

The Specialist

THE NEWSLETTER OF THE ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

MECA negotiations: several balls in air

By the time this issue of The Specialist is published and read there will be several balls in the air that, depending on how and where they land, will have a bearing on our national DHB MECA negotiations.

The first two balls: industrial action ballot

The first ball is the national ballot on limited industrial action currently underway. The deadline for responses is 11 December with the ASMS National Executive holding a special meeting on 14 December to deliberate on the results. The ballot is itself an unprecedented event in its own right. Its historical significance is that it is the first time senior doctors working in the public health system have balloted on national industrial action. Regardless of the outcome this event alone is a powerful message to government and DHBs.

Then there is the ballot outcome itself. In effect, the actual ballot outcome is another ball in the air and a separate event from the decision to conduct it. A vote in favour of industrial action is a further powerful message and would impact in no small way on the negotiations we are having with the DHBs. The extra leverage this would provide simply can't be ignored. Ironically, but correctly, the stronger the possible outcome for industrial action, the less likely it is that industrial action would need to be held. This is because of the power of the outcome's message.

"...under an interventionist health minister acutely aware of the longer term quality and fiscal advantages, it suggests a strong political interest in disregarding managerialism"

The third ball: new health minister; new political leadership?

Another ball in the air is the appointment of a new Minister of Health in the form of David Cunliffe. It is increasingly evident that the failure of his predecessor Pete Hodgson to develop effective relations with the ASMS and the gradual escalation of the MECA negotiations was critical to him losing the portfolio.

One of Mr Cunliffe's first steps as Minister was to initiate contact with the ASMS leading to a quickly convened meeting with us. He has a political imperative to fix this dispute. In contrast to his predecessor he appears to be an interventionist in those areas where he believes DHB and Health Ministry leadership performance is lacking.

The fourth ball: health professional leadership

This has led to another initiative, another ball in the air. There has been a sudden turnaround by government towards the ASMS's advocacy of health professional leadership. This is an initiative from the ASMS which would see health professional leadership in the engine room of DHB decision-making including, but not confined to, clinical networks between DHBs. Under the former Minister it never got off the ground and appeared to be buried in political disinterest and lack of leadership. But the new Minister has, at least to date, responded positively by urging the ASMS and DHB national representatives to reach agreement on the issue in order that this can be endorsed by him and become part of government policy and action.

While it is not a 'wink is as good as a nod', going down the path of health professional leadership offers the government significant advantages in the cost effectiveness of the health dollar and greater robustness over future health spending. The challenge will be to the managerialism culture far too evident in DHBs. But, under an interventionist health minister acutely aware of the longer term quality and fiscal advantages, it suggests a strong political interest in disregarding managerialism and the potential for widening their fiscal parameters in our MECA negotiations.

All these balls in the air suggest a new environment and new opportunities that are much more achievable than flying pigs. The next step is to see where they land and what we can make of them.

Ian Powell
Executive Director

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A Cotside Vigil

On a still night with stars in the firmament I was called to a birth. Not in a manger but in the glare of a fully equipped theatre. With all the facilities for the new life shoved, as usual, into an inconvenient corner. As I introduced myself to the expectant parents I was berated by the scrub nurse. He tried his best to make me feel uncomfortable in his domain. To show he ruled his realm. And I understood what some paediatric residents were subjected to as they juggled the demands of C-sections with the sick in ED.

Because I was the resident, I had the privilege of being present at the miracle of transformation from uterine to earthly life. Which happened in spite of my presence. Yet I was still privileged to be there. What had I done to deserve this privilege? To return to my growing up as a doctor. To be head down, bum up, reacting to beeps and lurching from crisis to crisis. Enjoying the thrill of the theatrical, and the charm of the challenging.

Twas a night for reflection. Not on comfort or discomfort in the acute work, which merely depends on my distance in daily duties and delights from the front door of clinical activity. Rather, reflection on the spiralling situation signalling more than just a tired me in the morning. The recurring gaps in RMO rosters signalling the rifts between what I signed up for and what I am now doing. And wondering whether these rifts represent momentary tremors, or transformative tectonic shifts. Shifts that bring a tired tear to my eye.

