ASMS

ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

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Submission to the Ministry of Health on Draft District Health Board Planning Guidelines 2016/17

17 NOVEMBER 2015

Background

The Association of Salaried Medical Specialists (ASMS) is the union and professional association of salaried senior doctors and dentists employed throughout New Zealand. We were formed in April 1989 to advocate and promote the common industrial and professional interests of our members. We now represent more than 4,000 members, most of whom are employed by District Health Boards (DHBs) as medical and dental specialists, including physicians, surgeons, anaesthetists, psychiatrists, oncologists, radiologists, pathologists and paediatricians. Over 90% of all public hospital senior doctors and dentists eligible to join the ASMS are in fact members.

Although most of our members work in secondary and tertiary care (either as specialists or as non-vocationally registered doctors or dentists) in the public sector, a small but significant number work in primary care and outside DHBs. These members are employed by the New Zealand Family Planning Association, ACC, hospices, community trusts, iwi health authorities, union health centres and the New Zealand Blood Service.

The ASMS promotes improved health care for all New Zealanders and recognition of the professional skills and training of our members, and their important role in health care provision. We are committed to the establishment and maintenance of a high quality, professionally-led public health system throughout New Zealand.

The ASMS is an affiliate of the New Zealand Council of Trade Unions.

General comments

We note that this consultation is for DHB staff to 'use as appropriate' to assist in the development of a DHB 'Planning Package', which includes planning guidance for the Annual Plans, Regional Service Plans, Māori Health Plans, Public Health Unit Annual Plans, updates to the Crown Funding Agreement schedules incorporating the Operational Policy Framework, Service Coverage Schedule, and health targets and performance measures. Virtually two weeks have been allowed to provide feedback. It is unrealistic to expect any organisation, let alone DHB staff members, to fully consider these documents and the additional documents associated with this package. We therefore question the meaningfulness of this consultation process.

Since the ASMS is unable to provide detailed feedback in such a short space of time, we have confined our comments to two key matters for inclusion in the documents where appropriate. These are (a) fostering distributive clinical leadership, and (b) addressing medical specialist workforce shortages.

Fostering distributive clinical leadership

The Minister of Health's Letter of Expectations for DHBs for this financial year states:

> ***Strong clinical leadership and engagement should be embedded in DHBs and utilised in all aspects of DHBs' core business, eg budgeting and service design****. Clinically driven service changes are encouraged where these make sense for patients and encourage positive system changes. DHBs are expected to include clear detail in their Annual Plans for 2015/16 that shows* ***how they will foster clinical leadership*** *(our emphases).*[1]

A recent ASMS national survey of our DHB-employed members found only 27% believed the culture of their DHB encouraged distributive clinical leadership.[2] Clearly, there is a long way to go before DHBs can demonstrate they are fostering the development of clinical leadership effectively. Accordingly, the Minister's expectations for 2015/16 need to be reflected in all 'Planning Package' documents for 2016/17 as appropriate.

Currently, the few references to 'clinical leadership' do not represent the clear intent of the Minister's expectations. For example, the Draft Annual Plan states (p 7/8):

> *Key principles that are foundational to planning in order to achieve BSMC services are… active engagement of 'front-line' clinical leaders/champions in health services delivery planning across the sector at both local and regional levels… This section should include an outline of how the DHB will support clinically-led service planning in partnership with primary care and other appropriate stakeholders to achieve its high-level objectives and BSMC service.*

And (p11):

> *DHBs are expected to demonstrate how they will use clinical leadership to drive system integration and the cross-government priorities, including Better Public Services…*

Both of the above examples fall well short of the Minister's expectation. The best way to remedy this is to use the Minister's letter as the basis for DHB reporting requirements on clinical leadership. For example:

> ***DHBs must provide in their Annual Plans clear detail on how they are fostering strong clinical leadership and demonstrate how clinical leadership and engagement is embedded and utilised in all aspects of DHBs' core business, eg, budgeting and service design.***

Furthermore, successful clinical governance, as envisaged by the *Time for Quality* agreement between the ASMS and the country's DHBs in 2008 and the Government's *In Good Hands* policy statement in 2009, requires **distributive** leadership embedded at every level of the system.[3] [4]

> *Clinical leadership must include the whole spectrum from inherent (eg, surgery, clinic, bedside, theatre relationships) through peer-elect (eg, practice, ward, department arrangements) to clinician-management appointment (eg, clinical directors, clinical board).*
>
> – In Good Hands, ASMS and DHBs

