

The Aotearoa New Zealand health system – failing or fabulous?

Introduction

This paper is one of three to inform discussion and debate at the 2023 NZNO Conference where the theme is *Challenging the System*.

The health system is a complex entity with multiple challenges that include the structure, infrastructure, funding, health workforce, patients and whānau. This paper is focused on why the health system is failing our people and whānau, what that failure looks like.

Is our health system failing our people, whānau, and the health workforce?

Nurses providing care in Aotearoa New Zealand work within an environment that persistently lets them down; the basic issue being a lack of long-range planning or solid investment in health care, affecting the entire public health-care system and all who rely on it.

For many years demand on the health care system has been increasing. The population is getting larger, living longer, and has greater complexity of illness. Demand for acute care is increasing out of proportion to population growth. Many medical treatments are becoming better, but they are also becoming more expensive.

Nursing is our biggest single health workforce, with nearly 70,000 nurses¹ holding an Annual Practising Certificates (APCs) in Aotearoa New Zealand. This is a huge increase from just over 50,000 nurses in 2015; yet we still need more to meet our patient and whānau expectations for excellent care.

At any given time, there are around 7400-degree level nursing students in training, alongside a smaller cohort of enrolled nursing students. Attrition in domestic training can be quite high. Around three in 10 nursing students do not complete their training; this is higher for Māori and Pacific students.

Aotearoa New Zealand has a very high proportion of internationally qualified nurses (IQNs) in our workforce compared to other OECD nations.² Given that Te Whatu Ora predicts this to increase to 40 percent, it will drive both underrepresentation of Māori (7.3 percent) and

¹ Te Whatu Ora – Health New Zealand. 2023. *Health Workforce Plan 2023-24*. Wellington: Te Whatu Ora – Health New Zealand. p4-5

² Figure 8.24, OECD (2021), "International migration of doctors and nurses", in *Health at a Glance 2021: OECD Indicators*, OECD Publishing, Paris. <https://doi.org/10.1787/d969fe68-en>

Pacific peoples (3.6 percent) in the nursing workforce³ and will make it harder to recruit in the context of global shortages. Over the past five years we have seen an average increase of 3900 new nurses receiving APCs each year. The growth in our current workforce is being driven by international recruitment, which peaked at more than 6000 IQNs in the year to 30 March 2023.

Since 2020, the *rules of engagement* for our health system and the expected and relatively predictable level of ill-health in the community have changed.⁴ COVID-19 has increased demand for health care through multiple pathways. Firstly, through managing those acutely unwell with COVID-19 infection. Secondly, by creating a large burden of *catch-up* care needed for those people whose care was delayed due to beds being reserved for those with COVID-19. Thirdly, because of long COVID, which, for some people, requires ongoing multidisciplinary specialist care. Fourthly, because of a deterioration in mental health associated with the pandemic and the public health measures to manage it.⁵ So, even if COVID-19 disappeared tomorrow, the legacy of health impacts through other pathways will remain.

COVID-19 uncertainty and future waves of COVID-19 may affect demand for services and constrain services' ability to meet it. There is also a risk that other outbreaks, for example, measles or influenza, coincide with COVID-19 waves.

Failure to tackle underlying drivers of health inequities over the past decade, population health approaches to health policy and social determinants of equity have, in general, been weak and ineffective. Aotearoa New Zealand's legislative and health system responses to modern drivers of health outcomes – food and alcohol industries, poor quality housing, and institutional racism – have been in many instances wholly inadequate, with resulting persistent inequities.⁶

The challenges for our health workforce are wide ranging, covering all areas of the health system and many have been persistent for a long time. The pressures health care workers are under are the result of increasing demand, the growing complexity of health care, an ageing workforce, recruitment, and retention challenges as well as persistent underrepresentation of Māori, Pacific, disabled and ethnic populations in the health workforce.

One predictable outcome is nurses find themselves before courts, inquests, and disciplinary committees as a system failure is investigated. Too often that system failure results in individual practitioners, nurses and others being investigated, appearing before an inquest, or charged because the system requires it. Individuals, rather than the system, are held to account. In some circumstance individuals are simply trying to practise in accordance with their professional codes and deliver a service.

³ Based on APC data provided by the regulatory authority. It is important to note that there may be small differences between published data and data supplied to Te Whatu Ora due to different reporting timeframes.

