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The Specialist

THE NEWSLETTER OF THE ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

Progressing in good hands

The last (March) issue of *The Specialist* featured the drive for genuine clinical engagement and leadership in DHBs by both the ASMS and the Minister of Health. On the ASMS side of things we have been advocating this in various forms for years. Politically it has really only received practical political support since late 2007 when newly appointed Labour Health Minister David Cunliffe played an important broker role in achieving the *Time for Quality* agreement between the ASMS and 21 DHBs. This has been taken further by current National Health Minister Tony Ryall with his February Letter of Expectations to DHB chairs and the *In Good Hands* policy statement, both published in the March issue of *The Specialist*.

> The ASMS knows that if we (and the Minister) don't actively promote *In Good Hands* then its aspirations will not be realised.

The ASMS knows that if we (and the Minister) don't actively promote *In Good Hands* then its aspirations will not be realised. There is simply too much inertia, too much preoccupation with coping with short-term pressures, too much negativity, and too much sense of being threatened by the principles of *In Good Hands* within various layers of DHBs to rely on them to deliver. Fortunately the Minister is also aware because of his own instincts and contacts and because the ASMS is liaising with him.

The Six Principles of *In Good Hands*

1. Quality and safety will be the goal of every clinical and administrative initive.
2. The most effective use of resources occurs when clinical leadership is embedded at every level of the system.
3. Clinical decisions at the closest point of contact will be encouraged.
4. Clinical review of administrative decisions will be enabled.
5. Clinical governance will build on successful initiatives.
6. Clinical governance will embed a transformative new partnership which will be an enabler for better outcomes for patients.

Roadblocks and risks

The ASMS is acutely aware of the road-blocks. It was disappointing but not surprising to learn of the negativity towards *In Good Hands* by a number of attendees at a national meeting in April of chief operating officers. The disappointment is that chief operating officers are critical to the implementation of much of what happens in DHB provided services. The lack of surprise is that this negativity is consistent with the culture of managerialism that we know some of them subscribe to. However, on the other side of the balance sheet, there are also positive signs. A number of chief operating officers embrace and endorse *In Good Hands*, albeit in some instances with a touch of understandable hesitancy.

We are also aware, from within that most peculiar body, DHBNZ, of employment relations advice which attempted to diminish the status of *In Good Hands* and cast the ASMS in a particularly negative light. It is disappointing that this attitude is still around and no doubt goes beyond the individual responsible for it. However, on the positive side, once the DHBs nationally became aware of it they quickly and fully disassociated themselves from it and made it clear that the advice had no status or credibility at all.

> The greatest risk to *In Good Hands*, is the adoption of a tick-box approach

The greatest risk to *In Good Hands*, however, is not short-sighted negativity by some senior managers or antipathy from the odd employment relations/human resources staff member, but the adoption of a 'tick-box' approach. It has been interesting to observe some chief executives, and also the odd DHB chair, 'hand on heart' maintaining that *In Good Hands* was already completely or largely in place. The reality was the opposite. However, they were not necessarily being deceitful. They genuinely believed it but they are wrong.

In one DHB a chief medical officer on behalf of senior management confidently declared in a letter to the ASMS that they had "excellent" relationships with clinicians and that five of the six principles of *In Good*

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Hands were already in place. He genuinely believed this to be so. But only a short time earlier the SMO Commission held a meeting with senior medical staff at this DHB and received a very strong message of disengagement and disempowerment. This is a case of a tale of two parallel DHBs on the same site.

Minister on the status of *In Good Hands*

In response to concerns raised by the ASMS over some signs of negativity within DHBs towards *In Good Hands* including questioning its status, Health Minister Tony Ryall could not have been more explicit when meeting the ASMS National Executive on 14 May. He was adamant that the *In Good Hands* document was part of official government policy. Further, Mr Ryall has also written to all 21 DHBs concerning their obligations to report on the implementation of the transformation to effective clinical leadership as provided for *In Good Hands*. If this is not a report with important government status, what is?

> Health Minister Tony Ryall could not have been more explicit when meeting the ASMS National Executive on 14 May. He was adamant that the *In Good Hands* document was part of official government policy.

There is one area where those nervous or uncertain about *In Good Hands* have some legitimacy. It is always preferable that new policy initiatives have some degree of ownership with those required to implement them, in this case DHBs. This requires reasonably extensive engagement and it was the case to a degree with the *Time for Quality* agreement last year which is now in part operationalised by *In Good Hands*.

For *In Good Hands* the process was truncated. The Minister formed a small task group with significant ASMS influence in late December and the report was completed in early February. There was simply no opportunity for sector engagement.

