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Health Dialogue

The Future of the Leaking Bucket

A commentary on the SMO Commission Report
Senior Doctors in New Zealand: Securing the Future

ASMS
Association of Salaried Medical Specialists

Preface

The *Health Dialogue* is an occasional discussion paper published by the Association of Salaried Medical Specialists (ASMS or the Association) to stimulate debate and policy discussion on health sector issues.

This issue of the *Health Dialogue* reviews the SMO commission report *Senior Doctors in New Zealand: Securing the Future*.

Comments from Len Cook who chaired the SMO Commission are included as Appendix 2. The *Health Dialogue* extends the argument posited by the Association in its submission to the SMO Commission *Repairing the Leaking Bucket* which is available on the Association website

http://www.asms.org.nz/Site/Publications/Surveys_and_Submissions.aspx

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The SMO Commission Report

The establishment of a Commission to recommend to three parties (Government, ASMS and DHBs), a sustainable pathway to competitive terms and conditions of employment for senior doctors and dentists employed by DHBs, was critical to resolution of the ASMS MECA negotiations with the DHBs in 2008. The establishment of the Senior Medical and Dental Officers Commission (the Commission) was necessary to break the impasse in the negotiations over the employment agreement covering the terms and conditions of employment of senior doctors and dentists. The Commission arose out of one industrial negotiation and was supposed to feed into the next set of negotiations to be held in 2010.

The Commission report, Senior Doctors in New Zealand: Securing the Future, was released on 3 July 2009. Key findings include that

- There is a collective specialist pay gap of around 35% between New Zealand and Australia.
- Shortages in the DHB specialist workforce has made the system "vulnerable" and retention is deteriorating.
- There is serious disengagement of senior doctors and dentists from DHB management, which the Commission attributes to "significant, detrimental influence" of managerialism that developed in the 1990s commercial business era.

An important point on which DHB managers and clinical leaders agree is where "pay and conditions offered in other jurisdictions, Australia in particular, have reduced their ability to recruit in a competitive global market".[1]

The pay gap between New Zealand and Australia is also "clearly a relevant factor" with regards to retention of SMOs, but the Commission is unclear on the degree of relevance. Indeed it appears to have become convinced that New Zealand cannot be competitive ("…New Zealand must rely on other strengths in order to recruit doctors into New Zealand's health services at less than international salary levels".[2]), and that having competitive terms and conditions of employment is not of prime importance anyway.

[1] P 64
[2] p 49

The Commission report reaches a "tentative"[3] conclusion – based mostly on the commissioners' impressions received during their meetings with specialists – that SMOs' frustration with management and their general work environment are more important determinants of decisions to leave New Zealand than the lure of better pay and conditions elsewhere.

The substance and tenor of the report are influenced by two underlying factors.

- First are the "significant data gaps"[4] and a lack of reliable workforce management information, which compromised the Commission's "ability to make decisions based upon good evidence".[5] The Commission concedes that "the nature of much of the available data requires a cautious approach to its interpretation".[6]
- Second is the Commission's position that a "sustainable pathway" to competitive terms and conditions of employment must take into account "fiscal sustainability". This is measured not in terms of costs and benefits relating to services, as recommended in overseas literature, but in terms of New Zealand's record of health spending as a proportion of GDP, (which the World Health Organisation and the Ministry of Health caution against).

The quasi-affordability focus appears to have influenced the Commission's approach to the report to the extent that it suggests, paradoxically, in order for a pathway to competitive terms and conditions to be sustainable by New Zealand, it cannot be competitive with the rest of the world or more especially Australia. Rather, the Commission focuses on measures that it believes might negate the need for competitive terms and conditions of employment.

In doing so it has highlighted some significant long-standing shortcomings in the system, including fragmentation, poor management practices and attitudes, poor service and workforce planning and poor management and organisational accountability – all of which can affect the morale of SMOs and may contribute to reasons for leaving.

[3] p 65
[4] p 2
[5] p 27
[6] p 2

In light of these findings, the Commission's recommendations, broadly speaking, are about changing to a culture that is more oriented to collaboration so that resources may be used more efficiently and effectively, "within the limits of fiscal sustainability".[7] They include suggestions on improving management-clinician relationships and the work environment, and to developing partnerships and co-operating more at all levels of the system, along with better regional and national service planning and workforce development.

They are largely processes (some of which are already in place) which have positive and commendable medium-to-long-term aims, and which by and large the ASMS supports, but none is directly concerned with providing "a sustainable pathway to competitive terms and conditions of employment".

It is possible that in the longer term, if all the Commission's recommendations are implemented fully and effectively, retention could be improved. It is a big "if", however, because the cultural and organisational changes identified require resources, a willingness to change from many players who to date have not shown an inclination to do so, and ongoing commitment from all parties over many years.

The enormity of the task is not a reason for not attempting to make the changes. They are important. But the current workforce crisis requires an immediate response, which requires an historical perspective on the recent rapid improvement in remuneration of specialists in Australia and recognition that international competition for SMOs is going to become more intense. Indeed many of the Commissions recommendations require a workforce that is in a strong position. It is difficult to envisage many of them progressing until the current shortage of senior doctors is addressed, regardless of any of the other prerequisites.

It is a great concern to us that the Commission accepts the current level of shortages "…will remain a significant element of the health service in New Zealand for perhaps 20 years, until we have made a sizeable increase in the annual additions to the SMO workforce from New Zealand medical school graduates."[8]

This again reflects the Commission's view that New Zealand cannot afford to compete effectively with other countries to address

[7] p 63
[8] p54

our shortages, which cuts across the task it was given to undertake.

It is untenable to expect SMOs to continue to operate safely and effectively while coping with significantly increasing demands on services, as identified in the report, and at the same time be instrumental in driving the changes discussed in the report.

Under such circumstances, and because the Commission has effectively side-stepped the issue of competitiveness, is highly questionable whether most of its recommendations would contribute – even indirectly in the longer term – to providing a "sustainable pathway to competitive terms of employment". Consequently, the Commission has not provided a coherent strategy to that end and has failed to fulfil its terms of reference.

Where to now?

At its meeting on 22-23 July 2009, the ASMS National Executive agreed unanimously on three resolutions:

1. *That, while encouraged by a number of the recommendations of the Senior Medical Officers Commission, the Association is disappointed that it did not fulfil its terms of reference with regards to a sustainable pathway to competitive terms and conditions of employment for senior medical and dental officers.*
2. *That the Association promotes the right of equal access for all New Zealanders to high quality public health services. Both access and quality are threatened by the medical workforce crisis in our district health boards. Critical to resolving this crisis are:*
    - *(a) a clear pathway to competitive terms and conditions of employment for senior doctors and dentists;*
    - *(b) recognition that district health boards are competing in an Australian medical labour market; and*
    - (c) *recognition that the Government is responsible for resolving the crisis.*
3. *That the strategic direction for the next national district health boards collective agreement negotiations be formulated by the Annual Conference 2009.*

In the meantime, as the Commission points out, a paucity of good information impedes progress, "and has contributed to

disagreement between the ASMS and DHBs around interpretation of basic wage and workforce information".[9]

We agree with the Commission that core information requirements (workforce numbers, turnover rates, vacancies, hours worked, use of locums, etc) should be available, should be transparent to all parties and each should have confidence in the robustness and reliability of the information, and that work commences urgently to that end.

We therefore support the urgent implementation of Recommendation 6 – one of the few recommendations that, if implemented effectively, clearly would contribute to the provision of a "sustainable pathway", if indirectly:

> *The Ministry of Health lead a sector-wide process to identify core SMO workforce management information and establish systematic ways of collecting, analysing and reporting to provide a common understanding of SMO workforce issues.*

This analysis of the Commission's report should be seen as a contribution to that process. It highlights areas where the report does not reflect a common understanding of SMO workforce issues, in part because of the issues outlined above, and in part because the Commission has accepted some fundamental but questionable information at face value compounded by what appear to be inconsistencies throughout the report.

[9] p 54

Summary of key points

- The Commission has accepted DHBNZ's measurement of a 9.5% SMO vacancy rate as a general indication of the level of workforce shortages. On that basis, it describes the DHB SMO workforce as "vulnerable" [the Minister of Health has acknowledged a medical workforce "crisis"] and notes a deteriorating retention situation. The Commission suggests the current level of shortages "…will remain a significant element of the health service in New Zealand for perhaps 20 years, until we have made a sizeable increase in the annual additions to the SMO workforce from New Zealand medical school graduates."

