 WHICH WAY, MINISTER CLARK? | P3

THE DR BAWA-GARBA CASE: CRIMINAL LAW AND HOW IT SHOULD BE APPLIED IN HEALTH CARE | P7

YOUR NATIONAL EXECUTIVE AND BRANCH OFFICERS | P10
New Health Minister Dr David Clark has announced a highly significant and wide-ranging review of health and disability services. It includes district health boards but goes beyond them to include primary health organisations (PHOs) and the wider primary sector.

The draft terms of reference are broad and open to public consultation, a positive approach which compares well with past government initiatives. The Chair is Heather Simpson (the rest of the review group is yet to be appointed). Given her role as the highly influential senior adviser to Helen Clark in her different roles, especially as a three-term Prime Minister, this appointment is open to political attack.

But it must be remembered that in a previous life she was an academic health economist. Further, she was centrally involved in the construction of the current legislation that created DHBs and replaced the commercial business model that had previously governed our public health service. She knows the principles our current Act is based on more than most, and no one, including political opponents, criticises the quality of her brain cells.

This doesn't mean ASMS will not have differences with some of the things her taskforce proposes. We may well do. But whatever that might be, it is likely to be considered, and not lacking in intellectual grunt.

The review deserves to be welcomed, but with caution, depending on which way the review and the Health Minister’s expectations go (hence the cover cartoon in this issue of The Specialist).

New Zealand’s public health system, compared with universal systems around the globe, performs very well. It punches above its weight. But there are difficulties, much of which are due to sustained under-funding in a sector affected by continuing and increasing demand (especially acute and chronic). The Government advises us that it intends to address this during its occupancy of the Treasury benches. It is off to an encouraging start, but one year of reasonable funding does not make up for eight previous years of under-funding.
The review should consider making explicit the legislation an obligation on DHBs to ensure workforce empowerment and the well-being and health of those they employ.

RELATIONAL COMMUNITY AND HOSPITAL CONTINUUM OF CARE

There are processes and leadership culture that also constrain the effectiveness of our system. There is too much focus on primary and secondary care as something being organically separate, leading to narrow constructs of ‘primary-lead’ and ‘shifting services’ from the former to the latter. The focus is structural, rather than relational. Instead, the emphasis should be relational based on the continuum of care between community and hospital.

The most mature example of this is the several hundred health pathways between community and hospital (broadly than just primary and secondary) at Canterbury DHB. These have been developed and agreed through effective clinical leadership (not just doctors) in both community and hospital. As a result, the outcomes are much more robust despite serious workforce capacity issues (shortages) amongst specialists at least.

Centralised, distributed clinical leadership, good service-based networking and patient-centred care, they have led to considerable gains both in the capacity and accessibility of patient care and financial performance. This includes the unparalleled experience of bending the curve of increasing acute demand.

This doesn’t mean that we don’t have disagreements with Canterbury DHB over engagement, we do. But this experience confirms the importance of this low transaction cost relational approach instead of the high transaction cost contractual and structural approach. Critical to its success is the leadership culture developing these pathways (distributed clinical leadership), its networking approach and the focus on patient-centred care.

The Minister’s review needs to focus on improving processes through relational lens (sometimes called alliancing). This is not just through the networking approach between community and hospital but also between DHBs sub-regionally, regionally and nationally. Clinically developed and led networks between public hospitals have achieved proven success in Scotland and New South Wales. We have made some progress in New Zealand but are way short of realising the potential.

This for to happen, however, we need to increase the capacity of the health professional workforce. This includes specialists who face (through leadership and neglect from government to DHB) a crisis as they suffer worsening chronic shortages, burnout, presenteeism and retention loss. This review should consider making explicit in the legislation an obligation on DHBs to ensure workforce empowerment and the well-being and health of those they employ.

The Minister’s review needs to focus on addressing them post haste.

NATIONAL AND LOCAL HEALTH SYSTEMS

A feature of all universal health systems is the tension between their internal local and regional systems. All health systems struggle with getting the balance right between what works best locally, regionally and nationally. Arguably, universal health systems are too dynamic to get the balance right. But it is not the struggle that is the issue. Instead it is the quality and robustness of the struggle, the better this quality and robustness, the better for our system overall.

Our current four regional boundaries are somewhat artificial. Largely historical, they do not neatly capture natural clinical synergies between DHBs. For example, Whanganui DHB has a need to consider a close relationship with its near neighbour Mid Central, particularly vulnerable smaller services and sharing critical mass, in respect of patient referrals its clinical synergies are further north in Auckland and further south in Wellington.

The political risk of such an approach, with the next election in 2020, is high. Only policy works with their heads in the clouds and their feet well away from the clinical front line would contemplate going down such a short-sighted direction.

There are several problems with this approach. DHBs are responsible for their own populations. These four populations are too big and dispersed for a DHB to have an effective operational focus in both community and hospital care. It is too big an ask. Look at how difficult the relatively new Southern DHB (the result of a top-down driven merger between Otago and Southland) is finding addressing the health needs of the most geographically dispersed defined population of all our 20 DHBs.

If the objective is to improve integration in the continuum of care between community (why it would not be otherwise), then smaller is better. Where there is more than one general practice voice or RHO in our 20 DHBs, it has proven very difficult to achieve the gains that have been made in the Canterbury DHB (which has the added advantage of one GP voice to engage with, Pagosa). Creating four mummies will severely impede this objective.

There is also a risk of the Government allowing shorter term exigencies to either be dumped in the bucket of the review’s scope or continuing to be ignored. These include the crises facing the DHB specialist workforce referred to above, and the lost opportunities caused by the failure to advance distributed clinical leadership.

Both of these were glaring omissions from David Clark’s first Letter of Expectations to DHBs in April. It is imperative that if the Minister is to be genuinely rather than rhetorically transformational, that he focuses on addressing them post haste.
The review deserves to be welcomed, but with caution, depending on which way the review and the Health Minister’s expectations go.

A positive aspect of the Minister’s Letter of Expectations to DHBs was the strong, unambiguous commitment to public provision of hospital services (and by direct contrast, his opposition to privatisation). This is also evident from his abandonment late last year of Public Private Partnerships in the South Island.

It took a long time for the penny to drop, but Taranaki DHB eventually realised the obvious and reversed its plan to privatise its hospital laboratory. But there is much more for Dr Clark to front foot on this.

With the various services, clinical and diagnostic, that have been privatised over the years, there is a need to plan for returning these to public provision as each goes. Over the decades old absurdly low threshold ($10 million) for capital works spending for triggering Government approval and Treasury monitoring.

A positive aspect of the Minister’s Letter of Expectations to DHBs was the strong, unambiguous commitment to public provision of hospital services (and by direct contrast, his opposition to privatisation). This is also evident from his abandonment late last year of Public Private Partnerships in the South Island.

It took a long time for the penny to drop, but Taranaki DHB eventually realised the obvious and reversed its plan to privatise its hospital laboratory. But there is much more for Dr Clark to front foot on this.

With the various services, clinical and diagnostic, that have been privatised over the years, there is a need to plan for returning these to public provision as each goes. Over the decades old absurdly low threshold ($10 million) for capital works spending for triggering Government approval and Treasury monitoring.