But there is method (and justification) in the madness. First, there was time exigency with the Minister wanting to link this policy statement on clinical leadership to his annual (and first) Letter of Expectations to DHB Chairs which was already later than wished. Second, in opposition, the absence of genuine and effective clinical leadership as a major weakness of DHBs had been highlighted and well signalled by National. It should not have been a surprise. Third, clinical leadership has been talked about for some years by DHBs and yet, despite some good developments here and there, was still little advanced beyond the level of isolated good examples and tokenism. Fourth, DHBs had damaged their own credibility over clinical leadership with their attempt to claw-back on engagement and consultation rights in the last national MECA negotiations. Finally, it has to be recalled that the groundbreaking *Time for Quality* agreement between the ASMS and 21 DHBs would not have been achieved without active intervention last year by former Health Minister David Cunliffe.

DHB ownership is important in principle but not when their performance to date has varied from being at the pace of a drunken snail to waiting for Godot.

Vigilance – ASMS and Health Minister

Without ASMS and Ministerial vigilance many DHBs will resort to 'tick box' reporting, only what they want to see, and cheerfully telling the Minister that all is well. The task of the ASMS will be to do its bit in providing vigilance. The teeth of *In Good Hands* are its reporting functions including the District Annual Plan (each DHB's key statutory accountability document requiring Ministerial sign-off) and Ministry scorecards. It is reporting where the ASMS needs to focus its scrutiny which includes using the vehicle of the Joint Consultation Committee between the ASMS and management in each of the 21 DHBs. This vigilance will need to focus on the key principles and transformation requirements that DHBs will be required to report progress on.

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The ASMS has already taken the first initiative in this important work. *In Good Hands*, including its reporting obligations, has been promoted in the successful engagement workshops jointly organised by the ASMS and several DHBs. At the more practical level of the Joint Consultation Committees the ASMS has with each of the 21 DHBs, we are now also encouraging initial stocktakes to be prepared on to what extent these principles are being applied and these transformation adjustments are being made. The intent is to then subject the initial stocktakes to scrutiny with a view to getting a shared assessment with senior management about the gap between current practice and goal, and what is required to bridge it.

Ian Powell
Executive Director

Six transformation adjustments required by *In Good Hands*

1. DHB Boards must establish governance structures which ensure effective partnership of clinical and corporate management. DHB Boards must be required to report on clinical outcomes and clinical effectiveness, via a nationally consistent framework. Quality and safety must be at the top of every agenda of every Board meeting and Board report.
2. The Chief Executive must enable strong clinical leadership and decision making throughout the organisation. Assessment of Chief Executive performance must include clinical outcomes, clinical effectiveness, and the establishment of clinical governance.
3. DHB Governance will promote and support clinical leadership and clinical governance at every level of the organisation. DHBs must report on clinical leadership and clinical governance through their District Annual Plans, their Statement of Intent, and scorecard reports to the Ministry. This reporting includes, but is not limited to, the functions of their Clinical Board.
4. Clinical governance must cover the whole patient journey, including horizontal integration across the sector and across primary and secondary/tertiary services. Tangible examples of clinical governance, which DHBs must report on, include:
   - Clinicians on the Executive Management Team as full active participants in all decision making
   - Effective partnership between clinicians and management at all levels of the organisation with shared decision making, responsibility and accountability
   - Decisions and trust devolved to the most appropriate clinical units or teams, which are many and varied, including clinics, offices and practices, wards and departments, hospitals and networks, regional and national bodies.
5. Clinical leadership must include the whole spectrum from inherent (eg surgery, clinic, bedside, theatre relationships) through peer-elect (eg practice, ward, department arrangements) to clinician-management appointment (eg clinical directors, clinical board). DHBs must report on the establishment, and effectiveness, of clinical leadership across the spectrum of their activities, aligning management to clinical activities.
6. DHBs and the health system must identify actual and potential clinical leaders, and foster and support the development of clinical leadership at all levels. To this end DHBs must together establish strategies to:
   - Provide on the job training to strengthen the competencies and attributes of clinical leaders
   - Measure the achievement of leadership competencies in their workforce
   - Link with Universities, Colleges, and professional associations to coordinate funding, access to internal and external training, and support for coaching and mentoring of leadership at all levels.

New Administration Officer

Joanne Jourdain has been appointed to the Administration Officer vacancy left by the resignation of Leigh Parish. Joanne began work with the Association on 14 April this year and has an extensive background in office administration, secretarial and customer services; recently as Personal Assistant to the Principal of Leeder Health in Tauranga, prior to that she worked in the computer training industry between 1996 and 2004.

What is a doctor worth?

Aside from the current political jokes doing the rounds, the question is on the lips of those doing ward rounds. On the minds of those left to populate the public health system with professional ethics and expertise. Those who await the determinations of the Commissions looking into SMO and RMO workforces. Those who want earnestly to believe they have the best job in the world, and want to encourage the fittest and finest to strive to replace them. Those who yearn to lead us out of the medical mire to the uplands of utopia.