Comment:

DHBNZ's data on vacancy rates lack credibility. First, there are major discrepancies in the base SMO workforce figures used to calculate the vacancy rate, both in comparison to MCNZ's statistics and to DHBNZ's own quarterly workforce statistics. Secondly, DHBNZ's vacancy numbers are understated, as is acknowledged by the Commission, be it tentatively. The ASMS vacancy survey of 10 DHBs compares the current number of FTE positions filled in individual departments, as reported by clinical leaders, against their departments' "job size",[10] *which is agreed with their DHBs*. This reveals a vacancy rate of 22.9% and is a more accurate reflection of the current shortages.

The Commission has not adequately explained why it chose to recognise DHBNZ's figures over the ASMS survey results.

The Commission's suggestion that the current level of shortages is expected to remain for many years is an indication that it does not expect New Zealand to be competitive in its recruitment and retention of SMOs, thereby belying its purpose.

- The Commission identifies a pay gap of around 30%-35% between current SMO salaries in New Zealand and Australia. It says the gap largely reflects a 28% gap between Australian and New Zealand wages in general, but concedes that there may be a factor of 5% where New Zealand SMOs are behind in relation to the rest of the New Zealand population, compared with Australian SMOs and the Australian population. The

[10] The average number of hours required per week for employees to undertake all their duties, including non-clinical duties.

Commission says this is a matter for consideration in the next MECA negotiations.

Comment:

With our common training system New Zealand specialists are more integrated into Australia than most other occupations and therefore the 35% gap is a real gap rather than a gap discounted by 28%. A 5% salary increase would, for example, do nothing to allow New Zealand to compete against Australia for overseas specialists and would do little to stop the loss of specialists from New Zealand to Australia.

If the correct step comparisons had been made the pay gap would have been around 42% and if Western Australia had been included the pay gap would have been 49%.

- The Commission highlights the disengagement of SMOs from DHB management, which it attributes to the managerialism introduced in the 1990s.

Comment:

The Commission's strong criticism of managerialism, and call for change, is welcome. However, its suggestion that college recommendations on staffing levels may be over-generous *because they are provider organisations* reflects the very attitude that underpins managerialism. Such comments raise questions as to whether much of the ASMS submission was overlooked in the Commission's report because it is a "provider organisation".

That managerialism is still entrenched in the system highlights the challenge of removing it.

- The Commission takes the view that "push factors" (eg poor relationships with management) are more important than "pull factors" (eg higher wages overseas) in SMO decisions to leave New Zealand. This view is based on "empirical and anecdotal evidence". The Commission's anecdotal evidence rests largely on the feedback it received from SMOs during its consultation process. The Commission says many SMOs felt under-valued and ignored by DHB management and it was these factors that drove them to leave rather than the attraction of better pay and conditions.

Comment:

It is not a surprise to the ASMS that many SMOs at the forums found it more comfortable to raise frustrations about management rather than dissatisfaction with their personal incomes. Any observer of the far larger stop-work meetings would certainly have received a different impression. The overwhelming support for industrial action by ASMS members ought to have cleared any doubts about the strength of feeling about pay and conditions.

An examination of the "empirical evidence" shows it is flawed. It is inconsistent with other empirical evidence, some of which was referred to in our submission, which was not considered in the Commission's report. Further evidence referenced in this paper reinforces the points made in our submission.

- The Commission comments that: "While discussion around pay and conditions is properly the role of the parties…it is important that the parties consider the complexity of establishing relativities in their discussions and **the minimal impact it is likely to have on long-term SMO retention relative to other measures that can be taken** to address the push factors identified in this report." [Commission's emphasis].

Comment:

The Commission's view is unsubstantiated and it fails to recognise the long-established and well-tested practice, within New Zealand and internationally, of using attractive pay and conditions of employment to recruit and retain staff.

- In its brief to recommend a recruitment and retention strategy that "will provide a sustainable pathway to competitive terms and conditions of employment" for SMOs, the Commission has interpreted "sustainable pathway" to include financial sustainability. It takes the view that New Zealand cannot afford to increase health expenditure without an overall increase in productivity and that New Zealand's spending is commensurate with our GDP per capita when compared internationally.

Comment:

The Ministry of Health and a World Health Organisation paper (see under Financial Sustainability below) point out there is no "right" or "wrong" proportion of a country's GDP to be spent on health, and cross-country comparisons cannot determine what

is right but rather simply what is commonplace. The affordability of our health system is a matter that the New Zealand public should be able to decide through the political process, supported by all the relevant information, including that which shows:

a) real health funding increases over recent years have not flowed through to many hospital services;

b) current negative measures of productivity in New Zealand are flawed and more sophisticated measurements overseas, including the quality and value of outcomes (eg saving lives), produce positive productivity results;

c) good health has a significant impact on a country's economic performance (so health spending is an essential investment in New Zealand's economy and New Zealanders' wellbeing);

d) the cost of not meeting health needs can be substantial (so this should be taken into account in health funding decisions).

The Commission's focus on "affordability" appears to have influenced its approach to the report to the extent that it suggests, paradoxically, in order for a pathway to competitive terms and conditions to be sustainable, it cannot be competitive. Rather, the Commission focuses on measures that it believes might negate the need for competitive terms and conditions of employment.

- The Commission believes recruitment and retention solutions lie in measures to improve the efficiency and effectiveness of the system, including improving the workplace culture so there is better engagement between specialists and managers, giving specialists more influence in how services are organised, developing more innovative practices, and reconfiguring services to provide better regional and national coordination.

Comment:

Many of the Commission's recommendations, if they are implemented fully, have the potential to improve the working environment of SMOs in the longer term. The current workforce crisis, however, requires an immediate response which needs to deal with the recent rapid improvement in remuneration of specialists in Australia and recognition that international

competition for SMOs is going to become more intense. Indeed many of the recommendations require a workforce that is in a strong position and it is difficult to envisage many of them progressing until the current shortage is addressed.

Partly because of the weight the Commission gives to "affordability", none of its recommendations directly address the provision of "a sustainable pathway to competitive terms and conditions of employment", and the extent to which most might contribute indirectly – if at all – to providing that pathway is debatable. Indeed, as commented above, the Commission's interpretation of affordability appears to have become the overriding influence in its approach to producing this report, to the point where the main focus is on a sustainable pathway to *quasi-affordable* terms and conditions, rather than *competitive* terms. Consequently, the Commission has not provided a coherent strategy to that end and has failed to fulfil its terms of reference.

- The Commission expressed some frustration at the lack of critical data and says the nature of much of the available data "requires a cautious approach to its interpretation". The lack of good, transparent data is seen as contributing to disagreement between the ASMS and DHBNZ. Urgent work is needed rectify this.

Comment:

We have also been frustrated by the lack of basic data. The quality of some of the data presented in the Commission's report indicates we are a long way from where we need to be. We take on board the Commission's caution about how it might be interpreted. We are keen to be involved in the process to identify what information is needed and how it should be collected. This analysis should be seen as a part of that process.

SMO Workforce Profile: the lack of good data

As ASMS also discovered during the compilation of our submission, the Commission found "significant data gaps"[11] compromising "our ability to make decisions based upon good evidence".[12]

The "critical information lacking" includes:

- Changes to vacancy rates over time
- Rates of turnover
- Exit interview data
- Comprehensive information on the use of locums

The Commission points out at the start that "the nature of much of the available data requires a cautious approach to its interpretation".

Not only is there a number of evident inaccuracies and inconsistencies of data used in the report but the authors themselves appear not to have heeded their own advice about how it is interpreted, having made some key assumptions and drawn some quite firm conclusions from highly questionable data.

At some point in the compilation of the Commission's report, value-judgements appear to have been made on what evidence was useful and what could be disregarded.

Examples are identified in various parts of this analysis.

This section of the report provides a statistical profile of the workforce using mostly the Medical Council of New Zealand's latest (2008) workforce survey results, which generally continue a trend noted in our submission.

Size of the workforce

The report, using MCNZ data, indicates a 46% increase in SMOs working in New Zealand between 1998 and 2008. No explanation accompanies this, for example in relation to demographic changes, the increasing demands on SMOs, historical shortages identified

[11] p2
[12] p27

by bodies such as the Clinical Training Agency (CTA), or the effects of a likely increasing trend in part-time employment (eg increased female participation and an ageing SMO workforce).

Furthermore, there is a significant variance between MCNZ's data and DHBNZ's data on the number of SMOs employed in DHBs. MCNZ's data (Table 5) indicate 3060 SMOs in 2008, while DHBNZ's data (Table 10) indicate 4063 SMOs in 2008. The report explains this difference as being the result of double-counting among DHBs where some SMOs work for more than one DHB. This would mean around 1000 SMOs – a third or a quarter of the workforce, depending on the data source – would be working between DHBs, which is highly unlikely.