A positive aspect of the Minister’s Letter of Expectations to DHBs was the strong, unambiguous commitment to public provision of hospital services (and by direct contrast, his opposition to privatisation). This is also evident from his abandonment late last year of Public Private Partnerships in the South Island.

It took a long time for the penny to drop, but Taranaki DHB eventually realised the obvious and reversed its plan to privatise its hospital laboratory. But there is much more for Dr Clark to front foot on this.

With the various services, clinical and diagnostic, that have been privatised over the years, there is a need to plan for returning these to public provision as each goes. Over the decades old absurdly low threshold ($10 million) for capital works spending for triggering Government approval and Treasury monitoring.

A positive aspect of the Minister’s Letter of Expectations to DHBs was the strong, unambiguous commitment to public provision of hospital services (and by direct contrast, his opposition to privatisation). This is also evident from his abandonment late last year of Public Private Partnerships in the South Island.

It took a long time for the penny to drop, but Taranaki DHB eventually realised the obvious and reversed its plan to privatise its hospital laboratory. But there is much more for Dr Clark to front foot on this.

With the various services, clinical and diagnostic, that have been privatised over the years, there is a need to plan for returning these to public provision as each goes. Over the decades old absurdly low threshold ($10 million) for capital works spending for triggering Government approval and Treasury monitoring.

A positive aspect of the Minister’s Letter of Expectations to DHBs was the strong, unambiguous commitment to public provision of hospital services (and by direct contrast, his opposition to privatisation). This is also evident from his abandonment late last year of Public Private Partnerships in the South Island.

It took a long time for the penny to drop, but Taranaki DHB eventually realised the obvious and reversed its plan to privatise its hospital laboratory. But there is much more for Dr Clark to front foot on this.

With the various services, clinical and diagnostic, that have been privatised over the years, there is a need to plan for returning these to public provision as each goes. Over the decades old absurdly low threshold ($10 million) for capital works spending for triggering Government approval and Treasury monitoring.

A positive aspect of the Minister’s Letter of Expectations to DHBs was the strong, unambiguous commitment to public provision of hospital services (and by direct contrast, his opposition to privatisation). This is also evident from his abandonment late last year of Public Private Partnerships in the South Island.

It took a long time for the penny to drop, but Taranaki DHB eventually realised the obvious and reversed its plan to privatise its hospital laboratory. But there is much more for Dr Clark to front foot on this.

With the various services, clinical and diagnostic, that have been privatised over the years, there is a need to plan for returning these to public provision as each goes. Over the decades old absurdly low threshold ($10 million) for capital works spending for triggering Government approval and Treasury monitoring.

A positive aspect of the Minister’s Letter of Expectations to DHBs was the strong, unambiguous commitment to public provision of hospital services (and by direct contrast, his opposition to privatisation). This is also evident from his abandonment late last year of Public Private Partnerships in the South Island.

It took a long time for the penny to drop, but Taranaki DHB eventually realised the obvious and reversed its plan to privatise its hospital laboratory. But there is much more for Dr Clark to front foot on this.

With the various services, clinical and diagnostic, that have been privatised over the years, there is a need to plan for returning these to public provision as each goes. Over the decades old absurdly low threshold ($10 million) for capital works spending for triggering Government approval and Treasury monitoring.
The specialist

“This case has highlighted the tension between the open, learning culture we wish to see and an adversarial and punitive approach to medical errors.”

those who hold doctors to account are far from developing the open, learning culture promoted as essential to patient safety. In New Zealand, it has also understandably prompted the question of what the Medical Council of New Zealand (MCNZ) would do in the same situation.

Many are also concerned by the decision to prosecute Dr Bawa-Garba for GNM in the first place, and here it is worth reflecting on some of the issues this case has brought into focus, how this area of criminal law has developed in different ways in different countries, and how (for some) it may develop in the wake of this case.

THE POSITION IN NEW ZEALAND

In New Zealand there is a statutory definition of GNM that mirrors the English legal test. Manslaughter by gross negligence is a statutory offence under the Crimes Act 1961 making it possible for New Zealand courts to treat the circumstances giving rise to the Dr Bawa-Garba case in a similar fashion to the English courts. However, for over 20 years there have been no GNM prosecutions in New Zealand and the system for holding doctors to account has developed in a very different way. Two distinct bodies unique to New Zealand, are worth considering because their influence, in my opinion, significantly reduces the likelihood of such prosecutions occurring in New Zealand.

The Accident Compensation Corporation (ACC)

When the ACC was set up in the 1970s it introduced a form of no-fault compensation for personal injury and since then an adversarial approach to medical error has not developed. Due to the scheme’s statutory ban on bringing civil proceedings against medical practitioners for injury, injured parties can instead seek compensation through a bureaucratic process. This means there are fewer barriers to doctors being entirely candid with patients when things go wrong. That said, if the ACC identifies a risk to the public health and safety, they may refer the matter to the MCNZ to consider a doctor’s competence.

The Health and Disability Commissioner

Health care professionals may not be accountable through the Civil Courts in New Zealand but they can be held to account by the Health and Disability Commissioner (HDC) if it is thought that they have infringed patient rights, as set out by the Code of Patient’s Rights. Where the HDC has serious concerns about an individual’s conduct or performance they can refer them to the Health Practitioners Disciplinary Tribunal and the MCNZ. Professional failings are therefore usually regarded as a regulatory, rather than criminal matter. The main purpose of criminal prosecution is to punish the offender, the other is to serve as an example in order to minimise the risk of recurrence. In New Zealand, the MCNZ and the HDC effectively fulfil both these purposes as they are afforded broad discretion in investigating, prosecuting and disciplining medical professionals accused of negligence. Hence, while the ACC does not offer medical practitioners immunity from criminal proceedings, criminal prosecution in the absence of ill intent is seen as purposeless.

THE POSITION IN ENGLAND AND WALES

GNM is a common law offence in England and Wales and has evolved from the same set of tests that apply to the civil test for negligence. In order to secure a conviction, firstly it must be shown that the individual doctor in question owed the patient a duty of care; secondly, that the doctor breached that duty of care and thirdly, that the breach of duty caused the patient harm. In civil cases these tests are used to establish whether compensation is payable to redress the harm. In the criminal arena, if the harm caused was the patient’s death then the possibility of a GNM prosecution arises. The final hurdle that needs to be cleared to secure a conviction is that the jury must be satisfied beyond reasonable doubt that the level of negligence is ‘gross’.

So what gives rise to such cases appearing in front of a criminal court? There are two essential components which lead from the death of a patient, to the criminal court. Firstly, those investigating the death are required to obtain an independent medical expert opinion on the actions of the doctor. If, in the opinion of the expert, the care was not just standard but a serious departure from the proper standard of care, the question of the doctor being blameworthy to a criminal extent may arise. It is important to stress that the standard the doctor is being measured against at this stage is one set by another doctor, not by a lawyer or the police. Without a very critical independent medical report, criminal prosecution will not get off the ground. Next, when the matter has been fully investigated and such medical expert opinion is forthcoming the case may be referred by the police or Coroner to the Crown Prosecution Service. The prosecutor must decide whether or not a prosecution is in the public interest and if there is a reasonable prospect of a conviction.

