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The Specialist

THE NEWSLETTER OF THE ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

To MECA we must go (again) – strategic directions

As expected it was developing the ASMS's strategic direction for the forthcoming third national multi-employer collective agreement (MECA) negotiations with the 21 DHBs that was the single most important issue at our record attendance Annual Conference on 3-4 December. In addition to a keynote presentation there were workshops, an open forum, and a plenary resolution session. The resolution overwhelmingly adopted by Conference summarises the ASMS's strategic direction (see box insert).

In plain language our strategic direction is based on the following premises:

- Patients are entitled to equal access to quality health services provided by DHBs.
- DHBs have a medical workforce crisis which threatens patient access and quality.
- DHBs need a pathway to competitive terms and conditions. Pathway is a key word; achievement does not have to be, for example, in the first year (MECAs can be for up to three years).
- DHBs are competing in an Australian medical labour market.
- The government (as the funder, owner and director of DHBs) is responsible for resolving the crisis.

The next stage will be a two day meeting of the National Executive on 17-18 February which will put the 'flesh on the bones' of this strategic direction as well as our formal claim (including considering the incorporation of a number of good suggestions from Conference delegates). The ASMS will then formally initiate negotiations with the 21 DHBs followed by a mix of informal discussions and formal negotiating sessions with them. The current MECA expires on 30 April 2010.

Caught in the vice of the medical workforce crisis

DHBs, the senior doctors (and dentists) they employ, and patients are caught in a vice created by our medical workforce crisis. Crisis is not collapse but it is a turning point at which collapse of the system is one practical outcome. Senior doctors are the glue that holds so much of public hospital and related services together.

The current state of senior medical workforce is characterised by the words 'brittle' and 'vulnerable'. Services are being held together by overworked senior doctors. We have too many vacancies and shortages. Many job sizing reviews in several DHBs have confirmed the need to increase the number of specialists in the service.

We are in the invidious position of losing too many of those we train to Australia; losing too many of the specialists we current employ to Australia and the private sector; and we are uncompetitive with Australia (which faces its own serious shortages) when we seek to recruit internationally. On top of this developing nations with expanding middle classes are likely to diminish as sources of recruitment (for example, India has changed from a net exporter to importer of doctors).

While the ASMS was disappointed overall in the report of the SMO Commission on Sustainable and Competitive Terms and Conditions of Employment, it nevertheless made several observations reinforcing the assessment that New Zealand's DHBs face a medical workforce crisis. In particular:

- There is a 35% specialist pay gap with Australia (this is the minimum assessment of the gap and current indications suggest that if nothing changes in New

ASMS Executive Resolution as voted on at the Annual Conference

That the Association's strategic direction for the forthcoming national DHB MECA negotiations be based on the following statement:

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.

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Zealand it will increase by around 4% per annum).

- Australia is our "primary competitor".
- DHB data revealed a 9.5% senior doctor vacancy rate (ASMS surveys of specific DHBs reveal much higher rates, up to 22%, as have many job sizing reviews).
- Due to factors such as isolation, lower remuneration, and hospital size, New Zealand suffers "relative disadvantage in the international market".
- DHBs are "vulnerable" to changes in recruitment and retention in other countries.
- 20% of vocationally registered international medical graduates leave New Zealand after six years (half of them after their first year).
- Australia employs one-sixth of all doctors with a New Zealand medical degree.

Why the importance of Australia

Why is it important for the ASMS to focus on Australia so much? After all it is not the only alternative source of employment – there are the private sector and other countries such as Canada.

As identified by the SMO Commission Australia is New Zealand's "primary competitor". Geographic proximity (one can shift to Australia and still maintain good contact with family and friends back home) and the same colleges and training systems gives Australia significant advantages over other countries as a competitor against New Zealand.

Since 2006 the Australian medical employment landscape has changed massively. New South Wales and Victoria are already well ahead of New Zealand base salary rates. But a series of subsequent very high recent settlements in Queensland, Western Australia and South Australia have significantly widened the gap. These large increases were what the three states needed to compete and against and recruit from the other two more populous states and also from New Zealand; and it has worked.

Australia also provides the clearest comparative benchmarks with New Zealand, particularly in base salaries, CME expenses, subsidised superannuation, and enhanced remuneration for after-hours rostered and shift work. Further, the closer we get to average Australian rates the more DHBs are able to compete with the private sector in New Zealand for certain specialties.

In a moment of inspired madness over a decade ago the Australian government concluded that the most effective way to control health costs (and doctor shortages) was to reduce the number of doctors. The inevitable consequences were specialist workforce shortages crisis and the Bundaberg tragedy. In response the government reversed its policy and significantly increased the number of medical students and medical schools.

But this does not mean that Australia will not need to recruit from overseas including New Zealand. The first state to receive the increased number of interns will be New South Wales in 2010. This will be followed by a minimum of another seven years training. Further, due to inadequate planning, there are insufficient training positions to absorb the increased number of interns.

Consequently the best we can expect is that some years after 2017 Australia might get back to the position it was in the mid-1990s when it first embarked on its ideological binge of madness.

Government objectives

The argument for negotiating terms and conditions of employment which enable DHBs to compete with Australia and the private sector is not just based on the medical workforce crisis. The government has a number of laudable objectives which the ASMS is in principle supportive of but DHBs do not have the senior medical workforce capacity to deliver on them.

The first major objective is the achievement of significantly enhanced clinical leadership and engagement at all levels of each DHB, not just senior medical/dental officers holding formal positions of clinical leadership. The government is placing considerable store on this in terms of improving cost effectiveness and performance of DHBs. But the current workforce lacks the time to make this work. Time requires increased senior doctor staffing in order to generate the time necessary to deliver the gains.

The second is the government's support for the recommendations of the RMO Commission (excluding the single employer proposal). These recommendations rightly envisage senior doctors playing a greater role in RMO training and education. There are also likely to be implications for service provision. Again the existing senior medical force lacks the capacity to deliver.

There are also other government objectives which will require additional senior medical staff because existing capacity is insufficient. For example:

- The government is keen to increase the capacity of public hospitals to undertake electives. This is behind its intention to build 20 additional theatres. This will not only require more surgeons and anaesthetists but also enhanced capacity in other branches of medicine such as diagnostic services and physicians.
- The six hour target for emergency departments is a hospital wide imperative rather than simply the emergency department. In some instances enhancing the capacity of hospitals to admit patients referred from their emergency department will generate additional staffing needs.

Furthermore, there are other objectives that are critical to improve performance especially when seen through a quality

lens. DHBs have committed themselves to encouraging senior medical staff to take sabbaticals of around three months between every 6-12 years of service. But many services are not staffed sufficiently to facilitate this. They should be.

Further, while there have been great strides in recognition of time for non-clinical duties through job sizing, there is still much short-changing. Services need to be better staffed to enable sufficient time for important quality activities such as clinical audit, quality assurance, and peer review.

Can we do it

The challenges facing the ASMS in the forthcoming negotiations are immense. But if we don't succeed threats to the accessibility and quality of services for patients will increase. DHBs and government can't escape this conclusion and that 'patients need doctors'. We have many stories to tell the public about the importance of DHBs being able to recruit and retain a viable senior medical workforce and we need to start telling them.

Can we do it? If DHBs and government are prepared to adopt a pragmatic 'can do' approach then we can. The ASMS is ready and willing to engage with them to achieve what should be shared objectives.

Ian Powell
Executive Director

Successful ASMS lobbying on new NHB

The ASMS actively lobbied government on some of the negative and potential destructive consequences of the recommendations of the Ministerial Review Group (known as the Horn Report after its key author, Business Roundtable member and former Treasury head, Murray Horn). This has proven successful with the Minister of Health's announcement on the establishment of the new National Health Board (NHB) in October.

The Horn Report recommended creating a new bureaucracy, the NHB, as a separate, less accountable crown entity, in addition to the Ministry of Health. This would have involved major restructuring, and risked increasing bureaucratic wastage and generating paralysis in decision-making. The ASMS supported the functions proposed for the National Health Board but not the recommended structure.

Consequently we lobbied hard in various forms including background briefing documents to MPs and specific advice to the Minister of Health. Instead we recommended that the functions be allocated to a specific enhanced unit within the Ministry of Health. This is exactly what the Health Minister has announced. It is a relatively novel experience of a government listening to us in such a specific way. While the Ministry will have to be rejigged, the government's decision has avoided the disruption of major restructuring and the negative effects of bureaucratic fragmentation. The new NHB will report to both the Director-General of Health and the Minister of Health.

Subsequently Health Minister Tony Ryall has announced the 11 members of the NHB's governing board. As expected many members are from the original Horn Committee which recommended the establishment of the NHB albeit in a different form. Most controversially is the appointment of Murray Horn as chair. How his coded pro-privatisation views will be reconciled with the government's express commitment not to privatise will be interesting to monitor.

The ASMS is particularly pleased with two appointments. One of our nominees, Dr Margaret Wilsher (physician and Deputy Chief Medical Officer at Auckland DHB) was appointed. Although the ASMS did not nominate any of our National Executive members, as a result of persistent 'shoulder tapping' by those well placed to do so, National President Dr Jeff Brown was also appointed in a personal capacity. This is a tribute to the credibility and performance of Dr Brown, including his chairing of the group that produced the *In Good Hands* report which now forms part of the government's policy on clinical leadership in DHBs. Both Drs Brown and Wilsher have deserved earned the respect of government at the highest levels and hopefully will provide good balance on the NHB.

Other doctors appointed to the NHB are public health specialist Virginia Hope (also deputy chair), Professor Des Gorman (Chair of Clinical Training Agency Board) and GP leaders Bev O'Keefe and Murray Tilyard.

The NHB has the responsibility for implementing important functions which will directly affect the operational work of DHBs. In principle this is good. But, this change will not work unless we have comprehensive health professional engagement and leadership consistent with the principles of the ASMS's *Time for Quality* Agreement with the 21 DHBs and the government's *In Good Hands* policy statement on clinical leadership embedded into the culture of the Health Ministry and DHBs at all levels. This is where the real health and cost effectiveness gains can be made over time.

Presidential Address to 21st ASMS Annual Conference

Below is the slightly edited address to the ASMS Annual Conference by Dr Jeff Brown, National President, at the Opening Proceedings on 3 December.

Are we there yet?

The incessant refrain from the backseat of any long journey. The repeated measure of boredom when only the destination seems important. The frustration from the backseat bunch whose hands are not allowed on the steering wheel, let alone able to reach the accelerator or brake.

Are we there yet?

We have certainly mapped out a whole new journey in the last few years, with significant milestones along the way. The concept of doctor as victim, of attack from all sides in a name, shame and blame game, has matured into looking at systems errors, of remedying the results of inevitable slip-ups. Complexity causing cock-ups is starting to be addressed rather than reacting with conspiracy theories swirling around knocking doctors off pedestals. We are learning from other industries, and being brave enough to share our own mistakes so others can learn from us.

Are we there yet?