How then, can a doctor's worth be determined? I offer four different lenses on the topic, to bring into focus what others have published and voiced, the tunnelled visions of players within and opinions without.

What is a doctor worth? What it costs to produce one?

Fresh and eager, oft little knowing
Contemplating terrors of tertiary educators
Harnessing loans and growing up
Differentiated or stem cell ripe for mitosis
Trained for today, not an unknown morrow
By fuddies of the past, for a frightening future
Perpetually justifying their pinnacle
Of value to public and politicians

What the market will pay to use one?

Guilds gilding private lilies
At the expense of aesthetes for public honour
Procedures ticking pecuniary pride
Over evidence based evocations
Skills Southern Crossed above
Cerebration, deliberation or chronic ills
Perpetually justifying their pinnacle
Of value to public and politicians

What it will cost to replace one?

Anything to keep the peace
Anything to keep the piecework
Anything to fill the hollow
Anything the balance sheet will swallow
Anybody the Council will allow
Anybody, anyhow
Perpetually justifying their pinnacle
Of value to public and politicians

What it will cost not to have one?

When we substitute skills
Do we substitute wisdom?
When we triage at and before the front door
Asking those minimally trained to differentiate
So the maximally trained can narrow their focus
On the tiniest gland and the shiniest machine
Perpetually justifying their pinnacle
Of value to public and politicians

Is it moral mendacity around every clinical corner?
Not to use the best differentiators up front
And delegate specific skills to teams
Of task oriented individuals, great at the good they do
When pointed in the right direction in the first place
By expensive expansive experts in everything
Perpetually justifying their pinnacle
Of value to public and politicians

These four accruals are not exclusive, but exemplars, from other critics to stir the pot. The pot not of gold, not even silver, but of ingredients begging for alchemy. Just letting the pot boil over is leaving the chemistry to economists who look at a bubble as an asset that is irrationally and artificially overvalued and cannot be sustained. Their response? Mathematically model rational choice hypotheses, then apply this "tool kit" promiscuously to all manner of questions, including social behaviour. They discuss humans' tendency to care about the views of others only as a violation of rationality, not a virtue. Yet Adam Smith, one of the fathers of the dismal science, said that people may appear selfish, but in fact they sympathize with the pains and pleasures of others.

Leaving the pot in the care of the tertiary trainers ignores the scalding soaring costs of professional education. In the US over the past 25 years average college tuition and fees have risen 440 percent, more than four times the rate of inflation and almost twice the rate of medical care. Yet Roger Scruton claims that the real purpose of universities is not to flatter the tastes of those who arrive there, but to present them with a rite of passage into something better.

Craft groups and guilds grabbing small pots of their own strive to justify the length of specialty training. But do they truly value the special worth of the generalist, or contemplate that the super specialist may not be the best general of the army of health workers? Are they traveling on isolated roads, separating jobs from careers from professions? Are they duplicating Lasch's argument about family structure and the socialisation of children. "Reorganising the production process has removed the father from the child's everyday experience and deprived him of the skills that formerly evoked the child's emulation and gratitude. It has uprooted families from kin communities and replaced intergenerationally transmitted

folk wisdom with social-scientific expertise dispensed by professionals. It has convinced parents that their children are entitled to the best of everything but that, without expert assistance, parents are helpless to determine what that might be."

Tenderly togetherly caring for the pot and its ingredients, rather than leaving it in the separate hands of the trainers, the market, or those struggling to recruit or replace, may allow what Thaler and Sunstein call a nudge - changing the default option in the "choice architecture". What this default option might be...

This column claims no curdled, bitter scepticism. Rather it aspires to be an effective critic, which Michael Walzer argues, is a member of the community he or she criticises, formed within and by it, intimate with its traits and traditions, serious about its morality. Past evidence all points to my eternal optimism. That we can and will transform, in the right direction, and without destroying or damaging beyond resuscitation the best of what has always made us what we are.

Doctors. And worth it.

Jeff Brown
National President

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

Other services

www.asms.org.nz

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

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

ASMS job vacancies online
www.asms.org.nz/system/jobs/job_list.asp

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

Substantial discounts are offered for bulk and continued advertising.

ASMS email broadcast

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

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

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What to do about DHBNZ? A bureaucracy with no status

If ever there was a misunderstood, confusing, perplexing and underwhelming organisation in the health sector, it would have to be District Health Boards New Zealand (DHBNZ). If ever there was an organisation that lacked credibility among so much of the health sector, including its own creators, it would have to be DHBNZ. If ever there was an organisation trying to signal to the Ministerial Review Group chaired by Murray Horn that it serves little practical purpose and should be got rid of, it would have to be DHBNZ.

A good idea at the time?

