ASMS

ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

TOI MATA HAUORA

Submission to the Ministry of Health on the Draft Updated New Zealand Health Strategy

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Background

The Association of Salaried Medical Specialists (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. 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 public hospital 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.

Summary

- Much of the substance of the draft updated health strategy lies in a number of other documents, including the Productivity Commission report, the Capability and Capacity Review and the Health Funding Review. They cover a broad range of sometimes complex and controversial issues. The Health Funding Review, for example, proposes radical changes that resemble policies of the failed health 'reforms' of the 1990s. To allow little more than a month for consultation on the draft strategy is insufficient time to enable a proper analysis of what is being proposed. This is made worse by the fact that the status of the above documents remains unclear. This consultation therefore feels rather like an exercise in shadow-boxing.
- Those comments aside, the ASMS supports the proposal to retain the seven principles of the original New Zealand Health Strategy. We also support the proposed additional *principle* of collaborating across sector to improve New Zealanders' wellbeing. However, there is much in the substance of the draft strategy, assuming the recommendations of the documents mentioned above are adopted, which we do not support and have serious concerns about.
- While the draft updated strategy is presented as representing "the common view of where we want to go" (Minister's foreword), it is in fact largely a reflection of current government policy. As such, the 'update' is an exercise in reframing the original New Zealand Health Strategy within the Government's policy agenda.
- If the essential aim of the draft strategy is to progress from the current state to a desired state in 10 years' time, it is vital that the current state – the starting point – is well defined. It is not well defined in this document due to its use of highly selective information. It fails to acknowledge the efficiency and quality of our health system relative to comparable countries, it fails to acknowledge the extent of New Zealand's current health need compared to other like countries, and it fails to acknowledge significant health inequality that is due to poverty.
- A Commonwealth Fund report shows the main weakness of New Zealand's health system is access to it – both in primary and secondary care.
- The challenges relating to future health spending are overstated to the point of being alarmist and are being used as the rationale for introducing 'significant change' to the current health system model. Government health spending has in fact been falling as a proportion of gross domestic product (GDP). It is a trend that is likely to continue under current policies, in line with a planned reduction in overall government expenditure as a proportion of GDP.
- We agree in principle that the health New Zealand system must continue to perform as efficiently as possible. As mentioned above, it is doing relatively well in this respect when measured against comparable countries. We therefore do not support the stated rationale for 'significant change' in the current model.
- If New Zealanders' health needs are not met by public health services, the costs do not disappear; they still have to be borne by the economy. The important question then becomes whether it is more efficient and equitable to pay for health needs privately or publicly. There are good reasons to conclude that it is more efficiently and equitably provided publicly.
- There is a significant opportunity to improve the cost-efficiency and effectiveness of our health services by giving a stronger commitment to distributive clinical leadership. This is policy which is supported across political parties because it has proven to significantly improve the effectiveness and efficiency of health services while managing the increasing costs of health care. Despite this, it has been ignored in the draft strategy. The ASMS considers this a critical oversight and calls for it to be remedied in the final document.

- The draft strategy acknowledges challenges such as the aging workforce, but no responses or potential responses are suggested. Unpublished MCNZ workforce survey data indicated that on recent trends, about 19% of the specialist workforce will be lost within the next five years due to the drop-off of specialists from the age of 55. A report prepared for Health Workforce New Zealand (HWNZ) offers solutions to improve retention of older doctors. However, the draft strategy is silent on the 'opportunities' to mitigate the effects of an aging medical workforce.
- The draft strategy acknowledges New Zealand's medical workforce is highly dependent on overseas recruits, many of whom do not stay long. However, its suggested solution – 'we need to continually invest in training' – is inadequate. It is only part of the solution and, for the medical specialist workforce, will have little or no impact for another 15 to 20 years. The challenge with regard to this workforce is here and now.
- Health Workforce New Zealand acknowledges: *"The most important issue is the impact of a prolonged period of medical labour market shortages on the workloads, wellbeing and productivity of DHB-employed senior doctors.* Accordingly, the draft strategy needs to recognise the importance and urgency in addressing senior doctor shortages.
- Research shows there are potentially significant gains to be made in the quality, effectiveness and cost-efficiency of health services by adopting a genuine patient centred care approach to service delivery. Despite these benefits, this approach has not been well established in New Zealand's District Health Boards (DHBs) because to a large extent it requires an upfront investment in services, especially in the health workforce.
- New Zealand's demographic trends point to a continuing rise in the number of people dying each year. However, our services are not taking the opportunity to help people plan to die well. In the last year of life, many experience a disconnected, confusing and distressing array of services, interventions and relationships with health professionals. Many do not get enough palliative care. A good death gives people dignity, choice and support to address their physical, personal, social and spiritual needs. So while the draft strategy focuses on people 'living well, staying well, and getting well', 'dying well' is also of critical importance and needs to be included in the document as part of the patient centred care approach.
- At the other end of the lifespan, a greater investment in 'starting well' is sorely needed as part of a long-term strategy and commitment to 'patient centred care'. This is where a genuine whole-of-government 'investment approach' (not the false 'investment approach' of the draft strategy discussed below) focuses on a woman being healthy when conception occurs, being healthy throughout the pregnancy, and the newborn being healthy for its first two to three years because of the significant physical, mental and emotional development that occurs in those early years. Young children are most vulnerable to the impacts of poverty, abuse and neglect, which have life-long impacts and costs. As such, effective public investment in the early years will deliver the best return on investment. Reaching young children requires investment in their parents/caregivers and family. In short, whole-of-government policy should ensure every baby should be born to a healthy mother and grow up in a healthy home.
- ASMS suggests 'Start well, live well and end well (or go well)' would be a better title for the strategy reflecting a better range of priorities.
- The proposed 'health investment approach' – based on the 'investment approach' currently used by the Ministry of Social Development (MSD) – may be used to 'target high-need priority populations to improve overall health outcomes'. The approach uses techniques from the insurance industry to calculate long-term costs to the government of health and social