We have established clinical leadership at the core of Government policy. But is it embedded? A year ago the newly warranted Minister of Health, Tony Ryall, addressed this Conference and made a pledge to reinstate elected representation to the Medical Council. He also followed up his desire for engagement by appointing a Task Group which I had the honour of chairing. Building on '*Time for Quality*' (the agreement on clinical leadership and engagement between the ASMS and the 21 DHBs) which had been facilitated by the previous Minister, David Cunliffe, our group produced *'In Good Hands'*. This report outlined core principles and the transformations which are required for DHBs to have real clinical governance.

There have been several flurries of activity throughout the sector in response to *'In Good Hands'*. Some attempted to marginalise it to maintain the mantra of managerialism. The Minister made it clear that the report is Government policy. The Ministry surveyed DHBs asking how *'In Good Hands'* was being implemented. The responses were variable to say the least. Some were encouraging but many assumed that a few appointed leaders ticked the boxes. They failed to grasp that clinical leadership must extend to every layer of the system, empowering the entire workforce. A further group was convened to formulate a guide for the Ministry. A guide on actively reporting achievements in DHBs towards transforming clinical governance. The essence of this reporting is that you and I are all involved in affirming the report, before it is sent in. Maybe we will have another set of league tables to publish.

Are we there yet?

The first nine months of the year also saw the gestation and delivery of, and responses to, the Ministerial Review Group (Ministerial Review Group established by the Minister of Health and chaired by Murray Horn) report. Many of the recommendations of this large report resonated with specialists. Most of us would strongly support the thrust to strengthen clinical leadership, to reduce bureaucratic wastage, to centralise several of the 21-fold duplications of DHB land, to cut through the 80 plus PHOs, multifarious NGOs, and countless contractual cobwebs clogging up clinical care.

The sticking point became the parenting of the new child, the National Health Board. Initially intended to be an isolated infant, learning to crawl, walk and run on its own, we argued that the NHB needed to be nurtured within the Ministry. Albeit a reshaped parent body. The Minister listened. The NHB will now be a part of the Ministry, and whole scale restructuring with all its associated confusion has been avoided.

The MRG report and the new NHB signal that the hard decisions are only just beginning. We face the triple whammy of shrinking recessional spending, insatiable demand for health dollars, and workforce crises calling for major engineering, not just tinkering, at medical student, postgraduate and specialist levels.

We will have to ration. Ration our time between patients and teaching. Ration our time between patients and leadership. Ration our time between all this work and our out of work lives.

We will have to ration. Ration our technology and skills. Ration our high cost - low utility interventions. We will have to convince our politicians and public to openly debate rationing health care. Because rationing is already happening. By stealth. By income. By post code. By age.

Are we all honest enough to entertain the rationing debates without fear or favour?

Are we there yet?

Next year we enter a new wave of MECA negotiations, and already your Executive has met with DHB representatives in open discussion about the big issues.

There is a huge gap between what specialists can earn in Australia and in New Zealand. Specialists who often train in common Colleges. And who work in a common market for employment, not infrequently with connections through living on both sides of the Tasman during their attractive and reproductive years. There are shortages of specialists in Australia. There are shortages of specialists in New Zealand. Who wins?

Should the next MECA aim to level that playing field? And if so, how soon? By 2025 or earlier? Do we take the recession on the chin, claiming our profession is the most serious in need of replenishment? Or do we sacrifice financial incentives aimed at attracting and retaining more of us? Sacrifice personal gain in the forlorn hope that money will go to the lowliest paid in the system? Is the country's debt ours to own, or is the quality of health care dependent on keeping highly paid specialists at home? Over the next two days this Conference must give direction, must govern our collective imperative. You must have the fortitude to decide the flavour of our approach to next year's MECA. How to season our expectations and set our goals. What we might gain in a short trip and what we might aim for in a long journey.

Are we there yet?

Today and tomorrow we will contemplate the funding of the health system, engage with the Minister of Health, compare the New Zealand system with other countries, hear an insider's guide to clinical networks, and inspect the implications of integrating primary and secondary care. Our journey together will look inside and outside the system we know, love and hate. We may even have some ideas on what needs fixing, and how we might help fix it. Ethically.

Doctors undoubtedly experience pleasure and reward when repairing broken bodies and broken minds. Is it possible to experience the same delight when repairing broken bits of a health system? It takes much longer, throws up more frustrations, and has more compliance and adherence issues than the most recalcitrant patient. The journey's destination may appear unachievable, the horizon keeps shifting, the goals more than abstract, and measurement of achievement harder to agree on.

Trying to fix the health system has more in common with general rather than hospital practice. Like dealing with the patient journey through health and illness rather than admissions of major catastrophe and drama. Rewards earned more from encounters and engagement than from episodic euphoria. I suggest we will have a more rewarding journey trying to transform the health system if we explore joint efforts with our general practice colleagues. Explore how we can integrate the system for the patient journey.

You are here because you are not just a spectator at the edges, but have at least a hint of participatory leadership in your veins. Matthew Taylor opines that it is the attitude of the spectator that induces pessimism, the experience of the participant that brings hope. He says the problem is not that change brings fear and disorientation (there's nothing new in this), it is that we lack the spaces and places where people can renew hope and develop solutions.

We can join with primary care leaders to blur boundaries and break down walls. Get together in rooms both real and virtual to decide the best place to make the best decisions for the best clinical outcomes. Then populate those places with the expertise when and where it is needed. Then require the contracts and transactions to enable, not control, the pathways and processes we have designed. Together.

Are we there yet?

We hear a lot about focussing on the patient journey. And how that focus will help avoid waste, reduce error, and improve outcomes. All laudable stuff. But the patient is not alone on their journey. We are with them, especially when the going is toughest. I submit that we have often ignored the doctor journey. We have improved patient spaces in clinics and wards, but ignored the physical spaces and tools, especially electronic, that improve the doctor's life and work. We have focussed on communication and empathy for the anxious and aching, but often treated the specialist as impervious to emotional harm. Our health care organisations have an unfortunate habit of leaving the pastoral care of our medics at the end any agenda, to be got around to when all the other work is done. And we ourselves are often the source of difficulties for our closest colleagues.

One challenge I give you is to look after yourselves, and to intervene before relationships sour. To improve the pastoral care of ourselves. To model, for those who will step into our shoes, how great our job really is. How brilliant our profession can be. How wonderful our calling. To improve, and enjoy, the doctor journey.

Are we there yet?

Geoff Shaw said recently in Christchurch that clinical leaders have two requirements: one, a stomach for

controversy, and two, ability to face harsh realities. I do not think he was suggesting we should be gluttons for controversy, but have the stomach to digest it without blowing off or suffering the screaming runs. And that harsh realities are to be expected, even embraced. When you do something real, people pay attention and there will always be responses equal in intensity and opposition because what you have done is truly remarkable. Not easy, but remarkable.

Reflecting on the challenges of leadership, I offer a new variation on an old misquote. The price of clinical governance is eternal diligence.

Personal diligence to keep up to date, not only with clinical medicine's knowledge and skills, but also with modern teaching, leadership, teams, and change. And group diligence to maintain momentum for marginalising managerialism, embedding clinical leadership, and refocusing attitudes and relationships on the patient journey and the doctor journey.

Diligence unbundling the edifices others have built around us. Diligence rebuilding from within the networks so critical to quality patient care. Diligence blowing the cobwebs away from constricting contractual conceits. Diligence reinforcing relationships with ourselves, and with those who walk with us on our journey.

I call on you all over the next two days, and henceforth, to embrace the doctor journey, on behalf of the patient journey, to transform our health system. All within the restraints of recession and the challenges of workforce crises. To garner reward from the journey, whatever the destination. To enjoy the back seat, if that is your desire, but not to nark at those who want their hands on the throttles, brakes and steering wheels. To grab the wheel, press the throttle, and pump the brakes if you have a moment to lead, an inclination to govern. To embed clinicians in the driving seat of the system from top to bottom and back again.

Are we there yet?

Dr Jeff Brown
President

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Applications should be forwarded by email to sarah.white@mps.org.uk or mail to:
Faculty and Education Support Coordinator, MPS Educational Services Asia Pacific, P.O. Box 1013, Milton, Queensland Australia 4064
Applications must arrive by 8 February 2010. Applicants who are shortlisted will need to be available for a video, teleconference or Skype video interview w/c 22 February 2010 and a selection interview in Auckland on 27 or 28 March 2010.
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PROFESSIONAL SUPPORT AND EXPERT ADVICE

Executive Director's Column

Getting the primary-secondary interface right

Transferring secondary services to primary care is a rather arbitrary policy of the government first announced through the Minister of Health's Letter of Expectations to DHBs earlier this year. Initially DHBs were supposed to be responsible for this and were given funding (around $6 million nationally) to support this work. However, the Minister subsequently revised his plans by withdrawing the funding and instead formally calling for 'Expressions of Interest' from the primary care sector for proposals in this area.

Mr Ryall's argument was that primary care organisations were claiming they had good ideas for improving the health system which were not being heard and consequently this was his way of providing them with the opportunity. This approach has merit in the sense of going beyond the formal statutory structures to seek views and ideas.

One of the consequences, however, was to marginalise DHBs from the process even though it might be the services they currently provide and their funding that might be affected. Some primary care organisations making proposals opted to consult with their DHB while others did not. 'Expressions of Interest' were due by 14 October with successful applicants advised by 4 November. These (nine in total) were announced by Mr Ryall on 4 November.

Business case challenges

These selected organisations are now required to develop a detailed business case, including costings, and a development pathway by the end of February 2010 (following concerns raised with the Minister at the ASMS Annual Conference on 3 December Mr Ryall agreed to extend this deadline by a fortnight) with evaluation of these business cases to be completed by the Ministry of Health by about a fortnight later. Those that cut the muster would move into contract negotiations while others will be invited to re-submit. The whole process, including approval of business cases and signing of contracts is required by government to be completed in May 2010.

For the first time DHBs are now to become directly involved. Their agreement on the business plans will be required before referral to the Ministry of Health. This creates major difficulties. DHBs are now forced to consider proposals developed by external bodies which, in some cases, they had no or minimal involvement in. Further, the expectations, time frame (even with the Minister's sensible extension until the end of February) and time of the year make it impractical to genuinely apply the requirements for clinical leadership according to the tenor of the *'Time for Quality'* agreement between the ASMS and the 21 DHBs and *'In Good Hands'*, which is part of the government's policy on clinical leadership. The exception is where there has already been a high robust level of engagement with secondary care health professionals in the development of the proposals (as appears to be the case with some).

ASMS approach

The approach taken by the ASMS is that there should be three key thresholds in considering whether services should be devolved from secondary to primary care – clinical appropriateness; fiscal sustainability; and avoiding fragmentation and disintegration and its consequences (eg, on teaching).

The Association has also raised more general concerns in reference to:

Confusion over what new developments in general practice can be charged to patients and what can't (things arising out of the evolving nature of general practice can be charged to patients but things arising out of this political initiative can't).

Possible budget-holding thereby giving more entrepreneur primary care business interests fiscal leverage over the DHB (including where DHBs lose funding but retain costs).

> the Midland (Pinnacle) proposal raises serious concerns with the desire to control around $66 million of secondary care funding, particularly in mental health.

