Australasian College for Emergency Medicine

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Report on the Health and Disability System Review:

An emergency medicine perspective

Aotearoa New Zealand Faculty Commentary paper

April 2021

About

The Australasian College for Emergency Medicine

The Australasian College for Emergency Medicine (ACEM, the College) is responsible for the training of emergency medicine doctors and the advancement of professional standards in NZ and Australia. As the peak professional organisation for emergency medicine, ACEM has a vital interest in working with governments, industries, and communities to give healthcare services the best opportunity to meet current and projected healthcare needs of patients.

ACEM acknowledges the importance and significance of Te Tiriti o Waitangi between the Crown and Māori. ACEM's board and leadership team support the implementation of Te Rautaki Manaaki Mana[1] and continues to explore, in collaboration with its members and allies, how ACEM can give appropriate effect to Te Tiriti and its principles.

Our vision is to be the trusted authority for ensuring clinical, professional and training standards in the provision of quality, patient-focused emergency care.

Our mission is to promote excellence in the delivery of quality emergency care to all of our communities through our committed and expert members.

The Aotearoa New Zealand Faculty

The NZ Faculty is one of nine regional faculties of ACEM throughout NZ and Australia. The NZ Faculty comprises 338 active FACEMs and 226 FACEM trainees. Current board members of the Faulty are listed here[2].

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Executive summary

Overall, ACEM supports the majority of the 108 recommendations from the final report of the Health and Disability System Review (the Report). There is a need for major health and disability system reform in Aotearoa New Zealand (NZ) as it is focused on changes that have the potential to leverage the strengths of the current system, and pathways to learn and evolve over the next ten years. However, we do not want to see this negatively impact our already stressed and vulnerable health system. Planning in terms of implementation, associated costs, and prioritisation of strategic objectives, as well as adequate stakeholder engagement and buy-in will be crucial for successful reformation at this scale.

Governance, planning and funding

- We broadly support the recommendations to the changes in the role of the Ministry of Health (MoH, the Ministry). This includes the establishment of new Crown Entities – Health New Zealand (Health NZ) and the Māori Health Authority (MHA). Still, significant concern has been raised around the added layers of bureaucracy across the various entities. It is important that the health and disability system remain responsive and can operate at same pace as our current environment.
- Regardless of the appointment/election process for Health NZ's Board membership, it must ensure Māori and minority groups are adequately represented.
- The limited commissioning power of the MHA has been questioned. They should have sufficient power to effect change, rather than having a purely advisory role.
- The disestablishment of the Health Promotion Agency (HPA), and reduction in the number of Responsible Authorities (RAs) could provide a more focused and leaner leadership structure to oversees these roles. However, the responsibilities of the MoH, Health NZ, MHA, and District Health Boards (DHBs) must be thoroughly outlined to ensure there are clear points of accountability, and that communication channels are established and clearly defined to the appropriate entity.
- The reduction in the number of DHBs and proposed plans for funding and resources is supported by ACEM. While it may facilitate better integration of primary healthcare (Tier 1) and secondary healthcare services (Tier 2); this must be supported by national guidelines to centralise and streamline processes to be more robust and functional. The reduced number of DHBs should not lose focus on the local context and the needs of health consumers/patients, whānau and communities, and should be carefully aligned such that those consumers/patients living in rural areas are not disadvantaged. It may reduce duplication across DHBs and is likely to be more cost-effective in the long run. The shorter transitional periods will need strong leadership from all levels of government on clinical, financial and strategic management. The reduction in the number of DHBs must also consider the impact on trainees and DHB employees.
- The notions of patient-centred care and consumer empowerment are to be commended, but will require improved public health education, further research and appropriate funding.
- Hospital management should also be easily accessible, transparent and have greater working knowledge of the ground level challenges clinical staff face. Specialised (formal and/or informal) training of hospital management staff may facilitate greater collegiality and support amongst clinical and non-clinical staff. Senior clinical staff must work alongside management to achieve this
- There must be increased funding for community-based primary healthcare services (Tier 1 services), including community-based mental healthcare funding and resources.
- There must be clearer commitments to preventing hospital access block* in emergency departments (EDs). Hospital access block is a system-wide acute healthcare access issue that manifests in EDs. We recommend that ACEM's new Hospital Access Targets (HAT) be adopted by the Ministry or Health NZ, and national implementation should commence immediately, and be completed by 2023. The HAT has been approved by the Ministry's DHB Performance, Support and Infrastructure (PSI) Directorate who are in the process of setting up resources to support this.
- Consideration must be given to provision of healthcare over extended hours (into evenings and weekends), not just office hours, to potentially ease the burden on the only 24/7 provider of healthcare, EDs.
- Pre-hospital and retrieval medicine (PHRM) including inter-hospital transport (IHT) is not adequately covered nor understood in the Report. The roles, responsibilities and relationships of key stakeholders within this space are currently too complex, and often conflicted and misunderstood. We recommend the Transitional Unit to establish a national interdisciplinary governance group that would provide national, cross-agency clinical oversight, leadership and coordination of the services offered across the PHRM and IHT sector. Regional funding for PRHM, including funding

for ambulance (land and air) services, will create better quality and more equitable care for all New Zealanders. We advise there be permanent resourcing made available within the Ministry or Health NZ.

- We understand the Ministry is in the process of developing a data and information strategy for health and disability and support this. However, currently there is a paucity of national, publicly available data sets in New Zealand. DHBs run variations of the same electronic health record (EHR) platform, including health records and clinical result management which is highly inefficient. A national EHR platform must be implemented as a priority. Specifically relating to ED data management, we also support the implementation of SNOMED CT as a national dataset for EDs. We note that all DHBs are encouraged to work towards the national implementation goal by July 2021. This will enable decisionmakers to accurately monitor clinical activity in EDs. Data will also support having equitable clinical pathway and information systems, audits, research and the development of guidelines, standards or legislation. There is, however, significant scepticism regarding the DHBs' ability to implement this by the set date. It will require more resources and funding than currently available.

Workforce

- ACEM supports a national health workforce plan (NZ Health Plan[*]) that ensures better representation of our communities, and that identifies specialist and general healthcare workforce needs for emergency/unplanned care in both urban and rural areas. It will need to be tied to adequate health workforce funding.

- This national workforce plan also needs to be co-designed with relevant stakeholders, including all vocational medical colleges/providers responsible for the 36 recognised and accredited vocational scopes of practices within NZ. Trainee entrance numbers must also be considered to ensure there is sufficient access to training positions, and specialist positions (once trainees receive fellowship/membership) in all regions. This is particularly important to adequately serve our rural and remote communities. Greater clarification is needed of the relationship between service provision and training of doctors, and the roles of Health NZ, DHBs and training providers in these relationships need to be defined.

- There should be a standardised recommended minimum level of staffing and number of beds that are in line with the local population and its estimated growth rate. Types of case complexities, presentation numbers and admission percentages must also be considered to ensure that safety and quality of care is maintained.

- Models of care where teams that include both medical (specialists and generalists) and non-medical staff can work well in EDs, but credentialing processes (by employers) should be standardised.

- We agree that facilities, data and technology are key factors that should be prioritised to enable and support the health and disability system. These directly impact on the workforce and could support better outcomes for our Māori and other vulnerable populations. The mentioned initiatives and priorities with regards to facilities, data and technology should also be implemented as planned, regardless of the impact of COVID-19 and the national vaccine roll-out plan. This will improve and support the health and disability system in any environment.

Education and training within an emergency medicine context

- The Report recommends that training be coordinated by Health NZ, with lead DHBs and partnerships with various training organisations. We recommend that vocational medical colleges continue to be key players in their recognised and accredited training programmes and recertification via its continuous professional development (CPD) programmes.

- We note the Report's overwhelming recommendations to aid the need for a 'generalist' and 'flexible workforce' that will better support the country's growing health needs. While some of the mentioned recommendations may be accommodated by vocational medical education and training providers in NZ, not all may be fitting for this environment. Government may struggle to get uniform buy-in from the various vocational medical colleges. Vocational medical colleges have inherent flexibility to adjust scopes of practice (through a regulated accreditation process). This includes changes to its education and training programmes and required competencies to accommodate changing needs. This also creates an opportunity for training providers and other entities to work collaboratively and look beyond traditional professional boundaries. This may include the creation of recognition of prior learning (RPL) pathways. Nonetheless, vocational medical colleges will remain protective of their own training programmes and their requirements. Most vocational medical colleges are also binational colleges that have a geographical footprint in both NZ and Australia. Issues with mandating regulatory changes to their programmes may be more complex, as they offer the same programme across both countries.

- We do not support the recommendations to increase online training in the initial fellowship training programme – mainly due to the practical nature of vocational medical education and training. However, increased online delivery for its recertification (CPD) programme is supported. There is some

contention noted surrounding the requirements for Competency-Based Assessments (CBAs) as opposed to clinical best practice. Vocational medical colleges are encouraged to work with localised clinical teams to ensure the requirements for CBAs reflect current clinical best practices, particularly for the binational colleges.

- The regulatory role of the MCNZ in medical education and training is not conclusive in the Report. At present, the MCNZ prescribes the curriculum framework and outcomes for prevocational medical training and oversee the administration and management thereof. This could be seen as a conflict of interest, for the same reason Government changed the mandate and structure for Industry Training Organisations (ITOs) as part of the NZ Reform of Vocational Education (RoVE). Whilst some are in transition, they will become Workforce Development Councils (WDCs). The MCNZ also initiated the InPractice CPD programme for doctors with general registration (managed by bpac). Whilst it was good to introduce this, as there was no oversight of any CPD requirements for a doctor with general registration (or non-specialist 'career medical officer'); this arrangement of its CPD programme is no longer fit for purpose. It is particularly ineffective for a non-specialist 'career medical officer' working in EDs and needs much more clinical rigour, governance and monitoring around it. We also recommend that prevocational medical training (and its ePort), as well as the CPD programme for general registered doctors be managed by Health NZ and supported by the Medical Schools of the Universities of Otago and Auckland instead.

- The validity and quality of the process for the evaluation of specialist international medical graduates (SIMGs) were also questioned. We suggest vocational medical colleges continue to closely engage with the Medical Council of New Zealand (MCNZ) to ensure SIMGs are appropriately evaluated when applying for vocational registration. Ultimately, there also needs much more guidance on the impact of the RoVE in the vocational medical education and training environment, as Government remains silent on this.

- There should also be consistency and further clarity around who should work in collegial relationships (as mandated by the MCNZ) in a variety of settings.

- The Report failed to identify the need for greater support in terms of coaching and mentoring and does not consider plausible or feasible solutions for trainee doctors to gain rural experience in a safe and supported environment. Vocational Medical Colleges may engage with rural stakeholders, including the Division of Rural Hospital Medicine (DRHM) to develop special skills placements.

Māori health equity

- Crown Entities, RAs, DHBs and training providers should be required to include equity as part of their routine audits to ensure that equity-related initiatives are on track.

- While the reduction in the number of DHBs has many benefits, we are concerned this may not best serve all Māori communities. The costs (of 'part charging') involved in community-based primary healthcare services, may mean that EDs become the main avenue of primary healthcare for the disadvantaged and vulnerable. Community-based primary care funding will also need to be drastically increased. It should be based on a fair population-based funding model, that possibly includes an allocated number of free services for the disadvantaged and vulnerable.