These discrepancies are complicated further with DHBNZ's workforce report as at September 2008 showing the total number of FTE specialists being 2693.1 compared with the 3169.9 SMO FTE positions filled in DHBNZ's data, as at the same date, provided in Table 10 of the Commission's report. As FTE positions, this cannot be explained by a double counting of heads. One explanation may be that Table 10 includes Medical Officers as well as RMOs but even then the number would be considerably less than the 3169.9 stated, according to DHBNZ's data.

DHBNZ's quarterly workforce reports – not used in the Commission's report – show that between June 2006 (when the reports began) and June 2008 the number of FTE SMOs employed by DHBs was virtually unchanged. This information was provided in the ASMS submission to the Commission, but has not been acknowldeged.

(Note: Table 21 – "DHB use of IMG SMOs and MOs by DHB for the years to 31 March 2008" – is headed the same as Table 5, but the data are totally different. Nor does the paragraph beneath Table 21 relate to that table.)

Public/private trends

Also not included in the report are indications of a possible shift in employment to the private sector over the last few years. MCNZ data show an increase of nearly 540 specialists active in the public and private sectors in the two years to March 2008, but DHBNZ's workforce database shows virtually no change in the numbers of specialists employed by DHBs in the two years to June 2008. (DHBNZ data is outlined in the ASMS submission, *Repairing the Leaking Bucket* pp 93-94 http://www.asms.org.nz)

Hours worked

SMOs working in public hospitals are reported to work an average of 47.7 hours per week but this average includes part-time staff (the MCNZ's survey data include practitioners working from four hours per week upwards). The data may also be skewed because the survey form suggests that if the hours of a typical working week could not be identified, the hours worked in the most recent week would suffice.

On-call hours

The report suggests that around 40% of SMOs who work at least some of the time in public hospitals do not work rostered on-call hours.[13] This claim is attributed to the Medical Council workforce survey. It is highly misleading as on-call hours are defined by the Medical Council survey as on-call but not actually worked. On-call hours that entail actual work (ie a call-out) are not included – they are instead reported separately as hours worked. This definition is provided as a footnote in Appendix 3 but is not included in the main body of the report. Furthermore, as with the "hours worked" question above, the MCNZ's survey form allows information from just the most recent week to be used.

The MCNZ does not collect data that enable the total number of SMOs that do on-call duties (ie on-call hours worked and not worked) to be calculated. Anecdotally, the large majority of SMOs undertake on-call duties.

Shortages

The Commission outlines four approaches to determining "shortages" of SMOs (Commission's quotation marks):

- Current vacancies against established positions [eg DHBNZ's official vacancy figures]
- An optimised vacancy measure comparing existing numbers of active medical specialists with what would be required to meet specialist-to-population ratios [ie recommendations of the colleges]
- Demand-driven projections based on demographic and health status projections

[13] pp 9,10

- A supply-side response looking at numbers of doctors being trained and service delivery models

While the Commission accepts "all these approaches have a degree of relevance and validity", all are seen to have drawbacks. With the first approach, "there is considerable variability in how establishment numbers are determined" and "vacancies will be affected by the capacity to replace staff who are needed" (ie posts are not advertised because management has no expectation of successful recruitment).[14] The Commission does not acknowledge that the accuracy of this approach is further compromised by questions over the accuracy of DHBNZ's SMO workforce total, as outlined above. The Commission sees the remaining three approaches as "estimates based on assumptions that we do not have information about".[15]

The ASMS vacancy survey of senior doctors in selected DHBs, detailed in our submission, is regarded as the second approach. The Commission comments:

> *The difficulty arises in determining whether recommended ratios are over generous by building in some safety margin (they tend to be generated by provider organisations) and whether ratios developed for higher income jurisdictions are affordable in lower-income societies.*[16]

First, the Commission has misinterpreted the ASMS survey. It was not a simple population ratio benchmarking exercise. Vacancy rates were determined by comparing the current number of FTE positions filled, as reported by clinical leaders, against their departments' "job size",[17] as agreed with their DHBs. The result from the 10 DHBs surveyed was a vacancy rate of 22.9%. In some cases, survey respondents gave *additional* estimates of staffing needs to meet a "professional standard", taking into account a range of factors, including the views of the staff, college recommendations, as well as their own observations, as indicated in the survey questions, giving a vacancy rate of well over 30%.

Secondly, to suggest that specialist-per-population ratios recommended by colleges may be over-generous because they are provider organisations reflects the very attitude that many

[14] p10
[15] p 10
[16] p83
[17] The average number of hours required per week for employees to undertake all their duties, including non-clinical duties.

managers show towards medical staff and which the Commission has identified as a major factor in staff morale.

The Commission's decision to accept DHBNZ's official vacancy rate (9.5% overall) but not the ASMS survey result (22.9 %, based on the agreed job size) is not properly explained. The Commission says DHBNZ's rate is "more likely to be an underestimate of the structural gap we now have as we are aware that the recent provision of a 30% non-clinical entitlement is not yet able to be taken up in a good many settings".[18] The ASMS survey includes at least part of the 30% non-clinical entitlement in its results.

The Commission says that the DHBNZ data was used "as the most direct and available measure of current SMO shortages", yet it is no more "direct and available" than the ASMS survey data.

If the Commission needed more information about the "assumptions" underlying the ASMS survey, as the report suggests, it needed only to ask.

The Commission describes a vacancy rate close to 10% (a "likely…underestimate") as putting the system in a "vulnerable situation".[19] It does not describe what a 23% vacancy rate means for the system. It should also be remembered that the vacancy rates under discussion are FTE vacancies. Actual SMO vacancies will be greater still, owing to an unknown portion of the workforce working part-time.

The Commission adds that: "…we recognise this gap [the estimated shortage] will remain a significant element of the health service in New Zealand for perhaps 20 years, until we have made a sizeable increase in the annual additions to the SMO workforce from New Zealand medical school graduates."[20]

The implication here, and in other parts of the report, is that New Zealand cannot compete effectively with other countries to address our shortages. The Commission also assumes that the additional graduates from New Zealand medical schools in the future will remain in New Zealand.

DHBNZ data

While it is important to have an overall picture of the specialist workforce, including both public and private sectors, given the

[18] p54
[19] p65
[20] p54

purpose of the Commission it would have been useful to have had a more detailed picture of the specialist workforce in the public sector. Most of that data are collated and published by DHBNZ. Indeed a stated aim of DHBNZ's Health Workforce Information Programme is to be a central point for: "Comprehensive analysis, modelling and forecasting of … workforce data that will produce key information for health workforce management and planning." (DHBNZ website). It includes data specific to the public sector specialist workforce.

Yet, aside from the figures provided on vacancy rates, DHBNZ's database has been overlooked. Significantly, it is this data that is likely to form the basis of data to be used to inform the next MECA negotiations.

Given that DHBNZ's data is at wide variance with the data used by the Commission, and given this has not been properly explained, the accuracy of both MCNZ's data and DHBNZ's data is brought into question.

The report is not helped by confusion over terms. SMOs are defined as vocationally registered doctors or specialists in most of the report, but junior doctors are defined as all doctors who are not SMOs. Some of the DHB data appears as if it includes medical officers in the term and a consultant is defined as a 'senior specialist'.

The ordinary use of the term senior medical officer in New Zealand encompasses both specialists and medical officers (general registrants who are not in a training programme). Consultant is usually used synonymously with specialist.

SMO Supply Constraints

Financial sustainability

In its brief to recommend a recruitment and retention strategy that "will provide a sustainable pathway to competitive terms and conditions of employment" for SMOs, the Commission has interpreted "sustainable pathway" to include financial sustainability: "Any pathway must also take into account fiscal limitations."[21] It takes the view that New Zealand is not in an overall position to increase health expenditure without an overall increase in productivity and that New Zealand's spending is commensurate with our relatively low per capita income.

Referring to the OECD's latest Economic Survey for New Zealand, the Commission says our health system fairs quite well in terms of spending and population health outcomes.

However, the OECD report says New Zealand spends less per capita on its health system than many OECD countries and raises concerns about the sustainability of the health service delivery model in the face of rising demands and looming health workforce shortages. OECD data on international health status show New Zealand does not compare well with countries such as Australia, Britain and Canada, as detailed in our submission [pp22-23].