Why is this so? Its formation by the 21 DHBs, soon after their own creation, made sense. In the shift from the commercially competitive health system of the 1990s, the 2000 Public Health and Disability Act created the 21 DHBs and required them to collaborate. The subsequent issuing of the New Zealand Health Strategy was a further reminder that, (in contrast with the other way around in the 1990s), there was a New Zealand health system with localised variations.

In the shift away from fragmentation and towards collaboration, DHBs had a strong and logical imperative to work together. Equally logical was the need to establish some form of national capacity. Consequently DHBNZ was formed with what seemed appropriate at the time, a name with a catchy acronym to boot.

At that time I thought that this was a good idea and that over time DHBNZ would evolve from its initial clearing house role into something useful and important. Well I certainly got the word "evolve" right but that's all.

Initially the ASMS's dealings with DHBNZ were useful but this was limited to industrial relations and, in reality, due solely to the competence and professionalism of DHBNZ's key employment relations adviser Maryan Street (subsequently elected to Parliament and now a former housing minister). One initiative was our Senior Industrial Officer Henry Stubbs and Maryan Street (with the approval of the DHBNZ chief executive) working together to develop an agreed formula for the application of the time-and-a-half relevant daily rate for working on public holidays under the amendment the Holidays Act. Both believed in good faith that they were developing a national agreement that would save the problem of doing it 21 different times.

However, having done their job (well as it happened) and the ASMS confirming acceptance, to the surprise of the ASMS (and even greater surprise to Ms Street) we learnt that DHBNZ had no ability to reach such agreements.

Sadly, as good as it gets

This fiasco was as good as it got with DHBNZ. Increasingly a range of health sector organisations became frustrated with their dealings with it. What was most confusing was its status. Certainly DHBNZ consider itself to be important because it kept telling people it was. This was reinforced by its name. If one is dealing with something called DHBNZ one reasonably assumes it to be an important organisation.

Unfortunately (arguably fortunately) I missed a DHBNZ briefing to health sector unions a few years ago in which DHBNZ's chief executive confidently predicted that it would replace much of the Ministry of Health's work, including workforce development, and marginalise the latter's role. My union colleagues who attended the briefing still dine out on this experience.

DHBs themselves have also lost confidence. Chief executives and board chairs were burned when they subsequently discovered that the DHBNZ chief executive was having meetings with then Health Minister Peter Hodgson without their knowledge or approval. Mr Hodgson no doubt genuinely believed that DHBNZ was representing the 21 DHBs at these meetings. Nothing could be further from the truth.

Inspirational DHB leadership!

The DHBs way of addressing this was not to review the functions and structure of DHBNZ but instead to deem that DHBNZ has no status. At a national tripartite meeting of the DHBs, Ministry of Health and health unions earlier this year, in response to a question from me, a DHB chief executive (with an embarrassed DHBNZ senior official sitting next to him) in the most unambiguous manner declared that DHBNZ had no status. How demeaning of an organisation was that?

So we now have the situation of a piece of health bureaucracy having no status but having a name that suggests it has an important status. But having declared that their own creation has no status, what do the DHBs do about it? They introduced a new alternative letterhead of the 21 DHBs when writing to the ASMS and elsewhere. There is quite a bit of intellectual capital among DHB chairs and chief executives but how on earth could they ever believe that introducing

a new letterhead would resolve the debacle. Rather than providing clarification it simply reinforces the confusion. Rowan Atkinson could do wonders with this script.

Dealing with the debacle

There are two ways in which the debacle could be sorted out before someone sorts it out for the DHBs. The first would be to blow DHBNZ up. The second would be to go back to the drawing board and develop consensus on what sort of capacity DHBs require for them to effectively work together at a national level with government, unions and other organisations. This would include looking at what DHBNZ currently does and re-assess what should remain, what should be done elsewhere (eg, Ministry of Health), and what should be ditched. This must also ensure that they have the right staff with the right attributes, skill mix and accountabilities for this revised body.

What we now have is either an emperor with no clothes or an empire with no homeland and territories. It is too easy to blame DHBNZ itself for this mess even accepting that it has made itself an obvious target. The greater responsibility rests with the DHBs who brought DHBNZ into the world but have failed their basic loco parentis requirements. If they don't do the second option then the first option for dealing with it becomes more plausible, perhaps with Murray Horn igniting the dynamite.

Ian Powell
Executive Director

National Executive Election Results

The following members were elected to serve on the Association's National Executive for a two-year term 1 April 2009 – 31 March 2011:

President
Jeff Brown — Paediatrician, MidCentral DHB

Vice-President
David Jones — Physician, Capital & Coast DHB

Region 1 (Northern District)
Judy Bent — Anaesthetist, Auckland DHB
Himadri Seth — Psychiatrist, Waitemata DHB

Region 2 (Midland including Taranaki)
John Bonning — Emergency Medicine, Waikato DHB
Paul Wilson — Anaesthetist, Bay of Plenty DHB

Region 3 (The rest of the North Island)
Torben Iversen — O&G, Tairawhiti DHB
Tim Frendin — Physician, Hawke's Bay DHB

Region 4 (South Island)
Brian Craig — Psychiatrist, Canterbury DHB
John MacDonald — Surgeon, Canterbury DHB

ASMS 21st Annual Conference at Te Papa

Thursday 3 – Friday 4 December 2009

DELEGATES REQUIRED

The ASMS makes all travel and accommodation arrangements for ASMS members to attend its 21st Annual Conference as delegates.