- In order to develop and support a culturally safe and competent health workforce, ACEM believes that guidelines and resources should be provided to aid DHBs and our EDs. This will ensure all staff know how to be Treaty compliant, pro-equity, culturally safe and anti-racist, and that this process starts during undergraduate education, but also includes both the existing workforce and international staff that join our workforce. ACEM's Manaaki Mana Rōpū is in the process of commissioning a project in Pae Ora standards for EDs and plans to have this completed by 2022.

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1. Introduction

1.1 Commissioned by the ACEM Aotearoa New Zealand Faculty

At its meeting on 9 September 2020, the NZ Faculty Board of ACEM considered the final report of the Health and Disability System Report (the Report) and resolved to consult its NZ faculty members/Fellows of ACEM (FACEMs), including trainees and other ACEM stakeholders (i.e. ACEM College units and Committees) to inform its response in this Commentary Paper (the Paper) to the Report. Member and trainee consultation consisted of a link to the Report, supported by an internal summary on the Report and guided by eleven free text questions. Its purpose was to solicit their current views on whether the recommended changes to the health and disability system would improve emergency/unplanned care in NZ. It also prompted for further (free text) responses they felt were not sufficiently covered in the survey. The survey was accessible from 13 October to 17 November 2020. Separate and supplementary feedback was sought from the Manaaki Mana Rōpū and other relevant College units.

This Paper draws on the expertise and knowledge of ACEM members and trainees and stakeholders who are passionate about advancing quality, culturally safe and appropriate emergency medicine in NZ. References to relevant data and academic literature are cited to support these views.

1.2 Background

In 2018, the Minister of Health commissioned a review of the New Zealand Health and Disability System (HDSR). The purpose of the HDSR was to consider the overall function of the health and disability system and to consider ways for the system to improve sustainability, achieve better and more equitable outcomes for all New Zealanders, and shift the balance of care from treatment of illness towards maintaining health and wellbeing.

The HDSR panel (the Panel), chaired by Heather Simpson, worked with a Māori Expert Advisory Group (MEAG) to assist the HDSR. On 16 June 2020, the Ministry of Health (MoH; the Ministry) published the final report of the HDSR. The Report provides a high-level view of how the health and disability system should operate in the future and key recommendations for Government to consider. The recommendations include legislative changes, as well as structural and cultural changes. The focus is on reforms that have the potential to leverage the strengths of the current system, and pathways to learn and evolve over the next ten years. The Panel was not in unanimous agreement on many parts of the Report[5 6], and there are significant changes between the interim report and the final report. The Report includes a summary of Māori Expert Advisory Group's (MEAG) advice on Māori aspirations.

Cabinet agreed to the case for reform and high-level direction outlined by the Report; but reserved their decisions on the individual recommendations until they receive detailed policy advice from the Department of Prime Minister and Cabinet (DPMC)[7]. A group of Ministers (the Ministerial Group) are responsible for overseeing this process: The Prime Minister, the Finance Minister, the Health Minister and the Associate Health Minister. Since December 2020, the Ministerial Group also includes the Minister of Disability[8].

A Transition Unit has been established within the DPMC with the Director of the Transition Unit, Stephen McKernan reporting to the Ministerial Group[9 10]. At the Council of Medical Colleges (CMC) meeting held in March 2021, Stephen McKernan highlighted the Transition Unit's case for change, recapping on the core problems with the current system:

- There is widespread inequity of outcomes and a number of priority populations are underserved.
- Financial pressure is undermining sustainability of services for future generations.
- The system has failed to keep up with consumer preferences due to a lack of focus on timely, efficient and effective services.

Additionally, in his speech delivered on 24 March 2021, *The case for change in the health system - building a stronger Health and Disability System that delivers for all New Zealanders*[11], Hon. Andrew Little's states there are five key shifts that must happen:

1. "the health system will reinforce Te Tiriti principles and obligations [...]
2. all people will be able to access a comprehensive range of support in their local communities to help them stay well [...]
3. everyone will have access to high quality emergency or specialist care when they need it [...]
4. digital services will provide more people the care they need in their homes and local communities [...] [and]
5. health and care workers will be valued and well-trained for the future health system."

The Transition Unit will work with the Ministry and central agencies to advise on the design and delivery of a coherent reform programme building on the direction of travel outlined by the HDSR. Cabinet has also invited the MoH to establish a Ministerial Advisory Committee to provide ongoing input into the work of the Transition Unit and to separately advise the Ministerial Group.

Also at the CMC meeting held of 18 March 2021, Stephen McKernan explained the actions to implement the reform, from legislative change, to structural and cultural change. This will require a determined change programme, over a number of years. He also advised on the indicative reform timeline that will probably include the following actions:

- a policy response to commence in quarter 3 (Q3) of 2020, through to Q2 in 2021
- an operational design to commence in Q4 of 2020, through to Q4 of 2022
- legislation to commence in Q2 of 2021, through to Q2 in 2022. By Q1 of 2021, the Transition Unit will report back to Cabinet on an Impact Statement/Implementation Plan). They plan to have legislation introduced to the House of Parliament by Q3 of 2021, and plans pass this legislation by Q3/Q4 in 2022
- budget bids in Q4 of 2020 to Q1 in 2021, and again in Q4 of 2021 to Q1 in 2023
- structural change to commence in Q3 of 2022
- NZ Health Plan to commence with design and development in Q4 of 2020, refinement in Q4 of 2021 and implementation in Q2 of 2022 that goes beyond 2024, and
- Tier One changes to commence in Q1 of 2021, and a phased rollout in Q3 of 2021, that goes beyond 2024.

1.3 Scope

The scope of this Paper is to consider the Report and its recommendations that are relevant to emergency medicine as vocational scope of medical practice, its doctors, trainees and their training programmes, their registration and other legal requirements, and workplace.

Following significant ACEM consultation, we provide a suite of recommendations for the Transition Unit to consider as they develop and refine the implementation of recommendations of the Report. In some instances, recommendations might be directed at other stakeholders within the health and disability system.

Special focus was placed on the following recommended changes to the health and disability system:

- Governance, planning and funding
- Workforce
- Education and training within an emergency medicine context, and
- Māori health equity (which is addressed throughout the Paper under each of the first three changes listed above).

2. Health and Disability System Review: An emergency medicine perspective

2.1 Governance, planning and funding

2.1.1 General comments

a. Support for a major reform of the health and disability system in a post-COVID-19 world

ACEM supports the need for major reform of Aotearoa New Zealand's (NZ) health and disability system and congratulate the Panel on the scope of their ambition. As with any major national reform, there are opportunities and risks with potential negative consequences. At present, the implementation of major reform may destabilise the health and disability system for some years to come, which is inopportune during the global COVID-19 pandemic. Regardless, priority in the investment for the COVID-19 response should not cause Government to be reluctant to commit to necessary and planned investments from the Report, i.e. urgent upgrades to hospitals, including EDs and other acute care areas. While we support the introduction of greater accountability and transparency within the health and disability system; a major reform may not enable the system to do this in the first initial years during the planning and implementation phases. All areas will be new and require pioneering effort that may or may not work. Such environments are often ambiguous, and do not have high levels of accountability and transparency.

We note the importance of the socioeconomic determinants of health to address healthcare challenges and agree that the health and disability system does not currently serve the diverse population needs of all New Zealanders. This has resulted in significantly different health outcomes. This is particularly real for Māori and Pasifika, those that are disabled or elderly, located in rural and regional areas, as well as those experiencing financial hardship. While there is already strong evidence outlining the reasons and solutions for the poor health outcomes as a result of socioeconomic factors, such as poor housing, diet, education, and poverty; action is now needed. This will require policy support and adequate resourcing. Access to social determinants of good health and wellbeing are also due to the structural racism in NZ society, as well as the ongoing impacts of colonisation, further and more focussed research is needed. This could for instance be on how to restructure our health system in a way that addresses the key issues raised in the Report, as well as social studies such as various types of patient journeys from an ED perspective. This would require closer collaboration with the Ministry of Social Development and other relevant Government agencies/Crown entities. There are often missed opportunities to collaborate between the MoH and other agencies/entities, that would not construct sustainable change if attempted alone. Overall, there needs to be a unified commitment from Government to addressing the known inequities within the health services.

b. Changing role of the Ministry of Health, and establishment of new Crown Entities

We broadly support the recommendations to change the role of Ministry of Health (MoH) and establish new Crown Entities – i.e. Health New Zealand (Health NZ) and the Māori Health Authority (MHA). However, significant concern was raised by ACEM members around the added layers of bureaucracy, as this may impede effectiveness and efficiency. The responsibilities of each entity – i.e. the MoH, the Māori Health Authority (MHA), and DHBs must be thoroughly outlined. Centralised decision-making and oversight may also negatively impact important support services. Overall, we would not like to see more complex bureaucratic processes and structures that will further disable our already stressed and vulnerable health system.

In their overseeing role, the MoH must have the ability to direct entities/groups to ensure there are clear points of accountability, and that communication channels are established and delineated with DHBs. With clearly defined accountability and closed feedback loops, the MoH could potentially be less reactive, but resume strategic control and monitoring of the vital aspects of NZ's health response. If not, this may have intermediate and long-term impacts on every New Zealander seeking access and funding for quality healthcare. Implementation timeframes should also consider the trends of the current global pandemic, not to further overwhelm the health and disability system.

ACEM members, trainees and stakeholders are not all convinced that rebranding the current system under a one-size-fits-all model will optimally serve our communities. The rebranding under Health NZ, will not solve the inherent existing and emerging problems, such as addressing localised needs, or when specific events occur. Similarly, the full scope and role of Health NZ and its relationship with DHBs remains unclear. We do however recognise that, if implemented the right way, it may lead to better sharing of systems and processes between DHBs. On the other hand, a top-down rule by decree may have adverse effects, including losing sight of local needs and reducing much needed innovation being developed within DHBs.

We also note the Report's recommendation for Health NZ be governed by a board of eight to 12 members that are drawn from DHB board members in each of the regions, and a chair. It further recommends that board members be appointed (as opposed to the current election process), and board membership to have 50:50 Crown–Māori representation. We also recognise that Māori are the most competent and expert in matters concerning Māori health, and acknowledge that due to institutional racism, competent and expert Māori are routinely passed over. Māori are often under-represented in decision-making that affects them directly. ACEM concurs with Hon Little[12] and is of the position is that Te Tiriti o Waitangi (The Treaty of Waitangi, the Treaty) principles should be incorporated across the whole health and disability system. Similarly, the Treaty recognises equal partnership between the Crown and Māori. We also recognise that national population-proportionate representation does not uphold the rights guaranteed to Māori under the Treaty. This would also not always be proportionate to the representation of Māori as a proportion of health consumers, as some regions have higher Māori populations than others. Whether appointed or elected, we would however like to see that the most capable persons lead this important work and could be supported by a framework for skills needed to best represent and serve the specific needs of their patient population. This could support the candidate selection prior to appointment/election process. Co-opted Māori members should be appointed to the Health NZ Board if they do not proportionally represent the Health NZ Board, particularly where there are higher local Māori populations.