services. However, it focuses only on costs and benefits to the government and not at the benefits to individuals and the community. Even the Productivity Commission has noted that "slavish application of an investment approach based purely on costs and benefits to government might lead to perverse outcomes".

- An ASMS *Research Brief* has identified considerable risks and uncertainties associated with the proposed use of Social Impact Bonds (SIBs). There is a lack of evidence that SIBs actually work as intended, especially given uncertainties surrounding how well they are likely to function in the New Zealand context. SIBs carry high risks of perverse incentives, with funding for SIBs programmes being dependent on measures of long-term health outcomes which will be influenced by multiple factors beyond the programmes themselves.
- The draft strategy highlights the need for 'trust, cohesion and collaboration'. However, the proposed new approach recommended in the Director-General of Health's commissioned Review of Funding contradicts this. If implemented, it would be a fundamental departure from the evidence-based collaborative, integrated model underlying current government policy and a return to the market-based policy of the 1990s. It would open up DHB services to competitive tendering, short-term funding, short-term planning, fragmentation of services and clinical teams, barriers to integration of clinical services, disruption to continuity of care, uncertainty for DHB employees and patients alike, lack of transparency due to commercial sensitivities (especially where private providers are involved), and increases in user charges for some (including, potentially, patients opting to travel for elective surgery).
- The draft strategy's aim to have a smart system depends largely on capital investments. However, whereas unmet health need is a sign of under-resourced clinical services, there is also increasing anecdotal evidence of DHBs accumulating a 'capital deficit' to attempt to balance their books. This is resulting in health professionals having to work with poorly functioning equipment and information technology which is vital for providing a safe and efficient service.

General comments

Much of the substance of the draft updated health strategy (the draft strategy) lies in a number of other documents, including the 400-page Productivity Commission report, the 40-page Capability and Capacity Review and the 40-page Health Funding Review. They cover a broad range of sometimes complex and controversial issues. The Health Funding Review, for example, proposes radical changes that resemble policies of the failed health 'reforms' of the 1990s. To allow little more than a month for consultation on the draft strategy is insufficient time to enable a proper analysis of what is being proposed.

This is made worse by the fact that the status of the above documents remains unclear. As far as the ASMS is aware they are at this point proposals which have yet to be decided on by the Government. This consultation therefore feels rather like an exercise in shadow-boxing.

Notwithstanding these comments, the ASMS supports the concept of a long-term strategy in health. We support the proposal to retain the seven principles of the original New Zealand Health Strategy. We also support the proposed additional principle of collaborating across sector to improve New Zealanders' wellbeing. However, there is much in the substance of the draft strategy, assuming the recommendations of the documents mentioned above are adopted, which we do not support and have serious concerns about.

One of the fundamental challenges of producing a 10-year strategy is to reconcile short-term political realities with a desire to plan in the longer term in a comprehensive way. In an ideal world there would be a process to produce broad public consensus, including cross-party agreement, on not only the principles of a health strategy but also the priorities, the challenges and the opportunities, leaving successive governments to implement the strategy in their own way, guided by their respective policies. In fact we believe there would be potentially huge health benefits if political parties could, to begin with, agree on policies to address the challenges at the 'start of life' and 'end of life' care. Without such agreement it cannot be assumed that current government policies will be continued by later governments over the next 10 years. This 10-year strategy, therefore, should not be dependent upon the policies and approaches of current government policies, especially where these are known to be contentious.

In the ASMS' assessment, while the draft strategy is presented as representing "the common view of where we want to go" (Minister's foreword) – it is in fact largely a reflection of current government policy.

It may be reasonable to promote government policy in the draft strategy where it happens to also be "the common view". However, there are aspects of government policy here that are controversial, such as the "investment approach" to services provision, the use of public-private partnerships, approaches to health funding, and parts of the government-commissioned report of the Productivity Commission, such as "social impact bonds". These do not represent the common view.

The political nature of the document is also evident in its less-than-candid perspective on a number of issues and omission of some notable inconvenient truths, which are discussed further below.

The current state

New Zealand has much to be proud of, including the health and health system indicators included in the draft strategy. But it is highly selective in the information it presents. The text box on page 2, for example, provides a number of positive indicators relating to our health system and New Zealanders' health status, but nowhere in the document is there a more comprehensive range of indicators, including the negative as well as the positive, to give a more balanced perspective.

If the essential aim of the draft strategy is to progress from the current state to a desired state in 10 years' time, it is vital that the current state – the starting point – is well defined. It is not well defined in this document.

