HEADLESS CHOOKS DON’T PROVIDE QUALITY

HEALTH LEADERSHIP

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This paper covers the following subjects:

1. Overview.

2. National DHB collective agreement (MECA) negotiations.


4. Association's health professional leadership initiative.

5. Tripartite process and proposed health sector relationship agreement.


7. Medical Council Elections.


OVERVIEW

1 Overview

Health systems throughout the world resemble dysfunctional families and New Zealand is no exception. When thinking of health systems I think of the most well known dysfunctional families in the world—the Simpsons, the Sopranos and the Windsors. Health systems and dysfunctional families both wrap up together the good, the bad and the ugly; the intelligent and the foolish. In amongst it all you can find the Lisa Simpsons and Meadow Sopranos (the appropriate favourable comparison for the Windsors is more difficult to readily identify). But no matter how good the odd Lisa or Meadow is, a dysfunctional family’s ability to provide effective sustainable leadership resembles a headless chook.

Two recent events when contrasted with our government’s approach to health serve to highlight the hegemony of the headless chook. In response to the equine flu outbreak the Minister of Agriculture and Bio-security appropriately and quickly announced protection measures preventing extension to New Zealand. Next, in response to the collapse of some financial investment companies, the Minister of Commerce announced her intention to review the law with the view to providing greater investor protection. However, in
contrast with these timely and expeditious responses, what was the response of the
government when hundreds of specialists in New Zealand in national stopwork meetings
concluded that the medical workforce in New Zealand had reached a crisis point? The
answer is a mix of silence, denial and inaction.

The most critical factor in this situation is the chickens are coming home to roost (to the
extent that headless chooks can undertake this flight task) over the failure of the
government to have a coherent strategic direction for public hospitals. The government
has strategies on most things including primary care and they are generally laudable.
However, public hospitals are seen as some form of fiscal black-hole when in fact they are
the most integrated part of the health system dealing with complex matters that other parts
of the system can’t deal with.

To its credit the government has increased health spending to record levels, something
which the ever critical opposition political parties do not dispute. But public hospitals have
been the poor cousin in that much of this funding has gone into:

- Primary care - much deserved and showing promising signs of improving access by
increasing affordability. However, early cost effective intervention is only one
outcome of increased access to primary care. Another, running in the opposite
direction, is that it also appears to be increasing the demand for public hospital
services because it is identifying more unmet need in a primary setting some of
which requires secondary treatment.

- DHBs have had to use some of the increased monies to reduce and remove fiscal
deficits.

- To the extent that extra funding has gone into public hospitals it has been absorbed
by welcome capital works development and service expansion. But what has
largely been neglected is the building of the current workforce capacity of DHBs to
provide existing services which are facing increased workload pressures as well as
service expansion. In a nutshell not enough is being done to build and sustain
existing capacity, largely workforce, thereby placing it under increasing stress and
strain. The workforce is expected to do more and more without being resourced
and supported to do so.

Compounding these difficulties has been the perennial challenge to all health systems, the
balance between national and local needs. No one country gets it right. Australia has its
own challenge as a larger country both in terms of geography and population and also the federal-state divide over primary and secondary care. In a small country like New Zealand this becomes particularly acute. The reality is that to achieve objectives of accessibility, quality standards, and cost effectiveness, New Zealand has to function as a national health system. This does not preclude local imperatives and initiatives being recognised; in fact, it depends on this. But it is a question of context and balance. In the 1990s under our unsuccessful and destructive commercial experiment, the direction was very much towards excessive localism at the expense of national collaboration. This decade it has improved but there is still insufficient recognition of the importance of regional and national collaboration and coordination as a critical driver.

2 National DHB MECA Negotiations

The acrimonious and precarious nature of these negotiations was reported to the previous Industrial Coordination Meeting in Adelaide (April). The current national DHB multi-employer collective agreement (MECA) expired on 30 June 2006. Negotiations for a new agreement commencing on 24-25 May 2006 and the last prior to our Annual Conference (1-2 November) are scheduled for 24-25 October 2007. In total, by the time of Conference, this will have involved 28 days of formal negotiation (14 of which have involved an external independent mediator).