The Commission has not considered in its report any of the counter arguments to its interpretation of "financial sustainability", as detailed in our submission. In summary, they are that:

The affordability of our health system is a matter that should properly be decided by the New Zealand public through the political process, supported by robust, relevant information. (This is point is highlighted in a European research paper on determining the value of health care: "The problem arises due to the different points of view concerning what is adequate, appropriate and economic. The definition of this range of services is a political decision which should be supported to the greatest possible extent by scientific data."[22])

- Information to support an open political assessment of sustainable health funding should include that which shows:

[21] p 62

[22] *BMC Health Services Research* 2007, **7**:1 doi:10.1186/1472-6963-7-1
Available at: http://www.biomedcentral.com/1472-6963/7/1

a) Real health funding increases over recent years have not flowed through to many hospital services.

b) Current negative measures of productivity in New Zealand are flawed and that more sophisticated measurements overseas, including the quality and value of outcomes (eg saving lives), produce positive productivity results. As one prominent academic put it: "If we ask the wrong question the answer may lead us to the wrong policy conclusion…Of course the burden of illness, injury and disability is very hard to measure, and so we use surrogates when we assess healthcare systems, whence the hazard. But the difficulty in assessing productivity is no excuse for using misleading shortcuts."[23]

c) Good health has a significant impact on a country's economic performance. Health spending is an essential investment in New Zealand's economy and New Zealanders' wellbeing. A World Health Organisation (WHO) paper on the economic costs of ill health in Europe found that "…in many WHO European Region countries between 1970 and 2003, the welfare gains associated with improvements in life expectancy totalled 29%-38% of gross domestic product (GDP) – a value far exceeding each country's national health expenditures…Policy-makers should be encouraged to factor welfare gains into their economic evaluations of health interventions. Failure to do so risks understating their true economic benefits."[24]

d) Conversely, the economic cost of not meeting health needs can be substantial.

- As is pointed out by the Ministry of Health[25] and reinforced in a WHO paper, there is no "right' or "wrong" proportion of a country's GDP to be spent on health. Share of GDP is a relative measure against an economic level and cannot define the optimum level of spending either in macroeconomic terms or in terms of societal priorities. And cross-country comparisons cannot determine what is right but rather simply what is commonplace.

[23] Don Berwick. "Measuring NHS productivity: How much health for the pound, not how many events for the pound. *BMJ* 2005 April 30; 330(7498): 975-976.
[24] Marc Suhrcke et al. *Economic costs of ill health in the European Region: Background Document*. World Health Organisation 2008, and WHO on behalf of the European Observatory on Health Systems and Policies 2008.
[25] Ministry of Health 2008. *Health Expenditure Trends in New Zealand 1996-2006*. Available at: www.moh.govt.nz

Surveys of New Zealanders have consistently indicated their desire to see the public health system adequately funded to meet their needs.

The Commission's interpretation of affordability appears to have become the overriding influence in its approach to producing this report, to the point where the main focus is on a sustainable pathway to *quasi-affordable* terms and conditions, rather than *competitive* terms. For example:

> *"…New Zealand must rely on other strengths in order to recruit doctors into New Zealand's health services at less than international salary levels".*[26]
>
> *"In the current environment of world-wide medical shortages, employing more SMOs is often not an option."*[27]

The confusion between being "competitive" and being "affordable" has resulted in a lack of clarity in the report, no more so than in the paragraph:

> *"Closing the [salary gap with Australia] raises financial sustainability issues in the current economic climate, which will impact on the gradient of the 'sustainable pathway' to competitive terms and conditions of employment."*[28]

This appears to mean that if we had more competitive terms and conditions of employment (in this case relative to Australia), it would be more difficult to achieve a "sustainable pathway" to competitive terms and conditions of employment. That is, the pathway may not be sustainable if it is competitive.

Recruiting SMOs internationally

The report acknowledges New Zealand's relative disadvantages in the international market. Up until now New Zealand has managed to attract a high proportion of IMGs to fill at least some of the gaps but the point is made that increasing global competition "could make the New Zealand trained health professionals harder to retain, and attracting the potential pool of foreign recruits more difficult".[29] It is a point well made but does not appear to have been considered by the Commission in its conclusions.

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[26] p49
[27] p41
[28] p65
[29] p16

Increasing local production of SMOs

The report acknowledges that recently announced increases for medical school intakes will not fully benefit the SMO workforce until 2029.

Drivers of Demand for SMOs

The Commission mentions some of the drivers of demand covered in our submission. For example, population changes will be a key driver of demand; changes to models of care may have an influence but it is too difficult to accurately predict; the global trend towards increasing specialisation will require a change in the way services are organised; and SMO retirement rates will increase.

Further to our earlier comments, in this section and throughout the report there is confusion over the subject of discussion. It is not made clear that when the reference is to SMOs, the data sometimes relates to "vocationally registered doctors" (including primary care practitioners) or when there is a reference to doctors, it sometimes means doctors in general, including GPs, registrars, Medical Officers and RMOs and sometimes means specialists specifically.

For example, the report[30] states that that OECD data show New Zealand's overall doctor/patient ratio is higher than those in countries such as the UK, Canada and Ireland and not far behind Australia. This is unnecessarily confusing - and misleading - in a report that is about specialists, particularly when the OECD provides the same data specifically for specialists, as detailed in our submission. That data show that not only does New Zealand have lower specialist-per-population ratios than the countries mentioned, it is near the bottom of the OECD table.

Workforce attrition

While some medical specialists change employers during the course of their working life, few change careers, so on a national basis the turnover rates for specialists are traditionally minimal. Reports from Australia, Britain and Canada indicate a rate of around 3.5% has been the norm. In New Zealand, turnover rates for specialists are not available, despite that being one of the intended purposes of DHBNZ's Health Workforce Information Programme when it was established in 2005.

In the absence of this data, the Commission has focused on cohort studies of recent vocationally registered graduates, which of course can give only a limited picture of workforce attrition trends.

[30] p18

The discussion is confusing in parts; again because it switches back and forth between different categories of doctors without it always being clear which group is under discussion. The section under the sub-heading "Retention of New Zealand trained graduates" refers to "New Zealand doctors" (ie, not including IMGs) who have completed vocational training, "many as general practitioners, but mainly as SMOs".

The section under the following sub-heading, "Long-term retention of New Zealand trained SMOs" begins with a reference to doctors generally, and then discusses International Medical Graduates (IMGs) specifically but it appears these are IMGs of all scopes of practice, not just SMOs, as the sub-heading would suggest. The next paragraph says the Commission was unable to access specific data on the retention of New Zealand trained SMOs.

The next sub-heading, "International medical graduate SMO retention", appears to include IMGs who have trained as specialists in New Zealand as well as IMGs who have trained as specialists in their country of origin. Retention rates are measured from the first year of vocational registration in New Zealand. So while the sub-heading - and the text[31]– refer to IMG SMOs, the data under discussion includes primary care practitioners.

The table and graph in this section[32] indicate that vocationally registered IMGs have a "very high" retention rate after an initial drop-off that is explained as being partly due to some IMGs being employed as short-term locums.

However, the retention rate is not as high as it first appears. The rate of retention is expressed in the Commission's report as a percentage of each subsequent year, producing a flat graph that gives the impression of no losses, and some data extends only until six years out.

The data source – the MCNZ 2008 workforce survey report - shows that while around 92% of a cohort of New Zealand doctors with vocational registration are retained eight years-post registration (though the rate is declining), around only 70% of IMG vocationally registered graduates are retained over the same period and, again, the retention rate appears to be declining.

In the most recent figures, of an IMG cohort vocationally registered in 2007, 20% were lost by 2008. The Commission comments: "It is

[31] p22
[32] p22

too soon to say whether this figure marks a change in retention patterns or is an isolated aberration."[33] Either way, it is significant and it may be more than coincidence that the drop has occurred at a time of rapid improvement in remuneration of specialists in Australia.

The report raises a question as to whether lower retention rates of IMGs without vocational registration is related to the way the regulatory framework operates. This question is raised in a referenced OECD paper. That same paper, however, also points out that in a competitive global market New Zealand may find international recruitment comes at an increasing cost "with increasing difficulties to attract the best skills" [quoted on pp15/16 of the Commission's report].

Any difficulties IMGs may be experiencing in achieving vocational registration may also be related to the quality of some of the IMGs New Zealand is attracting.

The report notes a drop-off in SMO numbers from age 50 onwards "but it is difficult to interpret what this means".[34]

It notes anecdotal reports that retention is deteriorating but states "recent information suggests a … complex picture" without elaboration.[35]

Factors reported to be contributing to lower retention rates included (in the order presented):

- Feeling under-valued and over-worked
- Lack of flexible working arrangements
- Increasing trend for doctors to settle overseas and
- "Better remuneration packages and working conditions *perceived* [author's emphasis] to be available in the private sector …and overseas."