THE POSITION IN SCOTLAND

Interestingly, the criminal law in Scotland has developed rather differently to that in England and Wales. Scotland has a separate legal system; manslaughter is not a term that features and the nearest comparable offence is culpable homicide which is defined as the killing of a person in circumstances which are neither accidental nor justified but where the wicked intent to kill required for murder is absent. In short, the unlawful act giving rise to the death must be intentional or, at least, reckless and/or grossly careless.

The other crucial difference in Scotland is that if a charge of culpable homicide was considered against a medical practitioner, the country’s most senior law officer who sits on the Scottish Cabinet is required to approve it. It is possible therefore that they would take a wider view regarding public interest than in England and Wales. It is widely accepted that a culture of openness and low blame should be promoted in the health service, in order to learn from mistakes. Is it then in the public interest to pursue criminal prosecutions of individual healthcare professionals? While such prosecutions are rare, their effect on staff perception and morale is greatly magnified. The culpable homicide law, and its application in Scotland, has seen one attempted prosecution resulting in acquittal.

CONCLUSION

The Dr Bawa-Garba case has been something of a watershed in the history of professional accountability. It has highlighted the tension between the open, learning culture we wish to see and an adversarial and punitive approach to medical errors.

The few health care professionals who willfully set out to harm patients, or are reckless, should face criminal charges. However, the vast majority of health care professionals - who make mistakes while working under difficult and complex conditions - should not be labelled as criminals.

In England and Wales, MPS has provided evidence to the UK Government’s rapid review into GNM in healthcare. At the heart of our recommendations, is a call for the legal bar for a GNM conviction in England and Wales to be raised; moving towards the Scottish position where charges are only brought against doctors if an act is proved to be intentional, reckless or grossly careless and is shown to be in the public interest. Many other recommendations are aimed at improving the way in which GNM cases are handled by the police, courts and the UK GMC. The outcome of the UK Government’s review is due to be published in the coming months and I know it will be closely scrutinised across the New Zealand medical community and beyond.

MPS has a wealth of experience in supporting doctors faced with GNM charges. Though it seems unlikely due to the differences between the New Zealand system and the England/Wales equivalent, if a doctor in New Zealand was to be charged with GNM as a result of an adverse patient outcome, MPS has access to the most experienced lawyers and barristers in the country to instruct in defence of our members.

In addition, MPS is constantly monitoring the New Zealand medico-legal environment, and if we notice a change in how the general public and relevant authorities approach the question of criminal prosecution against medical practitioners, we will use our influence and resources to challenge those who blame and castigate hard-working doctors and we will continue to protect the interests of members.

REFERENCE


“Could it happen here? and ‘Is a career in a high risk speciality wise?’ questions many health care professionals in New Zealand are asking themselves.”
YOUR NATIONAL EXECUTIVE AND BRANCH OFFICERS

THE ASMS NATIONAL EXECUTIVE FOR THE THREE YEARS TO 2021 IS:

• Murray Barclay, National President, gastroenterologist, Canterbury
• Julian Fuller, Vice-President, anaesthetist, Waitemata
• Paul Wilson, National Secretary, anaesthetist, Bay of Plenty
• Hein Stander, Immediate Past President, paediatrician, Tairawhiti
• Julian Vyas, paediatrics, Auckland
• Andrew Evens, emergency medicine, Waitemata
• Annette van Zeist-Jongman, psychiatry, Waikato
• Tim Frendin, geriatric medicine, Hawke’s Bay
• Angela Freschini, anaesthesia, Tairawhiti
• Saton Henderson, intensive care, Canterbury
• Katie Ben, anaesthesia, Nelson Marlborough

Thank you to everyone who put their hand up for either the National Executive or Branch Officer positions. We appreciate your willingness to advocate and support your medical colleagues, and this shows the Association is in good heart. We would also like to acknowledge those members of the National Executive and Branch Officers who decided not to stand for re-election, and thank you for your efforts and ongoing commitment.
High

Becoming President of ASMS is not something I imagined when I was approached six years ago to join the National Executive. As I come to grips with the Executive functions, I became increasingly involved in the research activities of ASMS, particularly senior doctor understaffing, and the well-being issues of burnout, bullying, and presenteeism. My research background meant that I was keen to see good data on these important issues to help drive improvement. I was therefore very supportive of increasing the research capacity of ASMS with highly competent staff. We certainly have those now. For those who don’t know me, I work as a gastroenterologist and clinical pharmacologist at CDHB. I am also a Clinical Professor with the University of Otago. I grew up in small town New Zealand, but I’ve lived through Otago Medical School, have a grown family and live on the rural edge of Christchurch. My leadership experience includes being President of the New Zealand societies of gastroenterology and clinical pharmacology, and clinical directorship. What is apparent from the ASMS research and member feedback is that the New Zealand senior medical workforce has some major problems that need addressing urgently to enable New Zealanders to get the medical care they deserve. When asked to be ASMS President, it was the findings of the research that convinced me this might be worthwhile as it is clear that further work needed to be done to both define these problems, but more importantly to attempt to bring about improvements. I have found that the ASMS team and national executive are exceptional in their approach and passion. All are dedicated to improving the lot of senior medical staff in New Zealand, and improving the quality and equity of health care in NZ. This makes working with them a pleasure that generates enthusiasm and hope that positive changes can be made.

**WHAT WE KNOW**

In 2013, New Zealand ranked near the bottom of OECD countries for number of medical specialists per head of population (figure 1). Updated data is being sought but requires validation. Medical staff burnout is topical globally but in New Zealand our frankly tragic burnout rate of 50% (figure 2) looks to be higher than in other countries where burnout has been studied. The consequences of burnout are serious for these senior doctors and for their patients who fail to get the health care benefits that result from proper engagement with their doctor. High workload is at least one of the factors predicting burnout. More recently, we have documented high rates of bullying in the New Zealand senior medical workforce, including 58% experiencing this at least weekly and 67% witnessing bullying at least weekly. Again, high workplace demand was strongly associated with risk of bullying (figure 3) along with reduced support from peers or non-clinical managers. Disturbingly, burnout and bullying are clearly even more of a problem for female senior medical staff (figure 2) with, in particular, a burnout rate 20% higher than males at each age band (70% in young female senior doctors) and a bullying rate of 40% versus 32%.

**WHAT FOR THE NEXT THREE YEARS?**

At the time of the MECA negotiations, the role of ASMS needs to be to negotiate for the best possible conditions for members. In between MECA negotiations, however, it seems clear that ASMS needs to take a strong role in advocating for the quality and equity of health care for patients in New Zealand. In relation to senior medical staff, the most obvious thing that needs to occur is a sharp increase in senior doctor numbers to combat unmanageable and dangerous workloads. Senior staff also need adequate time to consider service reconfiguration that provides better, more manageable health care for patients.

The New Zealand senior medical workforce has some major problems that need addressing urgently to enable New Zealanders to get the medical care they deserve.

