ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

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ASMS submission to the Ministry of Health on the Draft Health of Older People Strategy

7 September 2016

Background

The ASMS is the union and professional association of salaried senior doctors and dentists employed throughout New Zealand. We were formed in April 1989 to advocate and promote the common industrial and professional interests of our members and we now represent more than 4,000 members, mostly employed by District Health Boards (DHBs) as medical and dental specialists, including physicians, surgeons, anaesthetists, psychiatrists, oncologists, radiologists, pathologists and paediatricians. Over 90% of all DHB-employed senior doctors and dentists eligible to join the ASMS are in fact members.

Although most of our members work in secondary and tertiary care (either as specialists or as non-vocationally registered doctors or dentists) in the public sector, a small but significant number work in primary care and outside DHBs. These members are employed by the New Zealand Family Planning Association, ACC, hospices, community trusts, Iwi health authorities, union health centres and the New Zealand Blood Service.

The ASMS promotes improved health care for all New Zealanders and recognition of the professional skills and training of our members, and their important role in health care provision. We are committed to the establishment and maintenance of a high quality, professionally-led public health system throughout New Zealand.

The ASMS is an affiliate of the New Zealand Council of Trade Unions.

Introduction

The health of older people involves a wide range of factors. Due to the restricted timeframe and availability of resources, this submission concentrates on matters to do with access to, and provision of, medical specialist services.

Vision

The document's vision is outlined as to:

- prioritise healthy aging and resilience throughout people's older years
- enable high-quality acute and restorative care, for effective rehabilitation, recovery and restoration after acute events
- ensure people can live well with long-term conditions
- better support people with high and complex needs
- provide respectful end-of-life care that caters to personal, cultural and spiritual needs.

This 'vision' is too limited to promote good health for older people. First, it does not acknowledge the importance of the 'life course approach', as outlined in the document. Second, the vision should surely be to see high quality health care across all health and disability services, not just acute services. We also have concerns about the use of the term 'resilience', as discussed below. For the purpose of the vision statement, these recommended changes could be addressed simply by amending the first and second vision bullet points to:

- prioritise healthy aging throughout people's lives
- enable timely, high-quality health care and restorative care as needed.

These elements of the vision need to be incorporated in the detail of the strategy.

Workforce development

Shortages of geriatricians and 'some other medical specialists' are acknowledged in the draft strategy. The Association's recent national surveys on 'presenteeism' and burnout among district health board-employed senior doctors indicate the senior medical workforce in general is under great stress.[1] [2] Long-term shortages have been acknowledged by HWNZ in its report *The Role of Health Workforce New Zealand.* Specifically:

> *The most important issue currently is the impact of a prolonged period of medical labour market shortages on the workloads, wellbeing and productivity of DHB-employed senior doctors.*[3]

The 2014 report *Health of the Health Workforce*, noting the high numbers of senior medical officers (SMOs) approaching retirement age, identified a wide range of specialties and sub-specialties considered 'vulnerable'. The Department of Immigration's long-term and immediate skills shortage lists even more specialties where there are 'sustained and ongoing shortage…both globally and throughout New Zealand', or where 'there are no New Zealand citizens or residents available'. Together they reflect medical specialist shortages across the board. [4] [5]

New Zealand's specialist workforce is especially vulnerable because of our heavy dependency on international medical graduates (43% of the specialist workforce), which HWNZ has also acknowledged and indicated this needs to be reduced to around 15%. The relatively poor retention rates of IMGs are well documented in the Medical Council's annual medical workforce surveys. This places New Zealand in a precarious position when considering looming international specialist shortages. Our dependency on IMGs is especially significant when taking into account that the

medical workforces in most other OECD countries are even older than New Zealand's. OECD data show in 2013 25% of New Zealand doctors were aged 55 or over, whereas the OECD average was 33%.[6]

The Association supports the 'action' to 'Develop a range of strategies to improve recruitment and retention of those working in aged care,' but such strategies are needed to address senior doctor shortages across a comprehensive range of specialties. We reiterate our invitation to work with Health Workforce New Zealand to develop recruitment and retention policies and implementation plans as a matter of urgency.[7]

Integration in the health sector and across agencies

The Association has always supported the goal of better service integration and collaboration. There is strong evidence to show the best way to achieve this is through distributed clinical leadership.

> *Too often the talk around integration focuses on money and systems, with too little appreciation that integration ultimately depends on people and culture. There is no top-down, imposed way to integrate care; it will be done through distributed, engaged leadership or it will not be done at all.*[8]

International evidence shows integrated care is possible only if it comes from the 'bottom up' through the development of specific 'micro-level' interventions by a small number of providers. Organisational integration then comes as a consequence rather than a cause.

Canterbury DHB's incremental moves to better integrate hospital and community services over the past six years or so is, according to one analysis, one of 'a small stock of examples' where integration appears to have resulted in some measurable positive changes.[9]

Notably, the process at Canterbury involved a number of different initiatives developed and implemented 'from within, by empowering clinicians and others who are prepared to take responsibility for changing the way things work, instead of seeking to drive change through external stimuli…'. Clinical leadership was 'not focused on just a few heroic individuals in formal leadership roles', but was shared and distributed as a collective responsibility.[10]

In summary, the literature is clear that for integration of health services to succeed, clinical leadership needs to be firmly established across the system.

Resilience

The proposal to 'prioritise … resilience throughout people's older years' is problematic because the specific intent is unclear. 'Resilience' can be conceptualised in numerous ways.

