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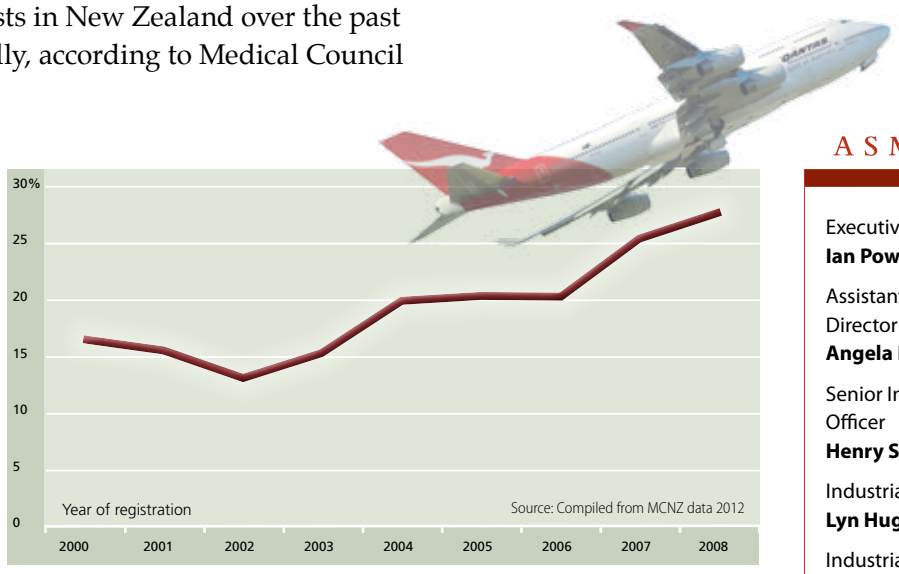
The flight of the IMGs

This article is written by ASMS researcher Lyndon Keene and sourced from Medical Council 2012 data.

Retention of immigrant doctors (international medical graduates) who have registered as specialists in New Zealand over the past decade has deteriorated markedly, according to Medical Council registration data.



IMG doctors lost three years after gaining vocational registration

In the three years to 2002 an average of 10% of IMGs were lost one year after gaining vocational registration; over the three years to 2010 that rate had increased to 17%. Aside from a few small fluctuations, similar trends emerge in subsequent post-registration years. By three-years post-registration (see chart), the latest trends indicated around 25% of IMGs are lost to New Zealand, compared with around 15% at the beginning of the decade.

By 10 years post-registration, approximately one third are no long practising here.

By 10 years post-registration, approximately one third are no long practising here. Around two-thirds of new vocational registrants are hospital specialists."

Concerning trends

These trends are particularly concerning given that 42% of New Zealand's specialist workforce is from overseas, which is up from approximately 35% a decade ago, and gives us the highest IMG dependency rate in the OECD. The fact that, on average, 49% of new vocational registrants over the last decade have been IMGs indicates our IMG dependency will stretch still further in the foreseeable future.

The high turnover of IMGs has created a high level of instability in the specialist workforce in DHBs. It results in an increasing share of senior and resident medical posts being filled by locums on short-term contracts (many of whom are themselves IMGs). This reduces the capacity to bring cohesiveness to medical services, which can have serious implications for training and implementing key health policies such as developing clinical leadership, clinical networks and new innovative models of care.

The turnover rates also lead to substantial costs and add to the supervisory load of other specialists. Health Workforce New Zealand's Executive Chair, Professor Des Gorman, wrote in the New Zealand Medical Journal (March 2011) that unless there is a significant improvement in retention of doctors, New Zealand will not have a sufficient medical workforce to meet future health demands of an ageing population.

The high turnover of IMGs has created a high level of instability in the DHB specialist workforce.

Why IMGs leave New Zealand

The available data indicate the task of improving retention rates of IMG specialists is especially urgent. But in

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order to develop effective policy measures to improve retention rates it is necessary to understand why so many IMGs decide to leave New Zealand.Given the importance of this question there has been surprisingly little effort from HWNZ to provide any insight. A survey commissioned by the Medical Council in 2009/10, reported on in *The Specialist* (March 2012) provides some useful indicators, though it was not specific to specialists. Only a summary of results have been published.

All IMGs who had applied for a Certificate of Good Standing before leaving New Zealand were invited to complete the survey (the number has not been published); 51 responded. They indicated, among other things, that 24% left New Zealand for family reasons, 22% left to take up other professional opportunities or higher training, and 16% left for higher remuneration. Perhaps most significantly, a large proportion of respondents (41%) said they had only ever intended to stay in New Zealand for a short time.

There has been surprisingly little effort from Health Workforce New Zealand to provide any insight over why IMGs have poor retention rates.

That is reinforced by DHB exit interview data, obtained under the Official Information Act, which indicate a high proportion of departing senior medical officers are on fixed-term contracts. Registration data suggest many of these are IMGs.

An answer to the question of how to address our poor retention rates for IMG specialists, then, appears to be directly related to New Zealand's poor recruitment record. Given that DHBs are facing ever tightening budgets, the indications that they are prepared to pay the high costs of hiring specialists through a revolving door of short-term contracts is a clear sign they lack the ability to attract adequate permanent staff.

DHBs preparedness to pay the high costs of hiring specialists through a revolving door of short-term contracts is a clear sign they lack the ability to attract adequate permanent staff.

The registration data and workforce trends strongly suggest that in order to improve specialist retention, DHBs first need to be in a position to improve recruitment.

Lyndon Keene
ASMS Researcher

Confessions of a serial optimist

I have had a dream. Not one sought or strived for, but nevertheless a dream. Almost ten years ago I was asked to step into the vacancy left by a President's move into the Ministry. After a while I realised that to do the job justice I would need to throw my own personality into it, as I took on a position representing the collective of 2200 hospital doctors and dentists, many of whom saw themselves as victims. Victims of rapid reforms, victims of rampant managerialism, victims of multiple jeopardies when the inevitable errors occur.

I have had the privilege and honour of participating in a change of culture. There are remnants of managerialism and command-control, particularly resurfacing in the constrained environments we increasingly encounter. However our Association and its members are increasingly active on the control decks as well as in the engine rooms of our system. From the bedsides to the boardrooms we are leading and changing, innovating and challenging. Leading even when we struggle to find the time aside from seeing patients. Patients who expect that with our knives, knowledge and nostrums we continue to push the boundaries of healthcare, while sharpening, shaping and shifting the very system we work within.

I have enjoyed and endured arguing at top tables, including an all night session in the office of the Minister of Health, and hosting a Prime Minister and her Deputy at the same Conference. I have seen the worst and the best of negotiators and factotums. I have joined with marvellous managers and administrators, while wondering how some of their colleagues seem to be so destructive to our aspirations.