⁴ McCay L. Covid continues to disrupt: what is the plan to deal with it? BMJ. 2022;378:o1780. doi:10.1136/bmj.o1780.

⁵ World Health Organization. Mental Health and COVID-19: Early evidence of the pandemic's impact: Scientific brief. 2022.

⁶ *ibid*

What does failure look like?

Despite a long-standing commitment to reducing health inequities, problems with access to care persist and the system is not delivering the promise of equitable health outcomes for all population groups. Primary health services and hospital-based services have developed largely independently, and major restructuring during the 1990s did not produce the expected efficiency gains. A focus on individual-level secondary services and performance targets has been prioritised over tackling issues such as suicide, obesity, and poverty-related diseases through community-based health promotion, preventive activities, and primary care.⁷

Other examples include:⁸

- In some former district health boards (DHBs), people are twice as likely to die from potentially preventable causes than in others, and three times more likely to be re-admitted to hospital for urgent needs.
- Some New Zealanders are twice as likely to get knee replacement surgery than others.
- In over half of our former DHBs, more than 10 percent of people did not receive cancer treatment within 62 days from diagnosis. In the lowest performing DHBs, nearly a third of people were still waiting for cancer treatment after 62 days.

Where you live in New Zealand should not dictate your access to good quality health care and this situation is only going to worsen without reform. By 2030, it is expected that 20 percent of New Zealanders will be aged 65 plus, compared with 16 percent in 2020. With an ageing population and growing burden of chronic disease we know that the demand for health services is going to grow substantially over the next decade.⁹

Equity

Over the past decade, New Zealand's health system appears to have a diminished focus on and commitment to equity in health outcomes. Persistent and marked inequities still exist in access and outcomes for Māori, Pacific Island, and low-income populations.¹⁰ Although these inequities have arisen from the broader social determinants of equity and from persistent and rising poverty,¹¹ they also reflect the loss of momentum over the past decade in the provision of innovative, accessible, and effective Primary Health Care for high-needs population groups. Continued increases in hospital spending, with the number of hospital doctors increasing at a greater speed than are GPs,¹² is contrary to the declared policy of investing in primary care to keep people healthy and reduce demand for hospital care.

⁷ Goodyear-Smith F, Ashton T. New Zealand health system: universalism struggles with persisting inequities. *Lancet* 2019; 394: 432–42

⁸ Ibid

⁹ <https://www.beehive.govt.nz/speech/case-change-health-system-building-stronger-health-and-disability-system-delivers-all-new>

Chin MH, King PT, Jones RG, et al. Lessons for achieving health equity comparing Aotearoa/New Zealand and the United States. *Health Policy* 2018; 28: 28.

Carroll P, Casswell S, Huakau J, Howden-Chapman P, Perry P. The widening gap: perceptions of poverty and income inequalities and implications for health and social outcomes. *Soc Pol J NZ/Te Puna Whakaaro* 2011; 37: 1–12

¹² Medical Council of New Zealand. The New Zealand medical workforce in 2016. Wellington: Medical Council of New Zealand, 2017

We also know that a stressed health system exacerbates inequities. For example, the drop in childhood vaccinations for all children in recent years has been worse for Māori and Pacific children,¹³ and lung cancer registrations and investigations seemed to reduce for Māori, but not for non-Māori/non-Pacific people, during the 2020 lockdown.¹⁴

Te Tiriti o Waitangi

The Crown's failure to honour te Tiriti o Waitangi has been the principal driver of the disparities in health, and other social disparities. The Crown failed to protect the rights and aspirations of iwi Māori that is the principal task of Kawanatanga set out in Article 1.

It has also deprived Māori of the resources and rights needed to enable them to exercise tino rangatiratanga and left Māori vulnerable to economic forces beyond their control and, as a result, deprived them of the capacity to shape their own destiny.

Te Rūnanga are claimants under the health services and outcomes Inquiry Wai 2575 examining grievances relating to health services and outcomes of national significance. In March 2018, at a judicial conference in Wellington NZNO Kaiwhakahaere Kerri Nuku raised several issues. They include institutional issues leading to the formation of Te Rūnanga, health disparities, the lack of proper recognition of te Tiriti o Waitangi, pay disparities for Māori and iwi providers, pay parity, cultural competency training, the voice of Māori nurses; and institutional racism and structural discrimination within the health sector. Many of the issues have yet to be resolved.

