ASSOCIATION OF SALARIED MEDICAL SPECIALISTS
TOI MATA HAUORA

ASMS submission on the Pae Ora (Healthy Futures) Bill to the Pae Ora Legislation Committee

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The Association of Salaried Medical Specialists (ASMS) is the union and professional association of salaried senior doctors and dentists. ASMS was formed in April 1989 to advocate and promote the industrial and professional interests of our members, most of whom are employed by District Health Boards as medical and dental specialists, including physicians, surgeons, anaesthetists, psychiatrists, oncologists, radiologists, pathologists and paediatricians. We have over 5,000 members.

ASMS promotes improved health care for all New Zealanders and recognition of the professional skills and training of our members and their significant 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.

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

ASMS is a member of the Health Aotearoa Coalition.

Key points

- ASMS generally supports the intent of the Pae Ora (Health Futures) Bill (the Bill) and the repeal of the New Zealand Public Health and Disability Act 2000.
- We agree with restructuring the health system and establishing new Crown entities - the Māori Heath Authority (the Authority) and Health New Zealand (Health NZ).
- We do not support shifting the emphasis of the health system to primary and community services, as it is too simplistic. We believe there must be greater focus on developing and supporting an integrated healthcare system.
- We strongly support the aim of achieving health equity for Māori and for Māori decision-making and power-sharing to reflect the Crown's obligations under Te Tiriti o Waitangi (the Treaty of Waitangi).
- We support the legal recognition of Iwi Māori Partnership Boards, the health system principles, the development of a Government Policy Statement on Health, a New Zealand Health Strategy, a New Zealand Health Plan, New Zealand Charter and a Code of Consumer Participation.
- We strongly support the establishment of a Public Health Agency (PHA) and a population health focus. We believe the PHA should be a stand-alone agency.
- We believe that the health budget must be significantly increased to provide healthcare to meet the needs of all New Zealanders.
- We believe there must be greater focus on building and valuing the health workforce, and greater attention to investing in public health system infrastructure.

Background

The Minister of Health has announced that one of the aims of the reforms is "to rebalance away from a reliance on hospital services, towards greater investment and access in primary and community services"[1]. A fundamental assumption with this is that the current level of hospital services is adequate to respond to demand, which it clearly is not.

Many thousands of patients are rejected for hospital treatment each year in New Zealand despite being assessed as needing treatment. Patients are turned away largely because hospitals simply do not have the resources to provide care for the number of patients in need. This unmet need for hospital care shifts costs to other parts of the health system. It imposes a heavy burden on primary care and patients and creates health inequity.[2]

Our submission on the draft terms of reference for the review suggested that, rather than viewing 'primary' and 'secondary' care as separate, the focus should be on developing a whole-of-system approach centred around the needs of patients. We submitted that "the emphasis should be on developing a wholistic multifaceted approach to reducing demand for hospital care and improving and maintaining people's health. It would involve improving the capacity and access to both primary care and secondary care and implementing policies for real integration and patient-centred care".[3]

Our research shows that under-resourcing, high clinical workloads and short staffing are taking a huge toll on the specialist workforce, resulting in doctors being stressed, fatigued, and burnt out.

Pae Ora (Health Futures) Bill: Comment

Purpose of this Act

Clause 3 of the Bill sets out why public funding and services are to be provided. Other parts of the Bill have important linkages to this clause. For example, under cl 31(a) the Minister must be satisfied that the Government Policy Statement (GPS) contributes to the purpose of the Act and, under cl 44(3),

the Health Plan must give effect to the GPS. Importantly, the objectives for Health NZ and the Authority include to design, arrange, and deliver services "to achieve the purpose of this Act"[4].

We strongly recommend that 'to ensure access to healthcare to meet the health needs of all New Zealanders' is included in clause 3. Health need would then have to be considered in the plans and policies, noted above, that will determine the future direction of the health system. It would underline that access to the health services people need, when they are needed, is essential to achieve pae ora.