Because time I spend as a RMO is time robbed from RMOs. Time robbed for teaching. Time robbed for supervision. Time robbed for leadership and planning. And reflection.

Knowing that some of my colleagues will be reflecting over this season and considering their futures, considering how they are treated, and how those around them are treated. Considering The Clash – should I stay or should I go now?

If I am to stay, I must fight to alter the inexorably creeping emptiness in our corridors. To demand conditions that will tempt my colleagues to work with me. Conditions in which we can celebrate teaching and supervising, revel in handing on the fabulous dimensions of our discipline to the doctors of the future. So that they desire to become us.

I need time. We all need time. Time for quality.

We must embed in our employment the time to teach, to supervise. DHBs must demand of doctors time in their daily grind for reflection. Must enable and encourage evaluation. Must expect expert involvement in their decisions on service design and delivery. Doctors must be visible at all levels of DHB leadership, not by vehemence, but by prominence.

So that in partnership, for the patient, we decide on services not by eminence, but by evidence.

This culture shift will not be comfortable. It will feel for many that their realm is being invaded. It will bring out behaviours that will make that scrub nurse seem welcoming. It will challenge our domains of dominance and our ways of relating. It will bruise egos and rattle cages. It will require poultices for perceived imputations to pride. Salves for petty spats. We will have to walk down each other's corridors in each other's shoes. And together.

But if we do not alter many of the very traits that have been selected by the current system, the system itself will not survive. We need to lift the horizon from next month's bottom line to the next generation of us. As individuals, as craft groups, as specialties, we need time to bring out the very best in us. And in those around us. So we can all be the best we can be.

The time we need is now. We need the time now. Not to produce more widgets or better widgets to satisfy a spreadsheet. Not to do the work of those missing from our corridors. Not to return to our growing up as a doctor. Not to infantilise our professional development. But time for quality. Quality leadership. Quality supervision. Quality planning. Quality reflection.

As I sing softly to soothe the newborn in the startled light of modern life and swaddle her to join her proud parents, I wonder fleetingly whether she will perhaps one day want to be a doctor. And whether my fight will have forged a system for her to be proud of.

And hope my gift to her is not a lullaby of broken dreams.

Jeff Brown
National President



Assistant Executive Director

Review of the Health Practitioners Competence Assurance Act

The Health Practitioners Competence Assurance Act is the Act that sets up the Medical Council and other health professional regulatory bodies, the Health Practitioners Disciplinary Tribunal, designates activities that are restricted to health practitioners with a particular scope of practice and allows for protected quality assurance activities. Its primary purpose is to protect the health and safety of members of the public but it is also the legislation that defines and delineates professional self regulation. It came into force in 2003. It was touted at the time as ground breaking legislation partly because it extended the system of recertification that had been in force for doctors since the passage of the Medical Practitioners Act 1995 to a further 20 professions. The Act now covers 25 groups of health professionals and has 15 regulatory authorities set up under it. A further 2 professions (speech language therapists and clinical physiologists) are seeking recognition under the Act.

One of the concessions that were extracted from the government in the substantial work the Association and others did on trying to change the Health Practitioners Competence Assurance Act (HPCAA) was the requirement for a review after three years (section 171). Earlier in the year comment was sought on the terms of reference for the review. These terms of reference were signed off by Cabinet in September.

The Ministry of Health has now asked the Association (among others) to participate in the gathering of information on the working of the Act. It has issued a document, 'Review of the Health Practitioners Competence Assurance Act 2003: Identification of Issues and Solutions' and asked for answers to a series of consultation questions by Friday 21 December. You can find this document on www.moh.govt.nz. This process is only part of the review of the Act which is planned to be completed by December 2008. A discussion document is to be issued in the middle of next year but as this initial information gathering exercise is likely to identify the issues for the discussion it is probably important to have an input.