I have had the pulpit of a three-monthly column to express in verse and prose my take on the world I inhabit. I have attempted prodding while stopping short of preaching. I may not have always succeeded, to prod effectively, or to avoid an occasional preach. The forcing function of a print deadline can freeze the pen as well as the brain. So I have often looked outside of medicine for teachings and learnings. I have taken the opportunity to funnel the wisdom of others while avoiding claims of any self-expertise. I have tried to be more than a conduit, rather reshaping the message for the moment and the audience. Many times I have tried to catch the inspiration between dreaming and waking, to distil insights flitting at the edges of consciousness.

The public pays
The public gets
In between lies the finery and the furore
Finery of striving to peak performance
Furore when any one impinges on my plans

The public pays
Through public CEs
More than a million to recruit and retain
Specialists so special they are beyond
The ken, of mortal men

The public pays
The public donates
To forlorn cases with heartstrings
Attached to far flung cures
Without the test, of evidence

The public pays
The public funds
Whims and fancies of superologists
Attached to far flung cures
Without the test, of evidence

The public pays
The public purse
For political cycles of convenience
While most important diseases
Have more than three years to run

The public pays
The public says
For what is right and proper
Trusting the carers and curers as one
For fair and forthright futures

Each column may have prodded or provoked one or two to consider their own world and own actions. I will never know if permanent change ensued. Whether they have been wake up calls, or merely snooze alarms. We can all get agitated for a while, but then we do not follow through, unless others are with us and encourage us to overcome inertia and barriers of our system and ourselves.

And is the system merely the cumulative outcome of ourselves? Jeffrey Kluger (in Simplexity) opines that human beings have always been confoundingly quarrelsome creatures, given more to conflict than to resolution. The fact that we ever settle any of our differences is a tribute to how deftly we can learn to manage them. The fact that we often fail to do so is a testament to how much more we still have to learn.

I am more optimistic, though the past decade has shown me the need for realism and pragmatism. To seize what advantage the moment and occasion allows, while also preserving the values of our public health system. Most of us are in this business for a clinical lifetime, and we recognise our forbears for what we can learn from their advances and their errors. On the storm tossed seas of change, often for short term targets and easily counted goals, we are the keels and rudders steering for distant horizons of long term improvements.

Of the many and multiple things that define us, leadership seemed to seek me. I have agonised when to stand at the front of the waka, taking the storm spray in my face, and when to stand at the stern, admiring the energy of the paddlers, pretending to steer here and there. I have relied on others to correct my stance when I chose the wrong end of the waka. I apologise when I have not followed their advice, for any offence I may have caused, and take personal responsibility for the outcomes of my actions.

There is a certain loneliness in captaincy. A need to be with the team and slightly apart from it. To represent at the same time as guiding. To lead whilst encouraging others to step up. To lead whilst encouraging others to challenge.

To lead whilst encouraging others to follow. To lead whilst encouraging others to take over.

I hand over to another paediatrician who spends his daily clinical life dealing with the effects of poverty and greed, with the deprived generation who we require to be our future healthy working tax-paying citizens, and with the challenges of small town and distant health care. I have confidence that Hein Stander will stamp his own style and caring on his Presidency of our marvellous Association.

The ASMS has stood, and continues to stand, at the pinnacle as defender of our public health system. It has achieved collective power and influence with longevity and relevance. Adopting an identity in Te Reo is long overdue. After seeking the wisest possible counsel, we have been gifted the name *"Toi Mata Hauora"*. It reflects our position collectively at the peak of health care, and our roles individually as the leaders of health care teams. We will adopt this identity at a gathering of branch presidents and vice-presidents this month. I trust using it will further advance our causes on behalf of our members and the citizens who depend on our leadership and care.

We now have almost 4000 members. Many of whom are leaders in their own right. Many of whom are embracing new clinical networks and new models of care. While trying to preserve the core values of our public health system, which ranks amongst the longest lived in the world. These members have diverse opinions and desires for themselves and for the patients in their ambit of care. They will not agree on many things. But I have found, time and again, they can be united in their passion for a high performing system based on fairness rather than favourites, on equity of access and equality of outcome. And outspoken when they see these principles sacrificed for political or other expediency.

I have spent ten years outspeaking, prodding, reflecting, uniting, occasionally guiding. I have inflicted prose and poetry in this column to cajole and encourage, to enter your thoughts and share some of mine. It has been more than a dream.

It is now time for my dream to end.

It ends in delight.

And.....

It is never ending.

I will continue to marvel at the brilliance, the obstinacy, the endurance, the vigilance, of every one of you - our dedicated specialist membership. And I have been tremendously inspired by the young leaders in our medical student cohort, who will be more able and more worldly than I could ever aspire to be. The future is In Good Hands.

I will partake and contribute, from a different position within the waka.

Kia kaha.

Jeff Brown
National President

Better, sooner, more convenient: ASMS industrial team

Since 2007 when we last established a new position in the industrial team ASMS membership has increased by over a third. Accordingly in July last year the National Executive authorised the establishment of a new full-time industrial officer position subject to the confirmation of suitable accommodation.

Although it will not be until later this year that we are able to take over the rest of the 11th floor at the Bayleys Building in Brandon St, Wellington, where we have our offices, we decided to go ahead and advertise and appoint even if it meant being a little over-crowded for a while. We have now appointed a new industrial officer, Steve Hurring, to the team.

From left: Angela Belich, Henry Stubbs, Lloyd Woods, Lyn Hughes, Steve Hurring

Steve has worked for the Engineering Printing and Manufacturing Union and the Public Service Association. He has a law degree and had been recently been practicing as a barrister and solicitor in immigration and employment law.

From 1 April Steve will be responsible for industrial matters in Waikato, Lakes, Bay of Plenty, Hawkes Bay, Tairawhiti, Taranaki, Whanganui and MidCentral DHBs.

Lloyd Woods will have responsibility for Wairarapa, Hutt Valley and Capital and Coast DHBs as well as all South Island DHBs.

Lyn Hughes will be working four days a week and will have responsibility for Northland, Waitemata, Auckland and Counties Manukau DHBs.

Senior Industrial Officer Henry Stubbs (who also works four days a week) will continue to work on medico-legal issues and support the industrial officers. Assistant Executive Director, Angela Belich, leads the team.

Politicisation threats to regulatory authorities

One of the things that the medical and dental professions (along with other health professions) fear is the politicisation of our regulatory authorities – the Medical and Dental Councils. As fearful as the professions should be, the greatest threat is to the public who depend on and fund a health system with high standards of quality and safety.