There is support for this amendment. A recent media release from the Health Quality and Safety Commission (HQSC) seeking consumers' input into the design of the new health system states: "all New Zealanders should get the health care they need, no matter who they are or where they live"[5]. The Labour Party's Health Policy states: "We believe everyone should be able to access the healthcare they need, when and where they need it"[6]. In addition, the purpose statement of the existing New Zealand Public Health and Disability Act 2000 (NZPHD Act) includes: "to achieve for New Zealanders the best care or support for those in need of services"[7].

We note that the objective of promoting inclusion and participation in society and independence of people with disabilities, contained in the NZPHD Act, is missing from clause 3. We are aware of the changes that have been announced for disability services and that a new Ministry is to be set up. However, it does not make sense to exclude this objective from the purpose of the Bill.

We also suggest the purpose clause refers to the Te Whare Tapa Wha health model.

Te Tiriti o Waitangi (the Treaty of Waitangi)
We support this clause in the Bill and the requirements around the Crown's intention to give effect to the principles of Te Tiriti o Waitangi. The NZPHD Act provides for DHB mechanisms to enable Māori decision-making and participation "to recognise and respect the principles of the Treaty of Waitangi, and with a view to improving health outcomes for Māori."[8] In spite of this, the disparities in health status for Māori remain unresolved. The provisions in the Bill to incorporate the principles of Te Tiriti o Waitangi across the health system and support partnership with Māori are welcome. However, we support the Health Coalition Aotearoa's position that Te Tiriti obligations in the Bill should be further strengthened. We also support its view that pae ora should be a defined term in the Bill on the advice of tangata whenua.

Health system principles
ASMS supports the high-level system principles in cl 7(1) of the Bill. They add a new legal dimension to the imperative of addressing health inequities. For example, the objectives of Health NZ in cl 13(a) include: "to design, arrange, and deliver services to achieve the purpose of this Act in accordance with the health system principles". The Authority has the same objective in cl 18(b), and cl 45(g) requires Health NZ and the Authority to be guided by the principles in the development of the Health Plan.

We are concerned, however, that cl 7(2) provides a qualifier for entities to be guided by the principles "as far as reasonably practicable, having regard to all the circumstances, including any resource constraints". We consider that the health system must be funded and resourced so people have access to services to meet their needs, there is equitable receipt of services and equitable outcomes, as set out in the health system principles in the Bill (cl 7(1)) . ASMS has called for a cross-party accord to be developed that agrees on a sustainable funding path to secure a stronger health system with the capability and capacity to address health needs.[9]

Clause 7 of the Bill requires the health system to provide choice of quality services to Māori and other populations by harnessing clinical leadership, innovation, and technology to continuously improve services (cl 7(1)(d)(iii)). This is the only reference in the Bill to 'clinical' apart from references to the continuation of the New Zealand Blood and Organ Service and Pharmac. There is no reference to 'clinician' in the Bill at all, which is disappointing.

Evidence shows that clinicians have the skills and knowledge to lead transformative change and must be involved in system improvements. Clinical governance will be essential to the successful implementation of the reforms, and to the operation, planning, commissioning and delivery of health services. A commitment to clinical governance requires establishing staffing levels that allow senior doctors access to appropriate non-clinical time to enable them to contribute. It requires a significant increase in workforce numbers with less pressure to work longer hours.

ASMS agrees with others in the health sector that sustainability in healthcare needs much greater focus and we recommend it is included as a health system principle. Hospitals generate a huge environmental footprint as high-end users of gas, electricity, water, and transport. They churn out hundreds of thousands of tonnes of waste each year, which is dumped into landfills, and consume millions of single-use plastic and plastic wrapped items.

ASMS does not agree that Pharmac should be exempt from health system principles in cl 7 (1)(b) and (c). We recommend that the exemption in cl 7(4) is deleted. Further, we recommend that cl 63 is amended to remove the qualifier that Pharmac is only required to consult "when it considers appropriate to do so".

Health New Zealand established

ASMS supports the establishment of Health NZ and the disestablishment of the district health boards (DHBs). We are pleased to see that a senior doctor with experience in clinical governance and clinical leadership has been appointed to the Board of the Interim Health NZ. We strongly recommend that clinical governance is added to cl 12(3) of the Bill to ensure future board appointments include this skill.