There has been some comment by DHB and Ministry officials that the Act has acted to perpetuate the professional "silos" rather than having the effect of breaking them down so there may be submissions attempting to move further in that direction. Other issues identified are the operation of the restricted activities provision, elections to regulatory bodies and single profession regulatory bodies. The extension of mandatory

reporting of health practitioners (at present applies only when concerns arise as to fitness to practice because of illness or drug or alcohol addiction) may be extended to concerns about competence in general. The Association and other health professional groups opposed this proposal vigorously when it was proposed in the HPCA Bill in 2001 but many others supported the proposal.

One of the difficulties that the smaller professions have experienced has been setting up a regulatory authority. The Medical Council represents one model with one regulatory authority representing one profession, the Dental Council another with one authority representing four professions. It is possible that the Medical Council may come under pressure to extend its brief to other professions. This is unlikely to be supported by the profession.

Angela Belich

Assistant Executive Director





Failing DHB leadership

A keynote speaker at the ASMS Annual Conference last month was Pat Snedden, then Chair of the Counties Manukau DHB and now Chair of the country's largest DHB, Auckland. Mr Snedden would generally be recognised as one of the most effective communicators in the health sector and, in fact, beyond. He was a key player in establishing community and union health centres and trusts to provide primary care particularly in areas of serious access problems. In many respects what he and his fellow pioneers did formed the foundation of what became known as the primary care strategy.

A key player in the health sector he is able, articulate and intelligent possessing the unusual qualifications of being both an accountant and anthropologist (he can count and is cognitive to boot). In addition, he has also won the New Zealand book award for a first time author.

Distance and dysfunction

And yet what was the experience of his address to the ASMS Annual Conference? For someone so able and thorough he demonstrated a considerable lack of awareness and misunderstanding of what was happening at the clinical frontline in secondary care. The effect of his presentation, through the mixture of confidence and misunderstanding, was after a witty start to talk down to Conference delegates, an experience that was not lost on them.

To his credit Mr Snedden has subsequently acknowledged that he did not succeed as a communicator and further has been actively involved in constructive discussions with the ASMS over increasing senior doctor engagement in decision-making. But it does highlight that even with one of the most able DHB chairs, there is considerable distance between their understanding of what is happening and what actually is happening. Compounding the problem is the fact that it is DHB chairs that Health Ministers tend to call upon, outside the Health Ministry, for advice and insight over what is happening within DHBs. This is a recipe for dysfunctional leadership.

Lack of national cohesion; the meaning of DHBs – 42

If our health system is to move forward then it cannot do it as 21 separate parts. We are simply too small a country. It is not a matter of merging DHBs but rather having a greater focus on a 'whole of system' approach inclusive of national and regional collaboration, which still allows for local application and sensible variation. But it requires national cohesion among DHBs for this to happen and this is precisely what we lack. It is highlighted by the fact that two of the largest DHBs (Auckland and Canterbury) refuse to

contribute to the costs of running their 'national secretariat', the misnamed DHBNZ.

DHB leaders themselves acknowledge, at least quietly, that they struggle to come to national positions and further that the health unions and professional associations are much more effective at it. This is also one of the factors which have contributed in no small part to protracted and difficult national DHB MECA negotiations. Their processes are slow and tortuous. It is not just a matter of having to resolve issues with 21 DHBs. In fact, it is 21 board chairs and 21 chief executives given their respective role demarcations. Ironically the answer to DHB fragmentation may be the answer to the meaning of life as revealed in the *Hitch Hiker's Guide to the Galaxy*—42!

What about the Minister?

Where does the Minister of Health fit in all of this? When Annette King became Health Minister in late 1999 she embarked upon an ambitious but important and justified task of dismantling and replacing the commercial system of the failed 1990s 'market experiment'. As she said to an ASMS Annual Conference during her first term as health minister, it was like turning around an oil tanker. This necessitated her to adopt direct leadership and intervention in order to ensure objectives were achieved.