The Health Practitioners Competence Assurance Act 2003 was in general a good, progressive and robust piece of law that provided the regulatory framework for the health professions and with the prime purpose of protecting the safety of the public. It is the statute from which the regulatory bodies such as the Medical, Dental and Nursing Councils are derived and to which they are accountable.

The Health Practitioners Competence Assurance Act 2003 was in general a good, progressive and robust piece of law

Not completely but to a large extent. it was based on the then Medical Practitioners Act 1995 covering doctors, which was then extended across to several other professions – some of which had their own less advanced regulatory legislation (such as dentistry and nursing) and others which had none at all.

One of the strengths of the Medical Practitioners Act was that it continued from its preceding legislation the right of medical practitioners to elect fellow practitioners to the Medical Council. Dental practitioners also had the same right under the Dental Act 1988. This right was important in ensuring that there were doctors or dentists on their regulatory authority that had the confidence of their peers. This is a strong contributor towards the confidence of the profession in their registration body and strengthening the safety of the public.

Downside threat of the HPCA Act

However, in what was the biggest downside of the HPCA Act this right was taken away in what constituted the biggest potential threat to the autonomy of the Medical Council for many years. While the Act provided for four medical practitioners to be on the Council these were to be appointments by the Minister of Health rather than elected by the profession.

Initially this was got round by the Medical Council continuing to hold elections (the Dental Association for the dental profession) and then referring the names of the four successful candidates to the Minister of Health who would then appoint them. This practice began under the architect of the HPCA Act, then Health Minister Annette King. However, this blew up when her Labour successor Health Minister Pete Hodgson decided for his own reasons to only appoint three out of the four and to instead appoint an unsuccessful candidate.

In response to what was seen as an encroachment on the independence of the Medical Council it led to a hostile reaction from a unified medical profession. Labour's third health minister David Cunliffe listened and agreed in 2008. But his attempt to reinstate mandatory elections was blocked by cabinet. Fortunately, however, this was picked up by the National Party in opposition.

Within a few days after it became government in November 2008 new Health Minister Tony Ryall announced that regulations would be introduced establishing that the four medical practitioner positions would be elected by the profession, not appointed by him, and further extended this to the Nursing Council which had never had positions elected from the nursing profession. Unfortunately this proved difficult to apply to the Dental Council because of the inclusion under its jurisdiction of other allied dental occupations.

Regret, irony, secrecy and new politicisation threats

Regrettably, and also ironically given that it involves the same health minister, threats to the autonomy of the regulatory authorities have re-emerged in two different ways. The first is a secretive process initiated by Mr Ryall in which the regulatory authorities are being pressured to amalgamate their organisational resources including staffing. This seems innocent enough and perhaps even sensible. But if this was so why the secrecy? Why are the professions being excluded by the Minister? Why is the Minister requiring this exercise to be conducted in a way that is the exact opposite of the clinical leadership and engagement that he has previously professed to support?

The official reason given was cost reduction through rationalisation. But it appears that the initial estimates of savings proved to be overly optimistic. The concern we have, along with other organisations of the medical professions such as NZMA and the NZ Nurses Organisation, is the risk of 'dumbing' down the expertise that the different vocationally based regulatory authorities need. If you make your expertise more generic by cost cutting, you increase this risk.

The concern we have, ... is the risk of 'dumbing' down the expertise that the different vocationally based regulatory authorities need.

Due to its unnecessary politically imposed secrecy it is difficult to know what is happening. However, inevitably there are leaks. One thing we know is that the secretive process has gone on much longer than intended. The Minister has the power to influence,

to cajole but not to require or instruct. It does appear that some of the regulatory authorities, the Nursing Council at least, is courageously standing up to this pressure.

Solutions look for problems

The second threat arises from the current review of the Health Practitioners Competence Assurance Act. One of the successes of the lobbying over the original Bill that led to the Act was the inclusion of a statutory requirement to review the operation of the Act three years after it came into force. That operational review was conducted in 2007. It concluded that the Act was working well but recommended some minor changes. Legislation to enable this was prepared in 2009 but to date it has not been introduced into Parliament.

Meanwhile Health Workforce New Zealand has leapt into the fray, on behalf of the Minister, with a new review. Its discussion paper has been severely criticised by a range of professional bodies (including the ASMS) as being solutions in search of problems. The thrust of the concerns involved diluting the Act's focus on the safety of the public (by introducing a new focus on workforce data despite the fact that this should be HWNZ's role) and increasing Ministerial power over the regulatory authorities. The latter might be driven by the difficulties confronting the government in achieving its objective in merging the authorities resourcing.

In opposition the National Party rightly criticised the potential threat to the autonomy of the Medical and Dental Councils by the then Labour led government and in government it rightly corrected it with the Medical Council at least and also extended this positive move to the Nursing Council. This makes doubly disappointing that it is now seeking to increase its influence in different and potentially more threatening ways, and through a process that excludes health professionals (contrary to Mr Ryall's advocacy of clinical leadership).

Ian Powell
Executive Director

jobs.asms.org.nz revamped

The ASMS has for many years provided a jobs listing service on its website for the benefit of our current and potential members and their prospective employers. In addition to holding New Zealand's most comprehensive listing of SMO job vacancies, the ASMS website is one of the first points of contact for most senior doctors and dentists seeking medical employment in New Zealand. Consequently our website receives a high volume of international traffic with an average of 3,000 visitors each month.

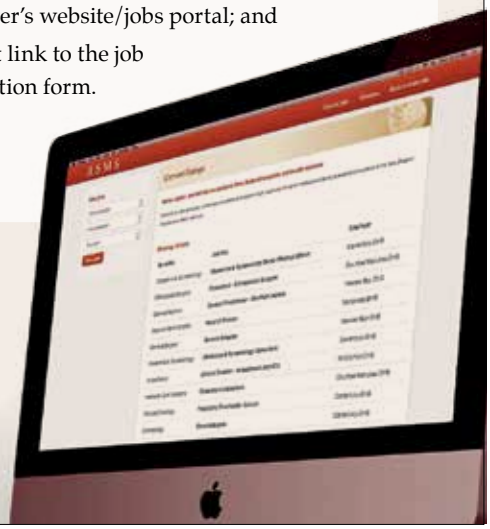
A key aim of the service is to help fill SMO vacancies throughout New Zealand's public health sector, particularly in our DHBs. The website has always drawn strong interest from international medical graduates looking for employment in New Zealand.

In order to further improve this service we have redesigned this section of our website, launching the new service in mid-March. The refurbished section has a range of features to simplify the vacancy listing process for advertisers and provide added functionality making the site much quicker and easier for advertisers to use. It also includes a number of enhancements improving the website's usability for SMO job-seekers which we expect will increase the number of repeat visits as well as build the total volume of visits.