The burden of health loss falls inequitably on Māori, in terms of poor health, disability and premature death.¹⁵ Differences in the social and economic determinants of health and wellbeing, differential access to health care and differences in the quality of care in health outcomes for Māori contribute to this inequity.¹⁶

There has been a lack of progress and investment in a sustainable Māori nursing workforce, despite various initiatives that to date have not delivered. Although nurses and other health practitioners are required to be both clinically and culturally competent under the Health Practitioners Competency Act 2003, this is not the reality or lived experience for many working nurses, patients and whānau in Aotearoa New Zealand. It is especially true for Māori whānau, hapū and iwi who have a te Tiriti o Waitangi right to a culturally appropriate health system. A lack of cultural competence leads to the unintended structural discrimination in the health sector which drives the poor outcomes Māori experience.

Nursing workforce

The Health Workforce Plan (the Plan) published by Te Whatu Ora and Te Aka Whai Ora estimated a gap of 4800 nurses and 1050 midwives in Aotearoa New Zealand. The Plan states that to maintain current rates of staffing with the expected population growth, the numbers in training and recruitment pipelines would need to increase by 8000 nurses and

¹³ The Immunisation Advisory Centre. National Immunisation Coverage for New Zealand, up to May 2021. 2021. Available at: <https://www.immune.org.nz/sites/default/files/publications/Coverage%20Report%20-%20July%202021.pdf>.

¹⁴ Gurney JK, Dunn A, Liu M, et al. The impact of COVID-19 on lung cancer detection, diagnosis and treatment for Māori in Aotearoa New Zealand. *N Z Med J.* Jun 10 2022;135(1556):23-43.

¹⁵ Ministry of Health. 2023b. Commissioning for Pae Ora Healthy Futures. Wellington: Ministry of Health.

¹⁶ Walsh M, Grey C. 2019. The contribution of avoidable mortality to the life expectancy gap in Māori and Pacific populations in New Zealand – a decomposition analysis. *New Zealand Medical Journal* 132(1492).

250 midwives by 2032.¹⁷ If we add the two numbers together, we require an additional 12,800 nurses and 1300 midwives to address the current and projected nursing workforce shortages.¹⁸

Furthermore, close to one in three nurses do not complete their training, with higher attrition rates for Māori and Pacific students. Reducing attrition by 20 percent would see more than 3000 extra nurses in the workforce by 2032.

On 1 August 2022,¹⁹ the Minister of Health said the number of nurse practitioners (NPs) being trained would double from 50 to 100 by 2024, but this caused confusion as there were already 70-90 new NPs being registered each year.

Only 50 places a year were available on the fully funded Nurse Practitioner Training Programme (NPTP) which offers more supervised clinical practice and other additional support to final-year trainees. This prompted concern among schools of nursing about a two-tier system for NP trainees, those who gained an NPTP place and those who did not. The outcome, the number of NPTP places, grew from 50 in 2022 to 72 in 2023 and then 100 in 2024.

The nursing team comprising regulated nurses: enrolled nurses, registered nurses, nurse practitioners, supported by kaiāwhina are the core health workforce, deliver care in all health settings across all levels. But there is now a proliferation of competing scopes: Anaesthetic technicians, physician associates, paramedics, and health care assistants who are impeding progress and the adoption of new priorities, for example nurse endoscopists.

Additionally international health roles, for example the physician's associates, have been introduced without consideration of other Aotearoa New Zealand nursing roles that require master's level degrees. The development of new roles, such as the perioperative practitioner, has unintended consequences where effective nurses, who are known as trustworthy and safe, will be displaced, marginalised, or replaced by a new workforce in the perioperative environment.

Micro-credentialing of unregulated kaimahi, has also been portrayed as the solution to the critical shortages of nurses in areas of specialist practice, for example renal dialysis. Nursing role disintegration is further magnified by the additional responsibility requiring nurses to supervise and be accountable for the work of the unregulated worker.

It is critical the health system has sufficient availability of health workers able to meet the needs of our communities and the services they require. Currently, the workforce is:

- not equitably distributed and accessible by the population
- not able to provide options for Māori and other population groups in relation to their health needs
- not culturally safe, responsive, or representative of the communities they serve
- not motivated, empowered, able to deliver quality care and continuously improve services, access to services and health outcomes

¹⁷ Te Whatu Ora – Health New Zealand. July 2023. Health Workforce Plan 2023-24. Wellington: Te Whatu Ora – Health New Zealand.