We are pleased that one of Health NZ's objectives is: "to promote health and prevent, reduce, and delay ill-health, including by collaborating with other social sector agencies to address the determinants of health"[10]. We also note Health NZ's functions include: "to collaborate with other providers of social services to improve health and wellbeing outcomes"[11]. We expect that the Ministry will monitor and report on Health NZ's performance relating to these provisions.

A recent health workforce conference, attended by the Minister of Health, took a close look at growing health inequities in New Zealand. The report from the conference stated that: "health inequities will not be addressed substantially until the broader socioeconomic determinants of health are dealt with"[12]. The most successful public health interventions to address the determinants of health require collaboration across agencies. However, successful collaboration doesn't just happen; it needs to be well planned and resourced.

ASMS has recommended the adoption of a 'Health in All' policy approach, such as the WHO's Health in All Policy.[13] This approach aims to have good health as an outcome of all policies. It requires multisectoral action with a focus on achieving health equity. It encourages consideration of the policy's impact on people's health regardless of the primary aim of the policy in question. We therefore support the view that there should be a legislative requirement for Health NZ and the Authority to be able to require public health (and health equity) impact assessments from the Public

Health Agency on proposed policies and laws across different areas, such as housing, without needing Ministerial permission.

Health NZ will be a very large public sector organisation with significant responsibilities across the health system. While we understand that undertaking these responsibilities will be challenging, we are disappointed that it is envisaged Health NZ will be split into two distinct arms – one for commissioning primary and community services, and the other for providing hospital and specialist services.[14] In our view, this split will work against developing a well-integrated health system in Aotearoa New Zealand. This includes how services are planned, funded and delivered. The opportunity to build a seamless system will be missed unless the emphasis is on a whole system that integrates hospital services, primary care and social services.

The Minister of Health has told the Pae Ora Legislation Committee that Health NZ will have a specific mandate for workforce development, although this is not included in the Bill. ASMS recommends that the Bill should identify the agency or agencies responsible for workforce planning and development. If this is to sit within Health NZ, it should be listed in its functions in cl 14.

ASMS has continued to highlight the significant shortages of medical specialists (senior doctors and dentists). We estimate that shortage to be 24% across the country. In addition, modelling by the Ministry of Health shows the projected need for specialists is greater than the projected growth of the specialist workforce. This modelling does not consider the current unmet health need, nor does it acknowledge current specialist workforce shortages.

We have called for the development of a health and disability workforce plan that lists key stakeholders and targets for medical training and progression. We have also recommended the coordination, publication and maintenance of a medical workforce census to support high-quality independent expert advice on all aspects of workforce policy.[15] The agency or agencies responsible for health workforce planning should undertake this work in collaboration with key stakeholders.

Clause 7 of Sch 1 provides for the continuation of a committee established by the Minister under clause 11 of the NZPHD Act. The Health Workforce Advisory Committee (HWAC) is such a committee, and we recommend that it continue in its current form and be included as a separate committee in Subpart 3 of the Bill. This would enable continuity of the work HWAC is undertaking and avoid the constant chopping and changing of responsibility for health workforce planning that has occurred in New Zealand over the last 30 years.

ASMS is concerned that, under cl 16 of the Bill, the board must ensure Health NZ "operates in a financially responsible manner and, for this purpose, endeavours to cover all its annual costs (including the cost of capital) from its net annual income". The capital charge was introduced in the 1990s to emulate market forces within government and create a level playing field with the private sector as part of the aim to create a competitive marketplace in health. ASMS has called for it to be abolished.[16] There is no good reason for its ongoing existence, especially if capital assets are to be centrally planned, owned and operated.

Māori Health Authority

The current health system is inequitable for Māori. The Crown has failed to meet its obligations to Māori under Te Tiriti o Waitangi to provide equal access to healthcare. As a result, Māori do not have the same level of health as non-Māori.