Increased Workloads

Many of the factors the ASMS identified in it submission contributing to increased workloads for SMOs are identified in the report, including those relating to changes in population and health status and increased training and supervisory pressures.

[33] p21
[34] p20
[35] p20

International Demand: flows to Australia

The report notes Australia employs around 1640 doctors who obtained their first qualification in New Zealand. This represents about a sixth of the New Zealand medical workforce. Reasons given as to why Australia is a "primary competitor" for New Zealand's medical workforce include:

- Geographical proximity
- Cultural similarity

Common colleges making qualifications immediately transferable, and

- "Australia generally offers superior pay and pay-related conditions to comparable roles in New Zealand"[36].

Despite an ASMS survey showing that New Zealand lost at least 80 specialists to Australia in the 18 months to July 2007, the Commission says "there is no data we have seen which shows large numbers of New Zealand SMOs currently relocating to Australia".[37]

It adds that "Australia has limited capacity to absorb large numbers of New Zealand SMOs, especially given that it has greatly increased its internal production of SMOs."[38] The Commission provides no evidence to support this. As the Commission report itself says, "Australian states [are] competing with each other for scarce skills."[39] As in New Zealand, the increased medical training capacity will not impact on the SMO workforce for many years.

Pay relativities

The Commission has estimated (based on the data in Appendix 8 its report) there is a 30%-35% difference in remuneration between New Zealand and Australian SMOs, but that this largely reflects a 28% wage gap between Australian and New Zealand in general. The Commission concedes there may be a factor of 5% where New Zealand SMOs are behind in relation to the rest of the New Zealand population, compared with Australian SMOs and the Australian population.

[36] P23
[37] p65
[38] p65
[39] p64

This is a specious argument. More so than most – if not all – other occupations, New Zealand medical specialists are part of an Australian medical specialist labour market. Unless one is in a specialty with significant earning capacity in the private sector, with our common training system New Zealand specialists can just as easily find a satisfying job in Australia earning much more. They are more integrated into Australia than most other occupations and therefore the 35% gap is a real gap rather than a gap discounted by 28%. A 5% salary increase would, for example, do nothing to allow New Zealand to compete against Australia for overseas specialists and would do little to stop the loss of specialists from New Zealand to Australia.

A positive feature of the report is that it accepts averaging of collective agreement terms and conditions for determining the collective pay gap. To get to 35% the commission selected four states – Victoria, New South Wales, Queensland and South Australia. But there are two faults with this:

- It compares the top steps of the Australian scales with New Zealand's top step but the Australian scales are all much shorter than New Zealand's as well as going much higher than New Zealand (the comparison should have been the average of the top Australian steps to the equivalent step number in New Zealand).
- It excludes Western Australia where one of the largest settlements was recently negotiated.

If the correct step comparisons had been made the pay gap would have been around 42% and if Western Australia had been included the pay gap would have been 49%.

In Australia there is a system known as 'salary sacrifice' or 'salary packaging'. Certain items (such as cars, superannuation and in some cases mortgages and meals) can be essentially bought for you by your employer without being counted as part of your salary and therefore without you paying tax on them. Some employers then have to pay a fringe benefit tax on these items as they would in New Zealand and this will often mean that they pass these costs on to employees. (It is this system that has essentially eliminated many fringe benefits in the New Zealand private sector. They have never been a major factor in the public sector.) Public hospitals, in Australia, are classified as public benevolent institutions and do not have to pay fringe benefit tax on salary sacrificed items under a designated amount. In addition items used primarily for a work

process appear to be exempt from fringe benefit tax. As well it appears that superannuation contributions made by an employer as part of a salary sacrifice arrangement are taxed as an employer contribution to superannuation (taxed within the fund). Consequently we hear from many senior doctors that they have received a much greater financial benefit from going to Australia than the actual amount of their salary and Australian tax rates would suggest.

The Commission concludes that closing the pay gap with Australia may not be a successful strategy to retain SMOs but that "DHBs will need to consider redistributing funds if necessary within the current spend" and that "money is better committed to retain a committed permanent workforce rather than paying high rates to attract locums".

There is also brief consideration of starting rates compared with RMOs which the Commission believes could be easily addressed by DHBs in negotiations.

The Commission concludes:

> *"While discussion around pay and conditions are properly the role of the parties ... it is important that the parties consider the complexity of establishing relativities in their discussions and the minimal impact it is likely to have on long-term SMO retention relative to other measures that can be taken to address the push-factors identified in this report." [Commission's emphasis]*[40]

"Push" v "Pull" factors

The Commission report states that while the differences in pay and conditions may seem a strong pull factor, "there is some empirical evidence that suggests push-factors may be a more important consideration…"[41]

This evidence, according to the paper, shows Canada "has a relatively low outflow of doctors compared to New Zealand, despite there being an absolute *and* relative improvement in living standards for SMOs associated with a move from Canada to the USA.

[40] p45
[41] p24

The evidence rests largely on one draft paper – a paper "not intended for citation, quotation or other use in any form"[42] – concerning migration of doctors between Canada and the United States, and by linking Canadian migration statistics with OECD data on American and Canadian physician incomes.

Given that the Commission repeatedly emphasises the importance of "push" factors over "pull" factors, based partly on this evidence, the response to this argument is more detailed than other matters raised in this analysis.

- The Commission paper has overlooked other empirical evidence on Canadian physician migration that indicates the "pull" of higher incomes is indeed significant. We referred to several papers providing this evidence in our submission [see *Repairing the Leaking Bucket* pp81/82].
- Empirical evidence suggests that the true extent of Canadian migration to the United States is underestimated and indicates that the number of Canadian-educated specialists practising in the United States in 2006 represented nearly one-fifth of the Canadian specialist workforce.[43]
- Putting aside questions over the accuracy of migration data, an area where there appears to be general agreement in the international literature is that since the early part of this decade the numbers of doctors leaving Canada have decreased while the numbers returning from abroad have increased, resulting in Canada having a net increase in migration for several years in a row.
- As pointed out in our submission, the positive Canadian migration pattern has occurred at the same time that Canadian physicians' income has increased. An OECD paper comparing the incomes of GPs and specialists across 14 countries – using the same data quoted in the Commission's paper – shows self-employed Canadian specialists' income increased on average by 4.6% in real terms between 1995 and 2003, while their counterparts in the United States saw a decline in income of about 3% in real terms over the same period, and while the American average wage increased by 15%. The data does not include

[42] Grepin K, *Brain Drain or Brain Train?* A longitudinal analysis of Canadian physician migration, working paper, Harvard University programme in Health Policy, May 2008
[43] Phillips RL et al, "The Canadian contribution to the US physician workforce", *CMAJ*, April 2007; 176(8)

comparisons on salaried medical specialists.[44] Another study estimates the average income of surgical specialists in the United States dropped by 8% in real terms between 1995 and 2003.[45]

Annual surveys conducted by the Medical Group Management Association (MGMA) indicate specialists' income, on average, has continued to decline in real terms over recent years in the United States. On the other hand, data from the Canadian Institute of Health Information shows total payments to Canadian physicians overall has continued to stay above the rate of inflation over recent years, as detailed in our submission. The weight of evidence, then, does not support the Commission's assertion that Canadian doctors have been returning at a time when the pay differentials between the United States and Canada have been widening – quite the opposite. The evidence therefore does not support the suggestion that "push" factors may be more important than "pull" factors (eg higher incomes).

- Despite an evident closing of the gap between Canadian and American incomes, the latter – at face value at least – still remain significantly higher than the former. However, it is well recognised that practising in the United States can incur significant costs, including high malpractice insurance fees, having the effect of reducing the gap in net income. This is recognised in the paper quoted in the Commission's paper: "it could…be true that many Canadian physicians expected to earn more abroad but one they arrived they realised that they had not factored in certain costs…or significant changes in the reimbursement of physicians and chose to return home."[46] The same argument does not apply with respect to the wide salary gap between New Zealand and Australian SMOs, as calculated by the Commission, which takes into account all significant costs.
- The Commission's paper has not recognised that the effect of "pull" factors can exacerbate or even create "push" factors. In particular, the loss of staff overseas has a consequence for those who remain, who are often faced with increased workloads, longer hours and, ironically, an increased dependency on locums and overseas recruits.