The overwhelming overall objective of the Association is to achieve an outcome that better places New Zealand to cope with our medical workforce recruitment and retention crisis. This was highlighted by the fact that an Association survey conducted in July revealed that from January 2006 until mid-2007 DHBs have lost at least 80 specialists to Australia, an average of around one a week. In addition, we are losing to the private sector in New Zealand, both in full or by reducing public time commitments in order to spend more time in the less complicated and more remunerative private sector. The shortage-driven Australian challenge also threatens New Zealand’s ability to compete in recruiting from other countries. Further, there are increasing reports of ‘trainee’ specialists taking their first specialist position in Australia on significantly superior terms and conditions with little prospect of returning thereby helping dry up another source of recruitment.

There are two broad factors why we are losing specialists to Australia. The first is the ‘push’ factor; largely dissatisfaction linked to disempowerment, devaluing, excessive and unrecognised workloads in response to work pressures, and lack of managerial and political leadership. The second is the ‘pull’ factor; the recent significant increases in
terms and conditions of employment for senior doctors in response to Australia’s own serious shortages offering packages of around 50%-100% more than in New Zealand (the most recent being Western Australia with increases up to 43% by 2009). The size of your shortages could absorb the total New Zealand specialist workforce. The difference between our two countries is that whereas Australian federal and state governments recognise the crisis, the New Zealand government does not.

Since the last Industrial Coordination Meeting in April the following main developments have occurred:

- The then DHBs’ advocate falsely reported to chief executives in April that the Association had withdrawn from mediation. Prior to the national stopworks this was arguably the most blatant of several misrepresentations of our position (and the DHBs’).

- The DHBs had several counter-claims remaining at the time of the April meeting. These included undermining time for non-clinical duties; restricting eligibility for sabbatical; disempowering the role of Joint Consultation Committees; increasing accountability of senior medical staff in service management and clinical leadership roles; and gutting current MECA consultation rights. Some other counter-claims were withdrawn earlier. Subsequently all but one (the last) have been withdrawn; the attempt to gut the current MECA consultation clause has been amended to a less harsh but still unacceptable watering down.

- The DHBs slightly amended their position in April and by June had further revised it. The difference between their pre-April position and their revised position that was taken back to the national stopwork meetings (discussed below) can best and most simply be summarised as follows: if all the increase monies were put into base salaries only, the improvement was from between 2% and 2.9% per annum over 36 months (plus six remaining counter-claims) to 3.8% per annum over 46 months (plus a one-off pro rata lump sum payment of $5,000) along with only one remaining counter-claim. At the time of the national stopwork meetings the Association’s position was based on a 24-month term.

- The DHBs’ negotiating team (and chief executives) considered this to be a significant improvement and asked that the Association take it back to our members. However, the Association’s negotiating team concluded that this revised position was only a minor improvement on a totally inadequate and unacceptable
position and further it did nothing to assist recruitment and retention. Consequently it was resolved to implement the 2006 Annual Conference resolution to hold national stopwork meetings (discussed separately below) including taking back the DHBs’ revised position. The meetings overwhelmingly rejected the DHBs’ position and similarly authorised the Association’s negotiating team to organise a postal ballot on limited industrial action should the impasse in negotiations continue.

- Following the national stopwork meetings mediation resumed but with only minor modification the DHBs still expected the Association to accept their position despite its overwhelming rejection by members at the stopwork meetings. This modification has included developing other potential processes to supposedly address recruitment and retention.

- On our initiative the Council of Trade Unions President took an alternative Association position to government based on an alternative 36-month term. The government has been reluctant to intervene and, while keen to see this negotiation settled especially before election year, is caught in a bind by (a) the fiscal pressures it had put on DHBs and (b) the reluctance of DHB chairs and chief executives to have their autonomy encroached upon.

- In a surprise and controversial development the DHBs’ advocate left New Zealand for a position in Canada. Subsequently there has been an almost complete clean-out of the DHBs’ negotiating team with a new and experienced industrial relations practitioner as advocate and two new chief executives.

- The parties have agreed to resume mediation on 24-25 October. The DHBs will be presenting a new proposal involving a full response to all the unresolved issues.

In summary the main fiscal issues of contention between the parties involve:

- The term of the MECA.

- The size of the salary increase and the structure of the salary scale.

- Moving to double-time for average hours worked on rostered after-hours call duties and extending this to after-hours shifts (eg, emergency departments).

- Increasing the ceiling on reimbursement of CME expenses.
Other important but less fiscally significant or non-fiscal issues include:

- The DHBs’ claim to water down consultation rights.
- Compensation for absences of RMOs.
- Explicit negotiating capacity in vulnerable DHBs.
- Removing the discrimination against part-timers without private practice in the reimbursement of CME expenses.
- Rationalising the system of pro rata calculation of remuneration.