Dinner and Pre-Conference Function

A Conference dinner will be held on Thursday 3 December. Delegates are also invited to attend an informal cocktail function on the evening of Wednesday 2 December.

Leave

Clause 29.1 of the MECA includes provision for members to attend Association meetings and conferences on full pay. Members are advised to start planning now and encouraged to make leave arrangements and register by 16 October 2009.

Registration of Interest

Please help us plan for another great Conference and to assist with travel and accommodation reservations by emailing our Membership Support Officer, Kathy Eaden, at **ke@asms.org.nz.**

Your interest in registration will be noted and confirmed closer to the date with your local branch secretary as each branch is allocated a set number of delegates. Extra members are welcome to attend the Conference as observers.

Understanding Budget 2009

Almost no-one will have been surprised that the future tax cuts that had been part of the Government's election platform were dropped and no-one would have been surprised that fiscal constraint was the main theme of the first budget of the new Government. What excitement there was surrounded the preservation of New Zealand's credit rating. Finance Minister Bill English seems to have achieved his objective of maintaining New Zealand's credit rating by getting the all clear from credit ratings agency Standard and Poors. Mr English should be grateful for the considerable help provided by his inheriting of a low level of debt from his predecessor Dr Michael Cullen.

Overall spending reduction and reducing financial planning capacity

The government has essentially limited fiscal stimulus to continuing the spending path already set out by the previous government... less $300 million, a 1.56% increase on budgeted government spending from the previous year. The Treasury inflation forecast is 2.5% so the budget sets out aiming for a minor decrease in real overall government spending.

Since 2002 the Labour led government had committed to a big increase in new spending in Vote Health. Much of this had been committed to in advance and had been made up by the Forecast (or sometimes Future or Forward) Funding Track (FFT) which is supposed to predict changes in costs[1] and the adjustment for changes in the population delivered through the Population Based Funding Formula. The Labour led government had initially committed to $800 million new spending in Vote Health for 2009/10[2] but appears to have decreased this by $50 million before leaving office projecting new spending in Vote Health at $750 million (the same level as the 2008/9 financial year).

The now not so new National led government has said that they have kept to the health spending package committed to by the previous government for the 2009/10 year. This 'package' also covers health priorities being purchased through Votes other than Health, for instance 'Vote Education' presumably for additional medical school places and other training and Energy ($25,000,000 for each of the next four years) for the home insulation package negotiated with the Greens. To an extent Vote Health is being raided to resource other Budget Votes. The package also covers capital expenditure to the tune of around $57.6 million. Whether this is actually the $750 million increase promised is arguable.

Effect of new government initiatives

New initiatives under Vote Health in the Budget include the boost for subsidised medicines, Plunket Line, the Voluntary Bonding Scheme, GP training and up-skilling in maternity care, and an extra visit from Lead Maternity Carers, $15 million over the next four years for hospices, training health professionals for the new elective surgery theatres and extra funding for training in rural and provincial areas ($500,000 this year, $1,500,000 next financial year and $1million in the next two financial years.) The Budget states that $77,206,000 of the funding for these new initiatives is to come out of the 'government's line by line' review of the non-departmental vote (nearly all of which is made up of DHBs) and reduction of the 'risk pool' (funding held by the Ministry).

The constraints presently being experienced by DHBs are because the government's new initiatives are being funded within this ceiling.

Even greater fiscal pressures next year

Next year (2010-11) the government has said that it will be only allocating $1.1 billion for new spending in its Budget as a whole and, further, has 'forecast' expenditure of $760 million in health. Commentators have pointed out that leaves very little new spending for anything other than Health and suggested that therefore we should be sceptical that the new spending for health will survive intact. In fact, the government itself has suggested this.

HEALTH SECTOR FINANCIAL ACTIVITY (figures in NZ$000s)

	2007/8	2008/9	2009/10	2010/11	2011/12	2012/13
CPI June year	4%	1.9% (forecast)	2.5% (forecast)	1.3% (forecast)	1.2% (forecast)	1.7% (forecast)
Total appropriations Vote Health*	11,041,305 (actual)	11,919,992 (estimated actual)	12,977,715	12,931,109 (estimated)	12,691,117 (estimated)	12,624,097 (estimated)
'Health package' new spending** over forecast period			750,000	762,599	791,089	797,827

* Summary of Financial Activity 'Information Supporting the Estimates for year ending 30 June 2010' (28 May 2009)

** Including capital expenditure

The above table illustrates a further interesting feature. The Budget shows forecast new spending in health increasing while the global appropriation in the whole of Vote Health is going down from 2010 on. The government seems to be expecting that existing or ongoing activity will cost less or at least have less funding over the period in order to make room for new initiatives.