ASMS strongly supports the establishment of the Authority as an independent statutory authority. We believe this signals a positive change that will help drive the health system towards achieving

health equity for Māori. We are pleased to see that doctors with considerable experience in governance and clinical leadership have been appointed to the Board of the interim Authority. We strongly recommend that clinical governance is added to cl 22(2) to ensure future board appointments include these skills.

We urge the committee to listen to tangata whenua submitters views in relation to whether the provisions in the Bill are sufficiently strong to ensure the Authority is fully empowered to co-lead the system with Health NZ and that is has Te Tiriti compliant decision-making authority.

The Authority's function in the Bill "to improve service delivery and outcomes for Māori at all levels of the health system"[17] is an outcome that the Authority cannot achieve on its own. We consider that the requirements (under cl 44 and cl 45) for Health NZ and the Authority to jointly develop the Health Plan and identify how they will go about improving outcomes for Māori will be crucial to improving health outcomes for Māori.

Government Policy Statement

ASMS supports the development of a GPS to guide the whole health system. We are pleased the GPS must provide a framework for regular monitoring of progress and reporting requirements. However, we consider that priorities and objectives for the health system must be long-term to achieve the purpose of the Act. The Bill should set a horizon for the GPS of 10 years (rather than 3 years), recognising that improving outcomes takes time. We also recommend that the GPS includes a long-term funding commitment for the health system to address inequities, unmet need and growing demand. Our expectation is that the Ministry will engage with key stakeholders, including health sector unions, in developing the GPS.

Health strategies

ASMS supports the requirement that the New Zealand Health Strategy includes an assessment of the current state of health outcomes and health system performance (cl 37(3)). We are pleased to see that it is required to set out opportunities and priorities for improving the health system over at least the next 5 to 10 years, including workforce development. This provision is mirrored in the health strategies for Hauora Māori, Pacific Health and Disability Health. Our expectation is that the Ministry will engage with key stakeholders, including health sector unions, in developing the strategies.

We suggest that national strategies for Mental health and Child Health are also developed.

New Zealand Health Plan

ASMS supports the development of a Health Plan for the health system. We are pleased that under cl 45(a) the Health Plan must contain an assessment of population health needs. We are encouraged that it must describe how other government agencies will contribute to achieving the desired improvements and outcomes (cl 45(c)).

We note that cl 47(1) includes that in preparing the Health Plan, Health NZ and the Authority must engage with organisations they consider appropriate. We would expect them to consult with health sector unions, including ASMS. Clinicians must be involved in developing the Health Plan and we recommend that cl 47(1) specifically includes this.

We are aware that the Transition Unit is currently developing an Interim Health Plan, which will be in place from 1 July 2022 until the first Health Plan under the Bill is developed within 2 years after that.[18] While Health NZ and the Authority must follow the process for engagement described in cl 47 when developing the Health Plan, the process for developing the Interim Health Plan is unclear. We

are concerned there is little opportunity being given for clinicians to provide input to, and feedback on, the Interim Health Plan.

ASMS disagrees with advice from DPMC that "a major cause of the significant pressure on hospital and specialist care is that they are not managed as a coherent network"[19]. The pressure on hospital and specialist services largely stems from years of underfunding in the face of growing demand, for example, from an increasing and aging population, increased chronic illness, complexity of inpatients and increase of day patients. The pressure comes from the significant shortfall of doctors, nurses and other staff needed to provide health services. It comes from hospital infrastructure that is not fit for purpose because investment in hospital and specialist services is long overdue.

As cited in the Productivity Commission's unpublished review titled *On the technical Efficiency of New Zealand District Health Boards' Hospital Services: A Dynamic Stochastic Frontier Approach*, the capacity of New Zealand's hospitals needs to expand considerably to be more efficient. This can include building new hospitals or expanding the physical capacity of current hospitals. The review found that a significant amount of investment is required to replace outdated clinical equipment with more modern and innovative medical technology to enhance productivity by reducing the sources of long-term inefficiencies.