In the main most of the proposals appear laudable in intent. However, the Midland (Pinnacle) proposal raises serious concerns with the desire to control around $66 million of secondary care funding, particularly in mental health. This would have been very contentious and would have been strongly resisted if the business plan stage proceeded down this path. We would have insisted that the affected DHBs (Taranaki, Waikato, Lakes

and Tairawhiti) apply and respect the engagement principles of *'Time for Quality', 'In Good Hands',* and the SMO MECA in this process according to their tenor and not in a tokenistic manner.

The ASMS has been advocating at every opportunity that this sort of outcome (controlling secondary care funding) was undesirable and would compromise quality and effectiveness. Consequently we are pleased that in a very recent decision Tony Ryall has advised DHBs that devolution of secondary services to primary care is not to form part of the business plans for the nine proposals, including Pinnacle (except when it is agreed with secondary care clinicians follows genuine engagement, sometimes that is inconceivable in this tight process). Once again it is good to be listened to.

But there is a better approach

There is a risk that this 'expressions of interest' approach may distract from the enormous potential advantages that can be derived by enhancing the effectiveness of the primary-secondary interface. The focus should be on collaboration (not power grabbing), we should jettison the demeaning and misleading term 'devolution', and reclaim the positive features of the term 'integration' or 'integrated care' (perhaps even call it 'intermediary care').

Rather than fiscal power and control the focus should be on the development of healthcare or clinical pathways across the spectrum of care by primary and secondary doctors. The collaboration between the Canterbury DHB and its main PHO with the over 180 pathways in what is known as the 'Canterbury Initiative' is an excellent example of what is possible; and it is the beginning not the end of realising the potential.

Ian Powell
Executive Director

ASMS services to members

As a professional association we promote:

- right of equal access for all New Zealanders to high quality health services
- professional interests of salaried doctors and dentists
- policies sought in legislation and government by salaried doctors and dentists

As a union of professionals we:

- provide advice to salaried doctors and dentists who receive a job offer from a New Zealand employer
- negotiate effective and enforceable collective employment agreements with employers. This includes the collective agreement (MECA) covering employment of senior medical and dental staff in district health boards which ensures minimum terms and conditions for around 3,000 doctors and dentists, over 90% of this workforce
- advise and represent members when necessary
- support workplace empowerment and clinical leadership

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

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Assistant Executive Director

Health funding in 2010 and beyond

A series of studies and books have come out in the last twelve months talking about 'unsustainable' and unproductive spending on health. The first of these was the OECD Country report last year which focused on health. It was followed by the Business Round Table report on productivity. More recently there has been a report by Temple Associates and in recent weeks a book by economist Gareth Morgan.[1]

The bitter debate in the United States about health care paints a slightly different story. If you have been following this you could be forgiven for thinking New Zealand had the most efficient system possible: largely a single health funder, a network of family physicians or GPs as gatekeepers, no fault personal injury system (the ultimate tort reform in US terms), a low number of specialists per head of population and constrained spending on pharmaceuticals through PHARMAC. (Professor Don Matheson expands on these international comparisons in an article elsewhere in this issue).

The diagram everyone should understand

In fact comment about the upward trajectory of Vote Health in itself is not quite the full story. If we look at the diagram below the trajectory looks more like a catch up with the rate of growth already tailing off.

At the end of the nineties New Zealand was behind the rest of the OECD in its average spend on health. From 2002/03 to 2006/07 there was a period of catch up. So even if new spending in Vote Health continued at $750 million each year we would be seeing a substantial tailing off in the rate of growth. As is apparent by tracking the pink line above which tracks the new funding as a percentage of the base line funding (essentially the previous years funding minus money allocated for one off initiatives), the rate of growth is tailing off in any case and was expected to once New Zealand caught up with the rest of the OECD. There appears to be no need to panic.

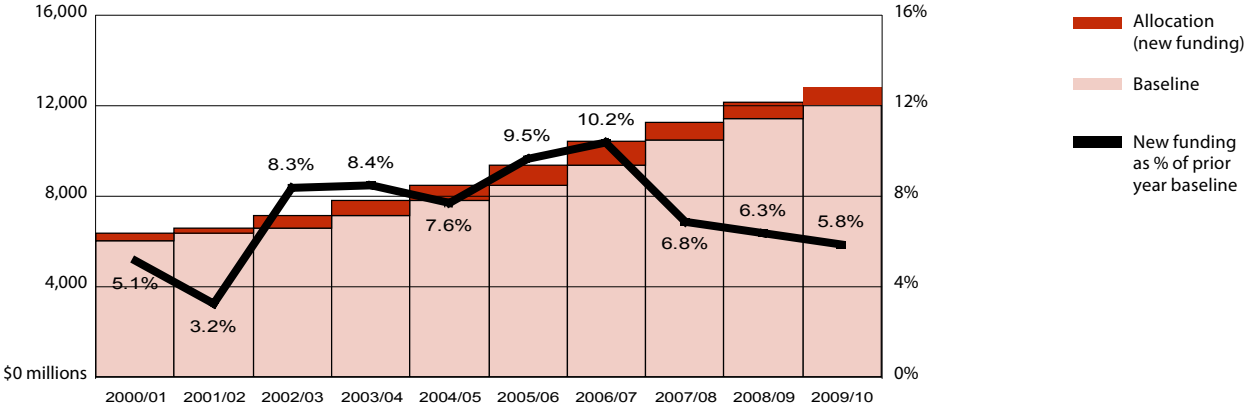
Budget 2010/11

The present government got elected on a commitment to continue the health spending already committed to by the previous government for the 2009/10 year. They kept to that commitment in the Budget delivered in May with new spending in Vote Health continuing at $750 million.

Considerable effort has been put in by the Government to talk down state sector spending expectations for the next budget. Peter Mersi, Deputy Secretary of Treasury has been giving presentations to many groupings within the wider state sector showing the government's trajectory on state spending and illustrating the projected restrictions on state spending apparently due to borrowing made necessary because of the recession.

The last Budget (2009/10) projected $1.1 billion new spend for the whole of the state sector for the 2010/11 financial year. This is compared to $1.5 billion for the whole of the

Vote health: new funding as a percentage of total operating expenditure (NZ$ millions, GST exclusive)



From draft paper 'Trends in Models of Care' Ministry of Health 2009. Source: Reserve Bank of New Zealand. Estimates of Appropriations 1996–2009; Treasury Budget Economic and Fiscal Update, RBNZ Monetary Policy Statements, bilateral minutes

state sector in the 2009/10 financial year of which $750 million went to health. Clearly DHB chief executives have also received this plethora of briefings; figures of $500 million and $300 million new spend have been mentioned.

> The most optimistic report is that which maintains new spending at 50% of the allocation for all of the government; still a big cut taking new spending in Vote Health from $750 million to $550 million.

If Vote Health was to be treated in a way commensurate with its share of the state sector it would get around 20% of the new spend; this works out at $220 million of $1.1 billion. A report by the Ministry of Health to the Minister outlining budget options doesn't go that far but looks at figures ranging as from 30% of the new spending to 50% ($330 million to $550 million). The most optimistic report is that which maintains new spending at 50% of the allocation for all of the government; still a big cut taking new spending in Vote Health from $750 million to $550 million.

The Ministry report also looks at the levels of savings required for future years (inflation is projected to hover just below 2% for the next few financial years (2009 to 2011). A 2% increase would be around $240 million so any figure below that would mean the Vote Health as a whole was not keeping up with CPI inflation. But there is good evidence that health inflation is higher than inflation in the rest of the economy.

Rising health costs

Ministry of Health figures suggest that health costs increase at about 6-7% a year. The future funding track was introduced in 2002/03 in order to offer some predictability and is meant to compensate for inflation. It is made up of 35% of the forecast CPI, 65% of the labour cost index with a further 0.5% as a technology adjustor. In the 2006/07 an 'efficiency' adjuster (of minus 0.5%) was applied which appears to have been a random amount deducted from new spending on the grounds that constricted spending engenders efficiency. From what it is possible to glean about budget intentions for the coming budget it appears that an 'efficiency adjustor' (that is a small amount taken off the FFT calculation so to engender efficiency) will be applied again.

The 'Future Funding Track' has historically delivered around 3% of new spending under Vote Health; the rest has been made up by special initiatives, debt and the demographic adjustor (some DHBs have falling or static populations so don't receive this).

This government has been very effective at feeling its way and testing the ground before embarking on policies that may prove very unpopular and it may be that this is the process which they are using to side step a potentially very difficult wage round.

Already Auckland DHB has extrapolated that cuts of 5-10% may be projected for next year. Further cuts are likely at other DHBs and it is hard to see how they can avoid cutting patient services if new funding is insufficient.

Heath care: an unaffordable luxury or an investment?

In our submission to the SMO Commission on Sustainable and Competitive Terms and Conditions of Employment we addressed the issue of the sustainability of health spending by saying:

"Sustainability means ensuring that sufficient resources, as determined by New Zealanders, are available to provide timely access to quality services that address New Zealanders' evolving health needs, and that those

Summary of percentage growth 2002/03 to 2009/10 by year

	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10
FFT	1.9%	3.1%	2.6%	3.1%	2.9%	3.1%	3.3%	3.1%
Additional cost above FFT[2]	2.6%	1.3%	2.7%	1.8%	2.4%	1.1%	0.1%	0.0%
Demographics	1.2%	1.8%	1.6%	1.6%	1.3%	1.7%	1.8%	1.7%

resources are managed efficiently.

- Real health funding increases over recent years have not flowed through to many hospital-based services. DHBs have reported that funding (the "Future Funding Track") which was intended to cover the costs of inflation, including labour costs, has not actually kept pace with inflation, leading to increased pressures on current resources.
- Continual improvement in the efficiency and effectiveness of our health services is vital, given the increasing health demands we face. An important part of that ongoing process is to develop better ways of assessing "productivity", recognising the value of producing good health outcomes.
- Health funding decisions need to take account of the substantial but so far largely unmeasured costs of unmet health needs. The New Zealand public has consistently indicated a desire to see the public health system adequately funded to meet New Zealanders' needs…
- Like many other countries, New Zealand's population is ageing, as well as growing, which will result in significantly increased demands for health services over the coming decades, which will require a corresponding increase in demand for health professionals."

Our view was that health care is not a luxury good but an infrastructural investment; an investment that is deeply valued by the public. In fact there are very good arguments that better health is a precursor to economic growth (though this is made mainly with respect to 'developing' nations).[3] This view is deeply contested at the present time.

Health care needs do not evaporate if they are not met but either have to be met out of individual's pockets for those with some resources or are not met in the case of those with no resources with the consequence of growing inequality, unnecessary suffering and death.

ASMS members will know that state sector spending on health has always been rationed to some extent (mainly by a system of restricting access or using doctors as gatekeepers); that more spending does not always mean better health care and that there are important issues with spending on healthcare at the end of life which is sometimes ill-thought out, reflexive and ultimately not in the interests of the patient. There are also organisational efficiencies to be made but public hospitals have been struggling even with the increases in Vote Health in recent years which have not kept up with costs.

The ASMS will have an increasing role in advocating for the public health system in the constrained public sector financial position that seems to be projected well into the future.