New Zealand has a relatively efficient, good quality health system

A Commonwealth Fund report comparing 23 health system performance indicators across 11 countries[1] shows New Zealand's performance on efficiency and quality of care is among the best, being ranked 3rd and 4th respectively. This has been achieved despite New Zealand being ranked bottom on health expenditure per capita. We note that while the draft strategy refers to this report, it overlooks these achievements, which are especially relevant given the repeated message in the document and some of the referenced documents that the system must undergo significant changes to become more efficient and affordable

The fact that the Commonwealth Fund gives New Zealand's health system an less-impressive overall ranking of 7th out of 11 is due to relatively poor performance indicators for access to services (7th), and equity (10th). And on a measure of 'healthy lives' (infant mortality, healthy life expectancy and mortality amenable to health care - that is, deaths that could have been prevented with timely care) New Zealand was placed 9th.[1]

Another measure where New Zealand ranks lowly is in physician numbers. According to the OECD, in 2013 New Zealand was 30th out of 32 countries on a measure of hospital specialists per population. We were above Chile and Turkey. (The figures include trainee specialists.) For primary care specialists, New Zealand ranked 20th. Physician numbers alone do not necessarily determine access to services – there are a range of factors – but it is reasonable to assume it is a key measure.

All of this indicates New Zealand's health system is performing comparatively well on what it actually *does*, but there are significant issues with what it *does not* do due to a lack of service capacity.

Poor access to diagnostic tests (11th out of 11 in the Commonwealth Fund report), long waits for treatment after diagnosis (10th), long waits to see a specialist (9th), cost barriers to primary care (9th), and long waits for elective surgery (8th) have all contributed to a growing, hidden unmet need.

Even in the Government's high priority services such as elective surgery, there have been numerous reports from around the country of increasing barriers to accessing treatment. It appears patients have to be in more pain to access elective surgery now than ever before. As the New Zealand Medical Association has put it, the gap between the patients who meet the clinical threshold for surgery, but fall short of our hospitals' financial threshold, is widening.[2]

[1] Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States.

So while it must be acknowledged that the numbers of operations have been steadily increasing, New Zealand's access to elective surgery (and waiting times for specialist appointments), as the Commonwealth Fund report shows, still lags behind many other comparable countries.

The health service indicators outlined above point to unmet health need which exists across a range of health care services, such as primary health care, dental health, mental health, sexual health, disability support and primary services for disadvantaged communities, as well as medical and surgical specialties.

New Zealanders' health status is poor in some key areas

In a number of common health status indicators (Table 1), New Zealanders' state of health tends to fall in the bottom half of OECD countries. New Zealand also ranks poorly in comparisons with Australia, Canada and the United Kingdom (UK).

Health status indicators are of course influenced by a number of factors, including social, environmental, economic and lifestyle factors. (Though focusing on education campaigns to tackle issues such as obesity misses the point that they are often a result of social, commercial and political decision-making much more than individual decision-making.)

Of course poverty (not mentioned in the document) has a major effect on health. Access to and the effectiveness of the health system is also crucial. The importance of the health system in improving health status has tended to be understated in the past.[3] Indicators such as high suicide rates and high mortality amenable to health care indicate unmet need in both preventive and treatment services.

Table 1: New Zealand's position in the OECD's health status indicators, 2013*

Health Status Indicator	**Position among 33 OECD countries** (1 being best)	**NZ position relative to Australia, Canada, UK** (1 being best)
Life expectancy at birth	10=	2= (behind Australia)
Premature mortality	26 (females) 18 (males)	4 4
Mortality from ischemic heart disease	23 (females) 25 (males)	4 4
Mortality from cerebrovascular disease	24 (females) 17 (males)	4 3 (above UK)
Mortality from all cancers	28 (females) 13 (males)	4 3 (above UK)
Suicides	27	4
Infant mortality	29	4
Obesity prevalence (adults)	27	2= (behind UK)
Diabetes prevalence (adults aged 20-79 years)	24	3 (above Canada)

Source: OECD Health Statistics, 2015; International Diabetes Federation. IDF Diabetes Atlas, 6th Ed. 2014; Global Health Observatory Repository, WHO 2015. *Or latest year where data are available

The challenges

Challenges to meeting health need tend to be understated, whereas challenges relating to resourcing the system are overstated.

Health status indicators

New Zealanders' health status indicators such as those listed in Table 1 show the challenges facing our health services challenges are much greater than is suggested in the draft strategy. New Zealand's health system not only faces the 'global' challenges of an aging population and, with it, an increase in long-term conditions (called a growing 'burden' in the document) such as heart disease, diabetes, depression and dementia, we are facing those challenges from a poor starting point compared with other countries.

Inequality

Further, although the draft strategy acknowledges health inequality as a key challenge, it only does so in relation to Maori and Pacific peoples. While we agree a concerted effort is needed to address Maori and Pacifica health inequalities, the same must be said for health inequalities related to socioeconomic status, which are well recognised in the health sector but are ignored in the document. Poverty – a word overlooked – must feature highly in the strategy as a major factor in health disparities and health outcomes, especially for children.

We note also an anomaly in the 'word map' where 'inequality' is under-emphasised due to being included twice.