Later on, however, she increasingly relied upon DHB chairs and her Health Ministry for advice and guidance and much less alternative sources. She became less directly involved and then this trend was taken to a much greater level by her successor Pete Hodgson. Essentially his argument, after one worked through the riddles he spoke, could be boiled down to the fact that the government had set up and resourced DHBs and that as a result what they did was accepted. If they claimed they engaged with senior doctors over a particular issue then this was accepted regardless of veracity.

The signs to date are that the new Minister, David Cunliffe, has a different view and recognises that there are serious deficiencies in DHB leadership. He appears to be prepared to champion national DHB cohesion and to intervene where necessary to achieve this.

With this political championing we hopefully will get to the point that the Pat Sneddens of the DHBs will connect rather than disconnect with health professionals. If we establish this connection, and there are encouraging signs from the new Health Minister, the health system and the citizens of New Zealand will be much better for it.

Ian Powell

Executive Director

ASMS services to members

- negotiate collective agreements and circulate copies;
- articulate professional concerns and interests;
- provide personal assistance and representation against unjustifiable treatment, unfair dismissal and discrimination;
- protect against breaches or incorrect interpretation of employment agreements;
- negotiate redundancy agreements;
- circulate up-to-date information about employment entitlements and industrial law changes; and
- provide general advice and support.

Other services

www.asms.org.nz

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

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

ASMS Job Vacancies Online

www.asms.org.nz/system/jobs/job_list.asp

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

Substantial discounts are offered for bulk and continued advertising.

ASMS email Broadcast

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

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

How to contact the ASMS

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Support service for doctors

The Medical Assurance Society and Medical Protection Society have joined forces to bring their members a support service. The support service provides access to a free professional counselling service. Doctors seeking help can call **0800 225 5677** (0800 Call MPS). The call will be answered by the Medico-Legal Adviser on duty who will then arrange counselling directly through EAP Services. The service is completely confidential.

MPS



We make it easy

Doctors' Health Advisory Service (New Zealand)

DHAS provides assistance – independent of all other medical organisations – for medical practitioners or students and their families with personal or health problems.

This service is available for medical, dental and physiotherapy practitioners – confidentiality is paramount.

FREephone

0800 471 2654

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Political perspectives and performance on health policy direction

Attached are extracts from a paper presented by Executive Director Ian Powell to the Australian Medical Association Industrial Coordination Meeting held in Canberra in October. The extracts focus on the current government's performance in health, with particular reference to secondary and tertiary care, largely since the 2005 election and the National Party's likely alternative health policy. The paper was presented prior to the decision of the Prime Minister to remove Pete Hodgson from the health portfolio and replace him with new Health Minister David Cunliffe.

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

Government performance since 2005 general election

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

Lack of strategic direction for public hospitals

The most critical factor in this situation is the chickens are coming home to roost (to the extent that headless chooks can undertake this flight task) over the failure of the government to have a coherent strategic direction for public hospitals. The government has strategies on most things including primary care and they are generally laudable. However, public hospitals are seen as some form of fiscal black-hole when in fact they are the most integrated part of

the health system dealing with complex matters that other parts of the system can't deal with.

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

- Primary care – much deserved and showing promising signs of improving access by increasing affordability. However, early cost effective intervention is only one outcome of increased access to primary care. Another, running in the opposite direction, is that it also appears to be increasing the demand for public hospital services because it is identifying more unmet need in a primary setting some of which requires secondary treatment.
- DHBs have had to use some of the increased monies to reduce and remove fiscal deficits.
- To the extent that extra funding has gone into public hospitals it has been absorbed by welcome capital works development and service expansion. But what has largely been neglected is the building of the current workforce capacity of DHBs to provide existing services which are facing increased workload pressures as well as service expansion. In a nutshell not enough is being done to build and sustain existing capacity, largely workforce, thereby placing it under increasing stress and strain. The workforce is expected to do more and more without being resourced and supported to do so.