Angela Belich
Assistant Executive Director

1. Health Cheque: the truth we should all know about New Zealand's public health system Gareth Morgan and Geoff Simmons Public Interest Publishing, 2009
2. Additional costs above FFT covered extra funding not related to extra services

   DHB funding also grew for Government new initiatives (eg primary care strategy), for devolution of contracting responsibility from the Ministry (eg transfer of Health of older people funding) and fro some movement to PBFF equity shares. Source Ministry of Health 2009, personal communication
3. http://www.ted.com/talks/lang/eng/hans_rosling_shows_the_best_stats_you_ve_ever_seen.html

Fully funding Accident Compensation[1]

Is there a "blow-out" in the costs of Accident Compensation or is the real problem the principle of full funding? There are some very strong arguments to suggest that an inappropriate accounting mechanism is being used to paint ACC as being in far more of a crisis than is actually the case.

Both the former Labour led government and the current National led government have been committed to moving ACC to an 'insurance' type model where its assets (however you assess them) matched its liabilities (however you assess them) or in other words fully funding ACC.

The original designers of the scheme believed that full funding was unnecessary.[2] The scheme was originally conceived as part of the social support that government provides to its citizens: social compensation, not simply insurance. The analogy is with the health system or social welfare which are strictly pay as you go. A paper, "Why does the Accident Compensation Corporation have a fund?", by Michael Littlewood, co-director of the Retirement Policy and Research Centre[3], sets out the risks of fully funding ACC and why accounting should not be driving decision making.

Investments

The ACC investment fund fell considerably in value as a result of the current international financial crisis. This is the nature of investment funds. The advice all of us are given when choosing investments is that it is better to take a long term approach which allows us to ride through normal economic cycles with reasonable confidence. This means that market value at any point in time is unpredictable and will fluctuate. ACC investment funds are no different. They will experience major downturns like the present, and price bubbles like the period immediately before the crisis.

Further booms and crashes are inevitable. Any future downturn of a year or more would again force ACC to increase levies by unacceptable proportions; any upturn could lead to lobbying to reduce levies (those of us with long memories will remember former Prime Minister Robert Muldoon capping levies for just that reason) to unsustainable values, resulting in uncertainty and loss of confidence in ACC.

Assessing liabilities

The actuarial estimates of the "liabilities" of a full-funded scheme are also uncertain. A small change in the underlying assumptions when assessing liabilities has significant effects. Treasury has noted that much of the current blow out in liabilities is due to changed actuarial valuations such as increases in predicted medical and rehabilitation costs. Huge fluctuations in liability valuations every time assumptions change are bad enough, it should not be assumed that these valuations are accurate even given a particular set of assumptions because of the nature of the valuation process. If the assumptions are not met in reality then further variations in actual values experienced must be expected. For example, a change of one percentage point in these values could lead to deficit values $2.3 billion less or $2.8 billion more than the deficit value of $4.773 billion in ACC's income statement.[4] Even given relatively small changes in real events, the deficit could be anywhere in a $5.1 billion range. Changes in other trends could make this variation even wider.

Evaluation of both future liabilities and the value of the investment funds accumulated to cover them are therefore very uncertain, to the point where it is questionable whether there is value in the effort and cost required to do them.

Raising taxes during a recession

The whole world including our government has supposedly rediscovered Keynesianism as we try (with some success) to stimulate demand during the recession by government spending. The New Zealand government has borrowed to maintain activity in the economy, and has stopped its contributions to the New Zealand Superannuation Fund to do so. It doesn't make sense that it is also, through raising ACC levies, counteracting its stimulatory measures by effectively increasing taxation to significantly increase the size of an investment fund. If it makes sense to do this for ACC why doesn't it make sense to do this for the New Zealand Superannuation Fund?

Susan St John[5] suggests that an appropriate size for an ACC reserve fund is between 1.5 and 2.5 years of claims expenditure, a level that should be allowed to "fluctuate as the economy and markets fluctuate". She also points out that multi-party support for the structure of the ACC is required so that fluctuations in reserves and funding requirements (which are inevitable) should not be used for political leverage to make unnecessary and damaging changes to ACC.

Angela Belich
Assistant Executive Director

1. This article is based on work by Bill Rosenberg, Director of Policy, CTU
2. A paper by Susan St John gives a useful history of changes to the funding of ACC: 'The rationale for pre-funding ACC', Pension Commentary 2009-2, 15 November 2009
3. Pension Commentary 2009-1, 19 August 2009, http://www.business.auckland.ac.nz/Portals/4/Research/ResearchCentresGroups/RPRC%20commentary/PC2009-1-WhyShouldTheACCbePre-funded12.10.09.pdf
4. ACC Annual Report 2009, p.71
5. The rationale for pre-funding ACC', Pension Commentary 2009-2, 15 November 2009

Features of Annual Conference

The 21st Annual Conference of the ASMS was a major success including a record attendance. The major feature was the time spent on the development of the ASMS's strategic direction for our national DHB MECA negotiations next year. This included a keynote address by Executive Director Ian Powell; delegate workshops; an open forum; and the adoption of a resolution (discussed more fully elsewhere in this issue).

Dr Jeff Brown's Presidential Address on the first morning set the tone for the Conference with the focus on the ASMS's journey (published elsewhere in this issue). The Minister of Health, Hon Tony Ryall, gave a well received address and was also answered several questions from delegates in an open forum. His address is available on the ASMS website www.asms.org.nz.

The case for a national clinical network for clinical ethics in New Zealand

There were several outside speakers who gave outstanding presentations. In particular:

- Dr Don Matheson (Professor of Health Policy at Massey University and former Deputy Director-General of Health) on how the New Zealand health system compares with other countries, including the debunking of assertions in the Horn Report.
- Dr Andrew Hamer (Chair, National Cardiac Network) on the National Cardiac Network.
- Professor Des Gorman (Chair, Clinical Training Agency Board) on medical workforce issues
- Dr Al Macdonald (renal physician at Capital & Coast DHB and former National Executive member) on the role of the case for a national clinical network for clinical ethics in New Zealand.

Other matters

- National Executive member Dr Tim Frendin and Lakes DHB Medical Director Dr Johan Morreau spoke on the opportunities of enhancing the primary-secondary interface and some of the risks of the government's 'expressions of interest' process.
- Angela Belich (Assistant Executive Director) provided background analysis and information on the government's funding of the health system, including public hospitals. This is also the subject of an article by her elsewhere in this issue.
- Henry Stubbs (Senior Industrial Officer) reported on the National Executive's review of the Association's branch structures and the likelihood of constitutional amendments to the 2010 Annual Conference. This was also the subject of a Conference discussion paper which can be accessed from our website www.asms.org.nz or by email asms@asms.org.nz.
- Annual Conference agreed to adopt the National Executive's recommendations that the membership subscription should be increased by $30.00 to $720.00 (GST inclusive) for the 2010/11 financial year (commencing on 1 April). In addition to expected inflation part of the justification for the increase was the need to build up the 'kitty' for the next national DHB MECA negotiations.
- WHK Wellington (formerly Sherwin Chan Walshe) were re-appointed as auditors for the 2009/10 financial year.
- The dates for the 2010 Annual Conference were set for 18-19 November in Wellington.

ASMS TWENTY FIRST ANNUAL CONFERENCE

Dr Michael Merriman, Dr Julian White, Dr Robyn Sekerak and Dr Chris Nunn, all from Waikato DHB

Hon Tony Ryall Minister of Health

Dr Torben Iversen ASMS National Executive, Dr Paul Wilson ASMS National Executive, Lloyd Woods Industrial Officer ASMS, Dr Jeff Brown ASMS National President

Dr Johan Morreau Lakes DHB and Dr Ashley Bloomfield Ministry of Health

Dr Rod Harpin Northland DHB and Lyn Hughes Industrial Officer ASMS

Dr Ruth Spearing Canterbury DHB, Dr Brian Craig ASMS National Secretary, Dr Alma Rae Canterbury DHB, Dr Eric Monasterio Canterbury DHB

Dr Bev O'Keefe The IPA Council of NZ and Stephen McKernan Ministry of Health

Richard Tyler Medical Assurance Society and Dr Jeff Brown ASMS National President

Dr Al Macdonald Capital & Coast DHB, Dr Peter Roberts Capital & Coast DHB, Professor Des Gorman Chair Clinical Training Agency Board; Head of the School of Medicine University of Auckland

Rae Lamb Health and Disability Commission, Bruce Corkill Central Chambers, Justine Peterson College of Surgeons

Dr Al Macdonald Capital & Coast DHB and James Judson Auckland DHB

Hon Tony Ryall Minister of Health talking with Dr Michelle Hunt Radius Medical Group Whakatane

Dr Tim Frendin ASMS National Executive

Dr Paul Bohmer Auckland DHB, Dr Trevor Cook Canterbury DHB, Fran McGrath Ministry of Health

Dr John Chambers Otago DHB,

Henry Stubbs Senior Industrial Officer ASMS

Dr Johan Morreau Lakes DHB

Dr Chris Wisely Otago DHB

Professor Des Gorman Chair Clinical Training Agency Board; Head of the School of Medicine University of Auckland

Dr Jeff Brown ASMS National President with Hon Tony Ryall Minister of Health

Dr Carolyn Fowler Counties Manukau DHB and Dr Judy Bent ASMS National Executive

Dr Ruth Spearing Canterbury DHB

Dr John Macdonald ASMS National Executive, Master of Ceremonies for the conference dinner

Angela Belich Assistant Executive Director ASMS

Professor Pat Alley General Surgery (Waitemata) Speaker at the Conference Dinner

Dr Andrew Hamer Nelson Marlborough DHB

Professor Don Matheson Professor of Health Policy, Massey University and former Deputy Director-General of Health

How the New Zealand health system compares with other countries

Below is Professor Matheson's address to the ASMS Annual Conference

Thank you for this opportunity to speak with you today. I last spoke to this ASMS annual meeting in the mid-1990s and now, over a decade later, I have been invited to talk with you again – a reflection of the similarity of the times in which we find ourselves.

I wish to discuss three points about the New Zealand health system:

1. Firstly, there is much that the rest of the world envies in the NZ health system and it is not the 'basket case' that some like to present us as in the effort to create a 'burning platform' for change.
2. Secondly, that despite our success, we do face a number of challenges in our quest for health – apart from reducing the estimated cost of health services in 2030.
3. Thirdly, I will discuss the folly of those that think they alone control the health system, especially when they see 'structural change' as the answer – and discuss approaches that are more in keeping with the complexity of the problems that we face.

I have been working as an international consultant in health systems during the last 18 months, following an eight year stint with the Ministry. My work has taken me to Geneva, Manila, London, Cayman Islands, Papua New Guinea, Kazakhstan, Fiji, the Northern Territory of Australia and Italy. But there is no place like home.

So the perspective I bring to this meeting is one of an insider who is now an outsider. I have participated in a number of international forums and reviews on issues such as social determinants of health, primary health care and healthcare financing. At these international forums I reflect on what is good and different about our little country at the bottom of the world, but also which of the problems we face are common to health systems in all countries, and which are our home-grown little messes and successes.