Aging workforce

Other valid challenges are identified, such as the aging workforce and the effects of climate change, but no responses or potential responses are suggested. On the former, the Senior Medical Officer Commission of 2008/09 identified a sharp drop in numbers from the age of 55, which it considered "seems likely to reflect a loss of [specialists] to the system through early retirement and emigration".[4] Unpublished MCNZ workforce survey data indicated that on recent trends, about 19% of the specialist workforce will be lost within the next five years due to the drop-off of specialists from the age of 55.

A report prepared for Health Workforce New Zealand (HWNZ) acknowledges that "older doctors are working fewer hours and many are retiring earlier… Concern about earlier retirement of doctors and the aging of the medical workforce has been noted by commentators and many of the specialist colleges, as it is considered this will exacerbate current workforce shortages."[5]

The report suggests that "if doctors can be encouraged to work longer, albeit for fewer hours per week, in different specialty areas and/or in different roles, workforce supply may not decrease as fast as predicted". It identifies a number of potential 'solutions', including suggestions for improving career satisfaction (including interventions to reduce stress), changing work roles, introducing more part-time and job-share positions and more flexibility in work hours, retraining in other specialties, and career and succession planning.

However, the report notes limited New Zealand research about doctors' intentions with respect to retirement, and what would keep them in practice. It calls for more research and information to

enable longer term workforce modelling and to align the needs of younger doctors wanting work-life balance and 'portfolio lifestyles' with more flexible working conditions for older specialists.

It is hugely disappointing that the draft strategy is silent on the opportunities to mitigate the effects of an aging medical workforce.

High dependency on overseas recruitment

The draft strategy acknowledges New Zealand's medical workforce is highly dependent on overseas recruits, many of whom do not stay long. However, its suggested solution – 'we need to continually invest in training' – is inadequate. It is only part of the solution and, for the medical specialist workforce, will have little or no impact for another 15 to 20 years. The challenge with regard to this workforce is here and now.

International workforce indicators point to an increasingly competitive market for medical specialists which, as an OECD report warned, "would make the New Zealand trained health professionals harder to retain, and the potential pool of foreign recruits more difficult to attract".[6]

In 2011, HWNZ's Executive Chair Des Gorman acknowledged "the key issues that are germane to the number of doctors in our workforce are recruitment, migration and retirement, and all three require address".[7] However, to date there are no significant measures in place that address these issues with respect to the specialist workforce.

In 2014, HWNZ's report *Health of the Health Workforce 2013 to 2014*, stated:[8]

While the [Medical Workforce] Taskforce initially focused on the immediate postgraduate period, a whole-of-career perspective has now been adopted. The most important issue is the impact of a prolonged period of medical labour market shortages on the workloads, wellbeing and productivity of DHB-employed senior doctors.

Accordingly, the draft strategy needs to recognise the importance and urgency in addressing senior doctor shortages.

For further information on the issues facing the medical specialist workforce, two reports, *The Public Hospital Specialist Workforce* (2013) and a follow-up publication *Taking the temperature of the public hospital specialist workforce* (2014), are available electronically via the following links:

http://www.asms.org.nz/wp-content/uploads/2014/07/The-Public-Hospital-Specialist-Workforce-web.pdf

http://www.asms.org.nz/wp-content/uploads/2014/09/Taking-the-temperature-of-the-public-hospital-specialist-workforce-August-2014-FINAL.pdf

Health system funding

The draft strategy includes an unchallenged Treasury view – and we consider it an alarmist view – that "New Zealand cannot afford to keep providing services as we do now" and that "without significant change, government health spending would have to rise from about 7 percent of GDP now, to about 11 percent of GDP in 2060".

There are several points to make about this.

First, it is accepted internationally that there is no 'right' level of funding for health care. It is not the role of Treasury to determine what is 'affordable'. That is a political decision.[9] [10] It may be that the current Government agrees with Treasury's view. But, again, while it would be reasonable for current government policy to guide the way the strategy is implemented, it should not form the platform to shape the strategy itself.

Second, Treasury data show actual Vote Health expenditure has been falling as a proportion of GDP over recent years – an intentional policy move flagged by Treasury in a document dated June 2012.[11] Treasury data, including recent GDP adjustments, show that while Vote Health's total operational and capital expenditure was close to 7% of GDP a few years ago, it is now closer to 6% (Table 2).

Table 2: Total Vote Health expenditure as a proportion of GDP

Year	***2009/10***	***2010/11***	***20011/12***	***2012/13***	***2013/14***	***2014/15***
Vote Health ($m)*	13,128	13,753	14,160	14,449	14,849	15,009
Nominal GDP for the year to June ($m)	195,399	203,791	212,307	216,585	234,027	240,571
% of GDP	**6.72%**	**6.75%**	**6.67%**	**6.67%**	**6.34%**	**6.24%**

Sources: Treasury: *Financial Statements of the Government of New Zealand for the Year Ended June 2015*, October 2015.