Striking the balance between national and local needs

Compounding these difficulties has been the perennial challenge to all health systems, the balance between national and local needs. No one country gets it right. Australia has its own challenge as a larger country both in terms of geography and population and also the federal-state divide over primary and secondary care. In a small country like New Zealand this becomes particularly acute. The reality is that to achieve objectives of accessibility, quality standards, and cost effectiveness, New Zealand has to function as a national health system. This does not

ASMS 19th Annual Conference highlights

The 19th ASMS Annual Conference was held in Wellington at Te Papa on November 1-2 with a very high delegate attendance...

There were also international visitors from the Union of American Physicians and Dentists, Australian Salaried Medical Officers Federation, Queensland Salaried Doctors Union, and Australian Medical Association. The Annual Report is available on the ASMS website www.asms.org.nz

The 2008 Conference will be held in Wellington on 20-21 November.

The underlying feature of the Conference was discussion over the negotiations for the national DHB MECA including the resolutions adopted at the national stopwork meetings held in July-August and the ballot on limited industrial action. This included a background report by Executive Director Ian Powell and the two resolutions adopted.

Other Features of the Conference:

- Dr Jeff Brown's Presidential Address which was previously electronically forwarded to members and is also available on the ASMS website www.asms.org.nz.
- Ross Wilson, former President of the Council of Trade Unions, on employment relations in district health boards.
- Pat Snedden, Chair of the Counties Manukau District Health Board, on health funding and spending but proved to be a lively session widening into disengagement of senior doctors in DHBs and our MECA negotiations.
- Professor John Campbell, President of the Medical Council, on key issues affecting fitness to practice including competence and supervision.
- Chris Hodson QC, Medical Protection Society, on recent decisions of the Health & Disability Commissioner.
- Sim Mead, Executive Director of the Australian Salaried Medical Officers Federation, and Rupert Tidmarsh, Queensland Salaried Doctors Union, on why and how Australia is trying to recruit New Zealand specialists.
- Senior Industrial Officer Henry Stubbs on the ASMS's completed policy advice document on speaking out and the draft document on industrial action by other employees.

Membership subscription

The National Executive's recommendation that the membership subscription increase by \$20.00 to \$670.00 (GST inclusive) for the 2008-2009 financial year was adopted by Annual Conference.

Annual Conference resolutions on MECA negotiations

The following two resolutions were adopted by Annual Conference, the first unanimously and the second overwhelmingly:

1. That the Annual Conference fully supports the National Executive's decision to conduct a national ballot on limited industrial action.
2. That the Annual Conference recommends a 'yes' vote in favour of limited industrial action in the national ballot.



Dr Jeff Brown with Dinner speaker Tom Scott



ASMS staff members Ebony Lamb (Administration Assistant), Kathy Eaden (Membership Support Officer) and Sue Shone (Industrial Officer)

ASMS 19th Annual Conference 2007



Helen Moore (Auckland), Clinton Pinto (Counties Manukau) and Andrew Morgan (Nelson Marlborough)



Phillippa Bascand (NZ Society of Anaesthetists), Dr Paul Wilson (National Executive member, Tauranga), Angela Belich (Assistant Executive Director) and Dr Peter Roberts (Wellington)



Barristers Bruce Corkill QC, Penelope Ryder-Lewis and Matt McClelland



ASMS President Dr Jeff Brown, Al Groh and Mrs Groh (Union of American Physicians and Dentists), Ian Powell (ASMS Executive Director)



National Executive members, back row: Torben Iversen (Tairāwhiti), Jeff Brown (National President, MidCentral), John Bonning (Waikato), David Jones (Vice President, Wellington), Paul Wilson (Tauranga), John MacDonald (Ashburton), Brian Craig (National Secretary, Canterbury). Front row: Gail Robinson (Waitemata), Judy Bent (Auckland) and Iain Morle (Hawke's Bay)



Carol Beaumont (Secretary of the Council of Trade Unions), Lyndon Keene, Ross Wilson (ACC Chair)



