ASMS

ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

TOI MATA HAUORA

TOUGHEN UP DAVID; THE FIRES ARE BURNING AND YOU ARE RUNNING OUT OF TIME

ADDRESS TO THE HOSPITAL AND COMMUNITY DENTISTRY CONFERENCE

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ADDRESS TO THE HOSPITAL AND COMMUNITY DENTISTRY CONFERENCE

Thank you for the opportunity to address you again. As always, my comments are personal observations, although in broad terms at least I believe they are consistent with the Association's view on the matters discussed. But, given that this both my 30th and last address from ASMS to your conference, I feel compelled to be somewhat blunter, if only because I can.

In my final year with ASMS there are two things I'm confident of. First, I have annoyed more people in the past year to date than I have over the past 29 years. This even surpasses the time when Bill English was Minister of Health. He used to refer to two different toxic trios. It was a long time ago and the main thing I can recall was that I was the only one in both trios. Interesting, really, as on a personal level he was the senior politician I liked the most.

Second, I am confident that whatever I do post-ASMS it will not involve being offered work as an external consultant engaged by DHBs to work a quarter as hard as I have for ASMS on double the remuneration and with a quality threshold to achieve of pure bullshit. Such remote odds will further increase once our health mandarins become aware of this address.

There are three main themes I want to focus on today – deficits and funding; the bitter and protracted resident medical and dental officer (RMOs) industrial dispute; and the precarious state of the specialist workforce in public hospitals. If I was to endeavour to put this into a sound-byte it would be: David Clark, please borrow Popeye's spinach and toughen up.

Missed opportunities

One of the achievements of this Minister of Health is to, in less than 20 months, make himself look responsible for much of what he has inherited by the neglect of the previous government. Quite an achievement.

Right from the beginning, opportunities have been lost. For good reasons the parties that make up our government oppose Public Private Partnerships promoted by the former government, which would have led to valuable health dollars in DHBs being syphoned off to bolster investor profits. Plans were in place to go down this path in the West Coast, Canterbury and Southern DHBs.

They were halted with the change of government. But there was no public statement from the then new Health Minister. The public were generally unaware of the PPP plans as were, at least outside two of these three DHBs, most DHB-employed health professionals. Had the Government made more noise publicly, then I'm confident that this would have been applauded both by the public and health professionals. An opportunity to demonstrate a fundamental difference in health policy between this Government and its predecessor was lost.

Associate Professor Phil Bagshaw has been leading an important project on rigorously assessing the extent of unmet patient need. In opposition, Labour supported this. There was an ideal opportunity to complete this project following the change of government in late 2017. Had the Government got behind this project with financial support we could have a published assessment of the extent of unmet need early on. Political opportunities like this are few and far between. The Government could have justifiably said that this was the extent of the huge problem it had inherited. But, by not doing this and significantly delaying its completion, if and when it is eventually concluded it will appear to most that this occurred on the current government's watch.

The Minister of Health and ASMS have similar views on the limitations of the official health targets. In summary, the targets only involve those things that can be counted but much of what happens in health can't readily be counted. Consequently, while not without merit, they are not an indicator of good performance by DHBs. The Minister has de-emphasised their role which is good but never proactively explained why, which led to much ill-informed public criticism about a

loss of accountability. I spoke about this in some detail in my address to you last year. This failure has recently given private hospitals the opportunity to seize the headlines with claims that private hospitals were the solution to the challenge of access to elective surgery.

The deficit of deficits

DHB annual operational spending deficits have been steadily increasing prior to the change of government. The reported $264 million deficit for the year ended 31 March 2019 is the highest for many years but it is part of a consistent upwards trend that predates this government. Of the 20 DHBs, 18 have deficits, and these deficits are crude indicators of under-funding.

The reasons are not easy to unpick and some DHBs have particular circumstances. Canterbury, for example, suffers increased patient demands as a result of the aftermath of natural disasters and the detrimental impact on the Population Based Funding formula because of the unreliability of the enrolment data that the formula depends on to be equitable, while Southern deals with the consequences of a top-down forced and inevitably unsuccessful merger.

Much has been said about the capital charge (the 6% per annum payment DHBs receiving government funding for major capital works must pay back to the crown) and its impact on the deficits. The capital charge lacks justification and is unfair on DHBs, but it is not sufficiently generalised in its application to the DHBs to make it an across-the-board cause. There has been neglect of major capital works for several years. To his credit David Clark has fronted this challenge.