We agree with the recommendations of the Report that the MHA should be established to lead strategic policy with respect to Māori health, ensuring its commitment to achieve equity. A more integrated approach with prioritisation of Māori health is needed and we are highly supportive of the incorporation of the MHA into decision-making. While the MHA will advise, monitor, report, and partner with the system to ensure that Matauranga Māori and other Māori health issues are incorporated into all aspects of the system; it appears as if they will only directly manage Māori workforce and provider development. The MHA must have power to create benchmarks that should be met, and not solely be limited to an advisory group. The limited power in its role and authority risk being tokenistic. With its proposed advisory role, it may relegate Māori voices to discretionary advice only. In addition, without commissioning authority, the status quo on proportionate universalism remains. Overall, there is concern that a disempowered Ministry and MHA would have little influence over outcomes if they are not commissioning services.

The planned increase in ethnicity and socioeconomic deprivation weighting is also well overdue and we note the recommendation to disestablish the Health Promotion Agency (HPA)[13]. We hope the increased focus and capacity of leadership through the changing roles of the MoH and the establishment of Health NZ and the MHA will result in transparent reporting and partnering to improve population health and health equity. By losing the specific health promotion focus as a separate entity, we do fear though that the gains from patients receiving timely quality treatment may not be enough to overcome worsening outcomes. This is often due to the lack of early intervention and prevention initiatives or dealing with the underlying causes of certain diseases. Clinical performance can be improved through standardisation processes at regional and national level. While greater integration between primary and secondary healthcare is an important goal, it is important to do this without removing currently effective healthcare processes or responsible body/entities. For instance, a move to abolish the HPA without an equivalent functioning body, plus the expectations on DHBs to provide more cost-effective solutions, as opposed to addressing some of the underlying issues related to clinical performance, may not result in better and equitable care for all New Zealanders.

Lastly, we also note the Report's recommendation to consider "alternate ways of delivering regulatory functions", which may include merging certain Responsible Authorities (RAs) within the next three to five years. Further detail and stakeholder engagement would be advised.

c. Reduction in numbers of District Health Boards

In principle, we support the recommendation to reduce the number of DHBs but should caution the risks.

Twenty DHBs[14] are not ideal. There are too many DHBs with significant operational duplications across them. Many DHBs also operate in silos. This lack of integration and over-arching leadership between DHBs is inefficient, diminishes the spread of national or regional innovation and best practice, and often leads to fragmentation of healthcare and poor handoffs. It is however hoped that fewer DHBs can deliver a reduced amount of bureaucracy and less barriers to quality healthcare, resulting in better co-ordination of care and a better balance of funding. More focused and targeted funding channels could improve primary healthcare and prevention services in the community. This may lead to freeing up valuable resources within secondary healthcare services, and potentially relieve some pressure on EDs, with possible reduced waiting room numbers and waiting times. However, further clarity of responsibilities is necessary to eliminate the duplication within the existing DHB system.

National guidelines should also be used to better integrate primary and secondary healthcare services, particularly for access to primary care and resources focused on preventative medicine and screening programmes, as well as improved outreach programmes, and those in rural areas. This would require a substantial centralised network to be effective, i.e. formal communication/handover of referrals and advice to facilitate appropriate continuity in care, and access to requests for appropriate investigation pathways. Improved accessibility to timely outpatient investigations, such as for ultrasounds, would also shorten wait times in outpatient clinics.

d. Funding and resources

We note the new planning and funding arrangements proposed, but our members, trainees and stakeholders agree with others in the sector that there are overall low expectations of the incoming health reforms[15]. DHBs serve different consumers/patients, whānau and communities, and funding should match these. Some DHBs will require a significantly increased amount of funding and resources as compared to others. Similarly so, the NZ population is growing both in size and diversity. The reduction of DHBs may result in a one-size-fits-all model to the funding and resourcing of local and regional healthcare services. This is unlikely to support or ensure equitable health outcomes for all New Zealanders. For instance, a standard model on funding or clinical practice would not be ideal. This could result in further centralised secondary care specialist healthcare service which could include also specialist acute and emergency care. Thus, causing patients to be even more geographically disadvantaged than they currently are.

Drawing from Health Alliance's experience, the reduction in the DHB numbers could further separate its consumers and Government healthcare structures. The barriers within the system may cause delays in completing projects, and resources could be directed away from smaller DHBs to more populous ones. For instance, EDs must be appropriately staffed so that trainee doctors can focus on training and have an opportunity to learn new skills, as opposed to being focused purely on service provision instead. Investment in reworking infrastructure in terms of time, personnel, protocols, and access is required. There are areas of need that remain unaddressed, and bigger structures are unlikely to improve this deficit. Addressing these on a small scale first and then cautiously extrapolating would be necessary as this will require major cultural reform in DHBs and the four medical industry bodies/unions, the Specialty Trainees of New Zealand (STONZ), the New Zealand Medical Association (NZMA), the New Zealand Resident Doctors' Association (RDA) and the Association of Salaried Medical Specialists (ASMS) will need to be included in this process.

We also support the recommendation to allocate (ringfence) primary care funding, but should also include:

- continued dedicated funding focused on epidemiological surveillance and planning,
- a greater focus on funding for effective mental health services in the community[16],
- more time allocation for complex general practitioner (GP) consultations[17], such as for patients with mental health issues, alcohol and drug related health issues or chronic co-morbidities. This would require a significant injection of funding, and
- appropriate funding of acute and emergency care that aligns with other services, such as elective surgical services.

In line with a proposed national asset management plan (NAMP)[18], and as mentioned in the Report, there are significant building and other infrastructural concerns. The NAMP states that older EDs do not meet current guidelines, and even some newer ones have reached capacity. Issues include undersized bed bays, poor layout corridors cluttered with equipment and even bed-spaces in corridors for patients. While some appear to be coping, most EDs across NZ cannot manage the current (let alone future) increased demand and cannot deliver the quality services they aspire to. They also do not have appropriate spaces to manage people who require a mental health assessment, and this is a major issue. Other infrastructural challenges such as more ambulatory care and short stay spaces in EDs must also be addressed.

We also believe that EDs should have generally more access to natural light, as this is healthier for staff, patients, whānau and especially mental health patients. This is essential if we want EDs (and hospitals) to be a place of healing that is good for the wairua (spirit/soul). This is a crucial aspect of health that is rarely addressed. Also noted is the slow progress with the implementation of national data standards and that IT infrastructure, networks and security are outdated and inadequate[19 20]. This may be addressed by the Report's recommendations explained in its proposed digital and data plan to set actions and responsibilities in building digital capability and implementing data and cybersecurity standards, and systems interoperability, as well as data and digital governance and stewardship, including the implementation of the SNOMED CT dataset for EDs nationally. However, we would not want to see this major system reform distract the Ministry's NAMP set out to be delivered by 2022.

There also needs to be clearer separation of funding allocated for facilities and infrastructural upgrades, and those for staff. Clinicians should not be restricted in their clinical provision due to the accumulated debt for new facilities. Better and more equitable management of Accident Compensation Corporation (ACC) funding is essential, recognising that costs (i.e. 'bulk billing') does not actually reflect the real cost/earnings of Accident Compensation Corporation (ACC)[21] cases.

There is a general lack of transparency with regards to funding expenditures – both from Government and at DHB level. For instance, in June 2019, Government announced eight million dollars in funding over the next four years to improve the response to mental health-related presentations in New Zealand's EDs. ACEM had several meetings with the Ministry's Mental Health and Addiction Directorate and understands that this was spent on a few pilot studies within a couple of DHBs. To date, no further details have been made available, and this is disappointing as ACEM would like to have been consulted and could have provided valuable input during this time[22]. Similarly, so, when it comes to workforce funding. In its report on The Cost and Value of Employment in the Health and Disability Sector, Health Workforce NZ states that, "in 2018/19, around $185 million was allocated to training and development of the health and disability workforce, including supporting medical vocational training, Nurse Entry to Practice, Midwifery First Year of Practice Programme, postgraduate nurse education and the Voluntary Bonding Scheme. In 2019/20 total funding for training increased to $211 million, plus an additional $5 million for leadership training" (page 27). Some data is published[23], but when probed, very little detail is available. Such trends are even evident at the highest levels. In his interview with Radio NZ (RNZ) on 25 March 2021, even Minister Little questioned what the increased health budget has been spent on[24].

We therefore advise the Ministry to develop a funding framework, coupled with appropriate stakeholder engagement when annual funding is made available. Similarly, available data on how this was spent should also be publicly available, as it would require greater transparency and accountability at DHB level.

ACEM is actively involved in advocacy for resource stewardship, and alongside the CMC, played a key role in the *Choosing Wisely*[25] campaign. *Choosing Wisely* is clinician-led and patient-centred with an aim of improving quality of healthcare by promoting elimination of low value, inequitable, inappropriate and/or harmful healthcare interventions. There is significant evidence of over-use of some tests, treatments and procedures that are unnecessary, not supported by the evidence, can cause harm, and also waste precious healthcare resources. Research has identified that large numbers of low value investigations or health care and duplication of health services continue to be supported and publicly funded. Several DHBs have funded *Choosing Wisely* co-ordinators to manage their DHB's initiatives with significant resource saving shown. We recommend that the Ministry fosters ongoing collaboration with the Health Quality & Safety Commission (HQSQ), medical specialties/doctors, and regulators to continue the expansion of the principles of *Choosing Wisely* and *Choosing Equity*[26], and to champion resource stewardship. Data gathered on low-value care provided in different healthcare settings will be invaluable in careful and equitable allocation of healthcare resources. Rational resource utilisation is absolutely critical for evidence-based, reasonable, fair and equitable utilisation of our rare and precious healthcare resources so that none is wasted and the harm of over-treatment, over-diagnosis and duplication is not manifest.

2.1.2 Māori health equity

The Report has adequate coverage and the right focus on Māori healthcare matters, such as the establishment of MHA, the importance placed on equity, investment in the Māori workforce, and the inclusion of kaupapa Māori throughout the system. However, failure to address inequities through institutional racism, conscious and unconscious biases and inadequate funding misses the key underlying issues characterising the current health system. It continues to acknowledge the disparities of health outcomes between Māori and non-Māori; but fails to action change. While the Report's recommendations to governance, planning and funding may reduce inequality and bring about better efficiency and effectiveness in theory; this may not occur in practice. Further in-depth stakeholder engagement will need to happen for effective buy-in from all stakeholders. This should be supported by clear advice and guidelines on how Government plans to reform the system to be free of structural racism, as well as to train a workforce that is aware of the existence of such racism and bias, and have the necessary skills to mitigate these biases. For instance, ACEM's Manaaki Mana Rōpū and our kaikōkiri (champions) around NZ are working actively within EDs across the country, dedicating time on how to approach this as individuals, and encourage other vocational medical colleges to follow suit. While we all learn together and recognise societal level change is a 'big ask', our health inequities will not disappear unless is recognised and addressed unapologetically.

There should be appropriate monitoring and evaluation processes to ensure Māori are best served by all recommendations from this Report, such as the reduction in DHBs. Primary care is underfunded, and Māori cannot always access primary care for multiple reasons. They are also disproportionately represented in NZ EDs and their presentations are often ones that can be treated in primary care, but there appears to be barriers. For instance, we know Māori are over-represented in lower Australasian Triage Scale (ATS)[27] scores, even though ATS three are not necessarily indicators of a benign outcome and in itself this might represent bias at the level of triage. In the Choosing Wisely means Choosing Equity paper referenced above healthcare resources applied to populations with less need (or who might even be harmed by unnecessary care) can be reallocated to those with real need. Access to quality and culturally appropriate primary care is critical for overall health and wellbeing and may at least reduce by a small proportion the patient demand for emergency care. It is however noted that these so-called 'GP-type patients' only constitute about <4% of the number of patients presenting to EDs. However, a reduction of DHBs may also mean a reduction in EDs that could result in a denial to such healthcare for Māori, widening the equity gap even further, particularly if measures to meet needs in other areas are not effectively evaluated as part of the programme of change.