Every year since 2002 there has been a government commitment to substantial new spending in health in future years. This has been committed to in advance and made up of the FFT (usually around 3%; it is 3.1% for 2009-10) the demographic adjustor (usually around 1%) plus various other initiatives. However the actual cost (in so far as it can be ascertained) of providing services has risen by around 6% each year[3].

In 2009-10 the commitment to new health spending in out years appears to be much less concrete. The ASMS is aware that Treasury is unhappy with having guaranteed future funding like the FFT and is seeking to revisit the approach. Normally the FFT would be calculated for the next year in December (so 2010-11 would be calculated in December 2009).

In the new financial year (2009-10) resident doctors, various professional groups represented by APEX, nurses and senior doctors will all have MECAs expiring and will be expecting to start negotiations (cleaning and catering staff have already started). It is clear that there will be problems if the government has not allocated enough money to keep scarce health professionals in New Zealand.

Angela Belich
Assistant Executive Director

1. 35% forecast CPI, 65% Labour Cost Index, 0.5% technology
2. Economic and Fiscal Update Budget 2008
3. Ministry of Health analysis of costing data

The 'Non DHB' Update

The Association provides the advantages of membership to 155 people in hospices, community health centres, union health centres, Family Planning Association, ACC, rural and community hospitals, NZ Blood Service and iwi authorities. Although this is a relatively small number it represents over 70% membership density (increased by 4% since 2008). We have 15 collective agreements across these organisations and although often these can involve prolonged negotiations they also give rise to a lot of activism by the ASMS members involved.

Status of Collective Agreements outside District Health Boards

Iwi Authorities

Ngati Porou Hauora (Gisborne) The new collective agreement with a term from 1 February 2008 to 31 January 2010 has been signed and distributed with an increase of 4.25% backdated to July 2008 and a further increase of 4.25% in July 2009, CME leave of 10 days with expenses up to $8000 but annual leave is still only five weeks.

Ngati Whatua O Orakei Community Health Services The collective agreement expired on 31 May 2008. A claim is being developed. There have been complications bringing about delays but initiation is impending.

Te Oranganui (Wanganui) The agreement (negotiated in 2008) expires in December 2009.

Te Runanga o Toa Rangatira (Porirua / Newtown) Claims have been developed for this collective agreement and initiation of bargaining is imminent.

National Health Services

New Zealand Blood Service The Blood Service was cited as a party to the DHB MECA but had indicated that it didn't want to be a party. A separate collective agreement was negotiated that mirrored the DHB MECA apart from the availability allowance which is being currently negotiated. The agreement expires in June 2010.

New Zealand Family Planning Association This is the second largest of our non-DHB collective agreements and expires in October 2009. The claim development process will start in June for initiation of bargaining in September.

ACC

There has been a strong increase in membership at ACC where we cover branch medical advisors. We have been involved in semi successful mediation process around salary increases and continue to work towards an eventual initiation of bargaining for a collective agreement.

Union Health Centres

Wellington Primary Health Care Service Multi Union Collective Agreement The collective agreement expires in June 2010.

Christchurch Union and Community Health Service The collective agreement expires in June 2010.

Waitakere and Otara Union Health Centres Work is underway to develop claims for initiation of bargaining of this collective agreement which expires in June 2009.

Hospices

We have a MECA covering 10 hospices. This is our biggest non-DHB collective agreement. It expires in June 2010.

Community Hospitals

Dunstan Hospital (Central Otago Health Services–COHSL) This collective agreement expires in June 2010 but we have been busy negotiating issues relating to its rural hospital vocational registrants scale.

Oamaru Hospital (Waitaki Health Services) A claim was lodged with the employer last April; we are still awaiting a response. This has been prioritised for action.

Other Non-DHB

Compass Health (formerly the Wellington Independent Practice Association–WIPA) The new collective agreement was successfully negotiated and it expires in June 2010.

Hokianga Health Service The collective agreement was successfully renegotiated and now expires in June 2010. Salary increases in line with the DHB MECA were achieved.

QE Hospital (Rotorua) Initiation of bargaining is due in July for this collective agreement that expires in August 2009.

Credentialling Framework for New Zealand Health and Disability Service Providers

The Ministry of Health has established a working party chaired by Dr Robert Logan (Chief Medical Adviser at Hutt Valley DHB) to update the 2001 report Toward Clinical Excellence: a Framework for the Credentialling of Senior Medical Officers in New Zealand and to look at extending credentialling to other health professionals, particularly nurses. The working party has produced a draft report to which the ASMS has responded identifying a number of concerns including a proposed new term of "organisational scope of practice" and implications for rights provided in the national SMO DHB MECA. Below is a summarised outline of the ASMS's submission to the working group.