The steadily increasing deficits should be seen in the context of what was happening to DHBs over the past decade. In its first year, the John Key government kept to the outgoing Helen Clark government's budgeted health spending. But in its remaining eight years there was sustained 'light austerity' (light by contrast to the drastic austerity in the health systems of the United

Kingdom and Greece, for example). But 'light austerity' is not light, particularly when accumulated over eight years.

We then had one year of improved relative funding under this Government, although ASMS and the Council of Trade Unions calculated this merely stopped the bleeding. The Minister rightly pointed out at the time that you can't make up for eight years of cuts in one budget. However, we have now had two budgets and the ASMS-CTU preliminary assessment is that the second is again merely a status quo budget overall. But that funding allocated specifically to DHBs is going to leave them short of what they need just to maintain services (a more in-depth analysis is due to be released shortly). There is no sign yet that the Government intends to actually fully redress eight years of funding cuts.

A major factor behind the deficits is certain to be the accumulated sustained underfunding of operational costs which led to neglect of basic maintenance and essential investment which, as we all know, costs more in the medium to long run such as right now.

But there is a second factor. Due to factors such as the ageing of the population and increasing sustained poverty levels within the population, we appear to have acute patient demand increasing at a level higher than both population growth and funding increases. This is reinforced by extensive increased presentations, admissions and bed occupancy rates. Our public hospitals whether big, middle-sized or small are under intense pressure. High acute demand drives costs.

Where does the Minister of Health fit in with all of this? In opposition he was critical of deficits but pointed the finger at the former government for underfunding rather than DHBs. In government, he is now pointing the finger at DHBs, even though their funding is little better in real terms than it was in the last year of the former government. This is not right. He can't on the one hand say that the former government is responsible but DHBs will be blamed if they don't fix it. He should not be so judgmental. DHBs are not responsible for being underfunded.

Instead the Minister should be assisting the transition to a more realistic and responsible funding path. If this year's budget for Health has been underwhelming in terms of that transition, he has at least taken an important step with his decision to directly fund DHBs for the cost of the capital charge. This is helpful although it continues as a time-wasting unnecessary bureaucratic process.

But looking ahead, the funding of major capital works and operational costs should be separated out, with the former based on a possible national risk pooling system of funding major capital works that takes the pressure off operational funding. Universal health systems are all about risk pooling.

Why not fully extend this fundamental principle to major capital works? The country should pool the risks from a small medical facility in Westport to a massive hospital rebuild in Dunedin.

But for the reasons discussed earlier, the capital charge appears not to be the driver of the current deficits; more of a compounder for some. Consequently, Dr Clark needs to either cut DHBs some slack over deficits until such time as a realistic funding path eventuates or use a clever manoeuvre of a former National Government in the late 1990s when confronted with uncomfortable deficits. In what was called the 'deficit switch', they transferred the deficits to the crown which, in effect, is what happens anyway because operational expense deficits do not carry through to the following financial year.

Calling a spade a spade; union busting

At its meeting last August, the National Affiliate Council of the Council of Trade Unions (which includes ASMS and NZNO) adopted a resolution highly critical of the DHBs' collective bargaining strategy towards RMOs represented by the Resident Doctors' Association (RDA). It included the statement that their strategy had the potential to be union busting.

My personal view is that the intent of the strategy was all about union busting. Union busting is not simply about employers seeking to eradicate an irritating union; it is about undermining its effectiveness to advocate on behalf of its members.

Although the issues sitting behind this protracted bitter dispute, including several strikes, are complicated, it was avoidable. Over many years the RDA has sought to reduce RMO fatigue by trying to make their hours of work safer through collective agreement negotiations. The dilemma is that enhancing safer hours requires more RMOs which fragments the relationship between specialists and registrars. This, in turn, fragments the continuity of training along with consequential effects on clinical handover and patient care.

This dilemma and its unintended consequences have been around for many years. In 2016-17, the RDA sought to further improve the safety of working hours in their national multi-employer collective agreement (MECA) with the DHBs by introducing two additional requirements – a maximum of 10 consecutive working days and 4 consecutive night shifts – along with consequential rostered days off. After acrimonious negotiations, which included two national strikes, the RDA succeeded, with an agreement known as Schedule 10 added to the national agreement. As a result, this dilemma deepened further.