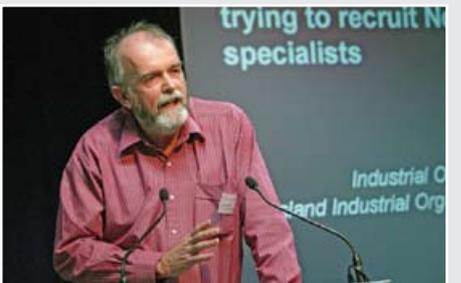
ASMS President Dr Jeff Brown



Dr Helen Rodenburg (Director, Medical Assurance Society) and Rae Lamb (Deputy Commissioner, Health and Disability Commission)



Drs Torben Iversen and Joe Diver (Tairāwhiti), Cameron McIvor (NZMA) and Dr Julian Fuller (Waitemata)



Rupert Tidmarsh (Queensland Salaried Doctors Union)



Ross Wilson (former President, Council of Trade Unions)



Counties Manukau delegates Drs Carolyn Fowler, Lynsey Hayward, Keith Allenby and David Galler



Dr Alistair Macdonald (former National Executive member, Wellington) and Helen Kelly (President, Council of Trade Unions)



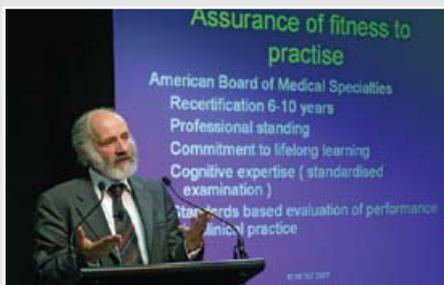
Sim Mead (Executive Director, Australian Salaried Medical Officers Federation)



Pat Snedden (Chair, Counties Manukau)



Chris Hodson QC (Medical Protection Society)



Professor John Campbell (President, Medical Council)



Dr David Jones (ASMS Vice-President)



Branch delegates at the dinner

preclude local imperatives and initiatives being recognised; in fact, it depends on this. But it is a question of context and balance. In the 1990s under our unsuccessful and destructive commercial experiment, the direction was very much towards excessive localism at the expense of national collaboration. This decade it has improved but there is still insufficient recognition of the importance of regional and national collaboration and coordination as a critical driver.

Dysfunction policy message: privatising public hospital laboratories

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

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

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

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

In response to the Minister of Health's first approval of privatisation of hospital laboratories (Otago and Southland DHBs) the Association, working through the Council of Trade Unions, initiated discussions with the Ministry of Health which led to a new provider selection protocol that has a stronger emphasis on public provision of core secondary services including an express requirement for health professional engagement. However, this has proven to be ineffective in subsequent privatisations because (a) the relevant DHBs have either evaded or simply ignored

the protocol, (b) the Ministry of Health when reporting to the Minister of Health have simply accepted what these DHBs say at face value, and (c) the Minister of Health has little real commitment to public provision beyond rhetoric (and simply not seeing DHBs as anything more than board members, chief executives and funding & planning divisions; the concerns of health professionals and the rest of the workforce simply do not compute).

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

Opposition National Party health policy

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

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

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

Areas of disappointment and concern: workforce, productivity, backdoor return to 1990s

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

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

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

Third, National says that it is not looking to restructure and, by implication, return to the commercial model of the 1990s. But there is an iron fist under the velvet glove. There is nothing headless about this chook. Where this is

most evident is its call for DHBs to convert their funding and planning divisions into "shared service networks across their regions." In other words, maintain 21 DHBs but devolve them of their funding and planning divisions, and create a smaller number of new regional bodies responsible for funding and planning. And what does this look like? The answer is the structure of the early and mid-1990s in which four regional health authorities purchased services from public hospitals (then crown health enterprises) and private providers.