Ministers of Health have repeatedly highlighted the fundamental importance of strong clinical leadership in health policy, as have their advisers:

> *Quite simply, the reforms we need are only likely to be successful if clinically led.*
>
> – Professor Des Gorman, Executive Chair, HWNZ[5]

Despite the high priority given to developing distributive clinical leadership in government health policy over the last six years, and despite its many well-documented financial and clinical benefits, the fact that clinical leadership has barely got off the ground in most DHBs signals a lack of accountability and a lack of commitment to it. To make real progress, DHB planning documents must not only give much greater emphasis to the importance of clinical leadership in providing a more efficient and effective health service, but must be more accountable for their performance in implementing this policy. One effective way of monitoring performance, and assisting progress, would be to require DHBs to conduct independent annual surveys of their clinical staff on how distributive clinical leadership is working in practice and how it might be improved.

The development of clinical leadership is further stymied by entrenched shortages of specialists.[6] A national survey of specialists on the application of clinical leadership in DHBs in 2010 found a mere 20% of respondents believed they had enough time to engage in clinical leadership activities or

development programmes. There have been no indications that the situation has improved since then.[7]

Addressing entrenched specialist shortages

International workforce indicators point to an increasingly competitive market for medical specialists which, as an OECD report warned, "would make the New Zealand trained health professionals harder to retain, and the potential pool of foreign recruits more difficult to attract".[8]

In 2011, HWNZ's Executive Chair Des Gorman acknowledged "the key issues that are germane to the number of doctors in our workforce are recruitment, migration and retirement, and all three require address".[9] However, to date there are no significant measures in place that address these issues with respect to the specialist workforce.

In 2014, HWNZ's report *Health of the Health Workforce 2013 to 2014*, stated:[10]

> *While the [Medical Workforce] Taskforce initially focused on the immediate postgraduate period, a whole-of-career perspective has now been adopted. The most important issue is the impact of a prolonged period of medical labour market shortages on the workloads, wellbeing and productivity of DHB-employed senior doctors.*

Accordingly, DHB planning documents need to recognise the importance and urgency in addressing senior doctor shortages. At the very least, this needs to be stated explicitly in the planning document sections relating to the strengthening of the workforce. Patient centred care should be an objective of all DHBs but this is unable to be much more than a noble aspiration while these entrenched shortages remain.

For further information on the issues facing the medical specialist workforce, two reports, *The Public Hospital Specialist Workforce* (2013) and a follow-up publication *Taking the temperature of the public hospital specialist workforce* (2014), are available electronically via the following links:

http://www.asms.org.nz/wp-content/uploads/2014/07/The-Public-Hospital-Specialist-Workforce-web.pdf

http://www.asms.org.nz/wp-content/uploads/2014/09/Taking-the-temperature-of-the-public-hospital-specialist-workforce-August-2014-FINAL.pdf

References

1 Hon J Coleman. Letter of Expectations for DHBs and Subsidiary Entities 2015/16, 17 December 2014.

2 I Powell. "Piketty on Conflicting leadership Cultures," *The Specialist*, ASMS, Issue 104, September 2015.

3 ASMS and 21 DHBs. *Time for Quality Agreement*, 7 August 2008. Available at: www.asms.nz

4 Ministerial Task Group on Clinical Leadership. *In Good Hands – Transforming Clinical Governance in New Zealand*, February 2009

5 D Gorman. "The disposition and mobility of medical practitioners in New Zealand", *NZMJ* 4, Vol 124 No 1330; March 2011.

6 ASMS. *The Public Hospital Specialist Workforce: Entrenched shortages or workforce investment?* February 2013. Available at: www.asms.nz

7 R Gauld, S Horsburgh, J Brown. "The Clinical Governance Development Index: Results from a New Zealand Study". *BMJ Qual Saf*. doi:10.1136/bmjqs.2011.051482

8 P Zurn and J-C Dumont, *Health Workforce and International Migration: Can New Zealand compete?* Health Working Paper No 33, OECD, Paris 2008.

9 D Gorman. "The disposition and mobility of medical practitioners in New Zealand". *NZMJ*, Vol 124, No 1330; March 2011.

10 Ministry of Health. *Health of the Health Workforce 2013 to 2014*. Wellington: Ministry of Health, November 2014.