Anticipating further conflict following the commencement of negotiations for a new MECA, and recognising our unique role representing those who train the doctors and dentists in training, last September ASMS proposed a collaborative and non-confrontational process to figure out how to deal with this dilemma of managing safer hours obligations without compromising continuity of training.

We invited the DHBs and RDA to meet with us to explore how we might do this, as the issues are too complex to address through the blunt instrument of collective bargaining. The RDA responded positively to our initiative, but the DHBs declined, preferring to address their concerns through the

blunter and adversarial process of collective bargaining. Had the DHBs agreed to participate, the industrial confrontation could have been avoided. In January they rejected a similar initiative from the Medical Council.

The chief executives' strategy on behalf of the DHBs was to take advantage of legitimate concerns over the impact of safer hours on continuity of training and continuity of patient care, rather than work through with us and the RDA the nuanced complexities of the challenge. Their strategy involved actively favouring a smaller competing union set up with the sole objective of removing Schedule 10. It should be noted that this was not a strategy fully shared by all chief executives. It was largely driven by those from the larger tertiary DHBs.

While negotiating at a snail's pace with the RDA, they quickly concluded an alternative MECA with the new much smaller StoNZ union which both removed Schedule 10 and other key protections previously negotiated, including reducing the ability of the union to effectively represent its members and contained financial inducements for RDA members to leave and join StoNZ.

They then only needed to wait until 28 February this year when the legal obligation to offer the expired RDA-negotiated MECA to new RMOs or RMOs who changed DHBs (outside the Auckland and Wellington regions at least) ended, leaving them with the only obligation being to offer their StoNZ MECA to those that depended on them for their training. They were able to ensure no agreement was reached before 28 February by proposing claw-backs to various rights and protections in their 'negotiations', knowing full well that the RDA would never accept (conditions that the RDA has fought hard to achieve over many years).

Ironically the DHBs did not seek the removal of Schedule 10 despite not forming part of the StoNZ MECA. Presumably this approach assumed that RDA's membership would plummet as a result of their strategy to the extent that it did not matter.

The rest, apart from the outcome, is history. There was a series of strikes which the DHBs publicly attempted to downplay. However, these strikes cost the DHBs an additional $20 million and resulted in high levels of fatigue among ASMS members.

The DHBs tried to argue that the issue was to ensure that decisions on rostering arrangements were made locally but, in reality, it was about whether chief executives should have ultimate control over determining the rosters of a young transitional workforce dependent on them for their training.

The dispute ended up in a legal process conducted by the Employment Relations Authority called facilitation (ie, non-binding but persuasive arbitration). This was initiated by the RDA and initially challenged by the DHBs. At this stage the outcome is not known but I am confident there will be a resolution and a new MECA agreed which recognises the core principle that because of their dependency on DHBs for their training RMOs are a vulnerable workforce.

I anticipate that some of the protections the RDA was fighting to retain will remain while others will be expressed in a different way but in a way that the RDA is comfortable with and short of what the DHBs were striving for. Most significant is that the RDA has retained its membership levels and remains a force to be reckoned with. Because it will cover many more RMOs than the StoNZ MECA, DHBs will be legally obliged to offer the RDA negotiated MECA in the first instance to new appointments.

Union busting failed, but it will leave a bitter legacy. This hard-line approach has had the effect of energising RMOs industrially but in an environment where the relationship between RDA and DHBs is at rock bottom. Oh, how our short-sighted health bosses reap what they sow. For ASMS the biggest concern is that at a time of specialist shortages in DHBs averaging around 22% we are likely to have a significant number of doctors and dentists in training who will no longer see DHBs as employers of choice due to their conduct in this dispute. These doctors and dentists will

provide the basis of our future specialist workforce in New Zealand – and they will have attractive alternative options overseas, while dentists will also have more immediate private sector opportunities.

The DHBs need a fundamental rethink of their attitude towards collective bargaining and employment relations. Their behaviours have consequences and they are not conducive to workforce confidence.

But this disastrous conflict has more significant implications because of the role of political leadership. If ever there was a case for political leadership to avert this avoidable 'war' in health, this was it. In the first instance this 'war' would not have eventuated if the Director-General of Health had advised the DHBs, as he was lawfully entitled to do, not to go down this adversarial path to resolve the complex issues of safer hours, continuity of training and continuity of patient care.