* $49 million has been subtracted from the funding allocations for 2012/13 onwards to account for estimated health provider superannuation contributions such as to Kiwisaver, previously paid for by the State Services Commission.[12]

The drop in health funding as a proportion of GDP is largely a result of significant funding shortfalls in Vote Health's operational funding since 2009/10. Data are not available to enable an accurate assessment of how much money has been saved over those years through genuine efficiencies and how much has been 'saved' through service cuts and increases in user charges. With that qualification, taking into account actual expenses, consumer price index (CPI), population and average wage increases, Vote Health's operational funding shortfall has accumulated to an estimated $0.8 billion between 2009/10 and 2014/15. This year's estimated funding shortfall would make that more than $1 billion.[13]

Similarly, core government expenditure has been falling in recent years, having peaked in 2011, and is forecast to drop to 29.2% of GDP in 2019. The intention according to Finance Minister Bill English is to see it drop to 25% within the next six to seven years. The continued under-resourcing of our health services, then, is not owing to unaffordability; it is a policy decision to give priority to a policy of reducing government expenditure overall and introducing tax cuts.[14,15]

In line with those policy priorities, the Government's trajectory is one of continuing cuts in health spending. Treasury's Budget 2015 data[16] and the Ministry of Health's demographic growth rate data[17] show Vote Health's operational funding is forecast to drop by approximately 4% each year, allowing for inflation and demographic changes. The extent to which that forecast funding is adjusted upwards depends on how much is allocated to Vote Health from the Government's general budget operating allowance. However, in the past, the additions to Vote Health from the operating allowance have not been enough to keep up with rising costs, population growth and new programmes.

The Treasury graph used in the draft strategy (p 6) projecting a steep rise in government health spending as a proportion of GDP over the next 40 years is not consistent with recent trends or stated government intentions for the coming years, so at the very least it needs explanation.

Thirdly, notwithstanding the points made above, the draft strategy implies that government health and disability services spending of 11% of GDP by 2060, as projected by Treasury, is excessive. In fact government health spending in some OECD countries is already between 9% and 10% of GDP. In England, where the public-private expenditure mix is similar to New Zealand's, an independent commission recently recommended to the English Treasury that public spending on health and social care (ie, including disability services and aged care) should be increased to 11%-12% of GDP by *2025*.[18] [19]

Fourthly, if New Zealanders' health needs are not met by public health services, the costs do not disappear; they still have to be borne by the economy. The important question then becomes whether it is more efficient and equitable to pay for health needs privately or publicly. There are good reasons to conclude that it is more efficiently and equitably provided publicly. As Treasury itself has noted:

We do not currently see a clear case for moving away from a predominantly single-payer, tax-financed health system. Systems like ours are typically better at containing health spending and there is no one system that presents a clearly more efficient alternative.[20]

If we add considerations of equity to cost-containment, private provision is not likely to be better for people, the country and the economy, and that is well illustrated by the costly and inequitable situation in the United States.

This is important because the argument that current levels of funding are 'unstainable' are used as the rationale to introduce 'significant change' in the model of our current health system (p6).

We agree in principle that the health New Zealand system must continue to perform as efficiently as possible. As discussed above, it is doing relatively well in this respect when measured against comparable countries. We therefore do not support the stated rationale for 'significant change' in the current model.

Opportunities

New Zealand has much to be proud of, including a largely publicly funded, universal health system; a no-fault accident compensation scheme; and a committed and highly trained workforce, as acknowledged in the draft strategy.

Distributive clinical leadership

There is a significant opportunity to improve the cost-efficiency and effectiveness of our health services by giving a stronger commitment to distributive clinical leadership – a policy which has cross-party support and therefore would be appropriate to include in the long-term strategy.

There is now a strong body of evidence showing comprehensive clinical leadership can do what New Zealand's successive attempts at health reform have failed to achieve: significantly improve the effectiveness and efficiency of our public hospitals across the whole spectrum of services (not just the selected few targeted by Government) while managing the increasing costs of health care.

Indeed, given the health indicators for the coming decade, the ability of our health system to meet the growing demands may well rest on the extent to which comprehensive clinical leadership is established in practice.

Quite simply, the reforms we need are only likely to be successful if clinically led.

– Professor Des Gorman, Executive Chair, HWNZ[21]

Successful clinical governance, as envisaged by the Government's *In Good Hands* policy statement and by the *Time for Quality* agreement between the ASMS and the country's DHBs requires distributive leadership, embedded at every level of the system.[22] [23]

Some of the many specific benefits of distributive clinical leadership include:

- effective and efficient development of new innovative service models
- quality training and supervision
- sustainable achievement of government health targets
- improved safety and quality of services and outcomes.

For this to succeed in any meaningful way, financial investment is needed to develop the capacity of the specialist workforce to enable 'time for quality'.

Despite the many benefits of distributive clinical leadership, and support by successive governments, it has been ignored in the draft strategy. We strongly recommend that this is rectified in the final document.

Patient centred care

In the context of the draft strategy, 'time for quality' is needed to provide 'patient centred care'. For example, for:

- "understanding people's needs and wants and partnering with them to design services to meet these;" and
- "encouraging and empowering people to be more involved in their health by engaging with them about their wellbeing and helping to make health choices" (p 11).

This is especially important given our health services are facing increasing numbers of patients with chronic and complex needs and for enabling patients and families to make informed decisions about end-of-life care.

New Zealand's demographic trends point to a continuing rise in the number of people dying each year. However, our services are not taking the opportunity to help people plan to die well. In the last year of life, many experience a disconnected, confusing and distressing array of services, interventions and relationships with health professionals. Many do not get enough palliative care.