It will be disheartening if there is a focus in the Health Plan for hospital and specialist services on reducing costs. We are concerned that the advice from DPMC relies on simplistic analysis of reducing variation across Tier 2 services (hospital and specialist services) to reduce 'cost pressure' on hospitals. The advice states that: "there is significant variation across hospitals with respect to unplanned admissions, unplanned readmissions, and length of stay. If this variation could be reduced, there would be significant benefits in terms of cost growth reduction from reduction in growth of bed days and staffing requirements" [20]. Their report estimates that this would save nearly 1 percent of Vote Health or approximately $4 billion over 10 years.[21]

This analysis uses data from the 2018 Census that had a high non-response rate and has been referred to as "a mess"[22]. While the analysis factors in population growth and ageing, it does not appear to consider health status, particularly for Māori, Pacific peoples, people with disabilities, or rural populations. The analysis does not acknowledge that hospitals are desperately stretched, nor does it account for difficulties in accessing primary and community care, including aged residential care, or other community supports in DHB districts. It does not actually explain how variation would be reduced.

Localities and locality plans

The Bill requires the boundaries of the localities determined by Health NZ (in agreement with the Authority) to be consistent with any regional arrangements through which Health NZ and the Authority must provide and arrange services. These arrangements will be set in regulations. As noted, we are concerned that the organisational structure of Health NZ, including the regional arrangements, will not support integration across the health system and will potentially create silos.

ASMS believes that locality plans should provide for access to a nationally agreed level of service, so they do not lead to inconsistency and inequities. We consider that clinicians must be involved in their development and that health sector unions are consulted. We recommend these points are included in cl 49 of the Bill.

New Zealand Health Charter

ASMS supports the development of a Charter that provides common values, principles, and behaviours to guide health entities and their workers (cl 50(2)). We note that Health NZ must consult

the Authority and Iwi Māori Partnership Boards and any other individual group that Health NZ considers appropriate (cl 52(1)). We submit that health sector unions, including ASMS, must be consulted, as the charter will directly affect our members. We also suggest that the Charter applies to a wider group of health organisations and workers than the definition of health entities in cl 4.

Code of Consumer Participation

ASMS supports the development of a Code of Consumer Participation (Code). The Code will set out how health service providers and organisations will involve and work effectively in partnership with consumers and whānau. We note that the HQSC is empowered to develop the Code, provided for under cl 53 of the Bill. We are aware that it has already been commissioned by the Transition Unit to start this work.

The process for engaging with consumers and whānau on the Code needs to be well resourced to provide for high quality forum facilitation and coordination. In addition, to have a meaningful say on how services are designed and delivered, communities will need access to comprehensive and relevant information, including local measures of unmet need for hospital care, as well as primary care. Data to identify service pressure points and assess where improvements are needed will also be necessary.

Conclusion and recommendations

The Bill establishes a new legal framework for the public health system in Aotearoa New Zealand. Although ASMS is generally supportive of the direction of the changes, we have some concerns.

A key challenge for the health system reforms is to build and sustain a strong workforce that can deliver the desired improvements. There is an urgent need for workforce planning and development and the Bill should identify the agency or agencies with a specific mandate to undertake this work. This should involve the collection of data on unmet need and projected need to inform health workforce planning.

Equally challenging is the health budget needed to deliver the desired improvements. In our view, there needs to be a national discussion on how public health services can be properly funded.

ASMS believes these challenges require:

- multi-party engagement and collaboration of key stakeholders including unions, colleges, Iwi, employers, and other health regulators to develop and implement a workforce timeline strategy; and
- a cross-party political accord that agrees on a sustainable funding path to secure a stronger health system with the capability and capacity to address health needs.

As noted at the beginning of this submission, ASMS considers the focus of the reforms should be on developing a whole-of-system approach centred around the needs of patients, rather than viewing ‘primary’ and ‘secondary’ care as separate.

We recommend that:

1. Clause 3 is amended to include: to ensure access to healthcare to meet the health needs of all New Zealanders.

2. Clause 3 is amended to include: to promote inclusion and participation in society and independence of people with disabilities.