The costs (of 'part charging') involved in community-based primary healthcare is another risk to be considered with the reduction of DHBs, and this could mean that EDs could become the main avenue of primary healthcare for the disadvantaged and vulnerable. Consequently, there should be increased community-based primary care funding, and this should be based on a fair population-based funding model. This could include an allocated number of free general practice (GP) visits, including Plunket and DHB nurses for the disadvantaged and vulnerable. This should however not assume that less acute care (in terms of beds and staff to provide the necessary care) will be needed. While a great amount of service provision can be done within community; acute care demand will remain high, especially in the short term.

2.1.3 Other concerns or gaps not addressed in the Report

a. Addressing dangerous levels of access block

EDs across the country have seen increasingly dangerous levels of access block[28], particularly in Auckland, Capital and Coast[29 30], Canterbury[31], Counties Manukau[32], Lakes, MidCentral[33 34], Southern[35], Waikato[36] and Waitemata DHBs. In March 2021, this has reached critical levels[37 38] in these regions, largely due to a mix of ongoing system-wide acute care access failures and lack of resources.

The most significant issue facing ED is their inability to admit the sickest and most injured acute patients to hospital wards when their initial care in the ED is complete. ACEM has developed a set of evidence-based acute care access measures or time-based targets – Hospital Access Targets (HAT). Time-based targets are underpinned by research and are designed to improve acute care provided to all patients in EDs and increase both quality of care and patient safety. Data and prior research[39] shows:

- The current SSED (shorter stays in EDs or six-hour target introduced in 2009) target of 95% of all patients departing the EDs within six-hours was achieved by most EDs in NZ in 2015, but since then performance has regressed to levels worse than 2009.

- Delays of more than eight hours to admit patients from EDs to a hospital ward (acute access block) result in worse outcomes and increased mortality for both acute and elective patients.
- Access block is a system-wide acute healthcare access issue that manifests as a "system-flow bottle-neck" in EDs.
- Patients waiting over eight hours in the EDs for a hospital bed, experience adverse clinical outcomes and spend longer time in hospital. Caring for such patients who should be in an inpatient ward accounts for at least one-quarter of the ED staff workload in New Zealand.
- New patients presenting to an ED in New Zealand have a ten per cent (10%) greater chance of dying within seven days of the presentation, when they present to an ED with more than ten per cent of patients waiting for admission.
- Patients waiting at least 12 hours in the EDs for a hospital bed after their care is complete have an even greater chance of dying in hospital.
- The extended time admitted patients wait for hospital admission is not due to processes within the EDs. It is due to inefficient admission processes and inadequate hospital capacity.
- There are also major challenges related to equity of care provided to Māori who represent 16.5% of the population yet accounted for 21% of EDs presentations in 2018 to 2019. Compared to non-indigenous patients, Māori patients are:
    - more likely to attend a less resourced EDs,
    - less likely to be seen on time for urgent presentations,
    - less likely to be admitted and more likely to leave prior to assessment, self-discharge or DNW (did not wait) presentation, and
    - have a 10% greater risk of dying in the EDs or during their admission.
- The poor experience of people who present to EDs in mental health crisis bears mention: Too many patients, following their initial assessment by an emergency medicine specialist, face unacceptably long waits for admission to inpatient beds or definitive psychiatric care, not infrequently greater than 24 hours now, when it is needed.
- It has been conclusively demonstrated that positive changes can occur in NZ when a whole-of-system approach is taken to address ED overcrowding and the extended time people spend in EDs.

In 2021, ACEM introduced its new HAT, and recommends that, to ensure there is accountability for patient flow across different aspects of the hospital, ED lengths of stays (LOS) targets are set for different patient streams, specifically for admitted/transferred patient with separate measures for discharged and short stay units (SSU) patient stream. This was discussed with the Minister of Health, Hon. Little on 26 March 2021, and in principle been approved by the Ministry's DHB PSI Directorate.

Patients cared for in rural hospitals experience a parallel "access block" resulting in delayed specialist and sub-specialist assessment and treatment, largely due to inadequate transfer services between many rural and urban hospitals. In considering access block solutions, our rural hospitals must not be forgotten. Careful attention should be paid to this issue, particularly when considering the funding and allocation of emergency medical services for intra-hospital transfers.

Finally, ACEM states categorically that it is entirely fatuous to suggest that EDs are busy because of all the patients there who should really just see their GP. Not only does this marginalise some populations with poor access to primary care, it also completely obfuscates the issue that a minor of "GP-type" patient in an ED does not require tests, a bed, or admission, and whilst there may be a few of them in the waiting room they are not the cause of ED overcrowding and hospital access block.

Please see Appendix 1 for more information on HAT.

b. Employment contracts and training

There are significant employment concerns regarding the recommendations for the reduction of DHBs. While details of specific initiatives were not in scope for the HDSR; ACEM members and trainees questioned whether some would be transferred to other hospitals within a region, should regions change. It is also unclear whether smaller hospitals would be losing resources, including staff. Further discussions within the sector are required.

The reduction of DHBs may also impact training, depending on how new DHBs decide to centralise their healthcare delivery. This may leave some trainees without exposure to the relevant case-mix. In addition, DHBs may decide to rotate trainees between their sites. While this could have a positive impact on the training coverage; maintaining a work-life balance is necessary and rotation may be detrimental to those who need to move or commute longer. This may also impact on accreditation of education and training sites, and vocational and other medical education and training providers would need to be considered.

c. Pre-hospital and retrieval medicine (PHRM)

FACEMs responsible for PHRM feel that PHRM (including inter-hospital transfers or IHT) was not adequately covered or understood in the Report. The roles, responsibilities and relationships of key stakeholders within this space are complex, often conflicted and misunderstood at the MoH and DHB level with multiple interacting stakeholders and complex funding. This was not specifically identified or addressed in the Report.

For years, ACEM has advocated for a national interdisciplinary governance group that would provide national, cross-agency clinical oversight, leadership and coordination of the services across the PHRM and IHT sector, including all road and air ambulance services. We suggest this would be within Health NZ via a dedicated directorate and/or governance group, or a (new) sub-entity, e.g. PHRM NZ.

At present, the MoH is largely responsible for health matters, including PHRM and inter-hospital transfer (IHT) services. ACC also funds much of the work done in the PHRM space through the National Ambulance Service Office (NASO)[40], which is a joint office between ACC and the MoH. They are mainly responsible for the administration and management of ambulance service contracts. As their focus has traditionally been on contract management, NASO distinguishes between ambulance service funders and service providers. They fund most road ambulance services, and through DHBs streams, they fund many PHRM and IHT ambulance services. However, some DHBs also act as clinical providers in such PHRM and IHT services. Until the existence of both funder and provider roles within DHBs are clearly recognised and managed, there is ongoing risk of significant misrepresentation and/or exclusion as well as inefficiencies in clinical care delivery.

Importantly, emergency medicine specialists working in DHB EDs play a key role in both PHRM and IHT systems. They most commonly act as the points of contact between ambulance services and DHB/hospital-based services. They are uniquely positioned as stakeholders in clinical governance mechanisms to provide feedback to most ambulance services. Emergency medicine must be represented in any attempts to plan and manage ambulance services at a national level.

Whilst we recommend a better regional co-ordination and funding model for PHRM/IHT services as opposed to the fragmented current planning and funding at the level of individual DHBs. A one-size-fits-all model of care across NZ would not be advised.

In part the inefficiencies and inequities of the current fragmented system may be addressed by simply reducing the number of DHBs, but this is likely to still produce a piecemeal system with ongoing inequity of access.

National planning, management and regional funding should include road and air ambulance services.

d. Further recommendation for health system changes

Emergency medicine doctors/expertise are often excluded from executive hospital leadership forums and medical/health forums in general. EDs are one of the numerically greatest points of access to the hospital and are well placed to articulate community health needs to executive hospital leadership forums. Similarly, NZ emergency medicine doctors and their teams have been at the forefront of major catastrophic events

over the last decade, including the Christchurch earthquakes in 2010/2011, Whakaari White Island disaster, the Christchurch Mosque terrorist attack and NZ's COVID-19 health response to date. Yet, they are usually not included in the MoH's expert or working groups, nor consulted on matters affecting them directly.

Hospital management should be easily accessible, transparent and have greater working knowledge of the ground level challenges clinical staff face. For instance, according to Jones (2020)[41] the initial improvements in SSED performances indicated that due to Ministerial leadership and buy-in across the hospital/health system, performances improved. When this ceased, performance declined. Having hospital management teams including senior clinicians will allow better understanding of the issues facing patients and hospital staff in the healthcare system. Alternatively, specialised training of hospital management staff may facilitate greater collegiality and support amongst clinical and non-clinical staff.

Virtual healthcare delivery services such as Healthline[42] could be better integrated into acute primary care services, such as accident and medical clinics, EDs and other acute care hospital services. It would be possible for a service like Healthline to book urgent appointments for patients or to facilitate direct communication with a hospital specialist team out of office hours when they have a complication of recent treatment. This will improve accountability that remains lacking within the health system and could aid patients when disparities and inequities occur, such as seeking access to specialised surgeries, or referrals. Touched on elsewhere in this document, extending the hours of healthcare delivery across the primary and secondary sector is highly likely to reduce demand and dependence on the only 24/7 point of access to healthcare, EDs.

Currently there is a paucity of national, publicly available data sets in NZ, including a national digital electronic health records (EHR), with each hospital currently running a variation of the same platform. This is not merely inefficient but is reducing the quality of care for patients. There is a need for a national IT system allowing integration with primary, secondary and tertiary care, such as clinical notes, referral systems, sharing of results, patient medication lists and pharmacy prescriptions. This will allow greater support to all healthcare providers when patients travel. This also makes it difficult to set national benchmarks and hold DHBs accountable for ED presentation numbers, waiting times and treatment standards, particularly for vulnerable and underserved populations such as in rural areas. For instance, at present ED data coding is extremely poor – only patients who stay longer than three hours in the ED get a formal ICD-10 code. This provides little meaningful information about ED presentations, diagnostics and clinical activity. We note the Ministry's plan to implement SNOMED CT in all DHBs by July 2021. We support the Ministry's initiatives for the development of a national data and information strategy and framework for the health and disability System[43]. This, and other data could also be used in audits to measure quality and equity of patient care. We recommend additional resources and funding be allocated for the initial set up and infrastructure, but also for data capturers. We recommend additional resources and funding be allocated for the initial set up and infrastructure, but also for data capturers.

We commend the notions of patient-centred care and patient empowerment, involving the inclusion of health consumers/patients, whānau and their communities, as well as focus on their wellbeing and autonomy. There is however not enough communication and coordination between healthcare providers, hospital management, and patients to ensure quality, culturally safe and appropriate patient-centred services. Too often patients present to the EDs and are not aware of preventative or other community-based healthcare options available to them – which could have prevented their acute presentation. This highlights the need for wider public health education, particularly around acute/emergency care access. Similarly so, patients access EDs because they perceive they have a need that cannot be met elsewhere at that time. Given the low levels of health literacy and disadvantaged groups that already do not necessary access care when they need it, premature messaging around patient-centred care and patient empowerment can be dangerous if they are not adequately informed. For instance, how is someone to know if the chest pain they are having is a heart attack, as doctors require clinical acumen and often an electrocardiogram (ECG)/a troponin blood test to rule this out? We would prefer to see both better primary and preventative care, as well as EDs being properly resourced to be the back stop for significant illness and injury.