**ASMS needs to take a strong role in advocating for the quality and equity of health care for patients in New Zealand.**

The ongoing series of DHB clinical director surveys on workload and FTE requirements appears to be showing consistently that New Zealand needs 25% more senior doctors per head of population just to deal with current workload expectations, let alone to provide optimal health care following full consideration of unmet need.

Our current best tool in the MECA for addressing departmental FTE requirements is regular job-sizing. In parallel, it may be that service-sizing that takes into consideration unmet health need may further define the requirements. Service and job-sizing requires significant resourcing from DHBs and ASMS but the outcomes should more than compensate. ASMS will be helping to drive these initiatives whenever and wherever possible.

The gender inequity highlighted in our surveys over the past two years requires further exploration and definition with a view to providing some solutions for our female senior medical staff. I believe this is now a high priority for ASMS.

ASMS is a mature organisation, almost 30 years in existence, and its activities have grown beyond contract negotiations. We now deal with issues around health advocacy, climate change, healthy eating, doctor well-being, gender inequity and others. Feedback from members has been positive in respect of these ASMS directions but it is probably a good time to reflect on priorities. ASMS will therefore be seeking views from members within the next year to help fine-tune priorities.

So there is plenty to do, but also some very good people doing it at ASMS. During my time on the Executive so far I have been fortunate to observe the great leadership styles of Drs Jeff Brown and Hein Stander who have brought a solidity, good humour and strength of purpose to the role that I hope I can, at least partly, replicate. And I look forward to the next three years with the hope that we can help bring about some significant improvements in health care in New Zealand, and in particular, better working conditions and job satisfaction for members.
I stood on some Lego. We’re dealing with a lot of very sick people, and it’s going to increase.

EMERGENCY DEPARTMENTS

WINTER IN HOSPITAL

PREPARING FOR A TOUGH RIGHT UP.

WHilst there is usually a 4-6% increase in presentations year on year in Waikato Hospital, there was a 19% increase in presentations in February/March compared to 2017.

“It's going to be pretty torrid this winter,” says Waikato Hospital emergency physician John Bonning, who's also the New Zealand faculty chair of the Australasian College for Emergency Medicine (ACEM).

“We're going to be flooded in particular with older people, particularly with chronic illness, as well as children. Not just at Waikato - hospitals all around the country are in a similar situation. Hospitals have been operating well above 80% inpatient bed capacity and demand has gone right up.

“At Waikato Hospital’s emergency department, there’s been a nearly 50% increase in presentations between April 2017 and April 2018. We're talking over 54,000 presentations pa to Waikato ED in 2010, increasing to over 63,000 in 2011 (8% increase) after the new ED opened, to well over 85,000 in 2017.

“That is a nearly 70% increase over 7 years. At the same time, the population hasn't grown by anywhere near that proportion over that period so the increase is really due to increased burden of chronic disease, diabetes, heart and respiratory illness, more trauma, more cars on the roads, older people living longer, more falls, and higher levels of untreated health need. We’d arrive at work at 8 o’clock in the morning and there would be over 20 patients waiting for inpatient bed spaces which were not available. And that was just in April before winter had started."

He says people with minor complaints are not the cause of the clogged hospital system.

“We’re not busy because patients can’t see their GP for something minor or because they’d stood on some Lego. We’re dealing with a lot of very sick people, and it’s going to increase.

“Ambulance ramping (being unable to unload patients from ambulances due to no physical space being available in ED to put them) will happen again this year (having happened in NZ for the first time in 2017 and happening in Australia for a decade) and we’ll see people languishing in ED corridors again. It will be tough to find a bed and people will end up staying many hours in ED.

“When pressure goes on ED, every part of the hospital system becomes stressed.

Valbon’s work has been recently published in the Australasian Journal of Emergency Medicine (AJEM).

“The rise in acutes doesn’t just happen on its own. It’s the result of a number of factors. Some are outside the control of the hospital system, such as changes to public health policy or unforeseen events such as severe drought followed by poor rain conditions. Other factors are more directly under our control, such as the acumen of hospitalists and nursing staff, the health of the public, and the pace of disease spread.”

“Acute patients come in and stay long, so we want ED to be the place to go when patients are acutely unwell. But we know that EDs are not the place to manage patients ongoing health needs for hours on end once their acute needs have been met.”

He says patients can help by taking some responsibility for their own health care, ensuring that they are vaccinated, don’t smoke, that they drink alcohol in moderation, and are aware of their sugar intake. Clinicians and patients also need to be aware of the Choosing Wisely initiative (www.choosingwisely.org.nz) to ensure limited health care resources are used rationally.

“We all need to help to manage our limited health care resources as best we can.”

Dr John Bonning

"When pressure goes on ED, every part of the hospital system becomes stressed."
The evidence indicates clearly that both primary care and hospital care services require significant boosts in resources.

Increasing health service use is far outstripping the rates of population growth, including public hospital admissions.

Acute and Non-acute Hospital Discharges (Actual and Case-Weighted [CWD]), 2010/11 to 2016/17

- Acute actual
- Acute c/w
- Non-acute c/w
- Non-acute actual

**Years of funding shortfalls merely shift the costs, both financially and socially, downstream.**

We want to make sure people get the health care they need to stay well. Early intervention and prevention work can also help take pressure off our hospitals and specialist services.

However, the evidence from New Zealand and overseas indicates that while measures to improve access to primary care are much needed, they do not necessarily reduce the use or need of hospital care. The dynamics are more complex.

If, under continuing budget constraint, the ‘strong focus’ on primary care is code for a ‘rob Peter to pay Paul’ approach to health service funding, the likely outcome would be an even tighter bottleneck to accessing non-acute hospital care, which in turn would create greater pressure on primary care and possibly, eventually, acute services.

The evidence indicates clearly that both primary care and hospital care services require significant boosts in resources.
We are frequently told “You can't raise wages before you raise productivity”. But productivity is barely rising: employers are not investing to raise it. Why not? Perhaps they don't feel the need to because wages are kept low. Perhaps raising wages would encourage productivity to rise, funding new wage rises and creating a virtuous spiral of rising wages and productivity. As I show below, there is good logic and evidence that that could be true.

WAGES ARE IMPORTANT SOCIALLY AND ECONOMICALLY...

Wages (including salaries) are important socially as well as economically. They are easily the most important way that families receive income. What people earn is an important part of people’s incomes, raising wages and reducing wage inequality would have a powerful impact on overall inequality. There is ample evidence that inequality has been a significant cause of rising income inequality (e.g. D. Card, Lemieux, & Riddell, 2003; D. Card, Lemieux, & Riddell, 2004; D'Andres, Fortin, & Lemieux, 1995; Jaumotte & Bultron, 2015; Koske, Fournier, & WANER, 2012; Western & Rosenfeld, 2011). Wages are low compared with other otherwise high income countries. New Zealand’s low share of income going to wages is one indicator, as the figure on the right shows. Another is the dominance of low wage industries in our economy, particularly in the export sector – agriculture and tourism. Qualifications, particularly vocational ones, are poorly rewarded in higher wages (e.g. Crichton, 2009; Crichton & Dixon, 2011; Jussaule, Maani, Kaye-Blake, & Zang, 2013). We have too many working poor (four out of ten children living in poverty come from working families, according to Perry (2017, p. 144)), and we would have many more if not for income support. Working for wages is one indicator of social and economic well-being. If wages had followed productivity gains, New Zealand would have more and better social benefits for their citizens.