¹⁸ Ibid p46

¹⁹ <https://www.nzdoctor.co.nz/article/news/np-nurse/nurse-practitioner-trainee-numbers-clarified-te-whatu-ora>

- not enabled to provide the cultural competencies and mātauranga Māori that is needed to achieve equitable outcomes.

This increased demand for health care is being managed by a health workforce with shortages that have been amplified by COVID-19. There will also be disasters happening that are less visible but will ultimately lead to poorer health outcomes. For example, delays in diagnosis or initiation of care for cancer or heart disease, or poorer management of diabetes because of difficulty accessing Primary Health Care.

Ageing, stressed, tired general practitioners and nurses; strikes by junior doctors; high feelings of burnout by the workforce all reflect and exacerbate the strains in the system and the out-of-date configurations for health professionals. Many in the health care sector feel burnt out, mistrustful, disillusioned, undervalued, and are struggling to deal with the moral injury of being unable to deliver safe care to their patients and whānau. This is further illustrated in the rolling wave of health care strikes that have occurred in recent years.

Workforce pressures in several health professions, especially in rural areas, have led to a high dependence on health professionals trained overseas. A workforce is needed that is responsive to patient needs, rather than persisting with a system designed around out-of-date configurations for health professionals.²⁰

Many staff have decided enough is enough and have resigned, with the result being further stress on those who remain. Nursing staffing shortfalls are extreme and health care assistants are one group being used as substitute nurses, a significant risk to patients and themselves by working outside their knowledge and skills.

Aotearoa New Zealand has traditionally had a huge reliance on overseas-trained health care workers, and the inexplicable and inexcusable failure to prioritise and maintain the inflow of overseas health care workers when the borders closed in 2020 has hit the health sector hard.²¹

Health and safety

Violence and aggression towards nurses are defined as: physical assault; verbal abuse; threats and aggressive behaviours; including physical contact, threats of a sexual nature, and/or the use of a weapon.²² The patient and accompanying persons are the source of the violence and aggression and the three main areas affected are emergency departments (EDs), Mental health and Aged and Residential Care.

While some violent acts result in physical injury, threats or intimidating behaviour can cause just as damaging psychological effects, including loss of morale, confidence, and long-term psychological stress. Nurses acknowledge the disproportionate harm they experience, and the harm is escalating year on year. Currently there are limited protections for nurses and no sustainable solutions.

²⁰ Gauld R. Disrupting the present to build a stronger health workforce for the future: a three-point agenda. *J Prim Health Care* 2018; 10: 6–10.

²¹ <https://thespinoff.co.nz/society/28-03-2022/if-this-isnt-a-healthcare-crisis-what-is>

²² Australasian College for Emergency Medicine. (2017). Violence in Emergency Departments. Retrieved June 20, 2019, from <https://acem.org.au/getmedia/a3358b1b-f126-4e49-8a8b-0a718275c148/P32-Policy-on-Violence-in-EDs-Mar-11-v02.aspx>

Emergency medicine

In emergency medicine the crisis takes many forms and the problems are the same nationwide: patients marooned in ambulances for hours because they are unable to access a staffed clinical space in the hospital; patients lying on beds in corridors and no staff available to assist them; delays in assessment by medical and nursing staff that grossly exceed expected standards; patients stuck in the ED because there are no staffed beds available on the hospital wards; mental health patients waiting up to three days in the ED for staffed inpatient beds to become available.²³ Despite subsidies for children and people on low incomes, many people put off visiting the doctor or just show up in the emergency room because of cost.²⁴

A leaked Te Whatu Ora staff survey shows only 19 percent of respondents at Middlemore Hospital's ED believe they have the resources needed to perform their jobs. The Ngātahitanga Pulse Survey was conducted nationwide in December 2022 and the results were released to staff in February 2023.

More than 1900 staff from Te Whatu Ora (Counties Manukau) responded. Only 19 percent of staff working at Middlemore Hospital's ED who completed it said they had the resources needed (including time, people, budget, facilities, and equipment) to perform their roles well. The survey shows a huge mismatch between what resources management think are available and what the frontline workers are saying.²⁵

Winter pressures will not be felt evenly across the country or by all population groups. Māori and Pacific people are more likely to visit busy EDs for things that could have been treated in Primary Health Care; older people and disabled people are more likely to go to EDs and stay in hospital for longer; and rural populations find it harder to get Primary Health Care appointments.²⁶ The Community Allied Health Rapid Response Service is short of staff to support people with complex needs at home, preventing hospital admission or facilitating early discharge.