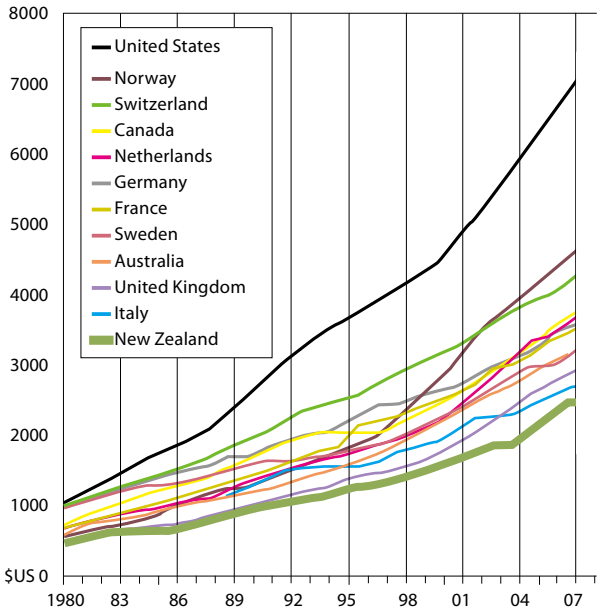
Basket case?

Do we spend too much on health care?

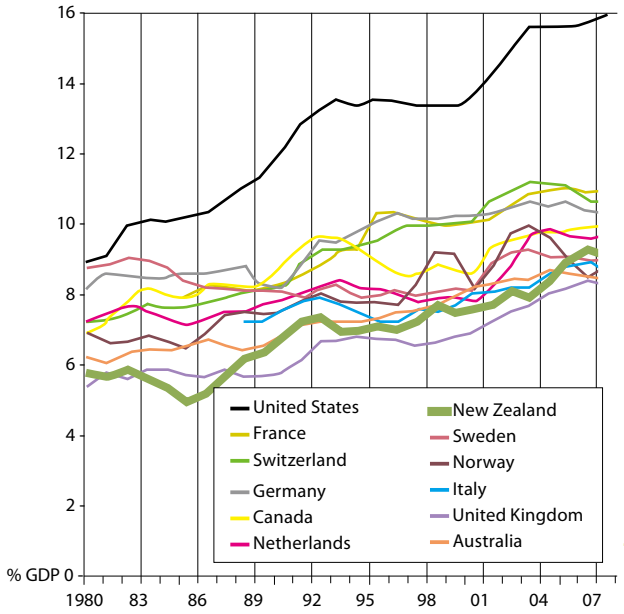
According to the *Horn Report*[1], *New Zealand spends a high proportion of its national income on health. It is higher than the OECD average and, with the exception of the US, Switzerland, France and Germany, it is not materially different for the highest in the world.* And it goes on to say: *Sustainability of our public health and disability systems is under serious threat.*

International comparison of spending on health, 1980–2007

Average spending on health per capita ($US PPP)



Total expenditure on health as a percentage of GDP



Source: OECD Health Data 2009 (June 2008)

But in the graphs on page 16 we see that NZ has the lowest level of spending of comparable countries, and is materially different from the highest spenders in the world. In fact, increased expenditure from 2003 to 2007 only enabled us to keep in contact with the lowest of the comparable countries.[2]

I've heard of creative accounting, but the statements in the *Horn Report* break new ground in trying to turn good news into bad. You might like to use a similar approach to describing your own work, saying "With the exception of the patients that died, suffered injuries, or ended up with HDC complaints, all our patients did exceptionally well this year."

There is a bit of a tradition of economists and bankers reviewing health care systems. Usually this turns them into late entrants to the school of public health. For example, our own Gareth Morgan has this to say: "*I accept that we need to treat obesity as we have dealt with smoking. This may mean being a bit of a nanny state, in order to avoid becoming a nursery state.*[3]"

In the UK the banker Derek Wanless, in a UK Treasury-sponsored report,[4] asserted that the only effective way to tackle the ever-rising cost of healthcare is for the whole of society to 'fully engage' with prevention. By 'full engagement' Wanless meant action at all levels and in all sectors to do whatever can be done to reduce the risks of developing the chronic diseases burden.

However, the *Horn Report* is unique amongst economists and bankers who have reviewed health systems, in its scepticism of the role of prevention. In fact, due to the narrowness of its economic lens, it is even cautious about past and future prevention efforts. It begrudgingly notes:

NZ's relatively strong commitment to prevention and public health has helped improve life expectancy, delayed the onset of disability associated with chronic disease, and reduced inequalities.

But then goes on to say:

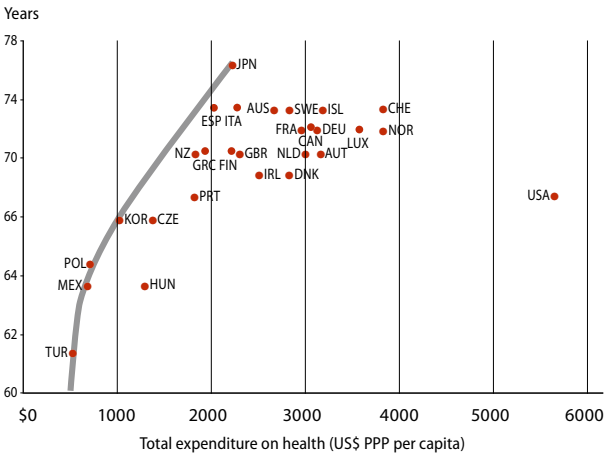
Opinion is divided however on the much narrower question of the extent to which further spending in this area at the expense of more immediate health needs might help reduce future health costs or improve the country's economic performance, thus making future health spending more affordable.

This breaks new ground in defining prevention and public health almost solely in terms of their impact on the economy. In fact improving life expectancy, delaying the onset of chronic disease, and reducing inequalities all improve economic performance[5,6,7]. However that is not the primary reason society chooses to do them. "Prevention is better than cure" is a widely accepted value in most societies, but obviously not in the future New Zealand that Horn envisions, where he is suggesting that the princely sum of 4% of health expenditure that we currently spend on Public Health should be spent on curative care.[8]

However it is not the misrepresentation of NZ's position in relation to like countries in the OECD, or the blind spot regarding prevention that is most troubling about this report. Its main problem lies in its lack of appreciation of current New Zealand achievements.

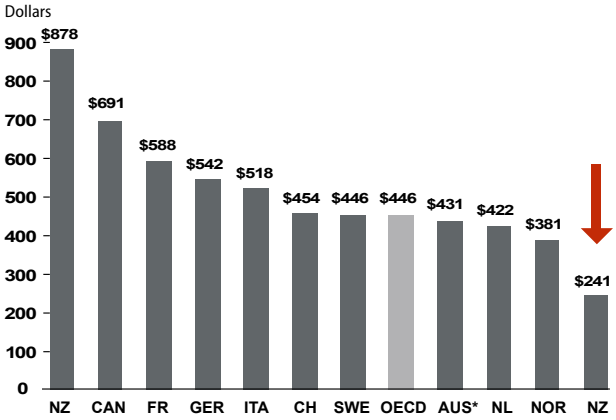
The relationship with healthy life expectancy? We have a great result with low cost. The countries near the grey line are the most efficient. The most inefficient country is the USA with extremely high costs and moderate life expectancy gains.

The relationship between spending and health outcomes in OECD countries, 2003 Health adjusted life expectancy (HALE)



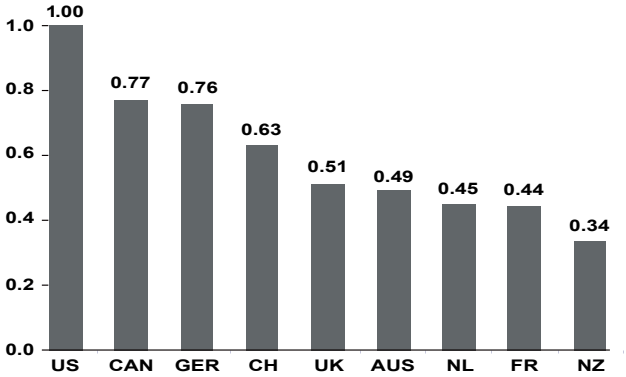
Drug purchasing? We have the best deal in the world.

Pharmaceutical spending per capita, 2007
adjusted for difference in cost of living



*2006 Source: OECD Health Data 2009 (June 2009)

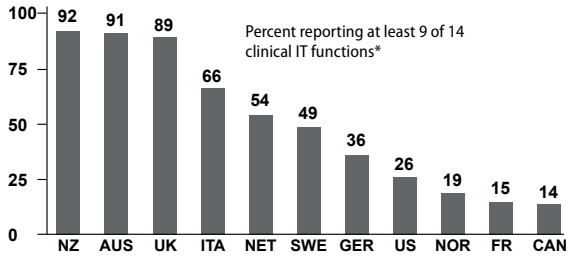
Drug prices for 30 most prescribed drugs, 2006–07
US is set at 1.0



Source: IMS Health

Our use of technology? The geeks rule down under.

Practices with advanced electronic health information capacity

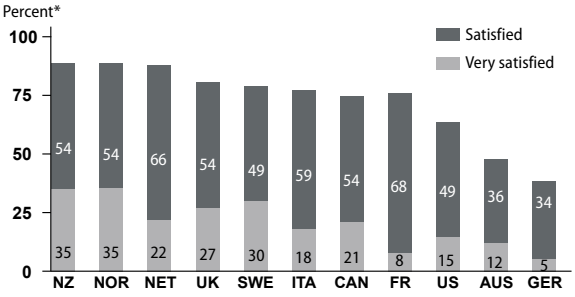


* Count of 14 functions includes: electronic medical record; electronic prescribing and ordering tests; electronic access test results; Rx alerts, clinical notes, computerised system for tracking lab tests, guidelines alerts to provide patients with test results, preventive/follow-up care reminders; and computerised list of patients by diagnosis, medications, due for tests or preventive care.

Source: 2009 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

Outbreaks of satisfaction amongst primary care doctors? Our rate is higher than the rest.

Primary physician satisfaction with practicing medicine

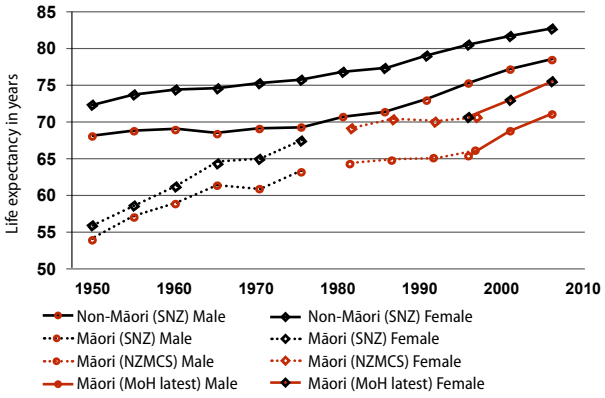


*The other responses were somewhat dissatisfied or very dissatisfied.