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

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

Exaggerated expectations of private sector potential

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

- It over-estimates how much the private sector can do to relieve the pressure on the public system. Electives are only a relatively small part of what public hospitals do. There is no workforce over-supply in either the public or private sectors. There is a role for collaboration but one should not be misty eyed over what it can deliver.
- There is no distinction made between forms of contracting to the private sector. One form, subject to agreement over price, is simply to hire spare theatre capacity in the private sector where it exists. This happens and has advantages at least until capital redevelopment is achieved.

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

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

government's promotion of so-called independent (private) treatment centres is making little impact on overall capacity and increasing volumes.

Questionable application of public-private 'partnerships'

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

A big thank-you to our sponsors for their contributions to another successful conference

The Annual Conference was launched at a well-attended cocktail function on 31 October, generously funded by the Medical Assurance Society.

The Conference dinner, again generously supported by the Medical Protection Society, was another most enjoyable occasion for delegates and national office staff.



We make it easy



Public debate and speaking out

If the current incidence and popularity of TV series and soaps about doctors and nurses (Shortland Street, ER, House, Grey's Anatomy etc etc) indicate anything, they indicate an enormous public appetite for stories about health and the practice of medicine; that is probably healthy but is certainly prurient and voyeuristic. It might well be argued that this appetite is actually insatiable and in recognition of this our TV news rooms, talk-back radio, indeed all elements of the print media have accepted it as part of their "public good" duty to the community to seek to satisfy that appetite in their own way. Like their soap opera and talk-back siblings, these "news" outlets also often present their stories and information pieces as breathless sagas, bearing only a passing semblance to the true life dramas, tragedies and successes played out in the country's hospitals each day.

Perhaps this is why there can be such tension when a doctor enters the debate and presumes to tell it as it actually is. The story the doctor wants to tell is often far removed from the sensationalism and shallow spin or obfuscation of the DHBs, the Ministry's or the politician's media releases and spokespeople.

Perhaps that is also why district health boards (through their policies) and governments of the day (through the State Services Commission) seek to control or temper what doctors and other state sector employees may say publicly about their work and the vital health issues of the day, including those of inappropriate and misallocated resourcing, cynical and harmful waiting list policies and appallingly inept management practices often based on foolish decisions.

The ASMS has long recognised this tension and sought to deal with it by championing our members' rights and duties to engage and sometimes lead the public debate about the delivery of health care and related issues. With this in mind the Association has revised and reissued its advice to members about *Public Debate & Speaking Out*.

This revised advice was approved by the National Executive on 30 August 2007 and presented to the Association's Annual Conference last month. It is reprinted here for your interest and has also been posted on the ASMS website.

Advice to ASMS members on their rights and obligations to participate in or lead public debate and discussion on the state of New Zealand's health services in general and their employer's planning and delivery of health services in particular.

Introduction

Medical practitioners have ethical and professional obligations that may well override their duties and obligations as employees and state servants. However, as employees of District Health Boards or other health providers doctors have well defined legal obligations to their employers, which they should ignore only after careful thought and having sought advice from appropriate agencies.

Speaking out and participating in public discussion about health services and their delivery is not a simple right that every doctor may take for granted. In the past, when speaking out a doctor might simply invoke: their status as the patient's advocate; their professional and ethical obligations; the Hippocratic Oath; or some other lofty justification. For the most part, Society accepted a doctor's right to speak out on its behalf and were grateful when he or she did so. In the matter of health services and hospital care, doctors were generally accepted as their community's guardians.

Subject always to the over-riding need to preserve patient confidentiality, by-and-large, speaking out was a matter of making a political point at the expense of the Government of the day, any one of a number of public agencies and the local health care providers or hospitals.

The contemporary legal framework

The rules surrounding a doctor's right to speak out and engage in public debate on health related matters are derived from a variety of sources, in particular:

- Your employment agreement – (MECA clauses 40, 41 & 42);
- The public health sector Code of Good Faith in Schedule 1B of the Employment Relations Act 2000;
- The Hippocratic Oath and other ethical and professional obligations;
- The NZMA Code of Ethics;
- Statements and advice from the Medical Council;
- The New Zealand Bill of Rights Act 1990;
- Policies of your employer, provided they do not conflict with your rights under your employment agreement;
- The State Sector Code of Conduct (effective November 2007).