The following issues have been agreed between the parties:

- More emphasis on years of experience and qualifications for the first placement on the salary scale.
- Bargaining fee ballot for non-members.
- Extension of paid leave from professional associations and colleges to “recognised activities” (eg, exams, teaching on courses).
- Provision of good quality overnight accommodation (specifics identified).
- Extended scope of appointments clause including to clinical leadership positions.
- Formation of a joint national consultation committee.

The critical next steps are the resumed negotiations on 24-25 October and the Association’s Annual Conference the following week (1-2 November) which will have a critical role in determining our response to any developments in the resumed negotiations including a possible ballot on industrial action as authorised by the national stopwork meetings.

What the DHBs and their political masters have failed to appreciate is that they can’t afford increases to the total cost of specialist terms and conditions of employment. If the costs of the MECA do not significantly increase they are more likely to increase outside the MECA. This is because DHBs are statutory bodies required to endeavour to provide secondary and tertiary services. Exigencies drive their costs. If the MECA fails to address workforce needs, workforce shortages will drive extra costs through a mix of above-MECA special
deals (the 80% salary loading for South Australian intensivists is an obvious example) and the generally more expensive locum option (less satisfactory for continuity of care). This outcome will be inequitable, unfair, non-transparent and more expensive than the planned and more sustainable alternative of a reasonable MECA settlement focussed on helping address recruitment and retention.

Thus the DHBs are left with two possible outcomes. The first is to negotiate a new MECA with a focus on recruitment and retention. The second is to wait for the inevitable crisis to occur and in the time honoured tradition of health sector leadership in both our countries resort to expensive crisis management such as in Queensland. The crisis in New Zealand may not be a Bundaberg (what happens to patients when the desperation of shortages affects appointment and quality monitoring processes) although we had a much smaller example of this in obstetrics & gynaecology in the Whanganui DHB. It is more likely to be the quantitative impact of both increasing shortages and the drying up of sources of recruitment (New Zealand and overseas trained) leading to a situation so unsustainable that the risks to service provision and cost blow-out (special deals and locums) can’t be ignored, no matter what the level of political and managerial spin. This may well then lead to a new negotiated outcome ironically more expensive than what would have addressed it in the first place. The lack of political and managerial foresight is arguably a reflection of their shorter shelf life.

3 National Stopwork Meetings

The holding of 26 stopwork meetings over nearly four weeks from 17 July to 9 August in the 21 DHBs was the largest logistical challenge faced by the Association in its 18-year history. The organisational challenge was immense and fully stretched the Association’s resources, including the administrative staff. The total estimated cost was nearly $116,000 with the main component being around $81,500 on media management. The next two larger components were travel (over $13,500) and publications (nearly $12,400). Should we embark upon industrial action then even greater costs will be incurred on similar but more such activities. However, the Association has strong reserves due to high membership support and there is a ‘war chest’ available.

Some of the organisational features included:

- Intensive preparation in advance of the stopwork meetings including (a) a substantive letter to all DHB chief executives outlining our position and the
differences between the parties and (b) a substantial background document for members and the media. We also circulated the DHBs’ position, in their own words, to members in advance of the meetings.

- The development of a special stopworks page on the website containing relevant background information and updating on developments.

- The engagement of media consultants CABIX to draft key material and many media statements.

- Two half page advertisements in the *Sunday Star Times* and *Herald on Sunday*, combined the largest newspaper circulation in the country, immediately preceding the commencement of the stopworks.

- Three 30 second advertisements which were played a total of 20 times for each stopwork meeting on commercial radio stations.

- A membership based survey of actual specialist departures for Australia revealing a minimum of 80 in the around 18 months since January 2006 (an average of one a week).

- A series of media statements, on occasions two a day, with both national and local messages.

- Regular electronic communications, around two a week, to members reporting on ongoing developments during the stopworks campaign.

- The temporary engagement of additional staff to ring most members in advance of each meeting reminding them of it. Fears of this coming across as a tele-marketing exercise did not materialise and the membership feedback was encouraging.