Waitlists

Waitlists and workforce are impacting on the system's ability to deliver timely, safe, and effective health services this winter.²⁷ In some situations, waiting list delays, stretched services and overworked staff have resulted in serious outcomes, including death. For patients and whānau who are missing out on treatment, or facing years-long delays, the insufficient care is the cause of significant stress and inhibits their ability to contribute to our economy and society.

For others, our struggling public health system can take a financial toll, by forcing people to gather all the money they can to pursue treatment in the private sector.

The system is currently staying afloat through the desperate triage manoeuvre of cancelling a huge amount of planned care. This is necessary but is not sustainable. Even with

²³ <https://thespinoff.co.nz/society/28-03-2022/if-this-isnt-a-healthcare-crisis-what-is>

²⁴ <https://www.auckland.ac.nz/en/news/2019/08/04/complex-fragmented-health-system-fuelling-inequities.html>

²⁵ <https://www.stuff.co.nz/national/politics/local-democracy-reporting/300842416/just-19-of-middlemore-ed-staff-think-they-have-resources-necessary-to-do-their-jobs>

²⁶ <https://www.tewhatoru.govt.nz/publications/health-system-preparedness-for-winter-2023/>

²⁷ <https://www.tewhatoru.govt.nz/assets/Publications/Proactive-releases/Cabinet-Paper-Winter-Preparedness-2023.pdf>

reductions in planned care the health care workforce is currently struggling to manage the combination of post COVID-19 and *business as usual*.

New Zealand's worsening access to non-urgent surgery

As of last October, 30,000 people were waiting longer than four months for surgery, up from 27,500 in May when the Planned Care Taskforce was formed to cut national surgical waiting times. At the same time, a further 38,000 New Zealanders had been waiting longer than the four-month target for being seen by a specialist for an initial assessment, up from 35,000 in May. On the upside, there had been a reduction from 5500 to 3500 in those waiting over a year for surgery.²⁸

The data highlighted major differences in access and care by region, the so-called *postcode lottery*. The situation is unacceptable and was never anticipated or expected in a country with universal access as a fundamental guiding principle for health care. This principle means everyone should be treated in a timely manner without any barrier to or inequality in access. These rising waiting lists, lengthy ED waiting times and uneven access can't be blamed on COVID-19 alone. The pandemic has simply added to the pressures and revealed more starkly the multiple cracks in our health system.²⁹

Traditionally, winter, and its increase in respiratory illness, puts increased pressure on health systems. In recent times these pressures have become more widespread, extending beyond the traditional winter season, and requiring ongoing (rather than seasonal) responses. In 2022, traditional winter pressures in New Zealand were compounded by COVID-19, the re-opening of the border and re-emergence of infectious diseases and interrupted preventative health care and screening.

These factors had two impacts on providers, they created increased demand for services, while also constraining services' ability to meet this demand due to staff vacancies, fatigue, and illness. These pressures were felt across hospital, primary and community care providers. On the ground this meant high ED attendances and hospital occupancy, a workforce challenged by vacancies, fatigue, and illness, and busy Primary Health Care practices, including those with high populations of Māori, Pacific people, and disabled people managing higher levels of health needs.³⁰

Seasonal and concurrent surges of COVID-19, respiratory syncytial virus (RSV), influenza, and other diseases are putting pressure on the New Zealand health system this winter. Officials also expect recent extreme weather events to continue to have an impact in affected regions. For example, in the response phase in Hawke's Bay and Tairāwhiti, planned care services were postponed and primary and community providers temporarily closed their doors. As the recovery continues, delayed care will likely increase demand on providers. The cyclone itself may also increase demand for services, for example, by increasing demand for mental health care.