Users can either go direct to **jobs.asms.org.nz** or link from the main ASMS website homepage (see *Advertising* and *Vacancy Listings* buttons in the right hand column).

New features for SMO job-seekers include:

- improved search features;
- the ability for jobseekers to subscribe for email alerts in regard to their search preferences;
- the ability to email a vacancy listing to a friend or colleague;
- an easy contact form direct to the vacancy contact person for a specific listing;
- a direct link to the full job description on the employer's website/jobs portal; and
- a direct link to the job application form.



Will patient safety still come first?

The Health Practitioners Competence Assurance Act Review

Last year saw the third attempt by two successive governments to review the Health Practitioners Competence Assurance Act (HPCAA).

The Health Practitioners Competence Assurance Act is the statute that sets up the system for registering health professionals in New Zealand and sets up the 'responsible authorities' such as the Medical Council. The purpose of the Act is to protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise their professions. It does this mainly by setting up an accountability regime through bodies like the Medical and Dental Councils which specify scopes of practice within which each practitioner is competent to practice.

An operational review was required in the Act. This started in 2007 and found that the Act was largely working well. The relatively minor changes that resulted from the operational review have been awaiting introduction into parliament for some time and were to have been sent to the Health Select Committee last year.

In 2010 Health Workforce New Zealand went through a consultation process on a paper called "How do we determine if statutory regulation is the most appropriate way to regulate health professions." Neither of these two rounds of consultation appear to have delivered the outcome required by Health Workforce New Zealand or the government so a third review was launched in 2012. This review required responses on some issues that were fundamental to the operation of the Act. The review asked for input by October last year. The ASMS responded to the review along the lines outlined below.

The HPCAA, at present, puts the operation of the registration system outside of the direct day to day control of the government. The review document suggests adding an additional requirement to the Act which requires the responsible authorities to be cognisant of workforce needs. This will, over time, risk diluting their public safety focus.

The review document suggests adding an additional requirement to the Act which requires the responsible authorities to be cognisant of workforce needs.

There are two ways that a body, whose mechanism for protecting public safety is the registration of individual practitioners, can help to meet workforce needs.

One way is by being very efficient and welcoming to those that meet standards. There will be no one in the sector that is not in favour of greater efficiency. Improved efficiency however is not achievable through statutory fiat.

The other way the Medical Council could help meet workforce needs is by lowering of standards. It would be very concerning if the outcome of the review was to lower the standard of doctors and other health professionals registered in New Zealand.

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HPCAA and expanding the number of regulatory authorities

Certain tensions are intrinsic to the way the HPCAA was originally constructed. The driving logic behind the HPCAA was to apply the principles that lay behind the Medical Practitioners Act 1995 to the other health professions partly because things like the issuing of practicing certificates annually to ensure that a practitioner had maintained their competence were seen to be a good idea and less explicitly, to put the other professions on the same footing as doctors.

It is (and was) entirely predictable that regulation under the HPCAA would be seen as the marker of a fully developed profession and therefore many small groups would seek to be regulated under the Act. There are several solutions to the ensuing problem of professions so small that they are unable to support the infrastructure of maintaining their own regulatory authority.

One is the second tier licensing regimen suggested by the New Zealand Medical Association (among others) and one is a shared infrastructure or a joint Council for the smaller professions as is in place in the United Kingdom. Whatever the solution it should not be at the expense of maintaining the expertise and improving the efficiency of the current responsible authorities

The Medical Council

Any organisation representing doctors in New Zealand will have a very high proportion of international medical graduates as members. The ASMS is no exception.

Though many of our members have been in New Zealand for many decades some of their more searing experiences with the process of getting registered remain fresh in their minds though they occurred under a different Medical Council, under different processes and sometimes even before the current Act. It is easy to be led into thinking that the process is in dire need of reform.

However it is the ASMS's view that the Medical Council processes for registration have improved and compare well with processes that our members have endured in other jurisdictions. The problems we currently perceive with the Medical Council are:

- A tendency to attempt to placate the demands of outside individuals or organisations such as the repeated attempts to make practice visits compulsory on the whole profession or placing a positive spin on unfavourable workforce data
- A failure to realise that their role as both judge and investigator requires precise, fair and consistently used terminology and processes that meet the requirements of natural justice.
- A real problem with achieving rapid registration of some doctors. Some elements of this may be insoluble because of the relative scarcity of the appropriate medical expertise in New Zealand that is required to audit overseas qualifications and experience

The proposals in the review, do not offer the prospect of improving these shortcomings. A joint secretariat, amalgamation of authorities, expanding duties to maintaining the workforce and the provision of workforce data and increased attention from the government will make all these problems worse.

The issue of the appointment of members elected by the profession to the Medical Council was of considerable importance to the ASMS and we would expect that this would continue.

Cost

The implicit criticism made of the Medical Council (and other responsible authorities) in the review document is that they cost too much. This has been of concern to the government because DHBs have agreed over many years to reimburse many of the costs that the responsible authorities levy off health practitioners. This includes provisions in the MECA.

The analysis that was done when this was mooted as a problem recently suggests that the amount saved by amalgamations either of secretariats or Councils would be minimal.

The government has required the authorities to amalgamate their secretariats by June 2013 to increase efficiencies. We doubt that this will save much while risking the dilution of expertise.

Health workforce data

One of the proposals in the review document is that the Act be changed to require the responsible authorities to provide workforce data.

The Medical Council already provides two forms of data. Data obtained from the registration database and data from the annual workforce survey.

Because of its registration function doctors asked for data by the Medical Council would feel constrained to supply it. It would be of concern to the ASMS if personal data supplied for this purpose was used for another purpose. This would be particularly concerning if individuals could be identified which with small specialities in a small country would often be quite easy.

Collection of health workforce data is a key function of Health Workforce New Zealand and was the major item in their first work plan. A large part of the health workforce is not regulated and much of the information is or should be held by DHBs.

There needs to be careful consideration by HWNZ, the responsible authorities and DHBs to coordinate the efficient collection of data without unnecessary duplication.

Teamwork and workforce flexibility

The HPCAA is regarded in some quarters as a barrier to workforce innovations. The review asks for comment on common standards for professions and on workforce flexibility

There is no doubt that much health care is delivered in a team context. Our members work in multi-disciplinary teams and there is some suggestion that the isolated health professional is most likely to be at risk of both burnout and anomalous practice. In addition, integration between secondary and primary care through agreed care pathways is developing at a fast pace in many areas

However the really effective team depends on individuals with a clear sense of their own professional skills that complement without exactly duplicating the skills of other professionals. Team members do not always know each other, particularly teams integrated over distance. However they will know what to expect of the professional exercising the role.