[44] Fujisawa R and Lafortune G, "The remuneration of general practitioners and specialists in 14 OECD countries: what are the factors influencing variation across countries?", *OECD Health Working Papers No 41*, December 2008.
[45] Ha T and Ginsburg P, "Losing Ground: Physician Income, 1995-2003, *Tracking Report No 15*, Centre for Studying Health System Change, Washington DC, June 2006.
[46] Grepin (2008)

- There are many examples around the world where the "pull" of increasing incomes is used as a key recruitment and retention tool, including the three countries with we traditionally compare ourselves, and are our main competitors for skills – Australia, Britain and Canada. The implication of the Commission's paper is that these and many other countries around the world are misguided.

The Commission's report in fact gives inconsistent messages on the importance of the pull of more competitive pay and conditions elsewhere. On the one hand it says:

> *"[Increasing global competition] could make the New Zealand-trained health professionals harder to retain, and attracting the potential pool of foreign recruits more difficult."*[47]
>
> *"Australia is the primary competitor for New Zealand's medical workforce for a number of reasons, including…[it] generally offers superior pay and pay-related conditions to comparable roles in New Zealand."*[48]
>
> *"[There is] an increase in the share of senior medical officers who work in the private sector as an alternative to emigration in a response to knowledge of international pay differentials."*[49]
>
> *"Australian SMOs earn relatively more…than do their New Zealand counterparts in comparison to their fellow citizens. Intuitively, it seems that this may be a consequence of Australian states competing with each other for scarce skills, with New Zealand caught in the slipstream."*[50]

The Commission then indicates some uncertainty about the pull factor:

> *"While acknowledging that good pay and conditions are important, the primary focus of [SMOs'] concern was frustration with an environment which does not appear to value and adequately support their key roles"*[51]
>
> *"Given the proximity of Australia within the same labour market the SMO remuneration disparity is clearly a relevant factor for consideration. Whether closing the gap is likely to*

[47] p16
[48] p23
[49] p64
[50] p64
[51] p44

be a strategy which ensures retention of SMOs in New Zealand is, on the evidence available, unclear."[52]

The Commission then indicates more certainty without providing further evidence to explain the change in view.

> *"While discussion around pay and conditions is properly the role of the parties…it is important the parties consider…**the minimal impact it is likely to have on long term SMO retention relative to other measures that can be taken** to address the push factors identified in this report" [Commission's emphasis].*[53]

The Commission repeatedly points out that "push" factors (ie poor relationships with management) rather than issues of income were stressed by SMOs during the consultation process.

However, it is not a surprise to the ASMS that many SMOs who turned up at the consultation forums found it more comfortable to raise frustrations about management rather than dissatisfaction with their personal incomes.

Any observer of the far larger stop-work meetings during the last MECA negotiations would certainly have received a different impression. The support for industrial action by ASMS members (9 out of 10 balloted) ought to have cleared any doubts about the strength of feeling about pay and conditions.

The Commission agrees with a suggestion that if SMOs had better relationships with management and a generally improved environment where they were better valued and supported, then they would be less inclined to seek higher incomes.[54] The suggestion is not substantiated. The Commission does, however, recognise the "significant, detrimental influence" of managerialism in our hospital services since 1990.[55] The Commission's strong statement on managerialism and the call for change is welcome. The ASMS will continue its efforts to gain traction for change. However, the Commission's comments highlight the extent to which managerialism has been entrenched in the system for many years. So even if one agreed with the idea that a changed management culture would reduce wage expectations, realistically it is not a solution to contemplate in the foreseeable future.

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[52] p44
[53] p45
[54] p44
[55] p60

Balancing Supply and Demand

The Commission acknowledges that importing foreign-trained SMOs to address shortages "will be difficult in a highly competitive global market".[56]

On the matter of workforce supply, the Commission says that "without better information it is difficult to determine whether a [workforce supply] crisis exists, what the nature of the crisis is, and how best to address it."[57] Later in the report the Commission has become certain, saying that the current situation is "a worrying but not yet crisis level of medical specialist vacancies"[58] but does not indicate what prompted the change of view. The current Minister of Health has described medical shortages as a "crisis".[59]

We agree that the lack of basic workforce data reflects the low priority given to workforce planning and development and limits the ability to properly understand what is happening. There is nevertheless a good deal of data available from a wide range of sources, much of it complied and referenced in our submission, which points to a crisis, gives some insight into the nature of the crisis, and ways that it could be addressed. That data, in large part, has not been considered in the Commission's report.

The Commission notes that in the future the larger cohort of doctors progressing through training "will require considerable input from SMOs to provide that training". It adds: "SMOs need to play a much stronger role in the training, supervision, management, and mentoring of doctors to support resident medical officers to stay engaged in training…"[60] It does not, however, discuss any further the resulting increased pressure on SMOs' workloads, as well as the additional supervisory pressures relating to increased use of locums and the ongoing dependency on large numbers of IMGs, as identified earlier in the report.

Rather than suggest the logical solution might be to increase the SMO workforce, the Commission recommends there be "a much stronger sense of team so that SMOs can …determine appropriate levels of delegation with confidence".[61]

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[56] p27
[57] p27
[58] p62
[59] **Health Minister's speech to launch the National Centre for Interprofessional Education and Collaborative Practice, 26 February 2009. Tony Ryall: New Zealand Medical Association Conference, 20 June 2008.**
[60] p28
[61] p28

Later in the report the Commission suggests, "Reducing RMO roles may help to fund an increased investment in SMO roles and provide better incentive for those in vocational training."[62] It is unclear what this means, given the plans to increase the supply of New Zealand medical school graduates.

Improving international recruitment and retention

DHB managers and clinical leaders identified that the pay and conditions offered in other jurisdictions, and Australia in particular, have reduced their ability to recruit in a competitive global market.[63]

The Commission believes "there is scope to promote New Zealand more aggressively as a potential job market to SMOs"[64] but it is unclear as to what specific aspects of SMO positions might be promoted more aggressively.

Fragmentation, with 21 DHBs competing with each other, is seen as a hindrance to international recruitment. A more collaborative, regional approach to recruitment is recommended but this would appear to require a reorganisation of the way most SMOs are employed (ie extending employment across DHBs).

The Commission heard consistent feedback from SMOs that IMG registration processes are complex, unclear and cumbersome, to the point where New Zealand was losing potential recruits discouraged from applying in the first place or dropping out of the process in frustration.

A streamlined IMG registration process is recommended to process applications more speedily and effectively in order to improve our ability to attract, recruit and retain IMGs. This would involve:

- National leadership
- Collaboration between DHBs, the Ministry, DHBs and the colleges
- Adequate resourcing
- Better accountability for all parties
- The Commission also recommends encouraging the return of New Zealand trained SMOs overseas by maintaining

[62] p44
[63] p64
[64] p30

frequent contact with them while they are away, and making an explicit commitment to employ them on their return.

The report says around 90% of foreign-trained IMGs at specialist level remain permanently in New Zealand.[65] In fact the MCNZ data show that over a period of eight years only 70% of IMG vocationally registered graduates are retained, and the retention rate appears to be declining, with the most recent figures showing 20% of the IMG cohort were lost in the year following vocational registration.

Improving local recruitment

Three strategies to improve recruitment of New Zealand-trained SMOs are suggested. Briefly, they involve:

- A more streamlined recruitment effort, taking a more collaborative, regional approach as mentioned above, which will require a reorganisation of the way services are provided across DHBs.
- Ensuring that doctors have a positive work experience during the course of their training to become specialists, and maintaining a good relationship with them over time.
- Managing growth in the SMO "casual locum" workforce. The Commission understands the SMO locum workforce is growing. On the one hand it says "an increase is not inherently bad" but in the same paragraph it points out: "Casual locums provide poor continuity of care…interfere with effective teamwork and raise safety concerns…".[66] Increasing the use of locums was recognised as a costly option. "There is a need to be proactive in managing the risk."[67]

All of the above, in theory, may be helpful, but there is no recognition on how current shortages will affect their ability to be implemented. The list in effect requires the shortages to be addressed before recruitment can be improved.

The Commission provides a number of factors that affect recruitment of SMOs. They are, in the order that they appear:

- career opportunities for SMOs and their family members

[65] p29
[66] p34
[67] p35

- scopes of practice and insufficient work volumes for subspecialists
- opportunities to be involved in the training of RMOs and in research
- DHB resources to fund professional development opportunities
- access to the latest clinical technology
- the quality of collegial relationships and support with the DHB
- the workload from on-call rosters because of working in small teams
- opportunities to supplement income through work in private practice
- DHB resources for recruitment initiatives
- social and cultural support networks within the local community
- DHBs' need for full-time SMO positions
- remuneration

Arguably, most of these factors are a reflection of New Zealand's size. The facilities, support and professional opportunities in rural and provincial New Zealand are more limited in comparison with the larger centres, and this is recognised in financial incentives to encourage doctors to work in those areas, such as the bonding schemes and the premiums DHBs pay to recruit in hard-to-fill positions[68]. A similar situation exists for New Zealand as a whole in comparison with countries such as Australia, Britain and Canada, where there is greater scope for professional development (as well as better pay and conditions of employment). This point is acknowledged earlier in the report [p 15]. This may in fact be a reason why IMGs from those countries have poor retention rates in New Zealand.