A good death gives people dignity, choice and support to address their physical, personal, social and spiritual needs. So while the draft strategy focuses on people 'living well, staying well, and getting well', 'dying well' is also of critical importance and needs to be included in the document as part of the patient centred care approach.

This should involve three reforms. First, we need more public discussion about the limits of health care as death approaches, and what we want for the end of life. Second, we need to plan better to ensure that our preferences for the end of life are met. Third, services for those dying of chronic illness need to focus less on institutional care and more on people's wishes to die at home and in homelike settings. [24]

At the other end of the lifespan, a greater investment in 'starting well' is sorely needed as part of a long-term strategy and commitment to 'patient centred care'. This is where a genuine whole-of-government 'investment approach' (not the false investment approach of the draft strategy, discussed below) focuses on a woman being healthy when conception occurs, being healthy throughout the pregnancy, and the newborn being healthy for its first two to three years because of the significant physical, mental and emotional development that occurs in those early years. Young children are most vulnerable to the impacts of poverty, abuse and neglect, which have life-long impacts and costs. As such, effective public investment in the early years will deliver the best return on investment. Reaching young children requires investment in their parents/caregivers and family.[25] [26] [27]

In short, whole-of-government policy should ensure every baby should be born to a healthy mother and grow up in a healthy home.

More broadly, research shows there are many benefits from patient centred care when it is properly implemented. When healthcare administrators, clinicians, patients and families work in partnership, the quality and safety of care rises and provider and patient satisfaction increase. Recent research indicates that a patient centred approach can also make health service delivery more efficient.[28]

Specific benefits include decreased mortality, decreased emergency department return visits, fewer medication errors, lower infection rates, and reductions in both underuse and overuse of medical services. In the care of patients with chronic conditions, studies indicate that patient centred approaches can improve disease management, increase both patient and doctor satisfaction, increase patient engagement and task orientation, reduce anxiety, and improve quality of life.[29]

A patient centred care approach has also been linked to improvements in long-term outcomes in cardiac patients and is seen as integral to preventative care.[30]

Further, it has been acknowledged that, to succeed, a patient centred care approach must address staff needs, because the staff's ability to care effectively for patients is compromised if they do not feel cared for themselves. Once the patient centred care approach is firmly established, a positive cycle emerges where increasing patient satisfaction increases employee satisfaction, and this, in turn, improves employee retention rates and the ability to continue practising patient centred care.[31]

Limited resources in the form of underfunding, low staffing levels and low morale in already overstretched systems are a perceived barrier to the practice of patient centred care.[32]

An underlying reason why a comprehensive patient centred care approach has not been well established in New Zealand's DHBs, despite all of these benefits and more, is that it requires an upfront investment in services, especially in the medical specialist workforce.

Good patient centred care also requires more active participation from elected DHB board members. If the desired approach is to "understand how health fits into people's lives, and how it relates to the common needs, interests and priorities," (p11), then one obvious avenue for this, aside from health professionals, is through the elected members of the district health boards. However, while currently most board members are elected by the public, all board members (both elected and appointed) are directly responsible and accountable to the Minister of Health.[33]

In the ASMS' experience, the result has been that, with a few exceptions, elected board members have been politically managed and community engagement and representation has fallen well short of what was expected when DHBs were established. The extent to which elected board members are able to advocate on behalf of their communities would be further diminished if boards are reduced to nine members, with six appointed by the Minister, as recommended by the Capability and Capacity review.

Quality and safety

We support the draft strategy's aim to improve the safety and quality of health services, which could potentially have a significant positive impact on the efficiency and effectiveness of the service. One frequently referenced study has estimated that adverse events in our health services could cost New Zealand $870 million per year, of which $590 million is due to potentially preventable events – mostly occurring in the hospital system.[34]

While a range of factors contribute to this, there are many examples indicating specialist staffing levels is an important factor, especially given the increasing complexity of health care delivery is placing greater demands on the expertise of doctors and teams of healthcare professionals. However, increasing heavy clinical demands have meant many specialists are unable to find the recognised professional minimum standard of time for non-clinical duties, including time for continuing education, research, quality improvement activities and, not least, training other doctors.

An Australian survey of quality and safety practitioners found, "The single proposal judged by survey respondents to have the highest potential effect on reducing adverse events was that the supervision and support of junior doctors be improved."[35]

'Smart system'

The draft strategy's aim to have a smart system depends largely on capital investments. However, whereas unmet health need is a sign of under-resourced clinical services, there is also increasing anecdotal evidence of DHBs accumulating a 'capital deficit' to attempt to balance their books.[36,37]

One of the most recent examples is the privatisation of the Wellington region's hospital laboratory services, which occurred after the Service Integration and Development Unit (SIDU) for Capital & Coast, Hutt Valley and Wairarapa DHBs reported that "upgrading the Wellington Hospital laboratory has been deferred for several years due to capital restraints" and "Hutt laboratory has had very little capital investment for many years". Some laboratory equipment was described as being "held together by bits of wire" and potential failure placed patients at risk. Privatisation of the hospital laboratories "allows for private capital investment to upgrade the facilities which the three DHBs have not been able to match".[38]

The short-term financial fix, however, comes at a cost in the longer term given the bottom line for private financial investment is to make a profit.