Health Professions have developed over time with different trajectories and different skill sets. It would be easy but erroneous to assume that a flexible generic health worker would be more efficient to train and easier to place. The closest fit to such a multi-use professional with skills focused on the diagnostic is the vocationally registered GP. There are multiple issues around both their training and retention and despite the longing for a generic quick fix evident in the paper no real way around the breadth and depth of the training required.

A practitioner must be grounded in their own profession and scope of practice and be able to confidently interact from a basis of a secure knowledge of what other professions know and can do. Paradoxically, system wide flexibility may be dependent on the solid, known competencies of the individual practitioner.

The HPCAA requires the mandatory reporting of health professionals by other health professionals if they are believed to be unable to perform their required functions because of a mental or physical condition. Prior to the passage of the HPCA bill into law there was considerable discussion of mandatory reporting of competence issues. In the end it was decided that this type of reporting would be neither necessary nor useful. We hope very much that this review will not be used as an excuse to reopen this argument.

Health Workforce New Zealand said in the discussion document that the findings of the consultation process will be published prior to public discussion in March and April this year with a final report in July.

Angela Belich
Assistant Executive Director

Sustainable healthcare – it's a clinical issue

This article has been written specifically for The Specialist by Drs David Galler and Clinton Pinto, intensivist and radiologist at Counties Manukau DHB. Both also gave a brief presentation on this subject at last November's ASMS Annual Conference.

It's hard to believe that there are still some people who don't believe in climate change and global warming, and that we humans are responsible for it.

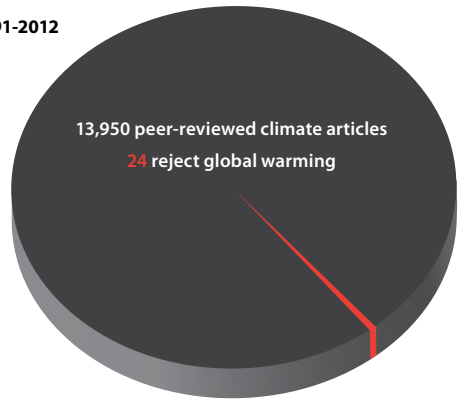
This debate should really be over, so one questions why it still bubbles on. Maybe this is explained in large part by the recent article in the Guardian weekly (14 February, 2013) reporting that major US Trusts, the Donors Trust and Donors Capital Fund, have been funneling millions of dollars to over 100 climate sceptic groups.

"The funds, doled out between 2002 and 2010, helped build a vast network of thinktanks and activist groups working to a single purpose: to redefine climate change from neutral scientific fact to a highly polarising "wedge issue" for hardcore conservatives." Suzanne Goldenberg, Guardian Weekly.

This funding stream reportedly far outstripped the support from more visible opponents of climate action such as the oil industry.

The science linking human activity to climate change and global warming is rock solid as this, the most important pie graph you will ever see, shows:

Climate articles 1991-2012



Climate change is already having disastrous effects on our planet, on our budgets and on our health. It is reflected in the costs of everyday goods and in ways that will become increasingly obvious across more and more domains of our everyday lives. For healthcare organisations like Counties Manukau, measures of our success as a high performing health system will soon include carbon, as well as patient and population outcomes, and meeting budgets.

Measures of our success as a high performing health system will soon include carbon, as well as patient and population outcomes, and meeting budgets.

Hospital facilities and carbon credits

We are not far off the era when healthcare organizations like ours that wish to extend their facilities, will need more than just the funding to do that, they will need carbon credits. The NHS Climate Targets dating back to 2008 and the development of the UK's NHS Sustainable Development Unit are a testament to that. As we plan new buildings here at Counties Manukau for maternity services and with the potential development of the Manukau Health Park being discussed, we need to be thinking about the return on investment that results from the sustainable design of those facilities.

It's for all of those reasons and more that it is important that all of us understand the science of global warming and what we must do to control the high levels of C02 in the atmosphere.

In broad terms, its cause is largely due to population growth, the lifestyle choices we make and in the words of Dr Frances Mortimer a public health physician in the UK, the *Carbon Dependency Syndrome* that so many of us suffer from.

Its effects are global warming, climate variability, a rise in sea temperature, the melting of the polar ice caps and all the consequences that follow from that.

Sustainability in healthcare moves into the more complex but exciting realms of new models of care and prevention.

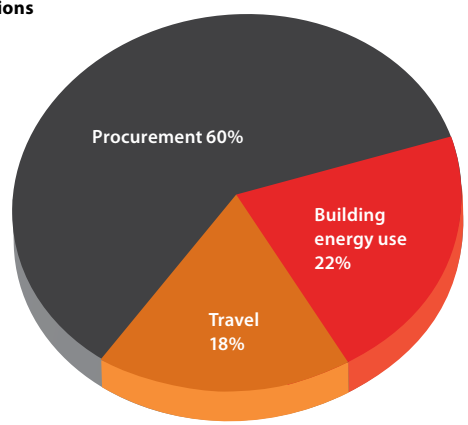
The good news is that for health services, almost everything we do to reduce our carbon footprint will likely improve the quality of care we provide and improve health outcomes. Simple examples of that include waste reduction and saving energy through measures like automated means to turn off computers and lights that frees up significant resources that can be used for core business. Over the space of a very short time, our friends at the Museum of Auckland have saved over $500,000 in this area alone. Better design of new buildings adds enormously to those long-term energy savings.

However if the whole DHB switched tomorrow to renewable energy sources, we would still not be sustainable. Only about 20% of the Carbon footprint of a health system results from direct energy use, the majority is from the procurement of medicines, equipment and the like (see chart over page). Every syringe and every needle we use, and every drug we prescribe, has its own carbon footprint. So sustainability in healthcare moves into the

more complex but exciting realms of new models of care and prevention. Hey, isn't that our direction of travel anyway? Isn't that handy!

The other major source of the footprint is travel; whilst staff travel is a substantial component of that, the distances our patients need to come for services is an enormous contributor to health's Carbon Footprint. So once again, our move to a single system of care with more and more services being delivered in the community where people live and work, together with an increasing use of new technologies to monitor and manage patients in their own homes and workplaces will prove to be sound sustainable practices.

Hospital CO2 emissions



Embarking on a programme

Last year following an enormously popular blog on sustainability by our Chief Executive Geraint Martin, a small group of Counties Manukau staff, led by ASMS members, persuaded the Board to embark on a programme to measure, manage and reduce the DHB's carbon footprint. On 27 February 2013, following some great work by our new Sustainability Officer Debbie Wilson, we celebrated our early success by gaining certification by CarboNZero (www.carbonzero.co.nz) through their CEMARS programme.