The importance and outcome of the meetings justified this level of additional organisation and the expense. The meetings were a great success and an achievement that is encouraging for increased membership self-confidence and empowerment. Attendances were outstanding with around 1,740 members turning up. Nearly every meeting was the largest that members attending could recall. This ranged from six salaried GPs at Westport (100%) to around 260 in Auckland Hospital (arguably the largest meeting of New Zealand senior hospital doctors).
The mandate provided by the meetings could not have been more explicit. A mere four members (0.23% of attendees) voted against rejecting the DHBs’ proposal for settlement. This is despite the fact that in advance of these meetings we forwarded the DHBs’ proposal in their own words to all members. By a similar margin members also voted to condemn the DHBs’ failure to negotiate genuinely a national agreement addressing recruitment and retention needs.

In what was thought to be the most contentious issue, the ballot on industrial action (limited by the exclusion of acute and emergency care), less than 50 attendees (around 3%) voted against the National Executive’s recommendation. In several meetings the vote in favour of the ballot was unanimous. Of course, there are qualifications to this overwhelming result. It was linked to whether the impasse in negotiations was continuing and it was over whether to hold a ballot rather than the actual taking of industrial action. The mandate is based on a high level of trust which must be respected and not abused.

The DHBs were surprised by the high turnouts and the high level of unanimity over the National Executive’s three recommendations. They had hoped for low attendances and divisiveness (if not lack of support for the Association’s position). But these aspirations were quickly destroyed by the first stopwork meeting with its high attendance, unanimity of support for the National Executive’s recommendations, and enormous media publicity.

Consequently, in response, their advocate announced to the media that the DHBs wanted the Association to agree to ‘final offer’ arbitration. This form of arbitration is ‘winner-takes-all’, guaranteed to leave an aggrieved party, and favours positions closer to the status quo (ie, the DHBs’ position). Our response was that this was an attempted ‘con job’ seeking to deflect members away from the meetings and away from further consideration of the industrial action ballot. In the subsequent meetings it became clear that this call failed to achieve this objective.

Next, in response to the coverage of the Association’s Australian survey in the Sunday Star Times, their advocate sought to undermine its credibility with the false claim that it was based on a ring-around of our delegates. In fact, the survey was an empirical understatement of the situation.

Finally their advocate made an absurd claim that the DHBs were offering increases in specialist earnings in the vicinity of $45,000. Creative accounting leapt to new levels. The mythical $45,000 was created by applying an embellished percentage increase on top of a manufactured, completely erroneous claim of average specialist earnings. It created a
few cheap media sound bytes but was buried as the Association exposed these false claims. While it was neutralised in the media many members, however, were deeply offended by this dishonest accusation of greediness. At the Auckland DHB stopwork meeting members responded quickly with a resolution expressing no confidence in the DHBs’ choice of advocate.

One of the most interesting features of the stopwork meetings was the series of resolutions from the floor describing the current medical workforce situation (not just specialist) as a crisis. Factors that led to this widespread collective assessment included the loss on average of one specialist a week to Australia, increasing numbers of specialists reducing their time in public hospitals in order to increase their earnings in the private sector (or withdraw completely to the private sector), ‘trainee’ specialists migrating to Australia for remuneration well in excess of what they can expect to earn in New Zealand and with little prospect of returning, and the current severe shortage of resident doctors forcing increasing numbers of senior doctors to once again work as ‘juniors’.

Successive resolutions highlighted the government (and also DHBs) has having responsibility for resolving this crisis. The most explicit was at the Otago meeting:

That this meeting has no confidence in the Minister of Health’s ability to recognise and appropriately respond to the crisis affecting the recruitment and retention of senior doctors.

Given some confusion with industrial action and their unprecedented nature, there were some concerns that the decision to hold national stopwork meetings would be controversial and divisive leading to membership loss. However, these concerns did not materialise. As a result of the decision six members resigned while there was an increase in the rate of our membership growth during and around the period with a total of 63 new members.

4 Our health professional leadership initiative

Since October 2005 the Association, with the support of the Council of Trade Unions, has been trying to persuade government to accept, promote and require health professional-led leadership in the provision of secondary and tertiary services, including facilitating the formation and strengthening of national and regional clinical networks and making specific recommendations on resource utilisation, organisation and provision of elective, chronic and acute services in each of the DHBs. Despite the pretence of interest, however, the Minister of Health’s direction and conduct has been in the opposite direction.
Unfortunately our initiative could only have succeeded with explicit political support and leadership which has not been forthcoming. This contrasts with the strong political leadership in the formation of the Greater Metropolitan Clinical Taskforce in New South Wales.