Many researchers have raised concerns about how social policies promoting 'resilience' can be interpreted as representing an individual's personal attribute and 'pave the way for blaming the individual for not possessing characteristics needed to function well'. This, in turn, can lead to political decisions to limit support for people who have not (for any number of reasons not necessarily connected with their own behaviour) achieved 'resilience' in the eyes of the state.[11]

While one cannot argue with a strategy that aims for the best - with 'a vision where older people age well and are healthy, connected, independent and respected' - equal attention must be afforded those who do not reach the ideal state.

As researchers Judith Davey and Kathy Glasgow comment in a critique of New Zealand's Positive Ageing Strategy, compared with those in Australia and the United Kingdom:

> *Those who are ageing in good health and are engaged in productive activities may benefit from increased opportunities if the strategies achieve their objectives. But the approach is*

problematic for those who are not, or who can no longer be, self-reliant and independent. Those who make demands on health and welfare services may be stigmatised and blamed for not making sufficient preparation or taking due responsibility for their health and wellbeing.[12]

To help avert any negative consequences from accentuating the positive, researchers recommend that policies or reports relating to 'resilience' should include 'a clear operational definition … and explicitly clarifying that it is not a personal characteristic of the individual'.

We note that: 'Positive psychology approaches that build people's strengths and capabilities are another important element to building mental resilience, increasing optimism and hope and reducing the potential and impact of depression, anxiety and cognitive decline.'

We suggest one important 'positive psychology' approach would be to provide older people with a security of knowledge that if they are in need of any health service or disability support, it is available in a timely manner, it is affordable and it is of high quality. This should be a priority of the Action Plan.

Respectful end of life

We support proposals to promote advance care planning and more effective end-of-life care in general. This requires senior doctors' time, which in turn requires an adequate workforce.

A Royal Australasian College of Physicians (RACP) survey of fellows' and trainees' attitudes, knowledge and practice concerning end-of-life care and discussions with patients about future health care options through Advance Care Planning processes found many patients nearing the end of life are provided with treatment that is inappropriate or against their wishes.[13]

Of all respondents to the RACP survey, 34% had commenced an Advance Care Plan conversation with a patient in the past six months and 32% had not done any. The survey identified the following potential barriers to undertaking Advance Care Planning:

- time constraints (62%)
- insufficient relationship with patients (46%)
- health literacy of the patient or family (41%)
- lack of skills of the doctor (30%)
- discomfort in having end of life or Advance Care Planning conversations (26%)
- unavailability of appropriate place for discussions (20%)
- patients aren't interested (18%)
- language barrier (16%).

Most of these identified barriers are directly or indirectly related to the doctor's time – whether it is time to have the (sometimes many) conversations with the patient and family, especially if the patient has difficulty understanding the information, or whether it is time for the doctor to undertake skills training or obtain other support as needed.

The doctor's time factor arises frequently in the literature discussing barriers to patient centred care.[14]

‘Social investment approach’

The social investment approach – assuming it is based on the ‘investment approach’ currently used by the Ministry of Social Development (MSD) – uses techniques from the insurance industry to calculate long-term costs to the government of health and social services.[15]

However, it fails the test of being an investment approach. A true investment approach should take a long-term view of both the costs and the benefits of public services in order to reduce costs while maintaining or improving effective services and benefits. It is the idea of spending now to reduce future costs.

Instead, far from being an investment approach to social welfare, MSD focuses only on costs and benefits to the government and not on the benefits to individuals and the community. The Productivity Commission recommended that the investment approach “should be further refined to better reflect the wider costs and benefits of interventions” and called for independent evaluations. It noted that “slavish application of an investment approach based purely on costs and benefits to government might lead to perverse outcomes.

Council of Trade Unions economist Dr Bill Rosenberg’s analysis of the ‘investment approach in social welfare concluded:

> *It treats citizens as liabilities [the draft strategy calls chronic health conditions a ‘burden’] unless they are employed, and even then they are not regarded as assets. This is the logic of the approach and is being demonstrated in harsh, poorly conceived welfare policy which ironically is short-sighted because it ignores human need. Based on commercial insurance actuarial methodologies, it confuses public services with private insurance. It places no value on the purpose for having public services such as social security. It promotes an impoverished approach to public policy which can be dangerously wrong.*[16]

Action Plan

Notwithstanding the matters raised in this submission, many of the proposed actions listed in the ‘Action Plan’ as a whole make sense, but there is no indication as to whether there is a budget for each of the ‘actions’.

The earlier, more candid Ministry of Health draft strategy on the mental health and addiction workforce plan acknowledged ‘All actions in the draft are tentative’ depending on the availability of funding.[17]

Given that, as the draft strategy states, “We currently spend 42% of the … health budget on people aged 65 years and older,” the amount of money to fund the Action Plan is likely to be considerable. We note that since 2009/10 the population of those aged 65+ has increased by an estimated 24% while DHBs have accumulated substantial funding shortfalls and health spending per GDP has dropped.[18] [19] If implementation of the Action Plan is, like the draft mental health workforce plan, dependent on funding being available, and current health funding trends continue, many of the goals are unlikely to be achieved.

Evaluation

We note the Ministry of Health will “Develop a system to evaluate progress against the goals of the Health of Older People Strategy...” There are many players and many activities involved, so an evaluation is likely to be no small task – though of course it is crucial. Again, there is a question of budget. There is also a fundamental question of the availability of baseline data on which to base an evaluation.

Finally, assuming a robust evaluation programme is able to be put in place, with the necessary funding, we question whether the Ministry of Health is the appropriate body to be given responsibility for it. As the Prime Minister's Chief Science Advisor comments:

> *It is important to separate as far as possible the role of … evaluation from the role of those charged with policy formation.*[20]

If the Ministry is to have responsibility for evaluating the progress of the strategy, in order to ensure public accountability, the evaluation should be undertaken as an annual report to Parliament.

References

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