...BUT LOW

It is widely accepted that New Zealand’s wages are low compared with other OECD Median wage adjusted by living costs (CPI)

DR BILL ROSENBERG | COUNCIL OF TRADE UNIONS ECONOMIST AND POLICY DIRECTOR

...WHICH HAS BAD SOCIAL AND ECONOMIC EFFECTS

The wage problem is also about how income is distributed: income inequality remains high in New Zealand (see Perry again). In the CTU’s August Bulletin (http://www.union.org.nz/economic-bulletin192), I summarised recent research showing growing wage inequality (Rosenberg, 2017). Gender pay inequality plays an important part too. Because wages are such an important part of people’s incomes, raising wages and reducing wage inequality would have a powerful impact on overall inequality. There is ample evidence that inequality has been a significant cause of rising income inequality (e.g. D. Card, Lemieux, & Riddell, 2003; D. Card, Lemieux, & Riddell, 2004; D’Andres, Fortin, & Lemieux, 1995; Jaumotte & Bultron, 2015; Koske, Fournier, & WANER, 2012; Western & Rosenfeld, 2011). With low wages, the tax and benefit systems have much more work to do to redistribute income.

...INCREASE FINANCIAL INSTABILITY AND CRISIS

It’s worth remembering some of the reasons why low wages are important. First, it works at the level of individual workers. Higher wages and fair treatment would encourage productivity to rise, funding new wage rises and creating a virtuous spiral of rising wages and productivity. As I show below, there is good logic and evidence that that could be true.

Inequality is highly correlated with, and likely contributes to many other social, mental and physical ills. But wages have not kept up with productivity – see the graph above. That is the case in the US and other parts of the world.

Productivity does need to rise for sustainable increases in wages in the long run – but there is nothing automatic about (real) wages following productivity. Since the collective wage setting system was largely destroyed outside the state sector in the 1991 Employment Contracts Act, that has not been the case. So to say wages must follow productivity is simplistic.

...AND PRODUCTIVITY GROWTH IS CHRONICALLY WEAK

But New Zealand has another problem: chronically weak productivity growth. There is no simple answer as to why, but perhaps an important reason is low wages itself.

ARE LOW WAGES THE CAUSE OF LOW PRODUCTIVITY AS WELL AS THE RESULT?

Raising real wages can raise productivity at three levels.

1. Higher wages and fair treatment would encourage productivity to rise, funding new wage rises and creating a virtuous spiral of rising wages and productivity. As I show below, there is good logic and evidence that that could be true.

2. Inequality is highly correlated with, and likely contributes to many other social, mental and physical ills. But wages have not kept up with productivity – see the graph above. That is the case in the US and other parts of the world.

3. Productivity does need to rise for sustainable increases in wages in the long run – but there is nothing automatic about (real) wages following productivity. Since the collective wage setting system was largely destroyed outside the state sector in the 1991 Employment Contracts Act, that has not been the case. So to say wages must follow productivity is simplistic.

4. And productivity growth is chronically weak. But New Zealand has another problem: chronically weak productivity growth. There is no simple answer as to why, but perhaps an important reason is low wages itself.

5. Are low wages the cause of low productivity as well as the result? Raising real wages can raise productivity at three levels. Higher wages and fair treatment would encourage productivity to rise, funding new wage rises and creating a virtuous spiral of rising wages and productivity. As I show below, there is good logic and evidence that that could be true.

6. But wages have not kept up with productivity – see the graph above. That is the case in the US and other parts of the world.

7. Productivity does need to rise for sustainable increases in wages in the long run – but there is nothing automatic about (real) wages following productivity. Since the collective wage setting system was largely destroyed outside the state sector in the 1991 Employment Contracts Act, that has not been the case. So to say wages must follow productivity is simplistic.

8. And productivity growth is chronically weak. But New Zealand has another problem: chronically weak productivity growth. There is no simple answer as to why, but perhaps an important reason is low wages itself.

9. Are low wages the cause of low productivity as well as the result? Raising real wages can raise productivity at three levels.
Wages are easily the most important way that employees get a share of the income their work creates so they and their families can live decent lives.

Chilling Impact of Poverty on Child Health

Children and young people living in the most deprived areas are three times more likely to die in childhood or adolescence than those living in the least deprived areas, says the Child and Youth Mortality Review Committee.

It released a report in April reviewing the deaths of children and young people for the period 2012 to 2016 – and Chair Felicity Dumble says the Committee’s work shows poverty is a key driver of child deaths in this country.

"Children living in poverty may not be able to access health services in the same way as others, getting to the doctor and picking up or taking medicines can be harder," she says.

"Their homes may be damp and cold, food may not be plentiful, mum and dad may work one or two jobs and are unable to take them to the doctor. They may live in a crowded home where infection is spread easily or resources are stretched."
Some observations from a provincial town.

On the edge of town is a lattice of new early childhood centres. A few minutes’ drive to rows of matted hair on maggot-infested scalps, clearing of all their caried teeth. I see coughing and wheezing kids from damp and cold houses. I see rotting teeth when I lift the lip of preschoolers, damp and cold houses. I see matted hair on maggot-infested scalps, ragged clothing, an eating cap to $165 per week, and a reduction in the benefit rate for moneys received over and above NZ Superannuation, increasing the earning cap to $165 per week, and a reduction in the benefit rate for moneys received over and above NZ Superannuation.

Although summarisation risks over-simplification of the data there were several key findings that are worthy of emphasis. The report catalogue causes of mortality from 2012 to 2016 for New Zealanders between 1 month and 24 years of age; and categories causes of death as: medical (56% total), unintentional harm (27%), intentional harm - injury by another person and self-harm (25%), and sudden unexpected death (7%). Overall, there were 2012 deaths during the time studied. We also show a steady trend for the total annual death rate to fall in the past, but this is not always the case.

The trenchant vignette “...from a provincial town” (xv) will come as no surprise to anyone whose work involves clinical contact with families or whanau living in poverty. Globally, the ineffectual link between poverty and poor health is long established, and is further demonstrated by the recent Health Quality & Safety Commission report by the Child and Youth Mortality Review Committee.

Although summarisation risks over-simplification of the data there were several key findings that are worthy of emphasis. The report catalogue causes of mortality from 2012 to 2016 for New Zealanders between 1 month and 24 years of age; and categories causes of death as: medical (56% total), unintentional harm (27%), intentional harm - injury by another person and self-harm (25%), and sudden unexpected death (7%). Overall, there were 2012 deaths during the time studied. We also show a steady trend for the total annual death rate to fall in the past, but this is not always the case.

The trenchant vignette “...from a provincial town” (xv) will come as no surprise to anyone whose work involves clinical contact with families or whanau living in poverty. Globally, the ineffectual link between poverty and poor health is long established, and is further demonstrated by the recent Health Quality & Safety Commission report by the Child and Youth Mortality Review Committee.
DR JUSTIN BARRY-WALSH IS A CONSULTANT FORENSIC PSYCHIATRIST WITH TE KOROWAI WHÄRIKI (REGIONAL FORENSIC AND REHABILITATION SERVICES), CAPITAL & COAST DHB. HE IS ALSO ASMS' WELLINGTON BRANCH PRESIDENT.