Source: 2009 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

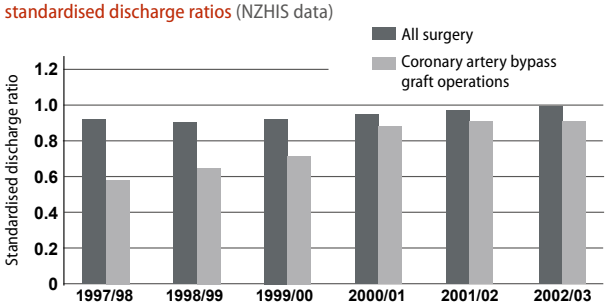
Health Equity? We are showing improvement, and the only country in the world able to measure it in a timely way[9].

Life expectancy trends by ethnicity



Since the late 1990's there has been a return to improved life expectancy for Māori, parallel with the improvement for non-Māori. (Note data missing for a period for Māori due to change in definition of ethnicity). We are once again back on a track, which if it continues could see Aotearoa again addressing the unfair differences in health outcomes between Māori and non-Māori. A similar pattern of reducing inequality is seen between low income and other citizens.

Addressing inequalities in surgery for Māori: non-Māori standardised discharge ratios (NZHIS data)



The achievement in addressing equity has been due to work both inside and outside of the health sector. Addressing health equity has relevance – inside a surgical unit, as the last graph illustrates where the equity gap is progressively being addressed. This graph shows that surgical intervention rates (all types combined) and CABG rates were lower for Māori than European ethnic groups (adjusting for age) until recently. Māori rates are still much too low when adjusted for need (eg CHD mortality rates are double those of Europeans, yet CABG rates are similar). This highlights the importance in seeing the pursuit of 'equity' as being across the health sector, including the work of cardiac surgeons as in this case.

The most comprehensive analysis of the NZ Health system performance in relation to other countries comes from the Commonwealth Fund. How does quality, access, efficiency and life expectancy in New Zealand compare with other countries? In the table below note that New Zealand has the lowest expenditure, yet the Fund concludes:

New Zealand, Australia, and the U.K. continue to demonstrate superior performance, with Germany joining their ranks of top performers.[10]

Overall Ranking

	AUS	CAN	GER	NZ	UK	US
Overall Ranking (2007)	**3.5**	**5**	**2**	**3.5**	**1**	**6**
Quality care	4	6	2.5	2.5	1	5
Right care	5	6	3	4	2	1
Safe care	4	5	1	3	2	6
Coordinated care	3	6	4	2	1	5
Patient-centered care	3	6	2	1	4	5
Access	3	5	1	2	4	6
Efficiency	4	5	3	2	1	6
Equity	2	5	4	3	1	6
Long, healthy and productive lives	1	3	2	4.5	4.5	6
Health, expenditures per capita, 2004	$2,876*	$3,165	$3,005*	$2,083	$2,546	$6,102

* 2003 data

Source: Calculated by Commonwealth Fund based on the Commonwealth Fund 2004 International Health Policy Survey, the Commonwealth Fund 2005 International Health Policy Survey of Sicker Adults, the 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians, and the Commonwealth Fund Commission on a High Performance Health System National Scorecard.

Country Rankings

- 1.0–2.66
- 2.67–4.33
- 4.34–6.0

The conclusion one draws from this is that New Zealand has one of the highest performing health systems with the lowest expenditure amongst comparable countries. From an international perspective, we have a health system that contains much to make us proud, and in fact is the envy of the rest of the world in many respects.

Rather than as the *Horn Report* requested, *a public health and disability system of the same standard as other OECD countries*[11] we should actually strive for one that maintains our health well above the OECD standard and remains value for money comparatively speaking.

For some reason, these inconvenient truths did not find their way into the *Horn Report*. Instead, efforts were made to catastrophise the NZ health system, to try and ignite a very damp platform to usher in radical change. Why? In whose interests is it to deny our nations successes, trumpet our shortcomings, create fictitious pictures of the future, and attempt to create a climate of concern that justifies a panicked response such as: *the sheer size and immediacy of this challenge* (the low cost of health care compared to other countries?) *suggests we need to move quickly on a number of fronts at once.*[12]

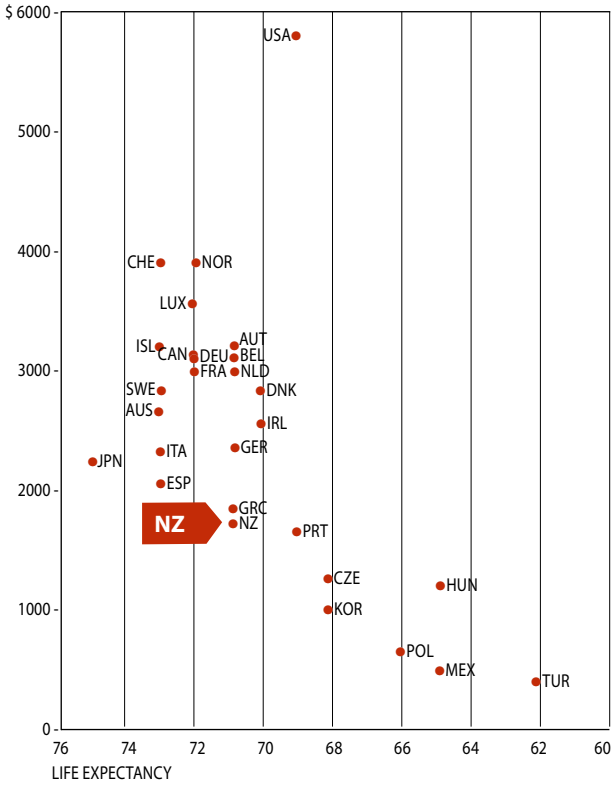
Many a general would be proud of such a clear and succinct instruction to his army! The enemy is everywhere, move quickly on all fronts!

In my view, the international comparisons are a cause for celebration not panic, and considered and appropriate action that explores the evidence for our successes and failures is required rather than "moving quickly on a number of fronts at once" in response to a non-existent crisis.

Unless of course you were viewing the problem from a different angle. Concerned about the gaping hole in the NZ healthcare market – a hole that you hoped with a bit less interference from the government some the private provider could fill. I refer to the untapped potential of the private healthcare market to sell medical goods, services and health insurance to the NZ consumer and government. The untapped potential to extend the private health sector, as has been so successfully done in the USA.

There are a number of parties with vested interests in the growth of the NZ healthcare market. One needs to look only at the efforts leading up to the last election to destabilise PHARMAC (over the Herceptin Issue) as evidence of that constituency. Being an "efficient" buyer in the market is not favoured by monopolistic sellers such as the pharmaceutical industry.

Potential for growth in the healthcare market ($US)



The private sector plays an important and irreplaceable role in the New Zealand healthcare system – however it needs to operate within the government's stewardship otherwise it will work against societal goals of a fair health system for all New Zealanders. I am opposed to seeing the NZ healthcare sector taken down a track where you end up with very expensive care and very poor health outcomes – a position the USA now finds itself in and is struggling to reverse.

Given that NZ is not a basket case, what are the challenges?

There are major challenges that we face in the New Zealand health sector. These are the continuing challenge of health equity, and the challenge of caring for our young.

Health equity relates to differences in the health of different populations that are unfair and unjust. In the late 90s and early part of the 00s we focused, quite successfully on health inequalities. In retrospect, I think health equity would have been a better word to use as it brings attention to the fact that it is not the differences in the populations that is the issue, but the unfair and unjust nature of those differences.[13]

We did make good progress on these issues in the last ten years – beginning in the late 90s, Wyatt Creech as Minister of Health championed the approach of a common strategy to improve the performance of the health system for all New Zealanders to:

- build certainty and confidence in the security and stability of the New Zealand health and disability system
- give equity of health status to all New Zealanders
- maximise the benefits of early intervention, proper integration of services, health promotion, and involvement of communities in developing their own solutions to their health issues.[14]

The approach to addressing health equity was internalised across the health system, with stunning results at the clinical as well as the population level.

New Zealand's leading role was recognised in the work of the Commission on the Social Determinants of Health[15] in its report to WHO that was approved by the world's health Ministers in May this year.

How do we find ourselves in 2009 with a review "Meeting the Challenge" that fails to emphasise that addressing health equity is a core purpose of our health system, unlike the view taken a decade previously? Have we had enough "Equity" for now? This would repeat the mistake of the 90s where we elevated efficiency to a goal in the health system, instead of seeing efficiency as an ingredient to achieving real health sector goals such as equity and quality.

"Better, sooner, more convenient primary health care 'for all New Zealanders'" is an admirable goal, but if it really is about primary health care then we must place the emphasis on these questions:

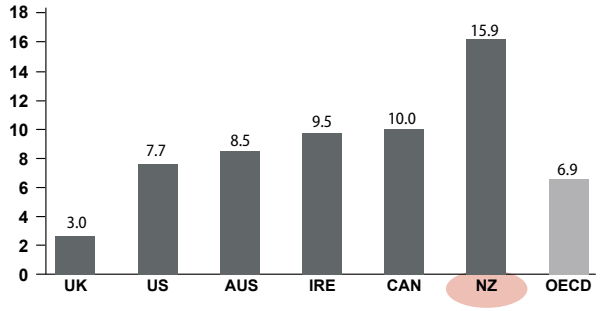
- Better for whom?
- Sooner for whom?
- More convenient for whom?

We already know that 6% of New Zealanders are unable to access PHC when they need it due to the level of fees charged alongside other access issues[16]. Is it going to be better, sooner, and more convenient for them?

One area that is a complete embarrassment in international terms is our support for children and young people. Our material support for children and young people is very low compared to OECD average, and although there has been some improvement, indicators such as teenage suicide remain unacceptably high.

New Zealand has the highest rates of youth suicide in the OECD

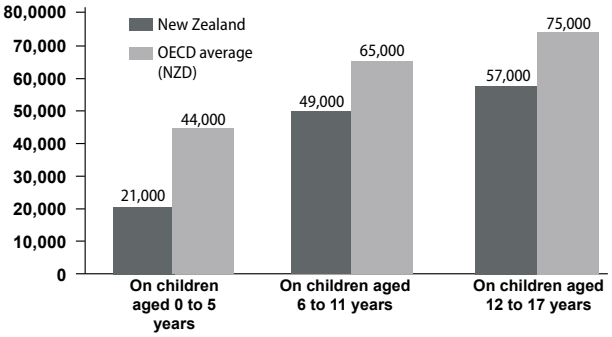
Suicides per 100,000 youth aged 15-19 (most recent data)



Source: www.oecd.org/els/social/childwellbeing 2009

Early childhood spending in NZ is half of that spent in later stages, 2003

Cumulated public spending per child in New Zealand ($) 2003

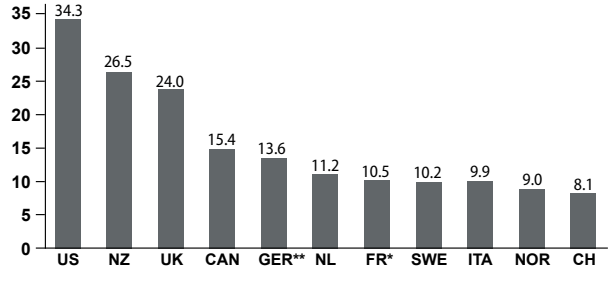


Source: www.oecd.org/els/social/childwellbeing 2009

Then there are the issues of overweight and obesity. Clearly this is an issue that needs focused attention, and something a little more sophisticated than the current "nanny" vs "non nanny" debate. Our prevalence is second only to the USA:

Obesity (BMI > 30) Prevalence Among Adult Population, 2007

Percent



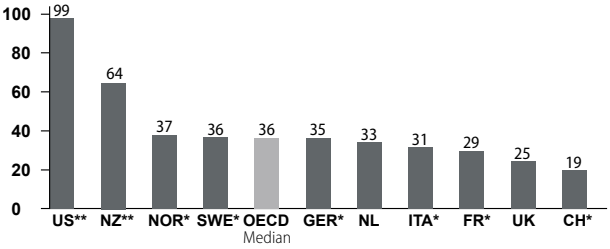
* 2006 ** 2005

Note: BMI = body mass index. For most countries, BMI estimates are based on national health interview surveys (self-reported data). However, the estimates for the US, UK, and NZ are based on actual measurements of weight and height, and estimates based on actual measurements are usually significantly higher than those based on self-report.