The term 'organisational credentialling' appears to have been embraced by the working party because the term 'credentialling' has another meaning in nursing. Credentialling now has an established meaning for SMOs should not be replaced by a term that suggests either that an organisation is going through the process or that the process is being done by the organisation rather than an agreed process carried out largely by peers.

Some ASMS members report that they will no longer proceed with credentialling of services because of continued management inaction on recommendations. Reports are completed but then get buried in the hospital quality improvement group never to emerge. In Auckland DHB SMOs have decided not to re-credential services again because of inaction on the outcomes (though they will continue to re-credential individuals). A general manager has refused to sign off a credentialling report at Canterbury DHB. Further, the working party report suggests that rather than credential services that credentialling be reserved for individuals: this is to condone those managements who failed to abide by the outcomes of agreed processes and withdraw support for those managers who have.

Standardisation

The ASMS is committed to credentialling as part of the quality improvement environment and we are committed to working with DHBs to implement quality improvement initiatives including credentialling. Our commitment to quality improvement has been further emphasised last year when we reached the *Time for Quality* agreement with all 21 DHBs. A further development has been the *In Good Hands* report which sets out what is required to meet the Minister of Health's requirements for clinical leadership. The principle that imbues these initiatives is that quality of care for patients is best achieved through clinical leadership and quality initiatives need clinical engagement to succeed. The Association's experience of credentialling has been that if SMOs are engaged then they succeed, if not, they do not. At its most simple this is because any conceivable process requires peers both within and without the service and specialty to participate.

Clause 35.2 of the ASMS MECA states:

Credentialling processes and implementation are matters to be agreed between the employer and affected employees. Credentialling will also consider the resources required for a particular service.

This requires agreement on process and implementation. It does not preclude processes that meet a high standard or processes that ensure a high standard of medical practice but does preclude a standardised bureaucratic process decreed by the Ministry of Health or any other central body. If it is accepted that clinician engagement is a necessary component of the process then this becomes a virtue. DHBs and services and departments differ widely and this will be reflected in how they review themselves and their peers. Where credentialling is presently 'owned' by SMOs (and this is not universal) the imposition of a central bureaucratic model may place the process at risk. It is important that credentialling does not become yet another useless compliance process high on process but devoid of content.

Organisational scope of practice

The terminology used in the credentialling process is that a doctor is credentialed for X or Y and not credentialed for W and V. Introduction of the term "organisational scope of practice" by the working party serves to confuse. A scope of practice is set by a regulatory agency, in this case the Medical (or Dental) Council. A doctor or dentist can be credentialed within their scope of practice either partially or wholly. If there is a need for a doctor to extend beyond their scope of practice then this is an issue that the doctor

needs to take up with the Medical Council. The activity then becomes part of the doctors scope of practice and they can then be credentialed within it. This should involve supervision.

When the HPCA Bill was being passed into legislation the ASMS, along with a number of other professional groups, had grave doubts about the development of individualised and narrow scopes of practice. Those employing health professionals and putting together multi-disciplinary teams need broad, predictable scopes of practice and health professionals who are able to do, to a high standard, what one expects of those with that scope of practice.

Burden of compliance

The working party, the Ministry, the Medical Council and the Health & Disability Commissioner all need to fully appreciate that they have the potential to increase the burden of compliance to a degree that places too much pressure on health professionals, DHBs and ultimately patients themselves either as taxpayers or as citizens wanting to access health services. Patient safety is paramount but good health professionals will make mistakes and the miniscule number of malicious health professionals will do their best to avoid detection. We should not orient our system around the exception but around enhancing the good practice which is the norm.

Vocationally registered general practitioners working in either general practice or in a similar capacity with minimal oversight for DHBs are classified as specialists and should already be covered by existing credentialling processes. Those working for DHBs who are not vocationally registered or who do not fulfil the definition above are medical officers. They will be working in a collegial relationship with a vocationally registered practitioner.

Currently the Medical Council is consulting around a proposal practice visits and the supervision of international medical graduates. These, plus College requirements need to be looked at as a whole. The compliance burden is not simply of concern for our members as they are credentialed but also the expectation that they provide a pool of peers to participate in the credentialling of peers. In some DHBs this burden plus the burden of supervision falls on a diminishing pool of vocational registrants.

Locums

An area of concern for ASMS members has been ascertaining the level of expertise of locums, particularly short-term locums. Often recruitment difficulties caused by vacancies or unexpected vacancies place pressure on our members on small rosters to supervise locums that they do not know and with whose practice they are unfamiliar.