WHAT INSPIRED YOUR CAREER IN MEDICINE?

It’s just something I ended up doing. I had an aunt who was a nurse and a grandfather who was a GP. I can recall at a young age thinking I would like to be a doctor. I was always interested in sciences so it was a question of what to do with that interest.

I studied at Otago Medical School. I was interested in having a good time, primarily, but I did develop several other interests during that time. I was leaning towards general medicine but later on I became interested in psychiatry. I was very privileged to have Professor Paul Mullen come to the university when I was there. He was a stark contrast to the rest of the psychological medicine department, an extraordinary man who provided captivating lectures. Later on I ended up working with him in Australia when I was doing forensic psychiatry, and he became both a mentor and a friend.

Anyway, I discovered in my trainee intern year that I was good at psychiatry. I won the prize for psychological medicine in 1986, and it made me sit up and take notice that this could be a good specialty for me, that I could flourish in it. Psychiatry was, and remains, an underdog and a Cinderella specialty. I looked at the exams for general medicine and also the exams for psychiatry, and chose psychiatry.

Most of my registrar training was in Wellington. When I finished as a senior registrar, I began my consultant career in Victoria, Melbourne. I returned to Wellington in 2003, and I’ve been here since. I specialise in forensic psychiatry, forensic means anything to do with the law.

We love to see people who offend as being part of the other, but we need to recognise that they are actually people, and they are very disadvantaged.

My work public involves the assessment and treatment of offenders, mostly mentally ill offenders. I write a lot of reports, mostly but not exclusively for the criminal courts, and I give evidence when required. I also provide ongoing treatment.

WHAT DO YOU LOVE ABOUT YOUR JOB?

Forensic psychiatry still holds the same interest for me. It’s a specialty that takes you into places that I think everyone should experience some of the prisons and the courts, as they are such critical parts of our system. It’s important to understand what awful places prisons are and why it’s a national disgrace that we have such a high rate of imprisonment, especially for Māori. We love to see people who offend as being part of the other, but we need to recognise that they are actually people, and they are very disadvantaged.

There are so many social determinants involved in offending, and we’re familiar with many of them. Addressing them would be a start. We need to do that, and change our thinking about offending. At the macro level, when we talk about being tough on crime, all we’re doing is letting people who have power make us feel afraid, which then helps them to maintain that power.

One of the things I’ve always liked about my specialty is that the knowledge base is so broad. There is so much value in reading across other disciplines, everything from philosophy through to the social sciences.

I don’t often get thanked directly for what I do, and that’s just life. But I do often see that my involvement makes a big difference in terms of the outcomes in the courts, which is a separate system from the prison system and as a result is usually more receptive because it’s not about punishment at that point. I work with people who have often done the most awful things in the context of severe mental illness. Working with them over a period of years, however long it takes for them to grow and recover, and then move back into the community, is very rewarding.

WHAT ARE SOME OF THE MOST CHALLENGING ASPECTS OF PRACTISING MEDICINE?

What I enjoy and what challenges me are pretty much the same. It’s important to maintain a non-judgemental and professional approach to things, especially when confronted with behaviour or issues that most people would respond strongly to. You can’t do some of the work I do without putting judgements aside.

There are also some fundamental ethical questions that arise when you work in a court system or as a prison as a doctor or healer. You are used to putting the interests of your patients first and yet you’re working in a system that has an interest in justice or punishment. One of the ethical problems we have is where we end up with more than one role, and whether that represents a real or imagined conflict of interest.

I’ve ended up with a real richness of understanding around a population that is the most disadvantaged and stigmatised. I’ve also been given opportunities to engage in other areas of work that are really interesting. Currently I am developing a fixed threat assessment service, with Police, the Ministry and Parliamentary Security. It involves screening impending communications, and identifying those of that require further intervention. The fixed are people who are likely to be mentally ill.

The area overlaps with extremist violence and counter-terrorism, but it is core. It is about improving the outcomes for people. That’s typical, I guess, to start working on something and then finding that I am drawing on a variety of different discourses from criminology, political science, and the philosophy of everyone from Zizek to Foucault. It’s one of the things I really love about my work.

I am an advocate for what I do. I always emphasise the value of being professional in what you do so that people can have a positive experience of psychiatry. I had a few jobs when I started in psychiatry but that doesn’t happen now. Colleagues understand the value of the specialty, although it’s still a Cinderella among medical specialties because of the stigma around mental health.

WHY DID YOU DECIDE TO BECOME ACTIVELY INVOLVED WITH ASMS?

When I returned to New Zealand from Melbourne, I was returning from a senior role that involved some leadership, and at first I didn’t have that in my role here. I’ve always preferred to engage with the service I’m in, so I looked for a way that I could become involved. I’m not someone who is happy to just do my job. If you see problems, it’s much better to be in a position where you can engage with people over those things.

The opportunity came up to work alongside Derek Slarring as the deputy president, and I loved it. It’s a role where you have to look across the entire DHB, which in turn increases your interaction with other colleagues and specialties. I became a clinical leader around the same time, about 2005/06, and that brought me more into contact with a wide range of people too.

In addition, I’ve always been a strong supporter of unions. Noam Chomsky says they’re an important democratising influence in a country, and certainly I wouldn’t want to live somewhere where unions are weaker than they are in New Zealand.

WHAT HAVE YOU GAINED OR LEARNED FROM YOUR ASMS INVOLVEMENT?

I guess it’s really emphasised the importance of unions. I acknowledge that because doctors are part of an elite, we’re in a privileged position and so belong to a union that is privileged. As a result it’s important that we don’t get too complacent and think that we’re in a privileged position. As a result it’s important that we do what I mentioned earlier, we have to look beyond our own sites and see ourselves as part of a DHB and part of the bigger picture.
For mothers who wish to breastfeed, returning to paid work following the birth of children can present significant challenges. Research suggests that many women stop breastfeeding upon the return to paid work due to structural factors such as lack of facilities and time to feed or express milk, as well as attitudinal factors such as the lack of support and understanding from colleagues and managers. This is despite the fact that breastfeeding is legislated as a right and breastfeeding upon return to paid work is explicitly supported by section 6 of the Employment Relations (Breaks, Infant Feeding, and Other Matters) Amendment Act (2008). In addition, women have the right to breastfeed and are protected from discrimination for breastfeeding under the Human Rights Act (1993).

Recent research by the ASMS suggests significant barriers for female senior doctors with children who wish to continue breastfeeding upon return to paid work after parental leave. ASMS has published a Research Brief looking at some of the issues that breastfeeding mothers and specifically breastfeeding senior doctors may face upon their return to paid work if they wish to continue breastfeeding. It concludes by posing potential questions for employers that employees may like to raise.

For definitional purposes, breastfeeding at work is used as an umbrella term to refer either to situations where mothers may seek to breastfeed their infants or express breast milk during work hours.


ASMS has also asked district health boards if they have staff breastfeeding policies in place and suitable facilities available.