Both patients and doctors should have access to current best practice research, which should be led by the Ministry. Greater transparency is also needed in terms of what data is available, as this is often unclear.

2.1.4 ACEM recommendations

- A strong national, regional and local leadership and management with significant clinical oversight is needed to ensure the national reform of the health and disability system does not cripple the already stressed and vulnerable health system, especially during the global COVID-19 pandemic. Planning, prioritisation, clinical governance and ongoing stakeholder engagement and buy-in will be crucial for successful implementation.
- The proposed changes to national governance roles and responsibilities should not add layers of bureaucracy that may cause it to lose its ability to be responsive.
- The reduced number of DHB must not lose focus on the local context and needs of patients, whānau and communities.
- The structural changes, alongside the reduction in the number of DHBs, must consider the impact on trainee doctors and its other employees.
- There should be clearer commitments to preventing hospital access block in EDs. ACEM's new Hospital Access Targets (HAT) should be implemented by the Ministry or Health NZ.
- There must be increased funding for community-based primary healthcare services (Tier 1 services), including community-based mental health funding.
- The Ministry must develop a funding framework, coupled with appropriate stakeholder engagement when annual funding is made available.
- Expenditure data at both national and DHB level must be publicly available.
- There needs to be improved public health education and further research to support patient-centred care and enable consumer empowerment.
- Hospital management should be easily accessible, transparent and have greater working knowledge of the ground level challenges clinical staff face. This may be supported by specialised (formal and/or informal) training of hospital management staff and facilitate greater collegiality and support amongst clinical and non-clinical staff. Senior clinical staff must be involved in hospital governance at the highest level
- The Ministry of Health NZ must establish a national interdisciplinary governance group and dedicated Ministry resources to provide national, cross-agency clinical oversight, leadership and coordination of the services offered across the PHRM and IHT sector.
- There must be regional funding for PHRM (as opposed to DHB funding) and should include funding for road and air ambulance services.
- The MHA must have commissioning power, as this may be seen as mere tokenism and may result in possible exclusion for Māori trainees, doctors, health consumers/patients, whānau and their communities.
- Community-based primary care funding will need to be drastically increased and should be based on a fair population-based funding model, that could include a number of free services for disadvantaged and vulnerable people.
- The costs (of 'part charging') involved in community-based primary healthcare services needs to be reviewed as this may increase visits to local EDs and further disadvantage Māori and other vulnerable populations.
- Crown Entities, RAs, DHBs, and training providers must do regular/cyclic institutional equity audits to ensure their own planned equity initiatives are progressing.
- There should be a national digital electronic health record (EHR) system used by all hospitals in the country.
- We support the introduction of SNOMED CT as a national dataset for ED attendances and presentations to more accurately monitor what occurs in EDs. We encourage all DHBs to work towards the national implementation goal by July 2021; and the Ministry to increase supporting resources.
- The Ministry fosters ongoing collaboration with the Health Quality & Safety Commission (HQSQ), medical specialties/doctors, and regulators to continue the expansion of the principles of Choosing Wisely and to champion resource stewardship for evidence-based, reasonable, fair and equitable utilisation of our rare and precious healthcare resources.

2.2 Workforce

2.2.1 General comments

a. Workforce plan

We note the Report states that Māori, Pasifika, disabled people, elderly/aging populations, people living in rural communities, those with socioeconomic disadvantage and other vulnerable groups often feel they are invisible to the health system and are often not consulted. Overall, we support the focus and prioritisation of these groups and a representative workforce. All New Zealanders need a health and disability system that encourages diverse healthcare workers who can bring their perspective and skills to enhance services.

We note the recommendation for the development of a national workforce plan – the NZ Health Plan. We advise that its co-design include all vocational medical colleges/providers responsible for the 36 recognised and accredited vocational scopes of practices within NZ[44]. They are the experts and peak professional bodies in matters pertaining to their scopes, and often consider solutions in addressing their workforce needs. However, without Government support, these solutions may only be captured in academic journals without any wider distribution and change. For instance, ACEM commissioned an internal issues paper, *Future of the Emergency Medicine Workforce (October 2020)* (the ACEM Workforce Issues Paper) that provided a series of possible solutions for our college to address workforce challenges, as part of the development of the future emergency medicine workforce in both NZ and Australia. The proposed solutions include three specific focus areas. The first is to look at alternative college accreditation models for sites to offer training. This would also take the focus away from concentrating on predominantly recruiting trainees to staff EDs. The second was to consider more rural training opportunities. The third was to consider better defining and advocating for a middle-grade, non-specialist workforce. Most colleges have done similar workforce analysis and could inform the NZ Health Plan. Another valuable resource could also include the Institute for Healthcare Improvement's Quadruple Aim[45].

We also note the work on the NZ Health Plan has commence with design and development in Q4 of 2020, that refinement is planned for Q4 of 2021, and implementation in Q2 of 2022 and goes beyond 2024[46]. However, the process of implementation and monitoring of the NZ Health Plan is still unclear.

It is also not certain whether such a plan would reduce the adversarial tone of contract negotiations currently characterising the system. For instance, there is a recognised ongoing shortage of qualified emergency medicine doctors across NZ, particularly un regional areas and this has not been adequately addressed to date. While there is a clear shortage (in terms of rostered hours) in the EDs – including rural and remote areas for which most emergency medicine doctors are also trained for – DHBs often prioritise other specialists instead; leaving many key positions vacant.

Similarly, vocational medical training defines a partnership between training sites, vocational trainees, Fellows/members and their medical college. This partnership supports the provision of patient-centred care that is respectful of, and responsive to the preferences, needs and values of patients. For many vocational trainees, this partnership is now under pressure, and further clarification is needed about the relationship between service-provision and training, as this is unclear from the Report. While NZ now retains more of its own graduates than previously[47], government continually demands an increased number of registered specialists per year to meet the Organisation for Economic Co-operation and Development (OECD) average by 2021[48 49]. While NZ's vocational trainee numbers have steadily increased the past decade, access to training positions, and specialist positions have not. Health Workforce NZ also acknowledges:

"There is a potential disconnect between contracted volumes per specialty and the number of DHB employed registrars. The Ministry notes difficulty prioritising training for different specialties due to not being the employer. Health Workforce primarily contracts with DHBs, identifying an agreed number of participants at each level and specialty."[50]

To date, the Government has not adequately determined the actual emergency medicine workforce needs in NZ. It has been left to the discretion of DHBs to determine, and funds are not ringfenced.

We also note the Report assumes there is a growing clinical workforce shortage and that the system will remain unsustainable unless models of care and workforce roles change. It appears there will be a greater push for more doctors with general registration ('generalists'), that will work within vocational fields but under the supervision of vocationally registered doctors (specialists). These doctors may want to do several types of certificates or diplomas as additional specialist skills that could be added to their general registration. Vocational medical colleges may need to consider what type of certificates and diplomas they can develop for this purpose and nurse practitioners may also be interested in this for further specialised professional development. Formal recognition of prior learning pathways could also be considered. Employers are encouraged to standardise their credentialing processes as this varies between DHBs. It should be noted that emergency medicine is in fact one of the truly generalist specialist scopes, defined as "*a field of practice based on knowledge and skills required for the prevention, diagnosis and management of acute and urgent aspects of illness and injury affecting patients of all age groups with a full spectrum of undifferentiated physical and behavioural disorders*".

From an emergency medicine perspective, we acknowledge that workforce supply concerns are complex. ACEM's Workforce Issues Paper identified that the sustainability of the emergency medicine workforce is most adversely affected by burnout due to the heavy workload due to both volume of patients and access block causing overcrowded EDs as well as regular occupational violence experienced in the EDs. Poor workplace culture, and system-level and employment status issues were other key factors. More FACEMs are reducing hours of clinical practice in favour of part-time work or moving out of direct clinical work in the ED and into other clinical areas (such as rural and urgent care, including retrieval and ambulatory care), or areas not involved in direct clinical care. This is partly driven by FACEMs' experiences of ED overcrowding and access block, which FACEMs have ranked as two of the top three workplace stressors and cause of moral injury to FACEMs. Sixty-one per cent of FACEMs and 70% of trainees who responded to ACEM's 2019 Sustainable Workforce Survey reported that they are likely to reduce their hours of clinical practice in the next ten years. Twenty-seven per cent of FACEMs and 15% of trainees reported they are likely to leave clinical practice within the next ten years. Following the process of consulting members on the ACEM Workforce Issues Paper, wider consultation and stakeholder engagement with the sector will be undertaken[51]. We wish to discuss our findings and possible recommendations with the Transition Unit (and the Ministerial Advisory Committee). We also recommend Government prioritise emergency medicine doctors as a key part of its emergency and acute healthcare response in NZ and a speciality with a broad, generalist scope.

Finally, we want to ensure there is a level of freedom for trainees to be involved in choosing what and where to train and work. For instance, we would urge government to refrain from saying there are too many emergency medicine doctors and redirecting trainees or specialists to another specialisation.

b. Staffing levels should be per capita as opposed to a general number

We note Government's plan to address the rural geographic maldistribution of the workforce. This has been highlighted in the Report, particularly focussing on increasing accountability for the system to be a good employer. Interestingly, findings from the *Health Workforce Funding Review – Current State Report (November 2020)*[52] explains investments in the health workforce and broader health sector can promote economic growth and complement it, and that the health sector workforce should not be regarded through the lens of cost and consumption alone. Professor Judy McGregor, Chair of the Health Workforce Advisory Board (HWAB)[53] also explains that new research into the value of the New Zealand health workforce shows that in five regions, the health care and social assistance sector is the largest employer in NZ, and in seven other regions it is second or third largest. This includes 213,100 people employed in hospitals, medical and other health care services and residential care services. With the health and disability workforce spending at an estimated $13.2 billion per annum; health institutions are regarded as 'anchor institutions' that, in tough economic times, connect both economically and socially to the communities they serve and service. Employment in the health sector can act as an economic stabiliser as it is less sensitive to cyclical fluctuations. The potential for the health sector to create long-term jobs in deprived areas is very relevant in our new normal of living with COVID-19.

In recognising this, we wish to reiterate the need for greater emphasis on having minimum staffing levels to ensure that safety is maintained, and that safe working conditions are provided to staff from both a physical and psychological health and wellbeing perspective. Not only in terms of numbers, but also seniority, as described in ACEM's *Guidelines on constructing and retaining a senior emergency medicine workforce policy*[54]. This will be essential for rural and remote communities, as well as in the current climate of ED receiving high numbers of complex acute presentations. There should be a recommended minimum level of

safe staffing for a population, considering the types of case complexities and presentation numbers. We also recommend a minimum standard of ED beds per 100,000 population. This should also include hospital and intensive care units (ICU) beds per 100,000 population to help address the chronic shortages and bed blocks currently being experienced across NZ.

c. The future demand for a 'flexible workforce'

The Report frequently refers to the notion of a 'flexible workforce', but the Report, and advice from its author or the Ministry[55] remain silent on what this means. Further discussion and clarity to the sector is needed. Emergency medicine has rapidly evolved over the past 20 years, with EDs now being one of the first access points for all hospital services, including imaging, specialist consultations, and provision of procedures that formerly required hospitalisation or theatre time which are now deliverable in EDs without the need for long and resource-intensive admission to hospital. Consequently, there is increasing pressure to provide these specialised services in a timely and safe manner, especially as life expectancy, chronic co-morbidities and population increase. Emergency medicine has in fact become both more specialised as well as 'generalised' (in terms of registration) across all age groups and the full spectrum of medical, surgical, traumatic and psychological conditions.