Source: OECD Health Data 2009 (June 2009)

And this contributes to a loss of human potential:

Potential Years of Life Lost Because of Diabetes per 100,000 Population, 2007



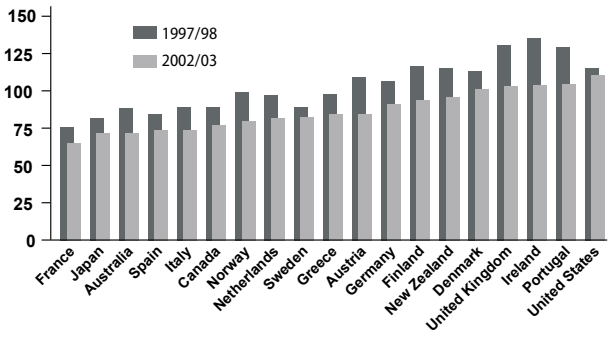
* 2006 **2005

Source: OECD Health Data 2009 (June 2009).

Much remains to be done by the NZ Healthcare system.

Mortality amenable to health care

Deaths per 100,000 population*



*Countries' age-standardized death rates before age 75; includes ischemic heart disease, diabetes, stroke, and bacterial infections.

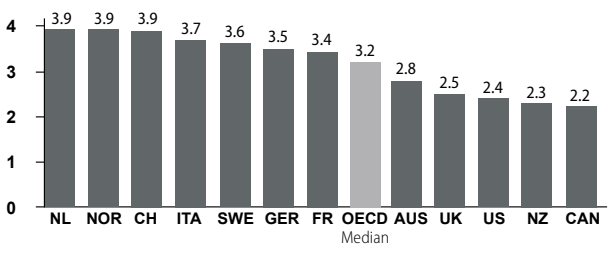
Data: E. E. Nolte and C. M. McKee, Measuring the Health of Nations: Updating an Earlier Analysis, Health Affairs, January/February 2008

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008

The graph above shows both the recent improvement (97–03) in mortality of people aged less than 75 that is amenable to health care. It shows good progress, but also considerable potential (compared to France, Australia, Japan) to make further improvements through the healthcare system.

To tackle this task we need a workforce. And comparatively speaking, it is lean:

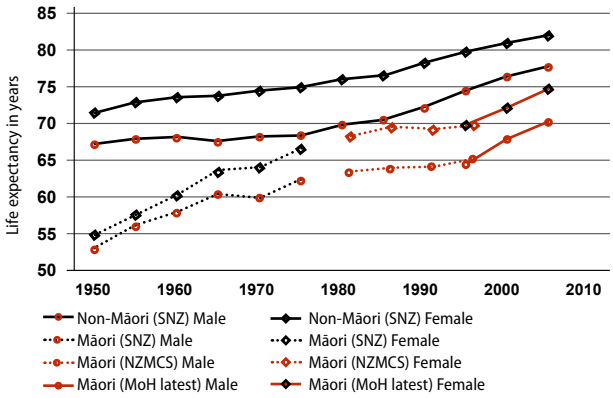
Number of practicing physicians per 1,000 population, 2007



We have considerable potential to improve further, and already have a leaner workforce than others to do the job.

This graph shows the positive impact of the health system since the 1950s in regard to ethnic inequalities, where we made great progress except from the late 80s to the late 90s.

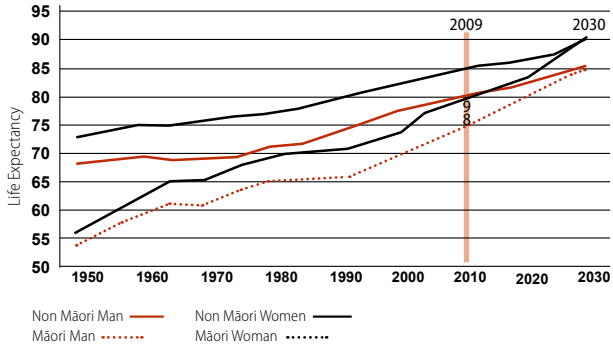
Life expectancy trends by ethnicity



So the NZ health system certainly does have its challenges – I suggest the focus on the human ones such as health equity and the welfare of our children and young people and chronic diseases such as diabetes would be a better focus for our activities rather than a focus only on the theoretical health expenditure in 2030. Then we can look at how we can achieve these more efficiently. Health equity for all New Zealanders is an achievable goal by 2030 –and a lot more achievable than GDP equity with Australia.

After all what is our "brand" as a nation? What makes us attractive? Clean Green? Internationally, a nation

A real target for Health Care in NZ



that values equity is attractive – most don't. Healthier young people boost productivity. Less chronic disease has a protective effect on social spending and increases productivity. In fact all these features have been shown to positively impact on economic growth.

The folly of health system structural change

The Cabinet response to the *Horn Report* has been reassuring. They have avoided the key recommendation for major structural change, and noted that structural change takes some years to be effective (which makes even more remarkable the achievements of the New Zealand health sector given re-structuring paralysis for most of that time).

Expanding the role of Pharmac, consolidation and focusing on health professional workforce and quality activities are sensible actions to take, provided (and this is the major concern) that health equity is a major goal and quality is not seen as divorced from equity.

Restructuring is a classic folly that health systems engage in. Follies are those useless but intriguing monuments that people build without reason. Structural change and restructuring health systems has a class of follies all to itself. Its evidence base for effectiveness is increasingly thin, and it is now so common that there is even helpful advice to clinicians about how to "restructure proof" their work[17] – by doing such novel things as using evidence, involving patients, and listening to junior colleagues.

Having been spared from creating a new HFA, we need to be mindful of the downside of other structural moves such as mergers, (which put UK PHCTs back 18 months). As noted in the UK this has shown that:

The gains in efficiency sought through restructuring are elusive at best, and reorganising twice in a six year period created the opposite, with inefficiencies resulting... Continuously rearranging things exacerbates this, creating bewilderment and even incredulity.[18]

In other words, one of the best ways to send our workforce to Australia is to restructure the sector .

So how should we approach change in a modern, complex health system? I suggest that the Cabinet approach, resisting the temptation to see the answers in structures, is a good one.

The New Zealand approach, popularised from the 90s, is to put out an EOI[19] and develop a business case. Although this may generate some good ideas, it is an inadequate process for developing system-wide thinking and change. Responders go into a solitary huddle, desperately searching to regurgitate the 'in words' so that their application has resonance with some unseen committee. As Jeff said in his talk this morning (see Dr Jeff Brown's address in this issue), "We lack the spaces and places where people can renew hope and develop solutions."

The current move to support 'super PHOs' for instance, presents a number of serious risks as well as opportunities to the sector that should be openly discussed and debated. These mainly stem from the not-so-hidden agenda for these super PHOs to move over time to be budget holders.

- Budget holding by large PHOs may undermine the

viability of rural and provincial DHBs. Particularly if there is "no extra money" – then the money will come from somewhere.

- The move to budget holding will move control from a public institution (a DHB) to a private institution (a super PHO) thus effectively removing the social barrier to user fees for secondary care, and potentially increasing the more inefficient forms of health care financing, out of pocket expenditure. In other words, more direct costs are pushed onto the consumer.
- Consolidation of funding streams (such as care plus, low cost access) appears amnesic about why these funding streams were introduced in the first place – ie that these activities were not occurring consistently and required greater incentives.
- Equity: the experience of budget holding in the late 90s demonstrated the highest rewards went to IPAs who covered the most expensive and erratic providers. This excludes providers of services to high need areas, who did not engage in budget holding, because they were thrifty to begin with, and hence missed out on the huge financial windfalls that it yielded.

WHO[20] in its recent report on systems-thinking for health system strengthening gives advice on a simple schema for approaching health interventions:

- Convene stakeholders
- Collectively brainstorm
- Conceptualize effects
- Adapt and redesign

To that I would add, the need to be clear about the fundamental values to which the country aspires, such as health equity, prevention of illness and universal access to care. In addition, the need to critically assemble the real research evidence, and not 'spin' it to try and create a burning platform.

As noted by Gauld, New Zealand's political system is not geared towards gradual and careful consideration of policy and intervention. Instead each incoming government is compelled to launch itself into poorly scoped implementation. This system abusive cycle is repeating itself again, with the 'rationale' for the reforms being based on a highly erroneous OECD report[21], and an over-reliance on the latest developments in the National Health Service championed by visiting English academics.[22, 23] Their advice is fine, but the context of the NHS is very different from that of NZ, and we need solutions that reflect our context.

In the current process, we are failing again (as we did in the early 90s and the early 00s[24]) to effectively engage with the full intellectual and emotional capital that we can apply to improving health care. The 'thinking' and innovation is about to be largely confined to a small group of PHO managers, largely remnants of the IPAs of the 90s, and the chance to involve clinicians, patients, and researchers in the wider creative process about the future direction of the system may be lost. This is further complicated by the frame of reference for this thinking being extremely narrow, the timeframe short, and the goals reduced to their impact on some far-flung economic marker.

However it is this third step of the WHO framework, to "conceptualise effects" where we most often fail – we do not collectively discuss the likely effects of system change, preferring to infer the impact on preconceived ideological positions rather than examine the real evidence of the performance of the system across disciplines as diverse as clinical medicine, economics and public health.

So taking the above discussion, our approach should be that of a top global performer, looking to see how we can keep ahead of the field at the next Olympics. Mindful of the fact that our current ranking has been due to the way all the parts of the system have cooperated, rather than the simplistic logic of what is politically hot or cold at this political micro moment, such as:

Big or small is good or bad, Ministry of Health is bad, back room function consolidation is good, DHBs are bad, big PHOs are good, too much PHC and PH is bad, more spending on hospitals is good, bureaucracy is bad, front line is good (except when it has to be bureaucratic then it is bad).