**DOES YOUR DHB HAVE A STAFF BREASTFEEDING POLICY?**

<table>
<thead>
<tr>
<th>DHB</th>
<th>POLICY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northland</td>
<td>Unclear - DHB to advise</td>
</tr>
<tr>
<td>Waitemata</td>
<td>Yes</td>
</tr>
<tr>
<td>Auckland</td>
<td>Yes. Facilities at ACH and GCC.</td>
</tr>
<tr>
<td>Counties Manukau</td>
<td>Yes</td>
</tr>
<tr>
<td>Waikato</td>
<td>Yes, but not specifically for staff. Room available on level 1 Waiaora.</td>
</tr>
<tr>
<td>Bay of Plenty</td>
<td>Work on a policy was done last year - not clear if policy has been rolled out. Departments identifying ‘bespoke’ solutions.</td>
</tr>
<tr>
<td>Lakes</td>
<td>Yes. A facility is available</td>
</tr>
<tr>
<td>Taranaki</td>
<td>Baby-friendly accredited. A facility is available, although members have noted need for improvements.</td>
</tr>
<tr>
<td>Tararwiti</td>
<td>Yes. No dedicated staff breastfeeding room, however. Facilities arranged on case-by-case basis as needed.</td>
</tr>
<tr>
<td>Hawke’s Bay</td>
<td>No. No dedicated staff facility but work to develop one will start in July.</td>
</tr>
<tr>
<td>Whangamata</td>
<td>No policy sighted. Breastfeeding facility available, but it is not staff-focused.</td>
</tr>
<tr>
<td>MidCentral</td>
<td>No. Breastfeeding rooms are near the cafeteria and in the post-natal area.</td>
</tr>
<tr>
<td>Wairarapa</td>
<td>Yes. No dedicated facility but DHB advised that staff can breastfeed in maternity unit or in their workplaces.</td>
</tr>
<tr>
<td>Hutt Valley</td>
<td>Yes. Facility with key access available on the ground by Māori health.</td>
</tr>
<tr>
<td>Capital &amp; Coast</td>
<td>Yes. Three breastfeeding rooms at Wellington Regional Hospital are available (two are public facilities and one is for staff) - near Vibe Café, level 3, ward support block. There is also a public facility at Kanepuru.</td>
</tr>
<tr>
<td>Nelson Marlborough</td>
<td>Yes. No specific facility available but individual solutions as needed.</td>
</tr>
<tr>
<td>Canterbury</td>
<td>Information to be put on staff portal. Not yet sighted. ASMS advised that arrangements are ad hoc.</td>
</tr>
<tr>
<td>West Coast</td>
<td>Yes. A specific room is available but most people make their own arrangements.</td>
</tr>
<tr>
<td>South Canterbury</td>
<td>Yes. Good facilities available.</td>
</tr>
<tr>
<td>Southern</td>
<td>No policy sighted. Facilities are provided.</td>
</tr>
</tbody>
</table>

*Information correct as at May 2018*
Every six months district health boards (DHBs) are required to pay the Government a ‘capital charge’ on the Crown’s capital (equity) funding received by DHBs. The charge, which is currently set at 6% per year, applies to any DHB operational surpluses as well as any new capital funding provided by Government. In 2017 the capital charge totalled $174.2 million (see table next page).

The expectation is that the charges will be funded from DHBs’ existing baseline funding.

The $750 million capital funding included in this year’s Vote Health therefore comes with a 6% sting in the tail in addition to the existing charges. That sting will be more keenly felt over the coming years as Finance Minister Grant Robertson has revealed DHBs need more than $14 billion to upgrade their facilities over the next decade, due in part to deferred maintenance of hospital buildings and lack of investment in new facilities during years of funding constraint and, ironically, exacerbated by the capital charge.

DHBs have tried to reduce the impact of the capital charge by using government loans to finance capital projects because they carried lower interest rates. As indicated in the table, total interest on Crown loans was $57.9 million in the year to June 2017. But this avenue of funding was closed off last year when the then Government told DHBs they could no longer access Crown debt financing for funding capital investment. All Crown capital funding is now made via Crown equity injections, and DHBs have been directed to convert their existing Crown loans into equity, thereby making Crown debt financing subject to the capital charge.

The special purpose of the charge

The capital charge presents strong disincentives for DHBs to invest in capital, including maintenance.

THE CAPITAL CHARGE: A FUNDING GIVE-AND-TAKE

LYNDON KEENE | ASMS DIRECTOR OF POLICY AND RESEARCH

DHBs are caught in a negative spiral where the capital charge on top of depreciation costs is contributing to financial pressures that are forcing them to defer maintenance.

The capital charge was first introduced into central government in the early 1990s (though later in the health sector) as part of a wider policy to emulate market forces within government. Bringing public sector capital accounting into line with private sector conventions in respect of returns on capital was an attempt to create a ‘level playing field’ by disguising the most significant difference between the two sectors. In addition, the proponents of the charge, including Treasury and private sector interests, argued that public service agencies tended to view capital as a ‘free good’. A capital charge would provide incentives for those agencies to improve their capital management and to dispose of surplus fixed assets (which then became available for purchase by potential competitors).

Despite the widely acknowledged failure of the market-oriented policies and the return to a more cooperative, non-
THE SPECIALIST

service life and were in such poor shape. Several buildings, including the patching up buildings on top of earlier pressure led to the ‘false economies’ of consultancy firm Sapere found financial the Southern DHB, where a report from This has been the case, for example, for past), maintenance costs become higher. However, in the longer term (and in times longer than an uninfected patient in infection on average remain in hospital 2.5 Service, patients with a hospital-acquired infection on average in numerous media reports over recent months, or poorly maintained heating, air-conditioning or water systems. According to a report on Britain’s National Health Service, patients with a hospital-acquired infection on average in hospital 2.5 months longer than an uninfected patient and incur hospital costs that are almost three times greater.

A SOLUTION?

In summary, the stated intention of the capital charge to create a level playing field for competition with the private sector is anachronistic - an example of the long-term distortions which the ideology-driven changes of the 1980s and 1990s continue to create for public services in New Zealand. The evidence on the other stated intent of the capital charge - to achieve greater cost efficiency in the management of health service capital assets - indicates the unintended consequences of the policy are resulting in not only significant inefficiencies in capital management but also inefficiencies and safety risks in service delivery.

After media enquiries about the ASMS Research Brief on the capital charge, released in May, Health Minister David Clark issued a statement to New Zealand Doctor, saying that he had asked for work to be done on the charge: “Treasury itself admits the capital charge may have caused delays in investment leading to the situation today where we have infrastructure, including hospital buildings, which is past its use-by date. It seems very sensible to me that we have a hard look at the incentives in the system and consider whether there are better ways of doing things. This is particularly important work given our plans for substantial investment in capital projects across the health sector including construction of the new Dunedin Hospital. However, in the case of the new Dunedin Hospital, there’s plenty of time for the capital charge issue to be addressed before the project is completed in 2026.”