Angela Belich
Assistant Executive Director

Positive response from Chair of working group

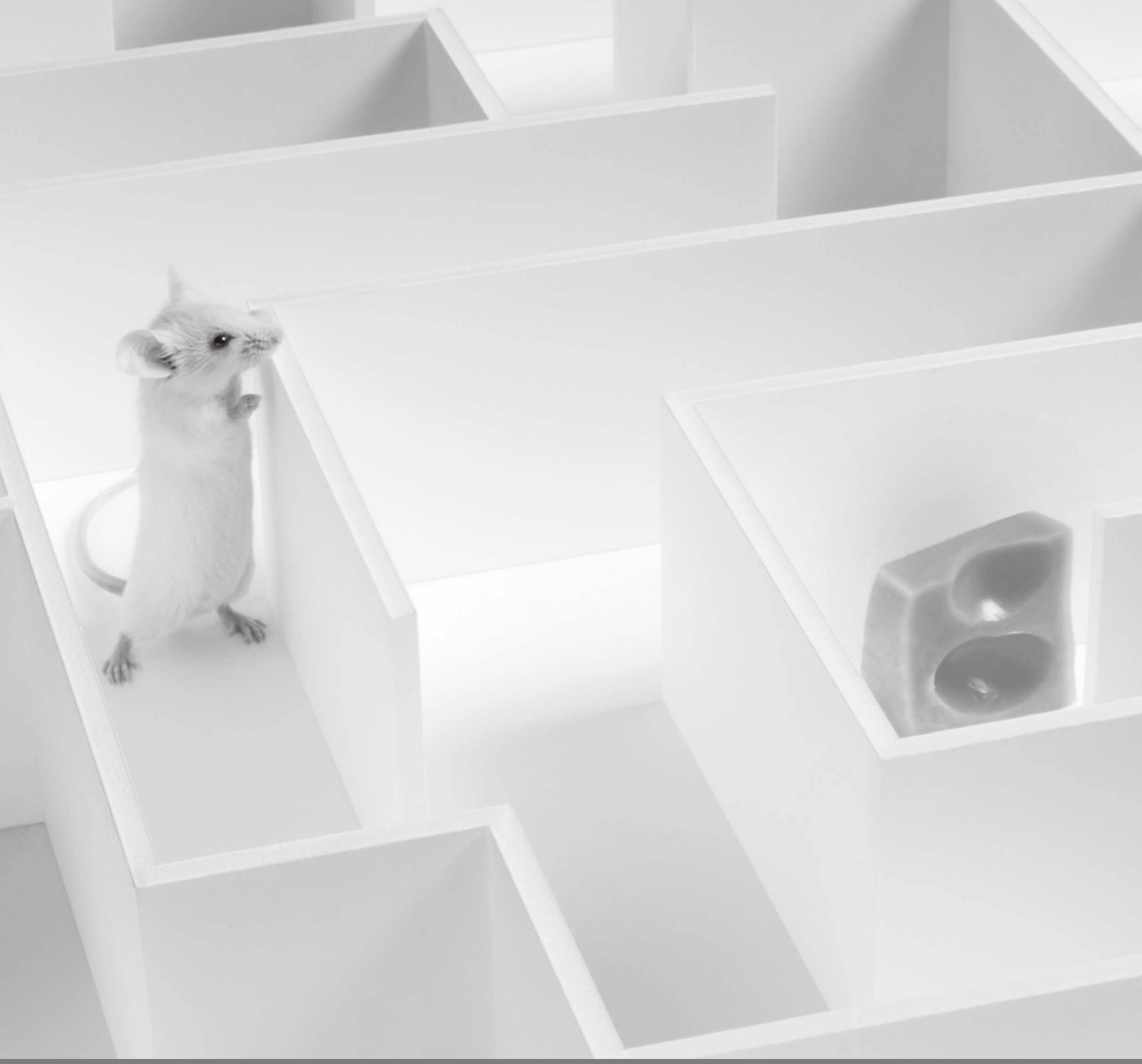
The ASMS has received the following positive response to our submission from Dr Robert Logan who chairs the working party:

"I am responding to your email as chair of the working party on credentialling. Thank you for your comments which are important since you are able to canvas a wide range of senior medical staff. We have already addressed some of the points which you express concern but I think the best thing would be to met with you when we have prepared the final draft. There is no point in releasing a final document which does not have the support of you and your Association.

Just one final point, the key aim at Hutt [Dr Logan is the Chief Medical Adviser at Hutt Valley DHB] is to have a process which actually enhances the work of individual SMOs which does mean attending to the environment including the service within which they are working. If the process was set up just to pick up a few incompetent doctors it would be a total waste of effort.

I look forward to discussing the final draft with you in due course and once again, thank you for your helpful comments."

The ASMS has also received an encouraging initial response from the Ministry of Health which includes noting that there has been little sector support for "organisational credentialling".



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