In an attempt to overcome this ministerial hurdle we initiated informal discussions with the Prime Minister who had previously expressed interest in our initiative. This led to a meeting with us convened by her and which also included the Minister of Health, Director-General of Health and CTU President.

It was a productive meeting in which the net result was an agreement to develop a memorandum of agreement (working title only) between the Government and the CTU health sector affiliates based on enhancing relationships and including the health professional leadership initiative. This would be a stand-alone agreement that would then feed into the various instruments of government policy such as the Ministry of Health’s Operational Policy Framework and the Minister of Health’s annual letters of expectations to DHBs.

The Prime Minister asked that the parties work together to provide a recommended draft agreement to her by the end of April which would then feed into the cabinet process. This work was undertaken by the Association and CTU and completed within her time-frame.

But in late April the Minister of Health was approached by DHB chairs anxious about the industrial climate in DHBs at that time. He then referred the draft agreement to them and very quickly the process changed from bipartite (which the DHBs would be expected to adhere to) to tripartite (with the DHBs able to shape and influence rather than inherit the agreement). This led to the derailing of the process with considerable revisions to the draft agreement including the disappearance of the health professional leadership initiative due to DHBs’ concerns about encroaching upon their roles and accountabilities and lack of political enthusiasm. It appears, at least with this Health Minister, that our initiative is dead and buried. This is discussed further below in relation to the proposed health sector relationship agreement.

5 Tripartite Process: Proposed Health Sector Relationship Agreement

In its first term (1999-2002) the Labour-led government set up a process known as the Tripartite process comprising cabinet ministers, DHBs and the Council of Trade Unions (health sector affiliates) although over the years the meetings have been irregular. The
intent was to provide a mechanism(s) for the implementation of a culture of constructive engagement throughout the health service. Its most noteworthy success was the Public Health Sector Code of Good Faith which now comprises a schedule to the Employment Relations Act as part of the 2004 amendments to the Act. It has a strong emphasis on promoting collective bargaining (including national) and union recognition, very beneficial to DHBs in such a highly unionised sector. It also includes a provision for life preserving services during strikes.

The only success this year was an amendment to the provision for life preserving services in the code of good faith removing any ambiguity that the definition included risk of permanent injury. The amendment required a process of consultation with the parties to the Tripartite process in which we were a key player.

The other main activity has been the attempt to establish a health sector relationship agreement signed by the three parties—the government (Health Minister and Director-General of Health), all 21 DHBs, and each of the CTU affiliated health unions including the Association. Ironically the catalyst for this proposed agreement was the Association’s advocacy of our health professional leadership which, for reasons discussed above, is no longer part of it. The Association’s initiative intersected with the DHBs approaching the Minister of Health in late April over difficulties in the ‘industrial round’.

This led to four Tripartite meetings between late April and mid-August culminating in a draft health relationship agreement about which there is a high level of consensus over the wording. However, the health professional leadership initiative, which was the catalyst for the agreement and supposed to be an attached appendix, was no longer part of it.

While the wording was innocent enough the proposed agreement lacked substance and did not resonate with actual behaviours either by government or DHBs. Consequently the Association has resolved not to sign the proposed agreement. This decision may be reviewed if circumstances change. The reasons for this decision were (a) the continued impasse and adversarial nature of our national DHB MECA negotiations, (b) the omission of our health professional leadership initiative, and (c) the lack of commitment of the government to public provision of core secondary and tertiary services most evident in politically approved or accepted hospital laboratory privatisation.

The Association’s decision has caused some angst within DHBs and government but it is unlikely that the circumstances will change sufficiently for us to review it. The next Tripartite meeting is scheduled for 8 November.
6  Opposition National Party Health Policy

If the polls are to be believed there is most likely going to be a change of government in a year’s time with a National led government (recognising, of course, that a week is a long time in politics). If this happens then the current government’s handling of the health portfolio will be one of the important reasons why. This is quite a turn-around because in its first six years the Labour led government had, in the main, managed to keep health below the radar and neutralised its political opposition despite growing public disquiet (primarily over access). In the past two years, however, National has taken a different more aggressive approach and taken the fight to government with success. It has turned health into an Achilles Heel for the government. Despite a pending major cabinet reshuffle and despite its strident attacks on his performance, National has resisted the temptation to call for the Health Minister’s head to roll as it knows that as things stand it is on to a winner.