The role of the health professionals is crucial in this. As Julian Le Grand[25] notes, we have the potential to act as both knaves and knights. As government employees, as knights, honourably committed to the public good, or as knaves, interested only in personal gain? Our voice and views, both knaves and knights, have largely brought us to where we are today. It is important that issues are fully explored from a systems perspective and consideration of the impacts on all parts of the system, without falling into the simplistic slogans mentioned above. You are inside the system – you know it intimately. The power is partially in your hands to take it forward – but not alone, not as a knave.

Dynamic networks are required that cross stakeholder groups and inspire new knowledge and innovation. Progress must be informed and supported by more system-wide planning, evaluation and research, and its credibility continuously checked with the real experience of our patients.

On the global scene, speaking broader than health, the last three decades have seen the abandonment of that search for a holistic balance, and imagination has been replaced with a sort of delusional certainty based on the belief surrounding an economic theory.[26] As John Ralston Saul says in his book *The Collapse of Globalism:*

Globalists have often stated that their ideology is not an ideology at all, but an expression of the inevitable and unstoppable forces of

technology and international market forces. Any attempt to claim inevitability for an economic theory is just a pseudo scientific version of the old 'God is on my side' argument.

Even the movement's supreme leader has been at a loss to explain why self-interested bankers collapsed the global system: "I still don't fully understand why it happened," said Alan Greenspan, former chair of US Federal Reserve Board, as the USA's financial bedrock collapsed.[27]

Maybe the answer is not to be found only through the lens of an economist.

We should take advantage of this period in human history where the market "emperor" can now be seen without even a jockstrap, and as we are a leader in global health systems see if we cannot forge a new direction for health, one built on the understanding of the complexity of the system, the complexity of the lives of the people we treat, the importance of our shared cultural values, the intimate relationship with the planet on which we live... and not fall again into the trap of following failed narrow neoliberal economic logic.

The pursuit of equity is core of this new direction, to quote Nelson Mandela:

"Massive poverty and obscene inequality are such terrible scourges of our times – they have to rank alongside slavery and apartheid as social evils... Overcoming poverty is not a gesture of charity. It is an act of justice. It is the protection of a fundamental human right, the right to dignity and a decent life."[28]

Clinicians can and must play a fundamental role in taking forward the health system of this country. I leave you with the words of Virchow:

Should medicine ever fulfil its great ends, it must enter into the larger political and social life of our time; it must indicate the barriers which obstruct the normal completion of the life cycle and remove them.[29]

Don Matheson
Professor of Health Policy, Massey University

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I know that medico-legal issues arise in all jurisdictions, but at least in New Zealand I can't be sued. Or can I?

While the ability to sue for damages was largely abolished in 1974 with the arrival of ACC, there still remain specific avenues through which doctors can be sued. At any given time, the Medical Protection Society (MPS) has a number of cases on its books where damages are being sought against doctors.

Failed sterilisation cases.

ACC will not currently cover cases where pregnancy arises as a result of a negligent medical act. In ACC v D, a failed sterilisation case, the Court of Appeal (by majority) did not view pregnancy as a "personal injury" for the purpose of cover under the ACC legislation. Other negligent medical acts resulting in an unwanted pregnancy are potentially caught by this decision.

In a failed vasectomy case, a patient brought proceedings against the DHB alleging, amongst other things, that the doctor failed to adequately inform the patient of the risks of remaining fertile post-surgery. ACC did not apply because the resulting pregnancy was not an injury and the person who suffered the "harm" (the wife who became pregnant) was not the person who underwent the allegedly negligent procedure (the husband who had the failed vasectomy).

> MPS, as an organisation run by doctors for doctors, places paramount importance on the protection of a doctor's professional reputation.

As a requirement of its insurers, the DHB joined the surgeon as a party to the proceedings. This meant that the surgeon's name was in the public arena (potentially damaging his reputation) and it exposed him to liability for damages for which he quite properly sought indemnity from MPS.

MPS, as an organisation run by doctors for doctors, places paramount importance on the protection of a doctor's professional reputation. In this case, after careful consideration involving both medical expert and legal advice, it was considered that the doctor had not acted negligently and therefore the claim should be defended. The DHB's insurers took a different view and settled. On behalf of the surgeon, the MPS continued the proceedings, successfully defending the doctor.

Claimant's who suffer mental injury, but no "physical" harm and secondary victims

ACC will not cover claims that arise in situations where the claimant has suffered mental injury only, and no physical harm, as a result of a negligent act. Furthermore, secondary victims who suffer psychiatric harm as a result of witnessing physical harm caused to someone else (the primary victim) may also sue the person who allegedly caused the harm. An example would be an expectant father who is traumatised (resulting in a diagnosed psychiatric condition) by watching his spouse die in labour as a result of medical negligence. MPS has assisted members in situations where these claims have arisen or been threatened.

Statutory damages

Privacy cases make up a significant proportion of the MPS case load where statutory damages are sought.

One unusual MPS case concerned an alleged breach of privacy and discrimination by a doctor. The alleged breach was said to arise because doctor A (the defendant) told doctor B, that the person who had tried to make a block booking of patients into doctor B's practice by telephone might have been the same person (the claimant) with a distinctive accent who was particularly vocal at a public meeting about patient access to primary care in their area.

The claimant issued proceedings before the Tribunal upon learning of the accusation alleging a breach of privacy and discrimination (on the basis that the suggestion that it was her was made because the person making the block booking had an accent). The privacy proceedings were abandoned without costs, but the additional human rights allegations were taken to the Tribunal, which eventually determined that there was W to answer.

Exemplary damages

Cases for proceedings against doctors for exemplary

damages are now rare, but damages are still an established feature of New Zealand law. Exemplary damages should be awarded by the Court only if the amount available in compensation is "inadequate to punish (the defendant) for his outrageous conduct, to mark their disapproval of such conduct and to deter him from repeating it".

Clinical trials

The Injury Prevention Rehabilitation and Compensation Act 2001 s32 provides that treatment injury includes personal injury as a result of treatment given as part of a clinical trial only where the claimant did not agree in writing to participate in the trial or where an Ethics Committee approved the trial and was satisfied that it was not to be conducted principally for the benefit of the manufacturer or distributor of the medicine or item being trialled. It follows that participants in trials conducted for the benefit of the manufacturer or distributor are not covered under the treatment injury provisions of the ACC. This is a common situation and means that doctors involved in such trials may still be sued for any allegedly negligent act resulting in harm to trial participants.

> The best course is always to attempt to avoid litigation...ring MPS as early as possible,

The best course is always to attempt to avoid litigation. Doctors are encouraged to ring MPS as early as possible, particularly when there is any suggestion of concern. In this way MPS can ensure all that is possible is done to diffuse concerns or mitigate loss. That is why MPS members have the benefit of specialist medicolegal consultants available 24/7 for advice and assistance. To access this service call 0800 2255677 (0800 CALL MPS).

Dr Brendon Gray
Medico-legal Consultant, MPS

Support service for doctors

The Medical Assurance Society and Medical Protection Society have joined forces to bring their members an important 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 or support. The service is completely confidential.

MPS

Medical Assurance Society

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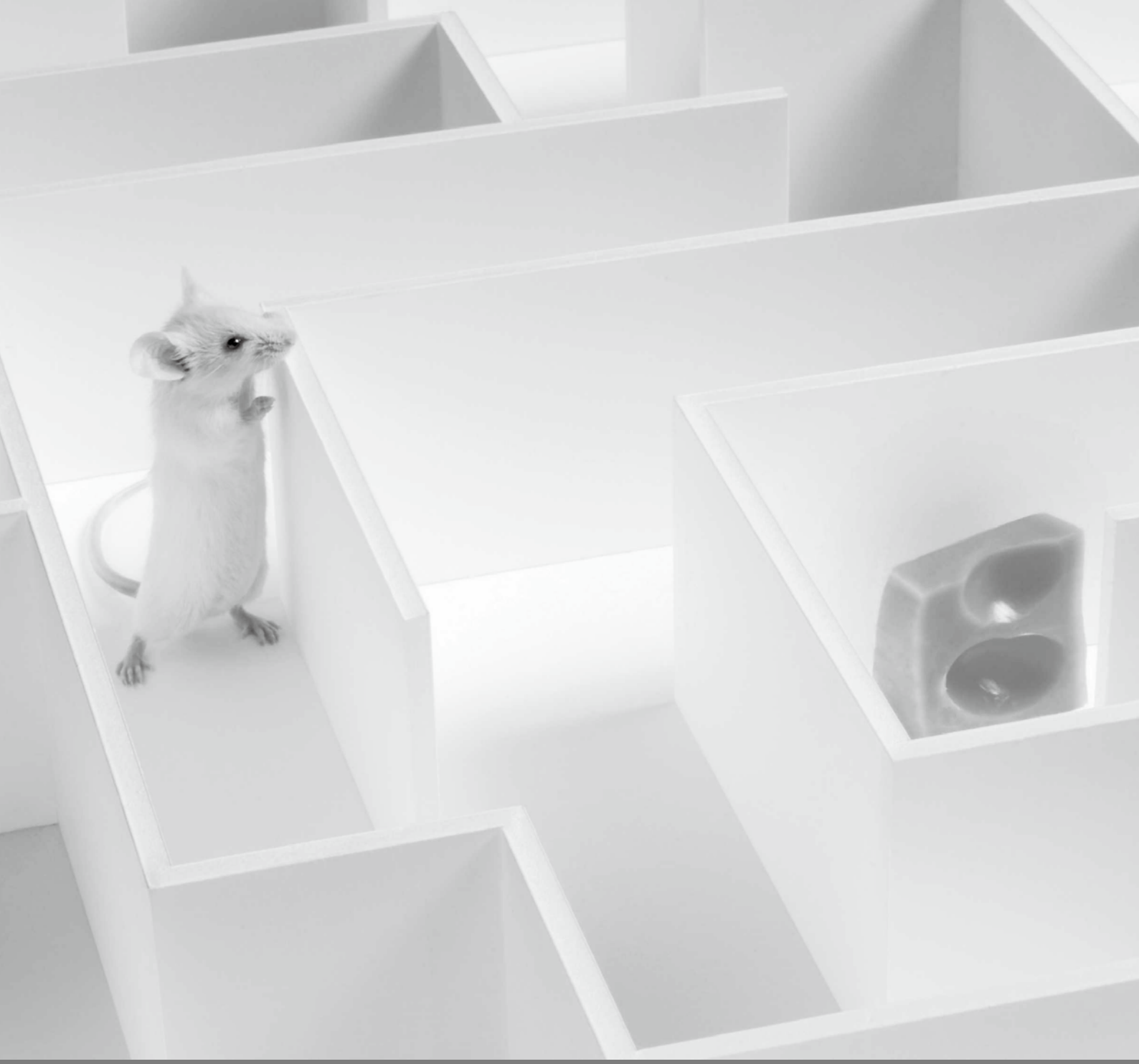

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Seasons Greetings

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

Standing – Lloyd Woods, Henry Stubbs, Lyn Hughes, Ian Powell
Seated - Yvonne Desmond, Joanne Jourdain, Angela Belich, Ebony Lamb, Kathy Eaden

The national office will be closed from Thursday afternoon 24 December through to Tuesday 5 January 2010. During this period messages of urgency can be left on the office answer phone which will be cleared regularly.
Throughout much of January we will be operating on reduced staff.