The Ministry and Health NZ may also consider reducing the number of vocational scopes; or that the parameters of vocational scopes (specialities) be changed – not to change how care is delivered but to be more inclusive of different types of care – for instance to include metropolitan, urban and rural care. This would also reduce the ambiguity and inequity around what is considered "in scope" of practice and what is not as its interpretation often differs from vocational scope to vocational scope. This results in some doctors requiring collegial relationships[56] in certain work environments, while others do not. Emergency Medicine is taught to be provided in all settings from major metropolitan to rural and including pro-hospital settings.

2.2.2 Māori health equity

Overall, there should be greater partnership and 'allyship'/alliance with Māori to provide more accessible care for Māori. We agree with the recommendations to develop a "Māori Workforce Plan". The Ministry's *Whakamaua: Māori Health Action Plan 2020-2025*[57] should also be considered, as it sets out Government's direction for Māori health advancement over the next five years. Access to quality workforce data (in terms of accurate ethnicity data) is often difficult for many DHBs and may (to some extent) be supported by the implementation of SNOMED CT by July 2021.

The development of Kaupapa Māori Provider workforce and Kaupapa Māori Whānau Ora/Public Health and Kaupapa Advanced Nursing needs to be prioritised to reduce workforce shortages in EDs nationwide. EDs in particular, will also greatly benefit from an increase of Hauora Māori/Navigators and Whanau Ora workers. In principle, they are reasonable goals, but the outcomes largely depend on allocated funding. Currently very few DHB's fund Māori health teams to work in EDs. Given our pivotal position in the health sector, this should change with Māori health embedded within the ED services.

Some ACEM members and trainees are concerned about isolating Māori healthcare staff, should they be completely separated into Māori and non-Māori healthcare streams. As we already lack adequate resource distribution, the added pressures of duplicating these beyond primary care may not bring about equitable health outcomes. Some feel that moving Māori workforce development with the MHA, with its limited powers (as currently outlined in the Report) to an advisory role only, will merely maintain the status quo. This will be particularly evident in EDs with respect to low numbers of Māori vocationally registered doctors, trainees and/or staff. There is potential for worse outcomes with inadequate funding of our Māori health system, coupled with Māori healthcare workers carrying extreme personal and professional cultural loads.

2.2.3 Other concerns or gaps not addressed in the Report

Although classified as secondary care (Tier 2 services), in reality emergency medicine sits between primary (Tier 1) and secondary care (Tier 2 services) and is therefore impacted by barriers and levers affecting both. Emergency medicine doctors are the commonest link between community based and hospital doctors. With the increased focus on widening primary care in the community, we encourage doctors in prevocational and vocational training to undertake more specialised or longer accredited rotations within EDs. This would help both the breadth of experience as well as to strengthen relations with these doctors and enable trainees in inpatient medicine wards and primary care services to gain a unique ED perspective.

There is also significant concern around the nursing workforce. Nursing graduates often find it difficult to find jobs in NZ hospitals as new graduates. There is also a need for more Māori nurses in our EDs – ideally proportionate to the local population. Areas which train nurses locally seem to have good success at retention to work locally, e.g. Gisborne Hospital has 40% Māori nurses, with the local population being 50% Māori. We understand that we cannot address access block in EDs, without also addressing the nursing crisis too[58].

2.2.4 ACEM recommendations

- Government must co-design and develop a national health workforce plan with all key stakeholders to grow a workforce that will better represent communities. This should include all vocational medical colleges representing the 36 vocational scopes of practice in NZ.
- The NZ Health Plan should identify general and specialist healthcare workforce needs. Funding to fill those positions must be increased accordingly and ringfenced to ensure it meets national, regional and local community needs.
- There should be standardised recommended minimum levels of staffing and number of beds in line with population at the DHB/regional level.
- The relationship between service and training, and the roles of Health NZ and DHBs in these relationships need to be more clearly defined.
- Vocational medical colleges are encouraged to consider different models of care within their scopes, to possibly include medical (both generalists and specialists) and non-medical staff in their clinical teams.
- Mentioned initiatives and priorities with regards to facilities, and data and technology should be implemented as planned.

2.3 Education and training within an emergency medicine context

2.3.1 General comments

While we support the Report recommendations, they may not be practical within a medical vocational education and training environment. We note the Report recommends that training be coordinated by Health NZ, with lead DHBs and partnerships with various training organisations. While operational details are absent, it is recommended that vocational medical colleges continue to be a key player in their recognised and accredited training and recertification (via CPD) programmes. Traditionally, medical colleges have had a conservative and established approach, and will remain protective of their own training programmes and requirements. Most medical colleges are also binational colleges that have geographical footprint in both countries. Issues with mandating regulatory changes to their programmes may be more complex, as they offer the same programme across both countries.

The regulatory role of the MCNZ in medical education and training is not conclusive in the Report. At present, the MCNZ prescribes the curriculum framework and outcomes for prevocational medical training and oversee the administration and management thereof[59]. This could be seen as a conflict of interest, for the same reason Government changed the mandate and structure for Industry Training Organisations (ITOs) as part of the NZ Reform of Vocational Education (RoVE)[60]. Whilst some are in transition, they will become Workforce Development Councils (WDCs)[61]. The MCNZ also initiated the InPractice CPD programme for doctors with general registration (managed by bpac)[62]. Whilst it was good to introduce this, as there was no oversight of any CPD requirements for doctors with general registration or non-specialist 'career medical officers', this is no longer advised. This CPD programme is not fit for purpose and needs much more clinical rigour, governance and monitoring around it. It is also unclear why some medical officers work within a collegial working relationship and others do not. We would like to see a much better CPD programme developed for medical officers with general registration, and regulations around who should work under collegial relationships be clear and uniformly applied. We also recommend that prevocational medical training (and its ePort), as well as the CPD programme for general registered doctors be managed by Health NZ and supported by the Medical Schools of the Universities of Otago or Auckland instead. We recommend that there be further guidance provided to the sector, and that the relevant stakeholders be involved.

The recommendation that the "primary objective of education and training is to provide the right number and mix of appropriately skilled and competent health and disability workers is also noted. Under the Health Practitioners Competence Assurance Act 2003 (HPCA Act) regulators ensure health practitioners are competent and safe to practice. They also have inherent flexibility to adjust scopes of practice and change standards and competencies with changing needs. This creates opportunities to work collaboratively and look beyond traditional professional boundaries to focus on the competencies the community needs and enable flexibility as to who is best placed to meet them" (pages 186 and 187). Overall, it appears the Report suggests education and training to:

- be recognised, such as, its programmes being accredited and recognised on a national qualification framework;
- be done within a shorter time frame;
- improve articulation pathways that would allow trainees to transfer more easily from one programme to the next; and
- be a flexible medical education and training programme/scheme (noting it should also consider the impact of RoVE[63]).

Our response to each is explained below.

a. Formal recognition of programmes

Overall, the Report recommendations focussed on aligning health sector qualifications and practices with international standards are highly regarded and more progressive. We note, however, that some vocational medical scopes of practice do have longer training periods than others, and that there may not be parity in terms of training requirements for what should be essentially the same type of qualification. Without diluting it, we would support a standardised framework for vocational medical qualifications. For instance, they could all be mapped on the same standards as the New Zealand Qualifications Framework (NZQF)[64] Level 9 (Master's degree) and the relevant level descriptors be used to determine the level in depth of knowledge, skills and application (see page 30 of the NZQF document). Similarly, both the Australian Qualifications Framework and NZQF have been referenced to one another and to the European Qualifications Framework that could potentially improve and support trainee and workforce mobility. This will support formal recognition of programmes, and improved articulation pathways (as discussed below).

The implementation of a qualification framework of vocational medical education and training programmes could also facilitate greater consistency across scopes. However, with most medical colleges being bi-national, it is not certain how programmes will be accredited and recognised in both countries and by their relevant authorities. Such a requirement may result in medical education and training becoming a bureaucratic and highly politicised quality assurance process, instead of the specialised pedagogical and andragogical discourse instead. Logistically, it may also be challenging as medical colleges already struggle to recruit staff that are specialists in one country's medical education, training and registration requirements. Knowledge of both may be unattainable.

We do however support the notion of standardising the process for minimum academic requirements for entry into specific vocational medical education and training providers/vocational medical colleges. An example could be to have a process for holding providers/vocational medical colleges to account for artificially raising entry standards, but without mandating the college entry requirements. For instance, there exist notions of 'elitism' and 'exclusion' in certain vocational scopes. Some examples include the requirement of candidate trainee doctors to almost (or actually) have Doctor of Philosophy (PhD)-level specialised research for consideration for entry into their programme, without reasonable justification. Such artificial raising of standards may keep out key future workforce representatives such as Māori, Pasifika, disabled people and those from other vulnerable groups.

b. Shorter time frame

Shorter training may lead to substandard specialists. We do not believe in the American model of 'hot-housed specialist medical education training' immediately after medical school. It lacks the general training and experience that House Officer jobs offer across the health spectrum (including general practice) amongst other disadvantages including further siloing of healthcare and narrowing of specialty scope

that makes the US system such an undesirable (if first world) model of healthcare delivery. We want to avoid very truncated training programmes that produce inexperienced and narrow-spectrum (of practice) specialists. Consequently, there has been an overwhelming response by our members noting the risk of diluting the quality of training in emergency medicine, and other vocational scopes (specialties). Shortening the vocational medical training programmes would require a change in values from the students/trainee doctors 'providing quality and safe services' to 'learning skills' that may not offer New Zealanders the quality healthcare they deserve and may even endanger patients or weaken clinical ED teams. Similarly so for the training of nurse practitioners. There is a fear that patient care will deteriorate with the implementation of the two-year nurse practitioner training programme as opposed to three years.

Different vocational medical training programmes have different lengths and requirements, but this is for a valid reason. The main reason hinges on the fact that colleges must ensure its vocationally registered doctors have sufficient competence in all relevant domains. That is, they can meet all competency-based outcomes in terms of medical expertise, prioritisation and decision making, communication, teamwork and collaboration, leadership and management, health advocacy, scholarship and teaching and professionalism. Another reason is due to the complexities of each vocational scope. It requires a diverse range of training experiences before they are deemed safe to work in any setting as prescribed by the recognised vocational scope, the RAs[65] and relevant legislation, and the public[66]. The price to pay is efficiency. This is markedly different from emergency medicine training for instance in the United States of America (USA), which can be completed in three to four years, instead of the five (full-time) to ten years (total part-time allowance) in NZ and Australia that we believe produces well-rounded, broadly experiences emergency specialists.