²⁸ <https://theconversation.com/nzs-health-system-has-been-under-pressure-for-decades-reforms-need-to-think-big-and-long-term-to-be-effective-198495>

²⁹ *ibid*

³⁰ <https://www.tewhatauora.govt.nz/publications/health-system-preparedness-for-winter-2023/>

Aged care

The residential aged care setting has changed over the years. People now enter residential services later in their lives. Consequently, many more are frail or have chronic or complex health conditions, including high levels of dementia.^{31 32}

The aged care workforce is under significant pressure especially in Home and Community Support Services (HCSS) and Aged Residential Care (ARC). The challenges of limited access to HCSS and ARC means there is potentially a longer length of stay for older people in public hospitals. This means hospital services are diverted from providing services to other population groups. It is not a level playing field for HCSS and ARC with the public hospital system and they struggle to retain and recruit nurses and suitably skilled support staff.³³

Shortages of nurses significantly jeopardise health care and support worker wellbeing through requiring nurses to work longer hours, to assume responsibility for more residents than usual or safe, to miss taking breaks, and to risk making errors of judgement that could impact the health and wellbeing of residents and/or jeopardise their professional ability to practise.³⁴

Nurse education

The review of Vocational Education (RoVE) that created Te Pūkenga, began in 2018 and has yet to deliver on the three unified nursing programmes (meaning there will be one programme of study aligned with each qualification). The programmes that were promised are: the Bachelor of Nursing, Māori, Bachelor of Nursing, and a Pacific Bachelor of Nursing. Work is still being undertaken to attain approval and accreditation from the New Zealand Qualifications Authority and regulatory bodies.

Proposed reviews, re-organisation of the provision of nursing education, redundancies in universities and Te Pūkenga of both undergraduate and postgraduate nursing education will severely limit opportunities to recruit nursing students. In addition will be potential harm to the nursing workforce pipeline and retention of educators considering the scale of change proposed in the tertiary education sector.

PHARMAC

PHARMAC has been extremely successful in keeping pharmaceutical expenditure down while ensuring population-wide access to medicines. Even so, critics argue cost savings have sometimes been achieved at the expense of access to medicines, especially new medicines.^{35 36} Other concerns expressed by stakeholders include non-transparency of the

³¹ Pagone, G & Briggs, L. (2021) Royal Commission into Aged Care Quality and Safety - Final Report: Care, Dignity and Respect, Government of Australia, Canberra

³² Aged Residential Care Industry Profile Chapman, McDougall, Reid, Dixon (NZACA- BERL 2021 - 2022)

³³ <https://www.nzdoctor.co.nz/article/undoctored/collective-action-needed-says-aged-care-commissioner>

³⁴ <https://www.nzno.org.nz/resources/submissions> NZNO to the Parliamentary Health Select Committee, in respect of mandatory minimum staffing in Aged Care and service standards.

³⁵ Wonder M, Milne R. Access to new medicines in New Zealand compared to Australia. *NZ Med J* 2011; 124: 17.

³⁶ Barber J, Sheehy K. Uptake of new medicines in New Zealand: evidence of a waiting list. *NZ Med J* 2015; 128: 12.

decision-making process, supply issues arising from sole supply agreements, and constraints and inefficiencies in the submission process for access to high-cost medicines.³⁷

ACC

ACC has created a dual system. If something can be deemed to be the result of an accident, you often receive superior care; whereas if your condition is deemed to be the result of wear and tear, you may have to wait years for treatment, and that's inequitable. At times it's impossible to know if something was due to an injury or was developing over a long time.

Although ACC is one of the great strengths of New Zealand's institutional arrangements, it has also introduced inequities, because different funding and benefit entitlements apply depending on the cause of a health problem. Co-payments for consultations with GPs or allied health professionals (such as physiotherapists) differ depending on whether the problem was caused by an accident or an illness. ACC patients requiring hospital treatment might receive treatment earlier than other patients, especially in situations for which ACC is paying income compensation while the patient is off work and could be eligible for a more comprehensive range of services, including home support.

Climate change

There is a considerable body of scientific literature and consensus on the harmful impacts of climate change on health. So much so that climate change has been identified as the most serious threat to global public health this century.³⁸ Direct impacts include death, illness, and injury due to heat waves and extreme weather events. Powerful indirect impacts on health are mediated by a complex interaction of social, environmental, and economic factors. These include shifting patterns of infectious disease, air pollution, freshwater contamination, impacts on the built environment from sea level rise, forced migration, economic collapse, conflict over scarce resources and increasing food insecurity.³⁹

The mental health impacts of climate change are likely to be significant and represent a poorly recognised burden on the health system. They include direct and indirect effects, with disproportionate impacts on populations already facing high rates of mental illness and substance use disorders, notably indigenous and socioeconomically disadvantaged communities.⁴⁰

Why has the health system failed?