In the United Kingdom, where private capital investment has been widely used by successive governments to avoid short-term public expenditure in the NHS, some regional services ended up facing such crippling repayments that the Government needed to inject (pounds)1.5 billion in 'emergency funding' so that services were not cut to pay the bills.[39]

The draft strategy highlights the importance of "information being reliable, accurate and available at the point of care" (p24). But again there is much anecdotal evidence that DHBs are not investing in information technology sufficiently to enable this to be a reality.

We agree it is important that the health workforce's activities are supported by up-to-date and functional information technology. Clinicians increasingly rely on information technology to deliver day-to-day services. This includes but is not limited to accessing patient information, electronic medical records, results of investigations, etc. Systems to enable electronic prescribing and electronic requesting of investigations further add to health professionals' reliance on IT for the management of patients. The ASMS raised with the Capability and Capacity Review team the frustration and time wasted, reported by our members, in dealing with unreliable systems and outdated software. Furthermore patient care can be severely compromised when access to IT is interrupted.

The National Health IT Board is pushing ahead with its work programme and vision of the shared medical record across providers and we fully support this. However, the National Health IT Board seems to have very little or no influence on individual DHBs' Information Services departments. Some basic functionality is lacking at the coal face. Outdated web browsers, difficulties in accessing email on different work stations, and system down-time adds to frustration and risk.

Patient expectations of what hospital information technology can deliver far exceed reality. Patients increasingly want to communicate with their doctor by means of email, text message and have access to their laboratory results, etc. They are willing to share their health information via insecure IT systems to expedite their care. We urgently need to find a secure solution.

Greater investment in technology, however, is not necessarily a cost-saver, as is suggested in the draft strategy. Technological change could potentially reduce demand for health services and lower costs or, just as easily, generate increased demand on the health sector and raise costs.[40] [41]

We note a government-commissioned review of New Zealand's Electronic Health Records Strategy[42] suggests more investment in technology could improve 'productivity' and lower costs but its arguments are based on fundamentally flawed 'productivity' measurements, which the ASMS critiqued in 2013.[43] The review also showed a lack of understanding of our health system by claiming New Zealand's costs and staffing levels per hospital bed were relatively high without recognising that our hospital bed numbers per population are among the lowest in the OECD. If the draft strategy's aspirations for greater cost-effectiveness through great use of technology are based on such advice, the potential for improvement will be less than expected.

We also caution that while greater investment in electronic health records and advanced access scheduling may be necessary to move medical care into the 21st century, this should not be conflated with achieving patient centred care. Simply implementing an electronic health record in itself is not patient centred unless it strengthens the patient-clinician relationship, promotes communication about things that matter, helps patients know more about their health, and facilitates their involvement in their own care. Similarly, advanced access scheduling would have limited value, in terms of patient centred care, if it simply leads to greater access to an overworked health professional workforce.[44]

‘Action areas’ with high risk of unintended consequences

‘Health investment approach’

The health investment approach – based on the ‘investment approach’ currently used by the Ministry of Social Development (MSD) – may be used to ‘target high-need priority populations to improve overall health outcomes’ (p 41). The approach uses techniques from the insurance industry to calculate long-term costs to the government of health and social services.[45]

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 at the benefits to individuals and the community. Even 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.

For example, some studies suggest that obesity might reduce future health costs as obese people die more quickly. A health system that sought only a reduction in future health costs might therefore do little, if anything, to discourage obesity.” (p231, *More Effective Social Services*)

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

It treats citizens as liabilities [the draft strategy call 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.[46]

Social impact bonds

Social impact bonds (SIBs) are a newly developing form of ‘results-based’ contracting between the Government, private social service providers and investors – which may be financial institutions, charities or individuals.

An ASMS *Research Brief* has identified considerable risks and uncertainties associated with SIBs. In our submission to the Productivity Commission we raised concerns about the lack of evidence that SIBs actually work as intended, especially given uncertainties surrounding how well they are likely to function in the New Zealand context. We further highlighted our concerns at the risks associated with the likelihood of achieving rates of return to investors, potential savings to the Government and being able to accurately measure the success of a SIB programme.

Perhaps the most complex feature of SIBs both for potential investors and governments interested in using SIBs is the ability to generate accurate metrics, both in terms of what will be measured and

how outcomes will be attributed and identified. There are also unknown but potentially large costs in developing accurate metrics. Debates around measurement feed into broader issues around the amounts of risk that investors are willing to shoulder, issues around attribution of outcome and factoring in the broader social context of individuals and how outcomes will be linked to payments for investors. There are clearly high risks of perverse outcomes emanating from perverse incentives.

It remains unclear who has responsibility if and when things go wrong. It is not clear whether there will be a gap in service provision if the SIB fails, and who has responsibility for defining and assessing outcomes which will have key ramifications for both the social group involved and future service provision under a SIBs model.

Yet the Productivity Commission maintains SIBs can stimulate innovation by sharing risk and linking payment to performance while leaving the providers (as opposed to the Government) free to determine how to achieve the agreed outcomes. Accordingly, it sees a role for them in encouraging experimentation and testing the effectiveness of new approaches, though it acknowledges "they may not be suitable for wide application across social services".