As a sign of its confidence National have recently released a largely aspirational consultation policy document. It was derailed a little when through political misjudgement the document omitted reference to National’s intention to remove a general practitioners fee control mechanism. But the document remains important because of what it signals. Much of it is difficult to take issue with and consistent with commonsense approaches. It contains good acknowledgments of the problems facing our health system. It borrows the Association’s term of ‘data cleansing’ to describe the removal from public hospital waiting lists of patients requiring assessments and treatment. There is also a high degree of commonality with some current government policies and directions with the differences more in degree than kind.

The promotion of clinical networks, taking the lead from New South Wales, is encouraging and acknowledgement is given to this being health professional led. It will be important, however, that in establishing regional networks that they actually are health professional led in the most embracing bottom-up manner. Otherwise there is the risk of it becoming a short-term pillaging exercise. Any successful regional clinical network must ensure that each part of it has the right critical mass to meet local needs. Raiding smaller DHBs simply to centralise in bigger ones will fail; the populations of the smaller DHBs will suffer and the bigger DHBs will be dragged down as they won’t have the capacity to meet the additional demand.

There is also some interesting, balanced and refreshing pragmatism in a discussion over tax rebates for private health insurance, something one might believe National would
instinctively support. However, based on Australian experience, National concludes that tax rebates are unlikely to increase the take-up of private insurance; instead they are more likely to make it cheaper for those who already have it. Further, the extra fiscal cost to government would not result in more elective surgery overall.

However, there are three broad areas of strong disappointment and concern. The first is the workforce in the context of recruitment and retention. Although the document’s final section covers workforce and describes it as in a state of crisis, acknowledges that it is the health system’s greatest resource, and does make pertinent observations, it still reads almost as an add-on. It fails to acknowledge that workforce vulnerability and risk is at the core of the difficulties our health system is facing and there is no strategic approach to addressing it (not that the government is much better in this respect). Instead, aside from a generic reference to improving job satisfaction and empowerment, its solutions are piecemeal and limited, including a naïve suggested linkage between productivity and pay. It lacks a commitment to maintaining and building the capacity of public hospitals to provide services.

In fact, the document has a resentful tone about increased health spending going into personnel, hardly surprising in a labour intensive sector in which real gains and value comes from the workforce. Owing to its small size, small critical mass and relative geographic isolation, New Zealand is always going to be vulnerable to recruitment and retention and has to strive to be competitive. Retention is critical. High levels of workforce stability is a positive incentive for recruitment; the opposite is equally so.

There is a minor error when the document cites the Association as the source for a statement that there was an 8% specialist vacancy rate last December. The figure comes from the DHBs which we have cited.

Second, National buys into the simplistic notion that productivity has declined despite increased health spending. But the use of the term productivity is misleading. It is simply a comparison of hospital expenditure with those things that can be measured which comprise around 35% or so of hospital activities and outcomes. Activities and outcomes in mental health and much of medical care, for example, are not counted. But this simplistic approach suggests (a) hospitals are less busy and (b) health professionals are not working hard enough, both of which are untrue.

Third, National says that it is not looking to restructure and, by implication, return to the commercial model of the 1990s. But there is an iron fist under the velvet glove. There is
nothing headless about this chook. Where this is most evident is its call for DHBs to convert their funding and planning divisions into “shared service networks across their regions.” In other words, maintain 21 DHBs but devolve them of their funding and planning divisions, and create a smaller number of new regional bodies responsible for funding and planning. And what does this look like? The answer is the structure of the early and mid-1990s in which four regional health authorities purchased services from public hospitals (then crown health enterprises) and private providers.

This elevates the distinction between funding and providing to a disproportionate and unjustifiable level. One of the greatest weaknesses of the 1990s was the propensity of funding decisions to be made in isolation from practical considerations. Rather than separation between funding and providing, they both work best when there is a high level of integration. Separation of funding and providing is an attempt to create a structure more suitable for market mechanisms, not ensuring the provision of accessible quality universal health services. One of the biggest problems of DHBs at the moment is when funding and planning divisions are disconnected with the realities of provision and act as aspirational fiefdoms. Good old fashioned ‘house-keeping’ is ignored. National’s approach would seriously worsen this situation by making funding and planning even more remote from practicality and less accountable.

This divorced model does not rest comfortably with National’s support for health professional led clinical networks which depend for success upon a high level of bottom-up integrated decision-making.