Meanwhile, the inefficiencies and safety hazards caused by the capital charge are worrisome with time. DHBs are caught in a negative spiral where the capital charge on top of depreciation costs is contributing to financial pressures that are forcing them to defer maintenance, leading to service inefficiencies and increased capital costs - and additional capital charges - down the track. On the weight of evidence, and considering the potential impact of the looming capital charges indicated for the next decade, there is a compelling case for their immediate abandonment.

The evidence on the other stated intent of the capital charge - to achieve greater cost efficiency in the management of health service capital assets - indicates the unintended consequences of the policy are resulting in not only significant inefficiencies in capital management but also inefficiencies and safety risks in service delivery.

The impact on services can also be costly, financially and in terms of the quality and safety of health care. As the Sapere report found, the “deteriorating physical environment is eroding quality of care, creating safety risks, and causing distress to patients and staff,” as well as causing delays and “leading to an increased likelihood of adverse events for both staff and patients.”

The literature strongly indicates poor maintenance can create health and safety hazards, including increased incidence of hospital-acquired infection, whether it is through damp and mouldy buildings such as revealed at Counties Manukau DHB in numerous media reports over recent months, or poorly maintained heating, air-conditioning or water systems. According to a report on Britain’s National Health Service, patients with a hospital-acquired infection on average in hospital 2.5 months longer than an uninfected patient and incur hospital costs that are almost three times greater.

Among other things, the Auditor-General has observed that challenging budgets over the years have led DHBs to focus on meeting immediate operating needs while there has been a consistent underspending against budget for capital expenditure. Ministry of Health data show DHBs underspent their planned capital spending by $200 million in the year to June 2017.

Aside from the pressures of funding constraint, the capital charge presents strong disincentives for DHBs to invest in capital, including maintenance. New and well-maintained assets generally have a higher value than older assets and so incur additional expenses (such as depreciation expense, as well as capital charges). By not spending on building and equipment, these additional expenses can be avoided in the short term. However, in the longer term (and in some cases the ‘longer term’ is today for some deferred maintenance of the past), maintenance costs become higher. This has been the case, for example, for the Southern DHB, where a report from consultancy firm Sapere found financial pressure led to the ‘false economies’ of patching up buildings on top of earlier patches. Several buildings, including the nine-storey clinical services block, were assessed as being at the end of their service life and were in such poor shape that they were unable to be economically ‘re-lived’. International studies show the long-term cost of deferred maintenance can be many times that of an early intervention cost.

31
ASMS SUBMISSIONS

In the past few months, ASMS has made the following submissions to parliamentary select committees and working groups:


VITAL STATISTICS

New referrals to psychiatric inpatient services increased by 70% between 2010/11 to 2015/16 (from 3,055 to 5,198).

New referrals to psychiatric outpatient services increased by 139% over the same period (from 1,055 to 2,517).

Workforce projections indicate an estimated 675 psychiatrists, or 13.2 psychiatrists per 100,000 population, will be practising in New Zealand by 2026. World Health Organisation and European Commission data indicate many comparable countries already have greater numbers of psychiatrists per capita, some by a wide margin. In 2015, eight European Union countries recorded more than 20 psychiatrists per 100,000 population.

SOURCES:

ABOUT WORKPLACE REDESIGN

If your work or office space is being ‘redesigned’ or moved, you must be consulted before a final decision is made and throughout the process to ensure that what you get is of good quality, suitable for your needs and generally ‘fit for purpose’ (MECA clauses 53.1 and 53.2). If you and your colleagues are not being consulted, seek advice from an ASMS Industrial Officer.

ABOUT VOCATIONALLY REGISTERED ‘TRAINING’ FELLOWS

If you are a ‘Training’ Fellow with vocational registration, even on a fixed term contract, both the law and the MECA require you to be paid as a specialist on the MECAs specialist scale (MECA clauses 11.3 and 12.2(a). If you or a Training Fellow in your service is being underpaid, you should seek advice from an ASMS Industrial Officer immediately.

ABOUT ADVERSE WEATHER EVENTS

If an extreme weather event or natural disaster stops you getting to work, you may still be ‘entitled’ to salary for the day under your DHB’s Natural Disaster (Adverse Weather) - Responsibility in Getting to Work Policy, which you might like to read. Your ‘right’ to receive salary in these events is not necessarily assured but the policy softens the general rule that, in return for your salary you have a responsibility to take all reasonable efforts to get to work on time.

ABOUT SECONDMENTS

The MECA clause 56.4 means you can apply for a secondment of two weeks, every three years. Secondments must be to a recognised unit for the purposes of your professional development and to upgrade your skills relevant to your duties and responsibilities. Contact your DHB for the process and application. If your application is declined then feel free to contact your industrial officer for further advice.
NEW ZEALAND MEDICAL ASSOCIATION

Ref: AE TOP 112/4/3
29 March 1989

Mr G Travis
Industrial Relations Manager
Palmerston North Hospital Board
Private Bag
PALMERSTON NORTH

Dear Mr Travis

CONDITIONS OF EMPLOYMENT - OPHTHALMOLOGISTS

We are initially taking an informal approach to alert you to the problems arising from the exceedingly heavy workload currently experienced by the three ophthalmologists employed by the Palmerston North Hospital Board.

It is quite clear that these specialists have been under a great deal of pressure and stress for the last 4 years since they have been caring for the patients from Wanganui as well as covering the full complement of patients from Palmerston North - in excess of 200,000 patients for 4.5 years whilst only being funded for 134,000. Although you have a small group of dedicated doctors, they have almost reached the end of their tether, and we feel it is in the interests of both our members and of the board that this problem be investigated and alleviated as soon as possible.

Neither the union nor the doctors concerned want to take a personal grievance but it is possible that this may be the only way to resolve the serious workload problem currently existing. One of our representatives will be available to come to Palmerston North to discuss the problem at any time should this be of any assistance.

Yours sincerely

ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

Jill Thomson
Executive Officer
(Salaried Medical Officers’ Services)

or Dr T R Ellingham

AFFILIATED WITH THE BRITISH MEDICAL ASSOCIATION AND THE AUSTRALIAN MEDICAL ASSOCIATION

ASMS SERVICES TO MEMBERS

As a professional association, we promote:
• the 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 DHBs, which ensures minimum terms and conditions for more than 4,000 doctors and dentists, nearly 90% of this workforce
• advise and represent members when necessary
• support workplace empowerment and clinical leadership.

OTHER SERVICES

www.asms.nz

TOI MATA HAUORA

34 THE SPECIALIST | JULY 2018
WWW.ASMS.NZ | THE SPECIALIST | 35
NEW TO NEW ZEALAND?
WE’LL HELP YOU FIND YOUR METATARSALS.

Join the 85% of NZ Medical Professionals* who protect what matters most with MAS.

Moving countries can be a little overwhelming, which is why we’re committed to helping you out. Our advisers are all commission-free and can meet at a time and place that suits. So if you want help with superannuation (pension), insurance or lending, get in touch.

Call 0800 800 627 or visit mas.co.nz/join-mas

*Market share from Medical Council of New Zealand Register as at August 2017. MAS is a Qualifying Financial Entity (QFE) under the Financial Advisers Act 2008. Our QFE disclosure statement is available by calling 0800 800 627. A copy of the authorised financial adviser disclosure statement is available, on request and free of charge.