Shortening ED training may also lead to an increase in the number of senior medical officers (SMOs) and decrease their experience before reaching that level. If changes are made to the system of SMO delivered care rather than SMO-led care, this needs to be explicitly planned and consulted on, not just implemented. There is also a risk of curtailing exposure to rural hospitals to cut down training time, which will lead to reduced applications for rural ED posts. Each training programme is highly specialised and streamlined already. If decreasing training time, the quality of doctors coming out may be reduced due to lack of time and both breadth and depth of experience. There is concern that governmental policies do not understand medical education and vocational medical training in NZ.

Some of our members also see the benefit of the reform within rural EDs and believe competency-based training could be effective if assisted by various specialists who are willing to share their niche skillsets. While this does not necessarily have directly transferable skills, it creates better relationships with other specialists in training. However, simultaneous shortening of training with a competency-based approach may also lead to a wave of portfolio requirements which risks becoming a tick box exercise for trainees rather than training for the development of true expertise and skill.

c. Improved articulation pathways

We note the Report recommendation to improve specific articulation pathways, allowing trainees to transfer more easily from one programme to the next. Many colleges do have existing memoranda of understanding identifying specific articulation pathways. However, to change training programmes to a different vocational scope is not always difficult; but the recognition of prior training when changing vocational scopes is often problematic and may require trainee doctors to redo all their years of training. While we do see benefit in something that requires some form of articulation pathway into other vocational scopes of practice, its practicality and ability to get uniform buy-in from the various medical colleges, may be challenging.

There was however, a high level of support from our members to the notion of cross credentialing between colleges, including apprenticeship training modules. It would be advised that some vocational medical colleges have memoranda of understandings with each other, based on extensive curriculum mapping and benchmarking to identify common or similar areas covered in their training programmes that could be cross credited and transferred. This may also identify specific articulation pathways. One suggestion was that there should be strict guidelines to be able to receive formal recognition of prior learning/cross credentialing. For instance, training time to achieve vocational/specialist credentialing could be reduced to a small number, for instance, ten per cent allowance in terms of numbers. Ideally this should also only be allowed at specific accredited hospital training sites with prescribed training rotations, limited electives, and very close supervision.

Those who were opposed, highlighted that a cross crediting system between training programmes may be unrealistic, as there exists a distinguishing split that separates vocational scopes and its doctors from one another.

d. Flexible medical education and training programme/scheme

The Report failed to acknowledge that each vocational scope is at least to a degree unique in its academic focus, clinical skillset and reasoning. Within the current knowledge economy, we find ourselves in, specialisation (and sub-specialisation) supported by niche-type qualifications and careers are becoming the norm, and we agree that this is not necessarily desirable. The narrower the scope of a sub-specialist the more likely that patients with broad and various medical conditions will need to see a myriad of different doctors for their health needs. Naturally, this goes against the recommendations of the Report – wanting more 'generalists' that could be utilised in the health system. Additionally, the 'on the job' internship-model used in vocational medical education and training makes it very difficult to accommodate a 'general' one-size-fits-all approach. Each supervisor, rotation/run, case mix, environment, and the like, bring its own set of skills, experience and expertise which cannot be quantified. Similarly, each country has its own government structures which may not always translate well. Hence, the possibility of training a 'flexible' and 'general', yet specialised workforce may be too unrealistic.

We also considered the impact of RoVE but it seems this may only apply to allied or lower-level vocational healthcare worker type of qualifications, such as for midwifery. Further clarification is needed. Similarly, the relationship between Health Workforce NZ and the Tertiary Education Commission (TEC) in the HDSR and RoVE needs more clarity.

2.3.2 Māori health equity

We support the Report's recommendations to ensure there are more Māori trainee doctors across the healthcare sector. ACEM also has its own Māori health strategy, *Te Rautaki Manaaki Mana: Excellence in Emergency Care for Māori (May 2019 - April 2022)*[67] in support of this. However, all vocational medical colleges and universities must also collaborate regarding increased pathways for Māori into medicine.

While there are many positive recommended strategic directions listed throughout the Report, greater thought is required regarding the necessary changes to learning models, particularly around the use of online modules and training, and how this may affect Māori. We would encourage the Transition Unit and the Ministerial Advisory Committee to do further research on this – i.e. particularly how to be responsive to Māori doctors and trainee needs[68], and whether they will benefit from such a change.

There must also be an increase in resources to support and enhance cultural safety and to develop a culturally competent health workforce. Most vocational medical colleges and their Māori advisory partners are required to resource its Māori health equity initiatives themselves. We note that there is already a system in place for trainees to share courses and resources between providers and vocational medical colleges and trainees do receive recognition for time spent on those courses or events. However, with the majority being bi-national colleges, their ability to roll-out and provide adequate and contextual cultural safety and competence training and support, is limited. It could be strengthened with national oversight and support, possibly within the MHA, or maybe even a national rollout of similar cultural competencies. International medical graduates (IMGs) require education in this area, but they are not alone in this[69].

There also needs to be clearer guidance on cultural safety and competency requirements within medical schools and vocational medical colleges. While there is an increased focus on cultural safety and competency (as required by accreditation processes) within medical education and training programmes, the scope and context of what this entails differ. Greater clarity may be required.

2.3.3 Other concerns or gaps not addressed in the Report

a. Rural experience in the vocational training programme

While we recognise the need to get more healthcare professionals in rural and (sub)urban or non-tertiary areas, the solution is not that easy, and the Report fails to identify this. For instance, trainees who have managed to secure a position (particularly in the larger Metropolitan DHBs), are often reluctant to apply for other temporary training positions in rural areas outside of their DHB as they would forfeit their permanent training position and any entitlements in their current DHB. We would encourage solutions that allow trainees to gain essential experience in rural areas outside their DHB, even if only for shorter periods, such

as a six-month rotation at a time, without it negatively impacting on their permanent training position (e.g. for a six-month rotation in Lakes DHB).

b. Complexities within competency-based assessments (CBAs) often used in medical education and training and the validation thereof

In some instances, CBAs as opposed to clinical best practice has been questioned. It is essential that doctors maintain the ability to set and achieve high clinical standards, but also need to be carefully assessed on 'book knowledge'. Sometimes there are differences in the requirements for CBAs as opposed to clinical best practice. Medical training providers are encouraged to consider updating their CBAs regularly to reflect current clinical best practices.

Some members and stakeholders perceive the MCNZ staff to have limited understanding of international vocational medical training and the recognition (and registration) thereof. This creates barriers for vocational doctors, particularly in rural settings. We suggest vocational medical colleges continue to closely engage with the Medical Council of New Zealand (MCNZ) to ensure specialist international medical graduates (SIMGs) are able to get due diligence when they apply for vocational registration.

c. Greater support in coaching and mentoring

The Report does not address the increased need for greater support in coaching and mentoring in the sector. This is particularly due to the growing popularity in utilising models of care that include non-medical staff, as well as the increased push towards 'generalist', and in specialist nursing practitioners and physician assistants. Such mid-level practitioners would need training and supervision provided by specialists.

d. Increased online training

Online training is a great tool but has limited scope. For instance, one cannot learn to intubate a patient with an online learning module. Due to the practical nature of vocational medical education and training, there was not much support for the recommendations to increase online training. While it may be useful particularly for recertification (CPD) programmes, it is not really fit-for-purpose for the initial vocational medical education and training, although some short academic or simulation activities could be useful. If used, it needs to be used carefully, to make sure trainees do not feel abandoned with limited or no in-person guidance and support. Also, the necessary IT infrastructure is essential to its success.

Due to the COVID-19 pandemic, there has been a significant impact on national rotations, redeployment, rostering, and recruitment of specialist doctors and trainees. This Report has not had an opportunity to examine the major strides medical colleges have already made to ensure education and training continues to be offered at a high level. Education and training sessions were shared amongst DHBs, and sometimes even across Colleges. With the use of technology, examinations, and the moderation thereof, have been offered in New Zealand, (which has traditionally been done in Australia).

2.3.4 ACEM recommendations

- Health NZ must continue to acknowledge vocational medical colleges continue as key players and providers in their recognised and accredited training and recertification (via CPD) programmes.
- The mentioned recommendations may not be feasible, or practicality suit the vocational medical education and training environment and Government may struggle to get uniform buy-in from the various vocational medical colleges, particular binational colleges.
- There needs to be further guidance on the impact of the RoVE in a vocational medical education and training environment.
- The future regulatory role of the MCNZ in medical education and training needs to be clarified, particularly for prevocational medical training. This is also the case for the CPD requirements for provisionally and generally registered doctors, and entities for those programmes. Further stakeholder engagement is needed.
- The need for greater support in terms of coaching and mentoring in the sector should be considered when a national workforce plan is designed.
- Workforce and funding barriers need to be addressed to increase opportunities for vocational medical trainees to gain safe and supported rural clinical experiences.

- Vocational medical colleges should continue to regularly update their CBAs to reflect current clinical best practices.
- Processes for the registration of specialist international medical graduates (SIMGs) should be refined. There should also be a closer relationship between vocational medical colleges and the MCNZ.
- There must be increased resources made available to support and enhance culturally safety and to develop a culturally competent health workforce.
- There needs to be clearer guidance on cultural safety and competency requirements within medical school and vocational medical colleges.
- Whilst some subspecialisation is useful, the narrowing of scopes of practice such as is seen in the USA is not conducive to a broad scope of medical practitioners.

Appendix 1: New Hospital Access Targets (HAT)

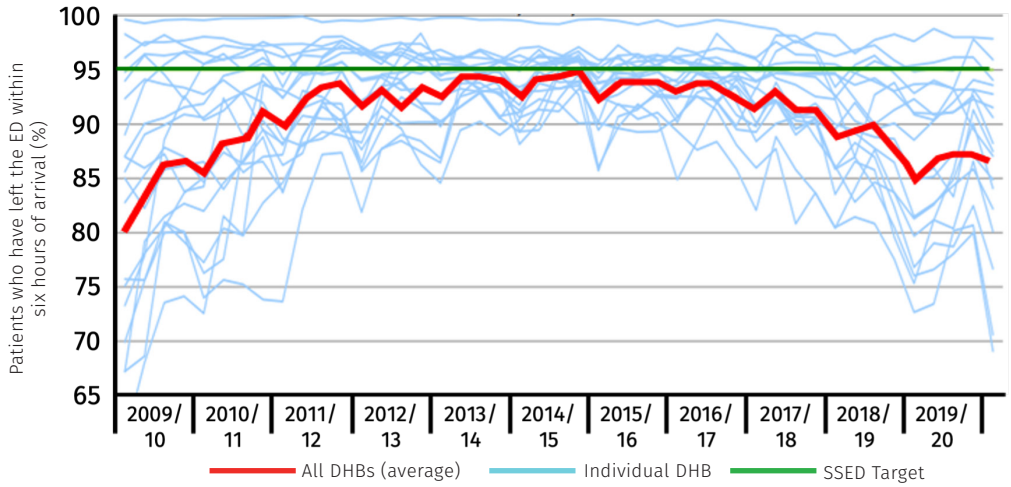
Shorter Stays Emergency Department Targets 2009 – present

Acute care access failures such as access block, Emergency Department (ED) overcrowding, and ambulance ramping result in poorer health outcomes and an increased risk of mortality for patients presenting in the ED. Access block (whereby patients become stuck in the ED for over eight hours because of a lack of inpatient beds or services to be transferred to for the next stage in their care) and ambulance ramping (the inability to off-load a patient due to no physical space in the ED) also prevents others from receiving timely care, increasing unnecessary costs of care and workforce stress. New research has shown that when more than ten percent of ED patients waiting for admission are access blocked, new patients presenting to the ED will have a ten percent relative risk increase in mortality[70].