Sustainability is a clinical issue and requires all of us to be engaged in working towards creating a sustainable health system.

In so doing we have now measured the carbon footprint generated from the Manukau and Middlemore sites and made a commitment to reduce it over time, in a transparent and measurable way. The details of those plans and our ultimate success in reducing our carbon footprint will largely be dependent on the engagement of all of our staff, clinicians and non-clinicians alike.

So it's clear, sustainability is a clinical issue and requires all of us to be engaged in working towards creating a sustainable health system. Our responsibilities include:

- Prevention – eg the mental health doctor takes an interest in addictions; the ED doctor in the provision of good primary care services
- Designing ever more patient centred models of care. Examples might include: patient preference considered as part of the treatment decision making process; copying notes, lab reports to patients so they do not need to come to the clinic for results; follow up as appropriate closer to patients' homes or by phone, email, skype, text or using telemedicine in remote areas; mobile services as appropriate eg mammography.
- Developing lean pathways of care
- Thinking about low cost/low Carbon options as part of the cost benefit of all choices we make.

For those who wish to explore this area more fully Google our friend Muir Gray who has led much of this work in the NHS and check out the websites below:
www.austhealthweek.com.au/Event.aspx?id=805632
www.hospital2020.org/Agreenhospital.html

Strengthening central control: amending the State Sector Act

The State Sector and Public Finance Reform Bill had its first reading on 29 November 2012 and has now been referred to the Finance and Expenditure Select Committee. The ASMS sent in a written submission.

The Bill provides that:

- The State Services Commissioner may, without union consultation, issue wide-ranging binding workforce policy orders relating to principles of pay and conditions or workforce strategy
- The Minister of Finance and the Minister of State Services will have wider powers to issue directions to much of the state sector including DHBs
- Redundancy compensation for employees in the state sector (including those working for DHBs) may be denied where they are offered another job elsewhere in the state sector (including where the employee elects not to accept the role in some cases).
- State Owned Enterprises and crown entities (DHBs are crown entities) may be partially privatised by order in cabinet (placing them in new schedule 4A of the Public Finance Act) without requiring additional legislation. This is an obscure provision in the Bill which hopefully will not proceed.

Under the Crown Entities Act DHBs are classified as Crown Agents and several provisions in the Bill will have a direct impact on senior doctors and dentists.

Redundancy and transfer of Employment Provisions

Senior Doctors are sometimes made redundant, generally because of a change in the type of services required at a particular location or restructuring (for example, the redundancy of medical officer anaesthetists at Ashburton Hospital) and the ASMS has negotiated provisions in the collective agreement with District Health Boards to deal with this hopefully rare contingency.

The changes proposed to redundancy payments in the Bill, as drafted, appear to apply to crown agents such as the DHBs. The intent appears to be that state servants who are made redundant in one job cannot take up another job with the state that has more or as favourable terms and conditions without forfeiting their redundancy payments. They also forfeit their redundancy if they are *offered* such a job.

The obvious answer is for a person in such a position to delay taking up such a job, or even searching for such a job, until the notice period is over. Apart from the obvious unfairness to the individual concerned the policy implications for a state agency, such as a DHB, the Ministry of Health or ACC recruiting a much needed senior doctor, do not appear to be in the public interest. For example, a paediatrician with the Ministry of Health being offered a job by his or her local DHB, or a DHB medical officer offered a position with ACC, would be well advised not to look for a position immediately but delay job search until after the notice period had expired.

Apart from the obvious unfairness to the individual concerned, it is hard to see how the public benefits from this. Not only do they pay the redundancy but also suffer in terms of an unnecessary interruption to the use of scarce skills.

Discussions have been held by the State Services Commission and the New Zealand Public Service Association suggesting that this provision would be restricted to the core public service. The hope is that our members and DHBs will be removed from the ambit of this provision.

Workforce Policy Orders (55B)

Since 1988, with the coming into force of the State Sector Act, the same employment relations legislation that applies in the private sector has applied to the public sector. This is based on the convention that state sector employers are employers in the same way that private sector employers are employers. The rules and institutions are the same and the parties negotiate and agree in the same way.

The difference between a private sector employer and the state as employer is that the state through legislation sets the rules within which bargaining takes place. The temptation for the state as employer is to put in place laws to give them what they were unable to gain in negotiations.

Under the pre-1988 regime this manifestly overweening power of the state in relation to its employees was tempered by a system of tribunals which included members of the judiciary and detailed parameters set in law as to the grounds for changing conditions of employment.

This was for many years a successful system that also served to distance politicians from direct involvement in run of the mill collective bargaining. It is worthwhile to note that at that time of greater centralisation there was also a separate Health Services Personnel Commission which fulfilled some of the same functions for the public health sector as the State Services Commission did for the public service.

However in 1987 the then government was so dissatisfied with what the legislation delivered in pay increases that it changed the rules fundamentally. The system still achieved distance between politicians and bargaining but this was through independence of the state sector employers from the government in matters to do with employees.

The proposals made in this Bill on Workforce Policy Orders will allow the State Services Commissioner to propose, and the government to pass, orders in Council which, we must assume will force state agencies to do something that they wouldn't otherwise

do. This is clearly intended to apply to collective bargaining as only decisions on individual employees under section 33 are exempt.

A workforce policy order is very close to a determination under the pre-1988 regime and has no equivalent in private sector employment.

Those drafting the Bill have attempted to couch this provision as if it were designed just to fulfil the role of some high level strategy with respect to pay and conditions for state servants.The government already has the ability to set strategies and does so. Orders in Council proclaimed by the Governor General have very much greater legal weight and are inappropriate for the high level strategic examples that have so far been given.

The inescapable conclusion is that some state agencies have used their statutory independence to arrive at outcomes to collective bargaining that the State Services Commission or the Government are unhappy with. There is no information on what the problems were that led the government to feel that it had to legislate to solve them.

Some protections are built into this provision in that (as with all directions under s103 of the Crown Entities Act) these orders must be published in the Gazette and tabled in Parliament.

For public service departments, good faith obligations may have some constraining effect on the Commissioner as their employer with respect to collective bargaining using this provision to interfere with collective bargaining. The Commissioner does not have the same obligations with regard to other state servants such as employees of DHBs.

The CTU proposes that this provision be subject to a duty to consult with employees and unions and that these provisions should not be able to be used with respect to extant collective bargaining. The ASMS supported this change with respect to the wider state sector but submitted that DHBs should be exempted from its operation. DHBs are partially elected bodies and very large employers (often the largest employer in their area). The State Services Commission has not demonstrated any expertise in the health sector. The Workforce Policy Orders should not apply to the public health sector.