Further, had the Minster of Health advised the Director-General to give this message to DHBs, then again 'war' could have been avoided. ASMS, in a meeting with the Minister involving our President, Vice President and me, in a separate session with our National Executive, and in a formal letter strongly urged him to provide leadership in order to de-escalate the dispute. Not only did he argue that this was not his responsibility but further, in complete disregard of common sense, he diminished the significance of the issues.

In fact, it became clear that behind the scenes he was supportive of the StoNZ-negotiated MECA, even though it left RMOs largely unprotected over safe working hours. In a cynical act just prior to the announcement of the settled StoNZ MECA, David Clark was a guest speaker at an RDA conference on safer hours where he commended the RDA for its hard work in this area. It is good to have a theologian as health minister but a pity to have one who looks at Pontius Pilate as a role model.

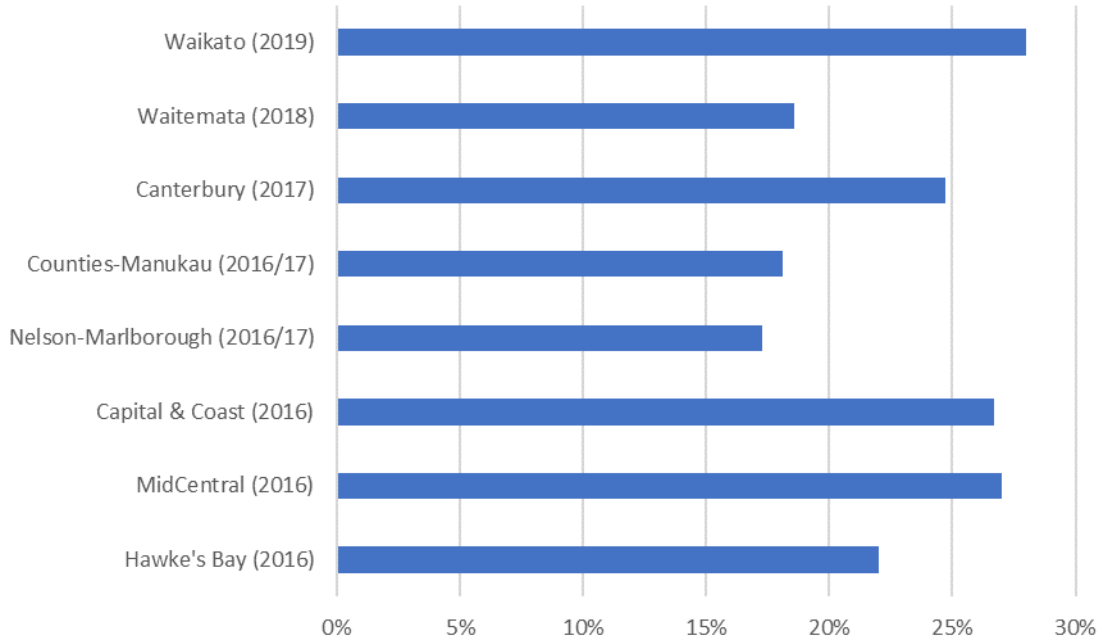
I have no doubt that despite the irony of a Labour-led government supporting union busting in this context, it was. It is not just the Health Minister. ASMS attempts to reach out to the Prime Minister and Minister of Finance were also ignored.

There is a book to be written on this fiasco.

Precarious state of specialist workforce in public hospitals

In my address to you last year I showed you a graph on the extent of specialist shortages in DHBs based on surveys of clinical leaders in four DHBs ranging from 17% to 27%. Now this has extended to eight DHBs (none of them small) with a similar range and an average 23% shortages:

Estimated SMO staffing shortfall as a percentage of current staffing allocations



Source: ASMS surveys of clinical leaders. Full reports available: https://www.asms.org.nz/publications/researchbrief/

Common messages from these surveys include:

- Shortages exceed official vacancies by a factor of two (up to three) to one.
- Specialists are unable to access anywhere nearly enough non-clinical time to undertake duties such as quality assurance, supervision and mentoring, education and training, and their own professional development.
- Inadequate internal back-up cover for colleagues on short-term leave.
- Inadequate access to locums or additional staff to cover for long-term leave.
- Inadequate time for ensuring patient centred care.