Improvements following the introduction of the SSED target

The introduction of the Shorter Stays Emergency Department (SSED) target in 2009 was a response to the growing number of acute care access failures occurring in the hospital. The goal of the SSED target was to have 95% of all patients presenting to a public hospital ED to be admitted, referred for treatment, or discharged within six hours of arrival. As shown in Figure 1, this was initially successful, improving patient outcomes through better patient flow, and reductions in ED lengths of stay (LOS), ED overcrowding, and patients who chose not to wait. Most significantly, it is estimated that time-based targets led to around 600 fewer deaths than predicted in 2012, and clinically important reductions in ED crowding, ED mortality, elective mortality, and the proportion of patients not waiting to be seen or to complete ED assessment[71].

Figure 1. SSED target by District Health Board (DHB) between 2009-10 and Quarter One of 2020-21.



Subsequent decline since 2015

By 2015, the percentage of all patients spending less than six hours in the ED from the time of arrival to their admission, discharge, or transfer had peaked. Indeed, as clearly shown in Figure 1, since 2015-16 performance has progressively declined. Furthermore, it can be seen that the performance data for all presentations is primarily driven by the percentage of discharged patients who depart the ED within six hours, which is markedly higher than patients requiring hospital admission/transfer (Figure 2). Figure 3 shows the increasing trend in the time it takes to get patients flowing through the system. In 2018-19, it took nearly ten hours for 90% of ED patients to be admitted/transferred out of the ED, an increase of over two hours compared to 2015-16. All other patient streams also saw increases in ED LOS; however, again it is the admitted/transferred patient group who experience the longest ED LOS. This further highlights the deterioration in the hospital's ability to cope with increased patient complexity and demand.

Figure 2. Percentage of presentations with ED length of stay within 6 hours of arrival for all presentations, admitted/transferred patients, and discharge patients between 2011-12 and 2018-19.

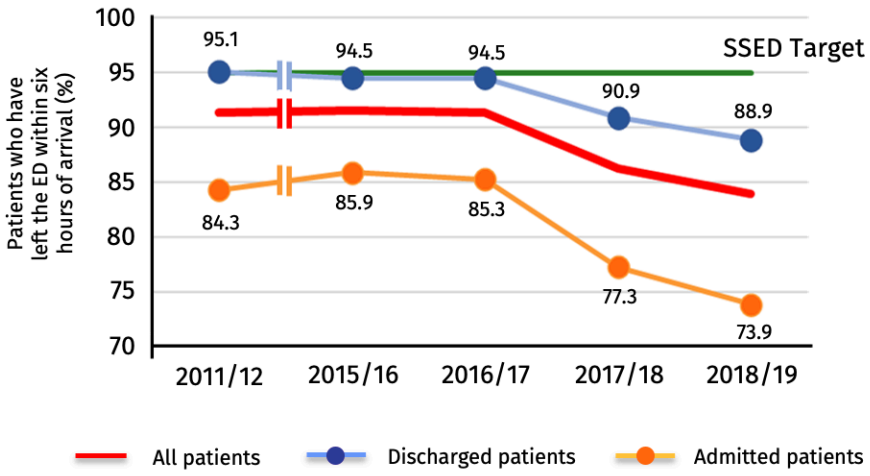
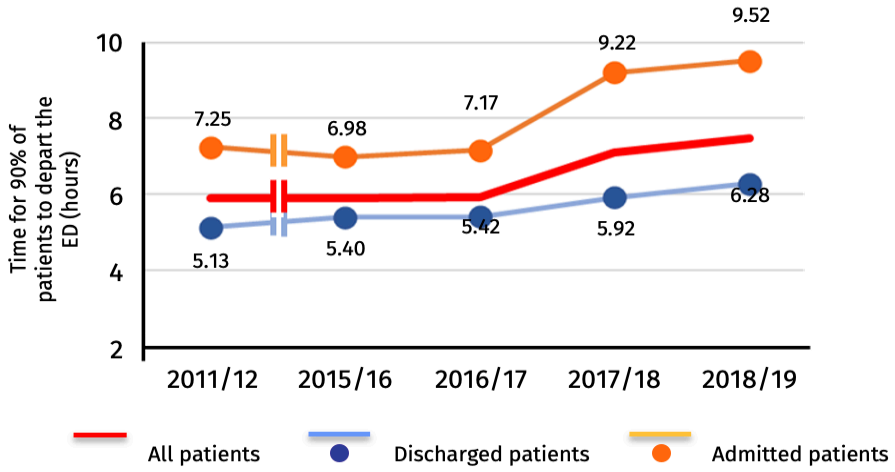


Figure 3. 90th percentile of ED length of stay (hours) between 2011-12 and 2018-19 for all presentations, admitted/transferred patients, and discharged patients.



The decline in performance began when a change in leadership occurred and the then Health Minister, Tony Ryall retired in 2014. The health portfolio was transferred to Health Minister Jonathan Coleman, who de-emphasised the ED locus within the Ministry, leading to reduced ministerial interest and support, and a change in focus away from the SSED targets, mitigating the progress made to provide timely care.

Collectively, these findings highlight the decreasing trend in target performances from 2015-16 to 2018-19, suggesting that the SSED target to have 95% of all ED patients to be admitted, referred for treatment, or discharged within six hours is not realistic, especially for the admitted/transferred patient stream. Notably, the needs of the patient can also be seen to impact how long patients spend in the ED, with discharging of less complex patients taking less time than admitting patients.

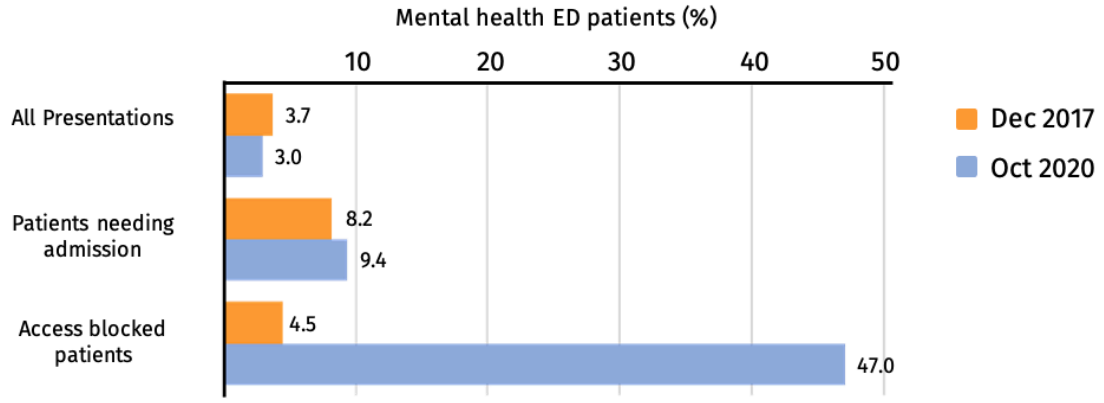
Clearly, introduction of the SSED worked, as performance of all District Health Boards (DHBs) improved, with markedly less variation across DHBs by 2014-15. However, not only has the performance of all DHBs declined since this time, the DHB variation is again more widespread to the point where performance has almost regressed back to 2011-12 levels.

Prevalence of Mental Health Access Block and Alcohol and Other Drugs

There has been a significant increase in the prevalence of patients presenting in an acute mental health crisis between 2017 and 2018. EDs are often the first contact for patients in psychological distress especially in after-hours care where there is often nowhere else to go. Mental health patients presenting in the ED are often waiting longer than other patients and their distress is further compounded by the crowded, noisy, and brightly lit environment. Figure 4 shows that the proportion of patients experiencing mental health access block has progressively increased from 4.5% in 2017 to 47% in 2020. Mental health access block can be attributed to the lack of mental health resources for acute care, limited inpatient psychiatric beds and community-based acute services, and resources for quality mental health assessment.

The ED also responds to patients arriving with alcohol and other drug related presentations. This can have a significant impact on other patients, workforce, and ED function. This includes verbal and physical assaults on both staff and patients. In our annual survey, 16% of patients in our EDs were receiving treatment for alcohol associated issues. Additionally, the proportion and number of methamphetamine-related presentations had doubled from 0.7% in 2018 to 1.9% in 2019[72]. Mental health presentations and alcohol and other drugs is exacerbating waiting times and overcrowding within the hospital system, further endangering the quality and timely healthcare provision to patients and staff wellbeing.

Figure 4. Proportion of mental health ED patients (total, admitted, and those who experienced access block) during a 7-day period in December 2017 and October 2020.



Proposed hospital access targets

It is clear that introduction of the SSED target has elicited beneficial effects, most notably a reduction in patient mortality had the SSED not been introduced. Nevertheless, as can be seen from the data within this report, performance against the SSED has been progressively declining since 2015-16. In addition, ED patients requiring hospital admission are spending significantly longer in the ED due to inadequacies in other parts of the hospital system.

It is ACEM's position that time-based targets like the SSED should be used. However, this should be contingent upon ensuring that systems and processes that are used are beneficial to patient care and the overall patient journey. In this regard, time-based targets should be a set of tiered targets or measures as opposed to an isolated target such as SSED, and should be separated into different patient streams for discharged patients, for admitted patients, and for those who need time in a Short Stay Unit (SSU) of an ED. Any time-based target must account for these differences and we suggest the following tiered targets for different patient streams.

1. *For patients requiring hospital admission (to a ward) or transfer to a larger hospital from the ED:*

- ≥80% should have an EDLOS no greater than six (6) hours

We also recommend an expanded set of measures for this patient group, which we believe will improve patient flow. Specifically:

- ≥60% should have an EDLOS no greater than four (4) hours;
- ≥90% should have an EDLOS no greater than eight (8) hours; and
- 100% should have an EDLOS no greater than twelve (12) hours

2. *The proposed target for discharged patients, the recommended target remains as per the original SSED:*

- ≥95% should have an EDLOS no greater than six (6) hours

We also recommend an expanded set of measures for this patient group, which we believe will improve patient flow. Specifically:

- ≥80% should have an EDLOS no greater than four (4) hours; and
- 100% should have an EDLOS no greater than twelve (12) hours

3. *For short stay unit (SSU) patients, the tiered targets are:*

- ≥60% should have an EDLOS no greater than four (4) hours upon SSU admission;
- ≥90% should have an EDLOS no greater than eight (8) hours upon SSU admission; and
- 100% should have an EDLOS no greater than twelve (12) hours upon SSU admission

3. Notes

1. https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Cultural-competency/Achieving-Equity-for-Maori-in-Aotearoa-New-Zealand
2. https://acem.org.au/Content-Sources/Members/Members-get-involved-in-the-College/Faculties/New-Zealand
3. ACEM defines access block as "the situation where patients who have been admitted and need a hospital bed are delayed from leaving the Emergency Department because of lack of inpatient bed capacity." https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Access-Block
4. As coined by Stephen McKernan, Chair of the Transition Unit at Council of Medical Colleges (CMC) Board meeting held 18 March 2021.
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6. https://www.newshub.co.nz/home/politics/2020/06/health-and-disability-system-review-aims-to-end-racism-in-new-zealand-s-health-sector.html
7. McKernan, S. 2021. Health and Disability Reform (Presentation). Council of Medical Colleges Board meeting held 18 March 2021.
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