may be under-stated. (To mitigate against this potential bias, Figure 1 includes only countries with a similar or higher GDP per capita to Aotearoa New Zealand's. The full data shows 37 European countries with a lower unmet need than ours.)

Some variations in the survey EU-SILC questions across countries may also affect data comparability: while most countries refer to both a medical examination or treatment, in some countries (eg, Czech Republic and Spain) the question only refers to a medical examination/ consultation, resulting in lower rates of unmet needs. The question in Germany refers to unmet needs for 'severe' illnesses, also resulting in some under-estimation compared with other countries.[46]

While every effort has been made to align New Zealand data with EU-SILC data, it relies on some assumptions. (More detailed information on comparability is provided in the table below.) Nevertheless, the New Zealand data may understate unmet health care need for several reasons, including:

- The number of referrals withheld by GPs because they don't believe the referral would meet the criteria for acceptance is not included as the number is not known.
- The number experiencing long delays in FSA follow-up appointments is not included as the number is not known.
- The number of people experience long delays on the planned care waiting lists are not included as it is assumed, by definition, that their treatment is not urgent. (Though there is growing anecdotal evidence that long delays are having a serious impact on patients' health and wellbeing.)
- Unmet need for medical care will often originate further upstream than the 12-month period commonly covered in surveys.
- Unmet need for after-hours services dues to cost or transport issues is not included.
- Unmet need for mental health care (estimated as 7.8 per cent of the adult population in the 2022/23 NZHS) is excluded as the unmet need for a doctor specifically is not known.
- People who are not enrolled in a primary care centre (6.5% of the total population) are not included.

45 Amos LM, Quintal C, et al. Unmet needs across Europe: Disclosing knowledge beyond the ordinary measure, *Health Policy*, Issue 12, Vol 123, December 2019.

46 OECD. *Health at a Glance, OECD Indicators*, OECD Publishing 2022.

Europe EU-SILC 2023	Aotearoa NZ 2022/23
Adult unmet need for medical examination or treatment (primary care and hospital care):[47] Survey question to adults 16 years and over: Was there any time during the last 12 months when you really needed a medical examination or treatment (excluding dental) for yourself? "The purpose … is to capture the restricted access to medical care according to the person's own assessment of whether [they] needed medical examination or treatment, but did not get it, experienced a delay in getting it or did not seek it." Medical care refers to services provided by or under direct supervision of medical doctors (ISCO-08 code 221 group on general and specialist medical practitioners), traditional and complementary medical professionals (ISCO-08 code 2230) or equivalent professions according to national health care systems. Included: medical mental health care; prevention if perceived by respondents as important. Excluded: Dental care. Follow-up for 'yes' respondents: What was the main *reason* [note singular] for not having a medical examination or treatment? Eight options are listed, of which the main three, combined, are commonly reported: **1.** Could not afford to (too expensive or not covered by the insurance fund)? **2.** Too far to travel/no means of transportation? **3.** Waiting list, don't have the referral letter? The survey explains the answer to the "waiting list" question "Is to be used for people who were actually on a waiting list and, at the same time, were not helped even though the need for care was urgent, for respondents experiencing delay in getting appointment soon enough to meet their need of care, as well as for respondents who were discouraged from seeking care because of perceptions of the long waiting times." "Excluded: waiting time to see a doctor on day of appointment (the time spent in the waiting room), being on waiting list for planned (non-urgent) care if the need is not seen as urgent."	**Adult unmet need for hospital specialist services:** • NZHS question to adults 15 years and over, 2022/23: In the past five years, was there a time when a doctor referred you to a specialist but you did not go for any of the following reasons? 1. Cost. 2. No transport or too far to travel.[48] • FSA waiting times > 4 months[49] • Radiology waiting times for scans > 42 days[50] • Endoscopy waiting times > 14 days (urgent); > 42 days (non-urgent); > 84 days (surveillance) • Declined referrals[51] • Withheld referrals: unknown Estimates for unmet need over the last 12 months were assumed to be 39% of unmet need over five years based on the results of a pilot study of methods for measuring unmet need for hospital care.[52] Waiting time figures for adults are assumed to be 80% of the total, in line with population data. **Adult unmet need for GP services:** NZHS: In the past 12 months, was there a time when you had a medical problem but did not visit a GP for any of the following reasons? **1.** Cost? **2.** No transport or too far to travel? **3.** Time taken to get an appointment too long?

47 European Commission. *Methodological Guidelines and Description of EU-SILC Target Variables*, 2023 Operation, 2023.

48 New Zealand Health Survey 2022/23

49 Te Whatu Ora. Elective Services Patient Flow Indicators (ESPI), September 2023.

50 Te Whatu Ora. *Planned Care Taskforce: Reset and Restore Plan*, September 2022

51 Te Whatu Ora. Response to a request for data under the Official Information Act, published in October 2022.

52 Bagshaw P, Bagshaw S, Frampton C, et al. Pilot study of methods for assessing unmet secondary health care need in New Zealand. *NZMJ*. 2017; 130(1452):23-38.