The Health and Disability System Review Interim Report highlighted how the business and professional interests of a few had a disproportionate impact on models of care, and access for everyone, particularly Māori.⁴¹

³⁷ Babar Z, Francis S. Identifying priority medicines policy issues for New Zealand: a general inductive study. *BMJ Open* 2014; 4: e004415.

³⁸ Costello A, Abbas M, Allen A, Ball S, Bell S, Bellamy R, et al. Managing the health effects of climate change. *Lancet*. 2009; 373(9676):1693–733.

³⁹ Woodward A, Smith KR, Campbell-Lendrum D, Chadee DD, Honda Y, Liu Q, et al. Climate change and health: on the latest IPCC report. *Lancet*. 2014; 383(9924):1185–89.

⁴⁰ Every-Palmer S, McBride S, Berry H, Menkes DB. Climate change and psychiatry. *Aust NZ J Psychiatry*. 2016; 50(1):16–8.

⁴¹ Health and Disability System Review - Interim Report, Executive Overview. Hauora Manaaki ki Aotearoa Whānui – Pūrongo mō Tēnei Wā. Wellington; 2019.

The Health and Disability System Review final report said that the system has become complex and unnecessarily fragmented. Organisations have unclear or overlapping roles, responsibilities, and boundaries. There is significant duplication of activity, and variation that creates a postcode lottery when it comes to accessing services.

Despite the series of institutional reforms over the past three decades, questions remain regarding the structure of the system. For a small country, the system is complex and fragmented, and this contributes to inequity and inefficiency. A health system that until 30 June 2022 had 20 district health boards (DHBs) and multiple shared support agencies that created duplications and gaps across service providers and required a huge effort to integrate its functions across service and geographical boundaries. Additionally, the dual nature of the primary and community and secondary sectors continues to impede service integration and obstructs efforts to unlock funding which has historically been directed towards hospitals.⁴²

With the establishment of Te Whatu Ora and Te Aka Whai Ora the health system is moving from a decentralised model of health to a very centralised one – the rational being to deliver Pae Ora-healthy futures by ensuring the right health services and better access. Yet, 13 months later removing the structure without embedding a replacement infrastructure and still working on confirming regions and how localities work detracts from delivering frontline care, while the costs increase, and the health workforce is becoming even more disenfranchised.

Restructuring Te Whatu Ora and Te Aka Whai Ora workforces to reduce duplication of positions and move resources to the frontline is admirable. But the experience to date has been slow and has created confusion and fear among the health workforce. Moreover, the push for a timely implementation process has in effect transitioned existing roles and management creating a lost opportunity to demonstrate support for the new entities with no change in culture.

There was a failure to involve unions and other professional organisations in the implementation process. For example, the resolution of major issues such as pay equity, pay parity, holiday pay and funding for the primary sector created a negative impact on the nursing workforce while, treating them as something to be managed rather than active engagement.

Historically planning has been reactive rather than establishing a solid foundation for the future. Investments in hospitals and the health workforce are largely within a short-term framing, dictated by funding availability and yesterday's needs. This means facilities are often inadequate and workforce shortages are ongoing. Hospital staff have been regularly asked to reduce expenditure to prevent budget blowouts.⁴³

Meanwhile, health care funding has increased with time, but it has not been adequate to keep up with increasing demand. These issues have been occurring for years and cannot be attributed to a single political party or government. On the clinical frontline, long-term deficiencies in funding, investment, innovation, and planning have led to ever-increasing

⁴² Goodyear-Smith F, Ashton T. New Zealand health system: universalism struggles with persisting inequities. *Lancet* 2019; 394: 432–42

⁴³ <https://thespinoff.co.nz/society/28-03-2022/if-this-isnt-a-healthcare-crisis-what-is>

deficits in necessary staffing levels, and health care being delivered in facilities that are frequently no longer fit for purpose.⁴⁴

The divide between primary and community health care and hospitals is increasing. Secondary health care is publicly funded while, primary and community are only partly publicly funded. This divide has led to a lack of integration for services.⁴⁵ Furthermore, funding has not kept pace with the ageing population, rapid immigration, and the rising cost of health care, which have helped keep the health sector in the red.