[68] p13

Improving retention

As previously discussed, the Commission heard through its consultation process that many SMOs felt undervalued and disempowered "and that it was this factor that drove them to leave rather than the attraction of better pay and conditions. Indeed, **this was one of the most powerful and compelling themes raised by individual SMOs** [Commission's emphasis] through the consultation process."[69]

Because of this, the Commission emphasises measures to improve SMOs' participation and influence in decision-making in order to improve retention. It outlines the issues contributing to SMOs' disempowerment and promotes clinical governance as a response to this.

> *"… New Zealand will be highly dependent on innovation and evaluation by health professionals to provide most of the impetus for the increased added value expected of health services. Implementation will need a strong partnership between managers and clinicians, using the available resources well, responding as needs change, and putting resources in the right place. It is important, therefore, to recognise the potential economic significance of clinical leadership and related input in adding value to the total health system."*[70]

Suggestions on how to improve teamwork, and mutual respect and trust, include:

- Developing and supporting medical leaders, with DHB chairs to be responsible for advancing the clinical leadership of their respective organisations, including a "top level leadership programme".
- Building on initiatives such as the Time for Quality Agreement and the Health Sector Relationship Agreement through the current collaborative processes.
- Joint training, where clinicians can develop closer relationships with managers.
- Introducing mutual accountability measures where chief executives, boards, managers and clinicians share

[69] p35
[70] p52

accountability for the performance of the health system as a whole, including training.

We support such measures. They may well contribute to improving retention rates in the longer term.

Meeting material needs

The Commission also identified a need to ensure the necessary space, tools and support are available for clinical staff.

Again, we support this. As the Commission points out, the poor attention to meeting SMOs' material needs in some DHBs may be as much a reflection of poor management-SMO relationships as it is about the ability of DHBs to respond to those needs. As such, this issue may be seen as a part of the larger cultural issue identified elsewhere in the report, which realistically will take time to address.

Flexible work arrangements

The Commission recognises an apparently growing trend in a desire for better work-life balance.

> *The health system needs to find a way to accommodate the desire for shorter working hours to retain part-time participation in the SMO workforce rather than have people withdraw from the workforce altogether.*[71]

The need to provide more flexible working arrangements for SMOs towards the end of their careers is also recognised. No suggestions on how this might occur are offered. Nor is there any acknowledgement of the effects that current workforce shortages have on the ability to introduce more flexible arrangements.

Reducing onerous workloads

Onerous clinical workloads were another commonly raised issue. It was noted that SMOs in DHBs tended to work longer hours than those in private practice.

The main causes of heavy workloads "were said to be":

- Persistent and significant staff shortages
- Providing cover for other SMOs during leave

[71] p41

- Less ability to delegate work to registrars and house surgeons
- Other pressures include:
- increased training and supervision of RMOs (ie, the oversight of short-term appointments and of those awaiting recognition of their qualifications as overseas graduates) and other clinical staff. ("It is generally accepted that training of RMOs takes 20% to 30% of SMOs' time."72)
- increased administrative workload
- population increases
- changes in health needs

The Commission notes: "Beyond a certain point, increases in overall workloads cannot be absorbed within existing SMO capacity."[73]

The Commission offers no specific suggestions on how onerous workloads might be reduced, but does suggest workforce shortages could be addressed by making better use of the existing workforce.

Registrar-SMO salary gap

A further "gripe" was the small or absent remuneration gap relative to senior RMOs.[74] The Commission offered no comment on this other than to say it was a matter that could be addressed in DHB negotiations.

[72] p23
[73] p23
[74] p36

SMO Shortages

Making better use of the workforce

The Commission appears to accept that New Zealand is a weak competitor, saying that in the current environment of world-wide shortages, "employing more SMOs is often not an option".[75] This implies that its suggested measures to improve recruitment may not be effective. "Other ways of providing services need to be found."

One suggestion is to make better use of available resources through "innovative workforce measures", but "realistically [this] needs to be funded and supported as national demonstration projects".[76] Better service organisation, such as regional clinical networking, is also suggested.

> *"It may be better where specialist expertise is scarce to concentrate that expertise in fewer locations, providing required access:*
>
> - *through outreach from regional or national or even international services*
> - *by transporting patients to other locations for their consultations."*[77]

As we explained in our submission, new models of care are works in progress and their impact on future health workforce planning is largely unknown. What is clear is that the evolution of new models will be restricted or even unable to proceed when there are ongoing shortages of specialists – especially if, as the Commission suggests, the shortages may continue for at least the next two decades.

Similarly, as discussed in our submission, reconfiguring services to improve coordination and collaboration regionally and nationally may not necessarily reduce the need for specialists. Depending on the models of service developed, there may be a need to increase the number of specialists to improve efficiency.

[75] p41
[76] p42
[77] p42

Use of the private sector

The Commission lists a number of potential benefits in developing public-private partnerships, such as:

- Private sector contribution to training RMOs.
- Joint public-private recruitment appointments
- Joint acute on-call coverage
- Use of elective capacity in the private sector
- Public-private collocation of services (a "win-win approach")[78]

Competitive tendering for services is likely to create further difficulties for the public sector in attracting and retaining staff and threaten the viability of some services.

The Commission does not acknowledge any potential downsides to making greater use of the private sector. It simply notes that the private sector "is often perceived as a threat to public provision", which it sees as "nonsensical, as the private sector is still very much present".[79]

Without a proper examination of the potential pros and cons of developing public-private partnerships, it is unclear how such arrangements would contribute positively to a national recruitment and retention strategy that will provide a sustainable pathway to competitive terms of employment for SMOs in the public sector.

[78] pp42/43
[79] p43

Conclusion

In carrying out its brief to recommend a recruitment and retention strategy that "will provide a sustainable pathway to competitive terms and conditions of employment" for SMOs, the Commission has interpreted "sustainable pathway" to include financial sustainability.

The Commission's interpretation of affordability (health spending as a proportion of GDP, which the Ministry of Health and a World Health Organisation paper caution against) appears to have become the overriding influence in its approach to producing this report, to the point where the main focus is on a sustainable pathway to quasi-affordable terms and conditions, rather than competitive terms.

In that context, the Commission has come to the view that:

Shortages in the DHB specialist workforce have made the system "vulnerable" (based on DHBNZ's estimate of a 9.5% vacancy rate) and retention is deteriorating. (The Commission has ignored the ASMS vacancy survey showing a 22.9% vacancy rate.)

Current shortages are likely to continue for at least the next 20 years, and that New Zealand cannot afford to offer competitive terms and conditions of employment to fill the gaps.

- There is a collective specialist pay gap of around 35% between New Zealand and Australia (but the Commission has the rather odd view that the pay gap is not influencing SMOs to leave New Zealand).
- The main retention issue is disengagement of senior doctors and dentists from DHB management, which it attributes to "significant, detrimental influence" of managerialism that developed in the 1990s commercial business era.
- Recruitment and retention solutions lie in measures to improve the efficiency and effectiveness of the system, including improving the workplace culture so there is better engagement between specialists and managers, giving specialists more influence in how services are organised, developing more innovative practices, and reconfiguring services to provide better regional and national coordination.

- Improving pay and conditions would have “minimum impact” on long-term SMO retention relative to the types of measures listed above (a view that is not substantiated in the report).

Many of the Commission’s conclusions are “tentative” because of a paucity of good data and workforce information, and “the nature of much of the available data requires a cautious approach to its interpretation”.

Partly because of the weight it gives to “affordability”, none of its recommendations directly address the provision of “a sustainable pathway to competitive terms and conditions of employment”, and the extent to which most might contribute indirectly – if at all – to providing that pathway is debatable. Consequently, the Commission has not provided a coherent strategy to that end and has failed to fulfil its terms of reference.

Appendix 1 Summary of Recommendations

Recommendation 1 DHBs and the Ministry of Health value the SMO contribution, and jointly develop effective clinical leadership and participation through strong clinician–management partnerships. This will get the best value out of public health spending.

Recommendation 2 The Government amend DHB mandates to drive critical health system goals, such as workforce and clinical services planning, through shared accountability.