Consultation and the State Services Commission

The effect of many of these proposed changes is to give added powers to the State Services Commission. We have doubts as to whether the Commission has the appropriate approach as it gains additional responsibilities with respect to the wider state sector and in particular the health sector.

The New Zealand public health sector is probably the most unionised section of the New Zealand workforce as well as being a treasured taonga of the New Zealand public. It also has developed consultative institutions between employers, employees and the Ministry of Health. The State Services Commission has demonstrated in the consultation process over this Bill that they neither understand nor respect that culture. This Bill was discussed with the CTU State Sector Council on one occasion. Further consultation has occurred with one or two of the larger state sector unions but not with the CTU State Sector Council or the CTU Health Sector Standing Committee. The State Services Commission does not see consultation as a proactive responsibility, rather just a box to be ticked and does not fully embrace any role with respect to all state sector unions and the wider state sector. They should not be entrusted with any further power over the public health sector.

Whole of government directions (proposed s107 Crown Entities Act)

The Bill proposes a widening of Ministerial power with regard to whole of government directions presently provided for under the Crown Entities Act. The present provision reads:

'The Minister of State Services and the Minister of Finance may jointly direct Crown entities to comply with specified requirements for the purpose of both—

- *supporting a whole of government approach; and*
- *either directly or indirectly, improving public services.'*

It is proposed that whole of government directions be widened to include;

- *to improve (directly or indirectly) public services*
- *to secure economies or efficiencies:*
- *to develop expertise and capability:*
- *to ensure business continuity:*
- *to manage risks to the government's financial position.'*

There is little that could not be justified under one or other of these headings including a whole of government order on collective bargaining.

In the health sector the introduction of this provision happens at the same time that Health Benefits Ltd is attempting to put in place what it sees as efficiencies in the health sector.

Part of the rationale for having crown entities and not just one giant government department is to fit the entity to the task it performs and the population it serves.

In a country with very few checks and balances to the power of the government of the day and very short electoral cycles, the considering eye of the District Health Board member or the member of governance bodies of other Crown Entities, may be a useful barrier to the rapid implementation of very bad ideas.

This and other changes proposed in the Bill, suggests that the Government is at least rethinking the rationale that lies behind the current configuration of the state sector as a collection of autonomous enterprises akin to private sector employers. Wide change involving the whole state sector requires wider public discussion than has so far occurred. Our DHBs, their skilled and dedicated staff and the patients they serve should not be collateral damage to the effort to centralise the machinery of government.

Angela Belich
Assistant Executive Director

Strong leadership leads to safer healthcare

This article is provided by Dr Alan Doris, medical-legal adviser, on behalf of the Medical Protection Society.

Influential management theorist Peter Drucker says "Management is doing things right; leadership is doing the right things". In complex hospital systems, doctors at all levels have to both manage and lead to ensure the best quality of care, and clinical leadership and clinical management are intertwined. This is done at the level of individual practice; in the management and leadership of clinical teams, and for those in senior positions, at a strategic level influencing the organisation.

While, undoubtedly, doctors in senior positions within an organisation require strong leadership skills, most doctors lead teams and so leadership skills are essential for all hospital doctors.

Management and some traditional models of "transactional" leadership focus on doing established tasks as effectively and efficiently as possible, thus maintaining the status quo. Leadership can additionally be conceptualised as an influence process that creates a vision of a better way of doing things and induces others to accept that vision and devote their energies to achieving it. Such transformational leadership is particularly important in the rapidly evolving area of hospital practice with the enormous variability of clinical situations and rapid advances in medical science and technology.

Personality characteristics

Much research effort has attempted to identify the key personality characteristics of effective leaders. Traits such as logical thinking, persistence, self-control and an ability to empower and motivate others have been seen as indicating a likely effective leader. Unfortunately, though there is good evidence that such traits are associated with the likelihood of promotion within an organisation, the evidence that the enterprises such people lead are effective is not so good. This may be because different situations call for quite different leadership styles.

It is therefore necessary that leadership skills are learned and mastered, rather than assuming the presence of particular personality traits are all that is required. Also, if the vision that others are being convinced to buy into is seriously flawed then the outcome can be disastrous - some high profile failures of medical care, such as at the Bristol Royal Infirmary or Mid Staffordshire NHS Trust in the UK, have been partly attributable to failures of clinical leadership. Poor leadership at the head of large organisations can have devastating consequences. Such failures have a tragic impact on many families, widespread effects on staff and the wider health professions.

Health & Disability Commissioner and Medical Council expectations

Closer to home, the Health and Disability Commissioner often considers clinical leadership when investigating a complaint. Attempts to change a culture of blaming individuals for adverse clinical outcomes have led to increased scrutiny of the management and leadership of the systems in which clinicians work. In some cases, individual clinicians and the organisations that employ them have been judged to be in breach of the Code of Health and Disability Services Consumers' Rights because of leadership failings. This may be due to inadequate supervision of other staff, failures of communication, inadequate training, or poor allocation of resources. Good clinical leadership is recognised as being essential for promoting clinical quality and critical for safe healthcare.

The Medical Council has guidance for doctors who are in managerial or governance positions, particularly relating to resource allocation decisions and the management of colleagues. It is important for doctors in such positions to be aware of the limits of their scope of knowledge and ensure that the care and safety of patients remains the first priority.

Problems, hazardous but essential

MPS is aware of cases where problems with leadership of a team has contributed to the occurrence of an adverse clinical event or led to a complaint. Not infrequently, poor leadership in handling a system's response to an adverse event or complaint exacerbates the problems for patients, families and the clinicians concerned. This in turn can magnify the consequences of the events leading to such things as lowered staff morale, resignations, deteriorating public confidence in services etc - all of which increase the likelihood of further adverse events and complaints.

Development of clinical leadership skills is now accepted as essential for medical specialists. Colleges have increasingly made this a required competency of candidates for Fellowship and emphasised the importance of leadership skills as part of contemporary medical professionalism. As many health leaders are not doctors, a strong emphasis on leadership skills for non-medical professionals is equally important.

As articulated by Jeff Brown in his final Presidential Address at the ASMS Annual Conference last November, being a leader can be hazardous, though for progress to be made it is critical that skills are developed and a courageous stance adopted. As well as increasing the range and standard of healthcare available to patients, good leadership brings about safer systems for everyone.

Media Statement
3 March 2013

Doctors and nurses warn Prime Minister over trade talks

Media Staement: Te Ohu Rata O Aotearoa (Maori Medical Practitioners Association) and the New Zealand Nurses Organisation.