It is in this context that the call for “smarter” use of the private sector should be seen. There is no doubt room to improve how contracting with the private sector for electives in response to capacity pressures is handled. But the emphasis in the document suggests a major shift in direction. There are limitations with National’s advocacy. In particular:

- It over-estimates how much the private sector can do to relieve the pressure on the public system. Electives are only a relatively small part of what public hospitals do. There is no workforce over-supply in either the public or private sectors. There is a role for collaboration but one should not be misty eyed over what it can deliver.

- There is no distinction made between forms of contracting to the private sector. One form, subject to agreement over price, is simply to hire spare theatre capacity in the private sector where it exists. This happens and has advantages at least until
capital redevelopment is achieved.

- The general experience of contracting out electives is that it is more expensive because of the additional profit drivers in the private sector. Further, the private sector has a strong financial incentive to cherry pick and grab the low hanging fruit. It is less equipped for the more complex cases. It is for reasons of fiscal pragmatism that a number of DHBs that have contracted out in the past are seeking to build up their own elective capacity.

- The more electives that are done in the private sector, the less attractive public hospital work becomes because of the predominance of onerous acutes and the lack of variety.

National’s call for separating acute and elective service provision should be seen in this context. There is an argument for some separation and this works reasonably well in Denmark, for example. But it is within the public hospital system and is coordinated. Logistical challenges are better able to be worked through. The Canterbury DHB is looking at this with the redevelopment of Burwood Hospital and Counties Manukau has Browns Road. But to have this separation based on a public-private sector demarcation would be potentially disastrous. Allowing the private sector to do the ‘easy’ work and leaving the ‘hard’ work with the public sector would simply make public hospitals unattractive to work in and worsen the recruitment and retention crisis. It is worth noting that the British government’s promotion of so-called independent (private) treatment centres is making little impact on overall capacity and increasing volumes.

There are also worrying signs in the way in which public-private partnerships are discussed. Without directly referring to it the document seems to be taking its lead from the Private Finance Initiative in Britain. PFI is, however, controversial. It is much more than the private sector doing the construction of hospital redevelopment; in this respect nothing is new. But the private sector also assumes control, or at least considerable influence, over design and management. In Britain the driver for PFI appears to be a mix of ideology and meeting European Union borrowing limits. The experience of PFI includes (a) inadequate planning for bed numbers, (b) significant cost overruns leading in some cases to discontinuation at much expense to the crown, (c) increased longer term fiscal risk to the crown, and (d) inflexible design for longer term expectations and needs. Profit margins rather than meeting actual and anticipated demographic needs have been a key driver. It is significant that the devolved governments of Scotland and Wales (and in
different circumstances Northern Ireland) have attempted to avoid using PFI wherever possible.

There are also some question marks about other aspects of their document. For example:

- It overpays the benefits of co-located GPs in emergency departments. It gives the example of Wairau Hospital in Blenheim. This has worked well in the past but as volumes and complexity change the benefits are becoming less evident. In the Whanganui DHB an after-hours GP clinic was co-located at the public hospital. However, the effect on the reduction of admissions has been low, consistent with specialist assessments and less consistent with managerial assessments. Arguably it is a very useful subsidy for GP after-hours care but the benefits to the emergency department have been very limited (as was expected).

- It suggests that a major problem facing hospital emergency departments is seeing too many patients who should have been seen by a GP. These are patients who walk off the street rather than being GP referrals. However, the numbers of patients who make the wrong call are very small and do not impact significantly on emergency department work pressures. The real problems facing emergency departments are lack of internal capacity to deal with actual emergencies and inability to pass patients on to the rest of the hospital because of inpatient capacity limitations (bed blocking).

- The document promotes more hospital based activities being undertaken in GP clinics. This is not a bad thing and should be encouraged where appropriate. But it can’t be decreed. Describing this as a public-private partnership is misleading. It is more of an evolutionary process of constantly evaluating which treatments are best done in a primary care setting and which are best done in a secondary care setting. This is not new but the report inappropriately suggests top-down mandating. The concerns are greater in the context of the above observations about establishing regional funding and planning networks.
7 Medical Council Elections

A significant set-back for the medical profession occurred in the Health Practitioners Competence Assurance Act 2003 which removed the long-standing right of the medical profession to elect some of the medical practitioner positions on its registration authority, the Medical Council. The Act does, however, allow the Minister of Health the discretion to allow for elections subject to a formal consultation process provided under the Act. In response to this identified weakness the Pan Professional Medical Forum was formed on the initiative of the Council of Medical Colleges in an endeavour to strengthen the effectiveness of pan professional representation.