Recommendation 3 The Ministry of Health accelerate the development of a clear process for regional and national service planning, to enable aligned SMO workforce planning.

Recommendation 4 The Ministry of Health require the Medical Training Board (or any successor) to review and recommend medical student intakes at three-yearly intervals to align intakes with future service needs.

Recommendation 5 The Government consider the recommendations of the Medical Training Board report and Commission on the Resident Medical Officer Workforce, and agree to the rapid implementation of co-ordinated initiatives that will significantly strengthen medical training.

Recommendation 6 The Ministry of Health lead a sector-wide process to identify core SMO workforce management information and establish systematic ways of collecting, analysing and reporting that information to provide a common understanding of SMO workforce issues.

Recommendation 7 DHBs and the Association of Salaried Medical Specialists develop an interest-based bargaining model that is:

supported by reliable and accurate base information and analysis

led by experienced and senior representatives with delegated authority to reach agreement (subject to ratification)

This will ensure negotiation is underpinned by expertise that is commensurate with the significance of SMOs to the health system.

Recommendation 8 DHB boards initiate and monitor an ongoing programme of SMO leadership development and report progress through their accountability documents. This will enable them to realise the contribution of potential SMO leaders.

Recommendation 9 DHBs, the Ministry of Health and professional colleges work collectively to use emerging national and regional service planning processes to determine the numbers and mix of general specialty and subspecialty training positions needed to match future service needs.

Recommendation 10 The Medical Council of New Zealand and professional colleges adapt their processes to provide the necessary support, responsiveness and facilitation to IMGs seeking vocational registration. This will ensure the wider public interest of appropriate SMO deployment across the New Zealand health system is met.

If necessary, the Minister of Health may need to review the mandate of the Medical Council of New Zealand to enable this to be achieved.

Recommendation 11 DHBs establish regionally co-ordinated recruitment functions that complement regional and national service planning, retaining the benefits of local strategies. This is a critical component of a national recruitment strategy.

Recommendation 12 DHBs review current arrangements and take necessary actions to improve space, tools and support for SMOs, recognising the importance of these factors to SMO retention.

Recommendation 13 DHBs, the Association of Salaried Medical Specialists and the Ministry of Health strengthen existing bipartite and tripartite processes to nurture an informed dialogue at all levels. This will contribute to a sustainable level of SMO staffing that is aligned to service needs.

Appendix 2 Comments from SMO Commission Chair

Comments from SMO Commission Chair, Len Cook on the ASMS review of *Senior Doctors in New Zealand: Securing the Future*; the SMO Commission report on the recruitment, retention and remuneration of senior medical officers'.

The SMO Commission found itself continually being directed by SMOs to their concerns of about the nature of their place in the system, and inadequacies in how the health system as a whole made decisions. These concerns were seen as the most important influence on how SMOs perceived that they were treated. The SMO Commission concluded that regardless of the nature of any salary settlement, the seriousness of these concerns meant that they needed to be understood and addressed with some urgency. We did not see addressing these concerns as a substitute for considerations of remuneration, but we ended our job with much doubt about the benefits of action that did not include them.

We recognised that the level of remuneration of doctors in New Zealand was on average lower than in the countries that we usually relate to, particularly Australia. The huge variations in remuneration among medical specialities in New Zealand appeared to be greater than the comparisons across countries, making any comparison of averages rather crude at best. Nevertheless we assessed the overall remuneration difference at near to 35 percent, of which nearly 30 percent reflected a general trans-Tasman remuneration difference, the remainder being a difference specific to medical specialists. We did not believe that we could make a definitive or exacting calculation about the effect this should have on future remuneration levels, as we did not obtain the depth of information or quality of analysis from any party to the deliberations of the Commission that should support such a significant judgment. Nor did we think that this was intended to be our role.

We were greatly disappointed overall in the information exchanged among parties about the recruitment, retention and remuneration of doctors, and believed that DHBs and the Ministry of Health need to do much more in this regard. We did not see the current negotiating approach as appropriate, and offered proposals to rectify this.

We noted the views of the Medical Training Board about the speed with which we might recover from the shortage of New Zealand trained doctors, and saw it as important that all in the sector recognise that we simply do not have the capacity to rectify this shortfall within the next decade. We do not judge this as satisfactory, and recognise that international medical graduates will continue to have the significance they now have in our health system over that time. We saw that we needed to manage the engagement and accreditation of international graduates more efficiently, without reducing our expectations of them.

We saw the past inability to grapple with critical decisions about national services, key system wide infrastructures, and the development of doctors in training as seriously affecting the capacity to be certain that decisions made at a service and local level were the best in the long run. We believed that the system wide decision-making capacity of the health system was inadequate on many matters of serious consequence to the retention of senior doctors, and their recruitment. This also impacted on improving the retention of New Zealand medical graduates during their post-medical school training years.

The New Zealand health system is increasingly vulnerable to actions taken in other health systems, particularly Australia, United Kingdom and the United States. Most of these we will simply have to respond to, and if remuneration is to play a larger part in this globalised market, then for New Zealand to successfully compete, we need to be ensuring that our pay levels can attract rather than compensate for deficiencies in our systems and professional engagement. While the way senior doctors are generally engaged in New Zealand hospitals is generally unsatisfactory, we judged that many of the causes of this could be remedied to very positive effect. In the absence of action here, then the normal expected response to a significant pay adjustment, in terms of higher retention and lower turnover, is less likely.

The anecdotal basis of the submissions received, including that of the ASMS, meant that visiting DHBs to talk to SMOs gave the Commission a much richer basis for placing the case studies that dominated the submissions. The Commission was surprised by the extent of concern by SMOs on these issues, including a large number of simple complaints that could be easily addressed. The Commission considered a huge array of factors, and while we gave a lot of emphasis to both the way in which SMOs were generally employed, and aspects of the health system itself, we did

not regard as inconsequential issues of salary. Indeed we recognised four dimensions to this, including relative salary. We were also aware that we had a reduced applicant pool for many jobs, because of salary. Competition is not only about pay, but it is about the way the workplace is run, the quality of processes, tools and support services, the overall place of the health services system in the public eye. These factors were all highlighted to the Commission on its visits as of serious importance to SMOs.

The Commissions focus was on ensuring that whatever pay rise were agreed to, it would have some impact because other pressures on morale. This did not mean that the Commission was arguing against pay negotiations based on relativities, but it was placing significantly more emphasis than has usually been done on the quality of the current workplace conditions and associated influences, because of the huge negative impact we understood them to be having, and our own assessment of the credibility of the concerns raised by the doctors we met. The Commission employed one of New Zealand's foremost experts on this matter, Peter Harris, to work for it and why his work was published in the papers of the Commission. A failure to act urgently on a recommendation to improve information would be serious, in that in the absence yet again of relevant information, the public of New Zealand will undoubtedly observe a continuation of past standoffs between employers and doctor organisations.

Doctors will continue to get higher salary increases because of international pressures, but hopefully there will be a growing body of evidence behind the judgments of when and how much. It is rather naive to assume that the extra-ordinary reliance of New Zealand's health service on attracting good overseas trained doctors to New Zealand will be settled by one big pay rise, given the huge array of concerns that were presented to the Commission. It would have been irresponsible to have asserted that pay would bring an enduring resolution where so many other concerns have such visibility. The Commission laid the basis for judgments about the significance of salary in any future settlement, but was not presented with any sort of robust information base to be explicit about this. This ASMS review does not take the New Zealand health system closer to that goal.

Comments on statistical analysis by the SMO Commission

The expertise that the Commission was able to draw on had a number of constraints, as the Commission was seeking analyses that were often not directly available from the key sources. The key sources had many limitations, which frustrated the Commission, for example, regarding the MCNZ's Health Workforce Survey Data, and that of DHBNZ:

- There is significant survey non-response to the MCNZ workforce questionnaire which, since 2005, has ranged between 19% - 24% of all the registered practitioners overseen by the MCNZ;
- There are problems with the questions asked in the MCNZ survey. The survey is undertaken annually, and seeks practitioners to provide estimates for the average hours worked over the annual period. The results will be subject to significant memory error due to the annual time period average hours worked is requested for. No attempt is made to correct for memory bias from corroborating data sources so is extremely unreliable.
- There is also some confusion within terminology around who are classed as Residential Medical Officers (RMO), Medical Officers (MO), House Officers (HO), and Senior Medical Officers (SMO).
- DHBNZ's HWIP statistic uses a Occupation based classification based on matching Job Title to Occupation, whereas ASMS and MCNZ use an employment "Role".

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