The key considerations

Under the MECA

MECA clause 40 quite explicitly recognises your role as patient advocate; your responsibilities and obligations

in relation to the Medical Council and its relevant policy statements and guidelines and your obligations in respect of the ethical codes and standards of relevant colleges and professional associations.

MECA clause 41 contains the express recognition by your employer of your right to *comment publicly and engage in public debate on matters relevant to your professional expertise and experience.*

MECA clause 42 deals with the somewhat narrower issue of serious concerns you may have *over actual or potential patient safety risks* and includes the procedures you should follow before speaking out on such specific matters.

Under the Code of Good Faith

Clauses 14, 15, 16 & 17 of the Code of Good Faith essentially replicate the rights you have under the MECA with the proviso that you must first raise with your employer any concerns you may have about their operations and allow your employer reasonable time to respond before going public.

Further considerations

As a general rule, neither an employer nor an employee should without reasonable cause conduct themselves in a manner which is likely to destroy or damage the relationship of trust and confidence that the law recognises as an essential ingredient of any employment relationship.

Nevertheless doctors continue to enjoy widespread respect within the community and that respect, coupled with their contractual, ethical and other obligations to lead and participate in public debate on health matters is likely to ensure a great deal of protection when speaking out professionally and dispassionately. This will be the case even if their public comments might be construed as being critical of their employer or otherwise undermine public confidence in their employer's operations.

The important point to remember is that you should not personalise your public comments and you should avoid direct or sharp criticism of your employer. Express your views and make your comments in a firm, professional and dispassionate manner.

Consult widely and speak collectively

You are more likely to avoid a personal and retributive response from your employer if you take steps to ensure wide support or "ownership" of the public statements and criticism you are about to make.

Ideally, if time permits you should consult widely with your colleagues before making your public statements and wherever practical the statements should be made on behalf of a group or organisation to ensure the individual doctor is one - removed from them and thereby protected from any critical reaction.

This will not always be possible; nevertheless such collegial support will add independent "objective" weight to the concerns being expressed.

ASMS recommendations in particular cases

If you believe that the standard or quality of care you and your colleagues are being called upon to provide has been or will be compromised by any action, (including the inadequate provision of staff and resources) or policy of your employer, we recommend that you:

1. Make your specific concerns known to your employer through a senior manager, Chief Medical Officer, the Chief Operating Officer or even the Chief Executive. This should be done in writing and should include an urgent request to meet with senior management (including the Chief Executive, if necessary) to discuss your concerns.
2. Consult with departmental and other professional colleagues to obtain their opinion and if possible their support. Such consultation might include:
 - The Senior Medical Staff Association (or equivalent);
 - The Clinical Boards (or equivalent);
 - Appropriate medical colleges or professional associations;
3. Seek advice from the ASMS national office, the NZMA or MPS.

Having decided to make your statement, we recommend you advise your employer what you are about to do and that you restrict your statement to your specific area of clinical responsibility and expertise; furthermore it should be couched in terms that reflect your responsibility to your patient(s) and the wider community.

Whenever possible such statements should discuss issues and not individuals.

If your statements are of a more general nature relating to funding or funding priorities, you should bear in mind that under the current funding regime, it is probably the planning and funding arm of the DHB, (your employer) that is immediately responsible for the concerns you are raising. Effectively, you will be criticising the decisions or actions of your employer.

Above all, you should ensure that any direct or indirect criticism of your employer, or a division of your employer, is couched in terms that are calm, professional and dispassionate.

Revised and approved by the National Executive: 30 August 2007



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Seasons greetings!



The National Executive and staff of the Association wish all members health and happiness over the festive season.

The national office will be closed from Thursday 27 December through to Thursday 3 January, 2008. During this period messages of urgency can be left on the office answerphone which will be cleared regularly. Throughout much of January we will be operating on reduced staff.