The public do not have a consistent say in the operation of the system or often have little choice about how they access services. Iwi and Māori communities are frequently consulted, but often in an advisory rather than decision-making capacity.⁴⁶

Nationally, health care delivery systems are under increasing pressures from other factors including health workforce ageing and supply, consumer expectations, and climate change.⁴⁷

Service improvements and the uptake of new technologies has been sluggish, with little shift of services from hospital to community environments, despite this being government policy for more than 20 years. Split and fragmented responsibilities for everything from information technology (IT) to human resources make it difficult to work across the system, share data and analytics, and identify and spread best practice.⁴⁸

To support the ability to plan, commission and evaluate health services effectively, access to nationally consolidated, population level primary health data is a critical example of what is required. The creation of a nationally consistent foundational primary care data set has been discussed widely since the Primary Health Care Strategy was published in 2001.⁴⁹ However, robust primary health data to support decision-making and population health planning at national, regional, and local levels has remained fragmented and incomplete since then.

At a high level, the problem for Primary Health Care is that there is not a nationally consistent and complete collection of data for Aotearoa New Zealand.⁵⁰ This means the health system often does not know about health conditions, when and how often people visit different practitioners, laboratories, or other health providers, in addition to their risk factors and behaviours, for example diet and exercise, smoking, etc of its population. What limited IT capability exists is being used to support inadequate existing systems and their renewal and repair. Te Whatu Ora spends nearly \$8 billion annually on primary and community care services provided by community-based organisations and yet there is limited information to manage investment or support outcomes for that spend.⁵¹

⁴⁴ ibid

⁴⁵ <https://www.auckland.ac.nz/en/news/2019/08/04/complex-fragmented-health-system-fuelling-inequities.html>

⁴⁶ <https://www.nzdoctor.co.nz/article/undoctored/case-change-health-system>

⁴⁷ Cumming J, McDonald J, Barr C, et al. New Zealand health system review. Health Systems in Transition, Vol.4 No.2. World Health Organization; 2014.

⁴⁸ <https://www.nzdoctor.co.nz/article/undoctored/case-change-health-system>

⁴⁹ <https://www.health.govt.nz/publication/primary-health-care-strategy> PP 21-23

⁵⁰ Pigden A et al. 2022. Developing a national primary care research network: a qualitative study of stakeholder views. Journal of Primary Health Care. doi:10.1071/HC22081

⁵¹ Te Whatu Ora – Health New Zealand. 2023. *Primary Health Data Set Programme (PHDP) Phase 2 Summary – Establishment of a Foundational Primary Care Data Set for New Zealand*. Wellington. May 2023

Conclusion

Today a range of complex global and local variables affect all aspects of our lives, including health. While change is a constant, COVID-19 has highlighted that we cannot predict the future precisely, and that we have complex challenges with few single causes or solutions.⁵²

Te Whatu Ora and Te Aka Whai Ora celebrated one year of being operational in July 2023. They continue to progress restructuring the health sector, albeit slowly, and have published Te Pae Tata the Interim Health Plan 2022,⁵³ which sets out the first two years of the health system transformation. To support this the Ministry of Health, Manatū Hauora has delivered six aspirational 'Pae Ora Healthy Futures for all New Zealanders' strategies for the new health sector.⁵⁴ Will these changes deliver a health system for our patients, whānau and the health workforce, especially nurses, or will they continue to deliver false promises?

Furthermore, we have the Health Workforce Plan 2023/24⁵⁵ that has been designed to relieve the current workforce pressures and meet the challenges of the future – that being the next 12 months. The Plan has multiple teams across the sector working to grow a workforce to support the health sector and address the backload of unmet care experienced by individuals and their whānau.

We have a new health structure, strategies, plans, taskforces, tactical taskforces, and the list goes on for the health sector that promises to deliver benefits for all. The problem remains the same, we do not have the nurses to do so. Something needs to change.

⁵² Health and Disability System Review. Health and Disability System Review – Final Report – Pūrongo Whakamutunga [Internet]. Wellington: HDSR; 2020 [accessed 22 January 2022]. Available from: <https://systemreview.health.govt.nz/assets/Uploads/hdsr/health-disability-system-review-final-report.pdf>

⁵³ <https://www.tewhatauora.govt.nz/whats-happening/what-to-expect/nz-health-plan/>

⁵⁴ <https://www.health.govt.nz/new-zealand-health-system/pae-ora-healthy-futures-all-new-zealanders>

⁵⁵ <https://www.tewhatauora.govt.nz/publications/health-workforce-plan-202324/>