Discussion

Over the last decade, Aotearoa New Zealand has recorded one of the worst declines in public satisfaction for access to health care among OECD countries (83% in 2012, dropping to 64% in 2022).[53] The 36% who don't say they are satisfied broadly reflects the level of unmet need for medical care, taking into account the data reported here, other recorded unmet need (eg, for inability to get time off work, lack of childcare, etc) and other unmet need or potential unmet need that is not recorded (those without a GP, withheld referrals, etc). While the Covid pandemic will have affected access to care for all countries, the average recorded unmet need for medical care in European countries is lower in 2022 than in 2012. Satisfaction levels relating to availability of health care has fallen by 2.5 per cent on average across 27 OECD countries, though it has either improved or remained the same in many of them, with Switzerland and Belgium topping the chart with 90 percent or more satisfaction levels.

It is increasingly recognised that to assess the effectiveness of a country's health system you need to know how many people have a need for health treatment that is not being met. Hence a resolution adopted by the 76th World Health Assembly in 2023 requested the WHO's director general review the importance and feasibility of using unmet need for health services as an additional indicator to monitor universal health coverage (UHC) nationally and globally.[54 55]

Similar calls have been made locally to monitor how well our public health system is serving the population. While unmet need for primary care has been measured via the annual New Zealand Health Survey (NZHS), only limited data are available on unmet need for hospital care. A pilot study of methods for undertaking a comprehensive national survey to measure unmet need for hospital care estimated a total unmet need of about 9% of the adult population over a five-year period. This included unmet need for surgical, non-surgical, dental, and psychiatric care.[56] For the first time, questions on unmet need for hospital specialist care were included in the NZHS in 2020/21, though questions were absent on the often lengthy delays in receiving treatment, and on GPs' decisions not to refer patients to specialists because of the likelihood of them not meeting the "clinical" (service capacity) thresholds for treatment.

The information presented here, while limited as described above, indicates Aotearoa New Zealand's unmet health need is far and away more serious than comparable countries and warrants urgent and more detailed and investigation to produce a strong evidence base for closing the health needs gap.

53 OECD, *Health at a Glance 2023: OECD Indicators*, OECD Publishing 2023.

54 WHO. ResoluKon WHA76. 4. PreparaKon for the high-level meeKng of the United NaKons General Assembly on universal health coverage. 2023.

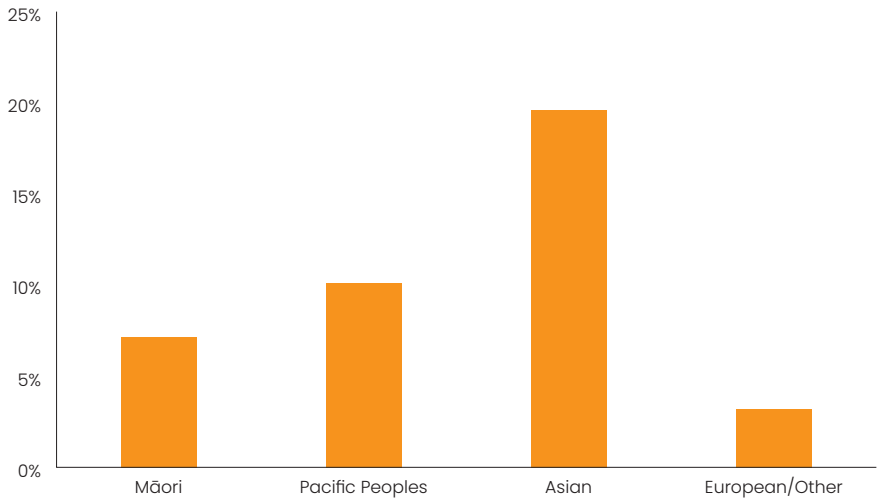
55 Rosenberg M, Kowai P, Rahman M, et el. Beler data on unmet healthcare need can strengthen global monitoring of universal health coverage, BMJ 2023;382.

56 Bagshaw P, Bagshaw S, Frampton C, et al. Pilot study of methods for assessing unmet secondary health care need in New Zealand. *NZMJ*. 2017; 130(1452):23-38.

Appendix 2:

Increases for Māori, Pacific peoples and Asian patients are significantly higher than for European/Other patients. Between July-September 2022 and July-September 2023, Māori presentations increased by 7.2 per cent, Pacific peoples 10.2 per cent, Asian 19.7 per cent and European/Other 3.3% (Figure 16).

Figure 16: Growth in Emergency Department presentations by ethnicity Jul-Sep 2022 to Jul-Sep 2023



Source: Te Whatu Ora 2023

Notes

ASMS

TOI MATA HAUORA