3. Clause 3 is amended to refer to Te Whare Tapa Wha health model.

4. Pae Ora is defined in the Bill on the advice of tangata whenua.

5. Clause 7(1) is amended to include the following:

   (f) sustainability should be at the core of every decision in the health system, including by—
   (i) giving measures to reduce carbon emissions a top priority; and
   (ii) aligning with targets set under the Zero Carbon legislation; and
   (iii) recognising and promoting the health co-benefits of measures to mitigate climate change; and
   (iv) adapting and preparing for the impacts of climate change; and
   (v) reducing waste.

6. Clause 7(2) is deleted. Funding must be provided to ensure people have access to services to meet their needs, that there is equitable receipt of services and equitable outcomes, as set out in the health system principles.

7. Clause 7(4) is deleted. Pharmac should adhere to the health system principles.

8. Clause 12(3) is amended to include clinical governance.

9. Clause 16(1)(c) is deleted. The capital charge regime should be completely abolished.

10. Clause 22(2) is amended to include clinical governance.

11. Clause 31(d) is amended to include health sector unions.

12. Clause 47 (1) is amended to include health sector unions and clinicians.

13. Clause 49(2) is amended to include:

    (d) provide for access to a nationally agreed level of health services.

14. Clause 49(3) is amended to include clinicians.

15. Clause 52(1) is amended to include health sector unions.

16. Clause 63 is amended to delete the words: when it considers appropriate to do so.

[1]Hon Andrew Little 24 March 2021: The case for change in the health system. https://www.beehive.govt.nz/speech/case-change-health-system-building-stronger-health-and-disability-system-delivers-all-new

[2] Creating Solutions, ASMS and Canterbury Charity Hospital, 2021, p16. https://issuu.com/associationofsalariedmedicalspecialists/docs/asms-creating-solutions-fa-web_-_final

[3] ASMS, 10 July 2018: Draft Terms of Reference for the Health and Disability Sector Review. https://www.asms.org.nz/wp-content/uploads/2018/08/Letter-on-Draft-Terms-of-Reference-Health-and-Disability-Sector-Review_170187.3.pdf

[4] Pae Ora (Healthy Futures) Bill, clause 13(a) and clause 18(b)(i).

[5] HQSC, 18 November 2021: A chance to have your say on health services in Aotearoa New Zealand. https://www.hqsc.govt.nz/our-programmes/partners-in-care/news-and-events/news/4391/

[6]https://www.labour.org.nz/health

[7] New Zealand Public Health and Disability Act 2000, section 3(1)(a)(iii).

[8] Ibid, section 4.

[9] ASMS (2020): Building the workforce pipeline, stopping the drain.

[10] Pae Ora (Healthy Futures) Bill, clause 13(c).

[11] Ibid, clause 14(1)(i).

[12] ASMS and Canterbury Charity Hospital (2021): Creating Solutions, p12. https://issuu.com/associationofsalariedmedicalspecialists/docs/asms-creating-solutions-fa-web_-_final

[13] ASMS Health Matters (2020): Framing the full story of health. https://issuu.com/associationofsalariedmedicalspecialists/docs/health_matters

[14] DPMC, March 2021: The Health and Disability System Review: Proposals for Reform, p2. https://dpmc.govt.nz/sites/default/files/2021-04/cabinet-minute-cab-21-sub-0092-health-and-disability-system-review.pdf

[15] ASMS (2020): Building the workforce pipeline, stopping the drain.

[16] ASMS Research Brief (2018): Should district health boards pay a capital charge. https://www.asms.org.nz/wp-content/uploads/2018/05/Research-Brief-Capital-Charge_169877.2.pdf

[17] Pae Ora (Heathy Futures) Bill, clause 19(1)(c).

[18] Pae Ora (Healthy Futures) Bill, Schedule 1, clause 3.

[19]DPMC, April 2021: Our health and disability system: Building a stronger health and disability system that delivers for all New Zealanders, p9. https://dpmc.govt.nz/sites/default/files/2021-04/heallth-reform-white-paper-summary-apr21.pdf

[20] DPMC, June 2021: Health System Structural Change to support Reform Programme, p26.

[21] Ibid, p4.

[22] Otago Daily Times, 4 March 2019: And then there were nine. https://www.odt.co.nz/lifestyle/magazine/and-then-there-were-nine