Sitting behind these severe shortages are high levels of burnout (50%) among hospital specialists along with presenteeism, including working while infectious, and with 25% of specialists surveyed intending to leave DHB employment in the next five years (several due to job dissatisfaction).

Given the central role of DHB specialists in the provision of quality health care, it is a political crime that the Government and Minister of Health have turned a blind eye to this travesty, displaying a callous disregard to the rights of patients and their whanau and to the wellbeing of

this workforce. It is this workforce that must cope with increasing acute patient demand, not mandarins and cabinet ministers at the whiteboard.

ASMS has persistently and assertively urged the Minister to require DHBs to focus as a priority on the wellbeing of the specialist workforce and to address the shortages. This includes calling on him to encourage DHBs to reach agreement with us on a safer staffing accord. He continues to duck the issue, despite having the means and authority to do so. This leadership deficit would make Pontius Pilate proud and makes the Government's claim of a commitment to wellbeing hypocritical.

When challenged on this at our Annual Conference last November, the best he could say was that his Director-General would form a committee. Whoopsie do! As I speak, seven months later, this committee has yet to be formed.

It is also short-sighted and, as a result, fiscally irresponsible. Specialists are masters of complexity and invaluable human capital. With the right engagement, culture and enough time created by increased workforce capacity, they hold the key to ensuring a better return for the health dollar by reducing duplication and variation and improving service design, configuration and delivery. But it can't achieve this when seriously overworked and burnt out. ASMS has reminded the Minister of this several times but he continues to smile and ignore.

Contrary to the Prime Minister's assertion 2019 is the year of non-delivery in terms of the specialist workforce in DHBs.

Firing things up

I was struck by the following piece of writing from a member titled 'The burning building' (published in the latest issue of *The Specialist*):

There is a building that has been on fire for many years. Each day, firefighters are sent in to put the fire out and to rescue people who keep entering the building. Increasing numbers of people keep entering the building, despite all efforts to keep them out. The firefighters are exposed to toxic fumes and their safety equipment is failing. They get no breaks and stay long hours trying to rescue all of the people in the building.

The firefighters have all become exhausted and are suffering from major health issues. Despite this, they keep coming back each day because they are the only ones qualified to do the work that needs doing. The firefighters have repeatedly asked for help to manage the fire and to help the people who need rescuing.

You are the Chief of the Fire Service and it is your responsibility to keep the firefighters safe. What is the most appropriate response to this situation?

1. *Continue with the present situation, knowing that it is likely that the firefighters will have severe health consequences and will not be able to keep going for long.*
2. *Explain to the firefighters that there is no more resource to help them in their situation and that they need to work faster and more efficiently to rescue the people in the building.*
3. *Explain to the firefighters that they should get some help with their health issues so that they can continue coming back to fight the fire and rescue the people.*
4. *Make a clear plan to manage the fire and keep up with the number of people who need saving. Resource this plan. Meet with the firefighters to determine what they need to recover from their health issues caused by their work and support them until they are well enough to contribute to the battle against the fire.*

The firefighters would rightly expect that those with the authority to make such decisions would without hesitation immediately go the fourth option. This is analogous with the public health

sector. Replace firefighters with DHB specialists. Tragically, our political masters and health bosses muddle somewhere in the first three options.

Leadership based on nice-nellyism and skimble-scamble

Despite the presence of several competent ministers in this government, sometimes I despairingly wonder if too many jumped straight from the playpen to the cabinet room. At least in respect of, but not confined to, health it is a leadership that fails the streetwise test. It is a default leadership culture too much influenced by nice-nellyism, a euphemism for an evasive style of writing and riddled with circumlocutions, and skimble-scamble (ie, rambling, confused or nonsensical).

Thank goodness this is influence rather than determinative. Otherwise it would remind me of a Swiss health economist who reportedly stated that "if healthcare was consistent with health policy then we would have been dead years ago."

The Government claims to be transformational. What nonsense. At best it is transitional but without a clear idea what it is transitioning to.

If David Clark does not get it together and toughen up over workforce, deficits and employment relations, it won't be long before people will be asking who the Minister of Health was between late 2017 and 2020 – was it David Coleman or Jonathan Clark.