Proposed changes to the ways services are funded

New Zealand faces particular challenges in providing an effective and efficient health service, with its small and largely widely dispersed population and an over-stretched medical specialist workforce subject to the pressures of international shortages. The approach to addressing these challenges by successive governments over recent times, following the disastrous competitive market experiment of the 1990s, has been a policy emphasis on collaboration and integration.

The draft strategy highlights the need for 'trust, cohesion and collaboration' (p9). However, the proposed new approach recommended in the Director-General of Health's commissioned Review of Funding contradicts this. If implemented, it would be a fundamental departure from the evidence-based collaborative, integrated model underlying current government policy and a return to the market-based policy of the 1990s. The structure may be different, but the effects would be the same: opening up DHB services to competitive tendering, short-term funding, short-term planning, fragmentation of services and clinical teams, barriers to integration of clinical services, disruption to continuity of care, uncertainty for DHB employees and patients alike, lack of transparency due to commercial sensitivities (especially where private providers are involved), increases in user charges for some (including, potentially, patients opting to travel for elective surgery), and so on.

The funding review goes further and suggests "a separation of DHBs' planning and funding from their provider arms should be considered".[47] Such a move would reintroduce a key structural element of the 1990s' policies which would open the way for a change to a more commercially oriented health system.

Even in much larger countries, market-based health policies (including those using the so-called 'internal markets') have been shown to be far less cost-effective and more difficult to manage than collaborative-based models because the complexities of delivering health services do not fit with basic market principles.

As one prominent health policy expert put it, anyone who believes competition works in health just as it works elsewhere "displays an ignorance of a literature stretching back 50 years".[48]

One of the outcomes of the policies of the 1990 was a loss of public trust in the health system; the same could very well happen if these proposals were adopted which, again, would work against the stated aims of the draft strategy.

The recommendations introduce a great deal of uncertainty for DHB services, with indications that funding will be dispensed only if planned 'milestones' are achieved. If they are not – and there may be various legitimate reasons why they may not – their funding would go to another provider. This could have a profound effect on DHB services as a whole.

If some elective surgical services are denied funding in one DHB, for example, presumably necessitating clinicians moving to a different employer, the negative flow-on effect for that DHB could include the effective delivery of acute surgical services, A&E, intensive care, and obstetrics, among possible other areas. For provincial DHBs especially, the impact would undermine the viability of the hospital services with a further downstream impact on primary care.

We note also that these sorts of moves would be in the context of proposed changes to national prices, though it is unclear what these changes would entail. A leaked document of the review explained they would "reflect lowest cost DHBs", which has been edited from the official document.[49] There is a high risk of perverse incentives where the primary goal of providing low-cost services takes precedence of quality and safety, especially considering we are still a long way from having a robust, comprehensive system of monitoring and evaluating quality and safety. As incentives to cut costs intensify, so too must the emphasis on ensuring quality and safety. This would involve more resources than are presently made available.

Indeed there is much contained within the recommendations that suggest increased administration and technology costs. When health funding is falling in real terms, including funding of the Ministry of Health, it is difficult to see where the resources are going to come from to implement these often complex arrangements.

Exacerbating the effects of a competitive approach to funding and providing services is the idea of splitting DHB funding into four pools. This does not correspond at all to the way services are provided to patients. Cancer treatment services, for instance, are provided right across community-based and hospital-based services. It is the same patient throughout, and to carve up the funding would seriously risk fragmenting the services and potentially causing patient harm.

We note that "at least to start with" the DHBs and the Ministry of Health will manage these multiple funding pools. There is no acknowledgement of the additional administrative costs involved in that task. Presumably there is a plan to shift this task to some other body in the future, again harking back to the 1990s.

We note also that the Funding Review's recommendations are at odds with those of the 'Capability and Capacity Review'. For example: "The revised [operating] model should … provide DHBs with funding certainty so that they in turn can lengthen downstream contracts with providers beyond the current one-year lengths."[50] As discussed above, it seems clear that if the Funding Review recommendations were adopted, DHB funding would be anything but certain.

It is important to recognise that the Funding Review recommendations are the result of a secretive process. They impose changes from the top. It is an approach that has a poor record in health systems internationally, not least in New Zealand. Time and again the opposite, bottom-up approach has been found to be more successful. Distributive clinical leadership is a prime example.

As Des Gorman has said:

> *Quite simply, the reforms we need are only likely to be successful if clinically led.*[51]

And the Ministerial Review Group:

> *The past is peppered with reforms, designed along varying philosophical lines, and implemented by various government agencies. These reforms have generally been top-down and have had mixed levels of success. None, however, have been led by clinicians, even*

> *though the resulting changes have often had significant effects on clinical practice. This was particularly the case during the 1990s, when reforms were occurring against the background of the need for a substantial reduction in public expenditure. Health managers have also been asked to implement reforms without the mandate or co-operation of the clinicians who would be key to making them successful.*[52]

Whether in the context of 'reform' or 'review', the above observations apply equally when the changes being imposed affect the way clinical services are delivered. Our reading of the proposed recommendations is that they certainly do impact on decisions concerning clinical services and on the way those services are delivered. The result, therefore, may well be the same scenarios where health managers are required to implement measures without the mandate or agreement of the clinicians who are key to making them successful.

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