More than 400 members of New Zealand's medical community have signed a letter to the Prime Minister asking for his vigilance that our future health is not being negotiated away under the Trans Pacific Partnership Agreement (TPPA).

For more information:

Signatories to the letter to the Prime Minister can be viewed online at: ***www.tppa-correspondence.org.nz/results.php***

The text of the petition can be viewed at: ***www.tppa-correspondence.org.nz/tppa_petition.pdf***

The letter, written by Christchurch paediatrician Philip Pattemore, was digitally signed online by 425 health professionals, mainly doctors and nurses. The letter expresses their concerns over whether the TPPA could have a significant impact on New Zealanders' future health and, in particular, the Government's stated goal of achieving a smokefree New Zealand by 2025.

The health professionals urge the Prime Minister and his Government to insist on strong protections for public health in all 29 chapters of the Agreement, including those dealing with investments and intellectual property.

"The negotiations are held in secret, so we cannot be sure how much pressure the Government is under to sacrifice important freedoms. For example, patent extensions and data exclusivity might benefit foreign investors of each signatory nation, but it could stifle PHARMAC's and Medsafe's ability to provide cheaper, subsidised generic medicines for New Zealanders who need them," Dr Pattemore says.

Auckland oncologist and Chairperson for Te Ohu Rata O Aotearoa Dr George Laking says the TPPA negotiations require some means to reassure New Zealand's health community that the efforts to reduce tobacco-related harm are not being undermined.

"If the Agreement creates protections for big foreign corporations, such as tobacco companies, it will mean they can hamper smokefree and other health-related laws by threatening then taking legal action. These disputes would be settled by more secret, offshore arbitration.

"There is no way of knowing whether the Government might be negotiating away its democratically appointed powers, handing them to foreign investors, and in effect putting public health at risk."

New Zealand Nurses Organisation policy advisor Marilyn Head says the stakes are enormous.

"PHARMAC has saved the New Zealand taxpayer $5 billion over the past 12 years and greatly increased the access we have to medicine. Giving up the fight on patents could hike up the price of medicines significantly, causing inequity in access."

University of Auckland Professor Jane Kelsey, who monitors the negotiations, says legal challenges to Australia's plain packaging legislation show how useful Free Trade Agreements have become for the tobacco industry.

"We've already seen hesitance on the part of our Government over plain packaging legislation due to legal wrangling across the Tasman. Our worry is that negotiations for the TPPA, while arbitration takes place over existing trade agreements Australia has with other nations, is putting a 'chill effect' upon our Government when it comes to following Australia's lead."

Smokefree Coalition Director Prudence Stone agrees, saying "the tobacco industry is responsible for the deaths of more than 5000 New Zealanders a year. It must not be allowed to find legitimacy in the context of international trade negotiations. Letting it do so sends a clear message that there is still working arsenal at the industry's disposal to fight us in our battle to end tobacco use."

The letter to Prime Minister John Key has been sent on the eve of the 16th round of TPPA negotiations which start Monday 4 March in Singapore. Negotiators are now facing pressure to narrow down outstanding disagreements.

Medical students concerned about patient rights in TPP

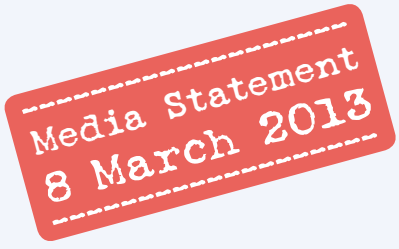
Press Release: New Zealand Medical Students' Association - NZMSA

The New Zealand Medical Students' Association (NZMSA) urges negotiators and politicians to preserve New Zealand's freedom to implement innovative health policy during Trans-Pacific Partnership (TPP) negotiations.

Tobacco control measures, including plain packaging, were still a major talking point during the stakeholder sessions of round 16 of negotiations in Singapore. The proposed TPP text includes provisions which could see New Zealand sued in overseas courts, much the way Australia is undergoing currently, if the government tries to use plain packaging to achieve the 'Smokefree 2025' goal. When asked, the lead negotiator for New Zealand assured stakeholders that it would be possible to "strike a balance" between commercial interests and safeguards for public health. NZMSA would like to remind negotiators and politicians that any agreement which gives any room to the commercial interests of tobacco companies is unacceptable, and to request that they continue listening to the voices of medical experts in the field. As Briar Mannering, third year medical student at the University of Auckland, states, "It certainly wouldn't hurt if one of these experts in the field was able to brief the health select committee on these issues."

Student doctors impress the importance of keeping intact not just PHARMAC's structure, but mechanisms that it uses to provide medicines at little expense to patients. "PHARMAC provides equal access to medicines, which are a basic need, not a mere commodity," says Ms Mannering. "PHARMAC's purchasing power has also been shown to provide New Zealanders with some of the cheapest medicines in the world". US pharmaceutical companies are pushing for provisions which would drive up the cost of medicines, and delay the entry of cheap generics onto the market. "Our drug buying policies should be kept separate from any trade agreement, or we risk paying out more in expensive hospital care."

NZMSA looks forward to further collaboration with other groups in continuing to bring attention to this issue, and asks that the health sector continues to work together both nationally and internationally to keep patient concerns on the table. We need to ensure that the health of all New Zealanders remains of the utmost importance and is not compromised in the pursuit of trade benefits during these negotiations.



ASMS services to members

As a professional association we promote:

- right of equal access for all New Zealanders to high quality health services
- professional interests of salaried doctors and dentists
- policies sought in legislation and government by salaried doctors and dentists

As a union of professionals we:

- provide advice to salaried doctors and dentists who receive a job offer from a New Zealand employer
- negotiate effective and enforceable collective employment agreements with employers. This includes the collective agreement (MECA) covering employment of senior medical and dental staff in district health boards which ensures minimum terms and conditions for around 3,000 doctors and dentists, over 90% of this workforce
- advise and represent members when necessary
- support workplace empowerment and clinical leadership

Other services

www.asms.org.nz

Have you visited our regularly updated website? It's an excellent source of collective agreement information and it also publishes the ASMS media statements.

We welcome your feedback as it is vital in maintaining the site's professional standard.

ASMS job vacancies online *www.jobs.asms.org.nz*

We encourage you to recommend that your head of department and those responsible for advertising vacancies, seriously consider using this facility.

Substantial discounts are offered for bulk and continued advertising.

ASMS email broadcast

In addition to The Specialist the ASMS also has an email news service, ASMS Direct. This is proving to be a very convenient and efficient method of communication with members.

If you wish to receive it please advise our Membership Support Officer, Kathy Eaden in the national office at ***ke@asms.org.nz***

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