In response to a debacle last year when the Minister of Health declined to accept all the successful candidates in Medical Council-conducted voluntary elections, a public uproar from the profession fearing political interference largely led by the PPMF successfully reversed the Minister’s decision and also persuaded him to initiate a formal consultation process over whether he should use his discretion to allow, by regulatory authority enabled by the Act, mandatory elections.

We are still waiting to learn of the outcome of this review. However, the Ministry of Health is trying to persuade the Minister to delay his decision for another year while a review of the operation of the full Act is completed. This is likely to be a delaying tactic in order to buy time so that the issue will hopefully go away.

8 State Sector Code of Conduct

In 2005 the passage of the State Sector Amendment Act (No.2) expanded the role of the State Services Commissioner to crown entities including DHBs. The main change was to give him the power to issue a code setting out minimum standards of integrity and conduct for state servants including those working for DHBs. A draft code was issued for consultation. Much of it was general and aspirational but there were concerns over a section on ‘impartiality’ which appeared to be in conflict with the right to speak out provided in the national DHB MECA and the Code of Good Faith for the Public Health Sector (a schedule to the Employment Relations Act) and would undermine public confidence in the role of doctors as patient advocates.

The Association took the initiative in working through the CTU in achieving an acceptable rewording of the offending section.
DHBs, as state sector employers, are now obliged to review and amend their own Codes of Conduct to ensure they comply with the new State Sector Code. This process of review is already giving rise to some concerns as individual DHBs may seek to go further than is necessary and seek to particularise behaviours in their Codes that may be used against employees in subsequent disciplinary proceedings.

9 Public Hospital Laboratories

Unfortunately privatisation of public hospital laboratories continued as a result of some DHBs floundering in their response to the devolution of community testing funding from the Ministry of Health to DHBs. While most have handled this in such a way as not to place their hospital laboratory at risk some others have not. Poor political leadership by the Minister of Health has also exposed serious hypocrisy in the government’s criticism of the National Party over asset sales and privatisation.

In 2006 the Minister approved the privatisation of the Otago and Southland hospital laboratories. In different ways and forms privatisation of hospital laboratories has continued and been approved or allowed in four more DHBs with a fifth queuing up for his ‘wink is as good as a nod’.

In the main the decisions to privatise have been characterised by factors such as:

- High levels of pre-determination over outcomes.
- Questionable use of selection and evaluation processes and the marginalisation of health professional input.
- Decisions largely driven by funding and planning divisions operating under the ideology of the funder-provider split of the 1990s.
- The ability of the private companies to be a ‘tail wagging the dog’ in achieving their objectives.
- Some serious performance and other concerns have emerged in some of the privatisations as the under-estimated differences between community and hospital testing and complexities of running a hospital laboratory become more obvious, and with the loss of some valued staff.

In response to the Minister of Health’s first approval of privatisation of hospital laboratories
(Otago and Southland DHBs) the Association, working through the Council of Trade Unions, initiated discussions with the Ministry of Health which led to a new provider selection protocol that has a stronger emphasis on public provision of core secondary services including an express requirement for health professional engagement. However, this has proven to be ineffective in subsequent privatisations because (a) the relevant DHBs have either evaded or simply ignored the protocol, (b) the Ministry of Health when reporting to the Minister of Health have simply accepted what these DHBs say at face value, and (c) the Minister of Health has little real commitment to public provision beyond rhetoric (and simply not seeing DHBs as anything more than board members, chief executives and funding & planning divisions; the concerns of health professionals and the rest of the workforce simply do not compute).

All this should be kept in context. The remaining 11 DHBs have, in a manner broadly consistent with our approach, not put their hospitals at risk when considering their response to increasing community testing costs (there are also three hospital laboratory privatisations of the 1990s remaining). The most impressive example of public-private partnership was achieved by the Hawkes Bay DHB which in tendering for community testing only also required a capacity support strategic agreement between the private provider and the hospital laboratory including a large amount of community testing being undertaken in the hospital laboratory; unlike privatisation an example of the ‘dog continuing to wag the tail’. It is also worth noting that three hospital laboratory privatisations of the 1990s have been reversed.

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