PATH TO PATIENT CENTRED CARE

TOI MATA HAUORA

RESPECT FOR PATIENTS’ PREFERENCES
- Physical comfort
- Access to care.
- Continuity and transition
- Welfare of senior doctors, including emotional support
- Entrenched specialist shortages (high undersupply of specialist positions) as distinct from advertised vacancies
- Capacity (numbers to generate the time necessary to achieve distributive clinical leadership throughout each DHB)
- Welfare of senior doctors, including health and safety, presenteeism, burnout and fatigue, with consequential increasing risks for patients.

This is all very laudable but what does the MECA have to do with this? Quite simply, health delivery is labour-intensive, and senior doctors and dentists are at the core of achieving patient centred care. The MECA both provides and enables the wherewithal to achieve patient centred care. The MECA both provides and enables the wherewithal to achieve patient centred care. DHBs need to be able to recruit and retain a significantly larger workforce that includes the capacity to provide realistic time for non-clinical duties (ie, duties not directly related to the care of an individual patient).

For this level of increased recruitment and retention, the MECA requires competitive remuneration and other conditions of employment. But it also needs sufficient teeth to ensure there are robust minimum standards for achieving patient centred care. Already the MECA requires DHBs to provide the necessary resources to enable senior medical staff to undertake their duties and responsibilities. Further, it expects that senior medical staff will provide the lead role in service delivery, configuration and provision with management in a support role. These are important provisions despite often being ignored by too many DHBs to one degree or another.

But more is required in the MECA, including senior doctors being able to organise a stocktake of what the minimum standards for patient safety care in their service should be, including staffing (not just medical or dental), equipment and accommodation. The MECA needs to require DHBs to be responsible for providing the necessary information and data for this stocktake. Finally, we need a dispute resolution process in situations where there are difficult blockages in achieving these standards; the patient safety clause (41) of the current MECA could be used for this purpose.

This journey of using the MECA to achieve substantive and comprehensive patient centred care will be a long one but one that is worth ASMS fighting for.

RELEVANCE OF PATIENT CENTRED CARE

Patient centred care is much more than a nice sounding slogan. Its dimensions are:
- Respect for patients’ preferences and values
- Emotional support
- Physical comfort
- Information, communication and education
- Continuity and transition
- Coordination of care
- The involvement of family and friends
- Access to care.

But why is this relevant to our MECA negotiations? The scene for this is nicely set by the Government’s health workforce advisory body, Health Workforce New Zealand, which recognises the vulnerability of the senior medical workforce in DHBs. In November 2014 it publicly stated that the most important issue currently is the impact of a prolonged period of medical labour shortages on the workloads, wellbeing and productivity of DHB-employed senior doctors.

This dire situation is summarised by the following underpinning features of the current state of the senior medical workforce in DHBs:
- Growing unmet need of patients due to factors such as population growth, aging and increasingly entrenched poverty
- Entrenched specialist shortages (high undersupply of specialist positions) as distinct from advertised vacancies
- Capacity (numbers to generate the time necessary to achieve distributive clinical leadership throughout each DHB)
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RHEUMATOLOGY WORKFORCE SHORTAGE

The frustration is evident in rheumatologist Fiona McQueen’s voice as she recounts how, a couple of weeks earlier, she saw a 30-year-old man with long-standing back pain and discovered he had a severe rheumatic disease that could be treated.

But that’s good news, right?

“No. It was a long time coming, and we got lucky. He’d been suffering with this condition since his late teens,” she says. “A treatment has been available for a number of years, but he really should have been seen by a rheumatologist at least three years ago.”

Hence her frustration, borne out of long-standing shortages in the public hospital rheumatology workforce.

“Getting money out of the DHBs is like getting blood out of a stone, but this is having an impact on patients,” she says. “There’s a lot of people we can’t get to see, which leaves them reliant on their GP, who may be very good but obviously isn’t a specialist in this area. It’s a real concern for rheumatologists.”

Dr McQueen moved to Invercargill last year to take up a part-time (0.4 FTE) position with the Southern DHB, after spending most of her working life as a rheumatologist in Auckland. She also works part-time (0.1 FTE) as a Professor of Rheumatology at Auckland University, and is President of the New Zealand Rheumatology Association.

She’s been at the sharp end of rheumatology service provision and training for more than 20 years, and says improvements are needed to provide the level of rheumatology treatment New Zealanders require.

“We need more publicly funded rheumatology positions, probably another 5 to 8 FTE, and we need to incentivise
“Waiting lists, however, do not take account of the unmet need of patients who, due to lack of access to rheumatology services, are referred to a less appropriate specialty or managed in general practice.”

More recently, a review of the musculoskeletal workforce and service published by the Ministry of Health in March 2011 (http://www.health.govt.nz/system/files/documents/pages/musculoskeletal-workforce-service-review.pdf), while not specifically about rheumatology, highlights a number of broader issues that affect rheumatologists. These include the growing number of people with conditions such as arthritis, the need to better integrate GP training within orthopaedic and rheumatology clinics, and existing barriers to improved provision of care, which include the DHB funding model and inconsistent use of clinical team members across hospitals.

The report argues for more consistency in managing patient referrals, and that a message that’s been picked up in rheumatology by Waikato DHB rheumatologist Douglas White and a team of other clinicians. They have developed a triaging tool that involves a short set of questions to be answered by the referring GP and a further three questions for the triaging rheumatologists. It’s early days but they think that using the tool electronically can reduce the turnaround on referrals from five days to one day. Their research has been published in the international Journal of Clinical Rheumatology (August 2015) and also won an award for excellence in health improvement at last year’s ARAC Forum in Auckland (https://www.1000minds.com/about/news/health-improvement-award).

“This project is about streamlining the process,” says Douglas White.

““As a country we have fewer rheumatologists per head of population than many other countries. We can’t provide the same service that rheumatologists do in other countries so we have to be selective about the patients we see. The shortage of rheumatologists is driving the need for work-arounds.”

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### Rheumatology Specialist Workforce as at 2012*

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<tr>
<th>DHB</th>
<th>2012 FTE</th>
<th>FTE per Population</th>
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<tbody>
<tr>
<td>NORTHLAND</td>
<td>0.64</td>
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<td>AUCKLAND</td>
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<td>COUNTIES MANUKAU</td>
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<td>WAIKATO, BAY OF PLENTS, LAKES, TARAWHITI, TAAMANAKI</td>
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<td>130,609</td>
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Source: Andrew Harrison, from a presentation at the 2012 New Zealand Rheumatology Association Annual Scientific Meeting.

* Service provision may have changed since these figures were compiled.