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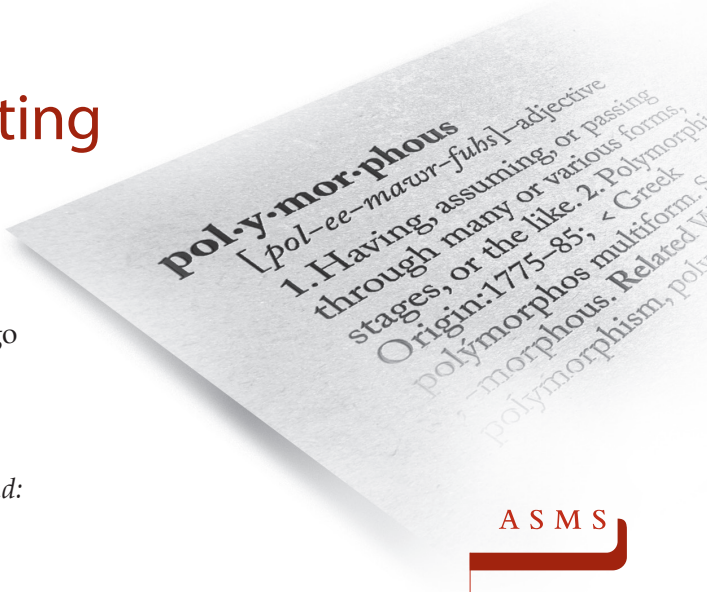
The Specialist

The newsletter of the Association of Salaried Medical Specialists

Dictionary guide to negotiating with polymorphous DHBs



The ASMS's negotiations with the 20 DHBs is now at a critical stage. Since negotiations commenced over a year ago in the main they have proceeded in a constructive manner with the highpoint being the achieving of the joint ASMS-DHBs developed and supported document - *Securing a Sustainable Senior Medical and Dental Workforce in New Zealand: the Business Case.*

This document provides a blueprint for the health system including the practical application of the *Time for Quality* agreement between the ASMS and the DHBs and *In Good Hands*, the government's policy statement on clinical leadership in DHBs. It offers the framework for the government to achieve its objectives, including cost effectiveness and reducing financial wastage and duplication.

Negotiations have reached a precarious state, however, just at the point when the ASMS and DHBs were edging close to a recommended settlement with some hope that this might be achieved by the end of April. The last week of April was not a good week as things went to the proverbial 'custard' with the DHBs endeavouring to worm their way out of the *Business Case*. Hopefully by the time this article is read it is a better week!

"Negotiations have reached a precarious state … just at the point when the ASMS and DHBs were edging close to a recommended settlement"

One of my daily enjoyments is to receive an email from 'Dictionary.com' advising of their 'word of the day'. Sometimes I even manage to remember some of them! While focussing on reaching a 'better week', this has provided an insightful tool for improving my understanding of DHB decision-making in a journey from *polymorphous* to *effloresce* via *osmose*.

A bit of poly and a bit of morphous

The adjective *polymorphous* comes from the combining of the Greek roots *poly-* (many) and *morphous* (shape) and means assuming, or passing through, many or various forms, stages, or the like.

Never, in my view, has a word so well described DHBs. At a governance level boards are quiet different ranging from the disruptive effect of toxic elements of some individuals to well performing and functional (even where there are different views among board members – a plus rather than a minus).

But it is at the operational level that *polymorphous* has greater impact. At one supra level it is cultural including different managerial, medical (and dental) and nursing cultures. Within senior management it is surprisingly polymorphous. At times, when talking to chief executives, chief operating officers, chief finance officers, human resources and employment relations, multilingualism is required. And this is without mentioning payroll and IT!

"For much of our MECA negotiations to date the DHBs had been constructive and collaborative"

Consequently it is not surprising that in dealing with DHBs on a range of issues we are confronted with many different and changing shapes. For much of our MECA negotiations to date the DHBs had been constructive and collaborative, even when dealing with some thorny matters. But in the last week of April the DHBs were publicly sharply critical of the ASMS following our reporting back to members of the *Business Case*. This was despite the DHBs being forewarned and accepting, that the report back was positive, and that there was no criticism of the DHBs.

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As recently as early April the DHBs were still talking positively about the *Business Case* but by the end of that month, through *polymorphous*, they were trying to worm and squirm their way out of it.

Oppugn versus irenic

Here the verb *oppugn* comes into play. Born from the combination of the Latin *op-* (to oppose, attack) and *pugnare* (to fight; similar to pugilism), it means to assail by criticism, argument, or action; or to call in question or dispute. The DHBs response to the ASMS reporting back the *Business Case* to members, especially being so upfront supportive of it, was to oppugn us, including misleadingly claiming it was unaffordable (as if they had never read the *Business Case*), feigning surprise at the release to members, and demeaning it as merely a discussion paper when over a fortnight earlier they had accepted it was not.

In contrast the ASMS was trying to be irenic, an adjective with biblical origins from the Greek *eirenikos* and meaning to tend to promote peace and be conciliatory. Clearly *irenic* did not work!

The DHBs response to the ASMS reporting back the Business Case to members … was to oppugn us … demeaning it as merely a discussion paper when over a fortnight earlier they had accepted it was not.

Getting DHBs to effloresce

There are some options for the DHBs to pursue next in our negotiations. They might resort to the adjective *splenetic* from the Late Latin *spleneticus*. It includes being irritable, peevish and spiteful as well as morose, bad tempered and melancholy. There have been suggestions of this in recent correspondence from the 20 DHBs.

They could also try the adjective of *plangent* which derives from the present participle of the Latin *plangere*, to beat, to strike noisily, especially to strike the breast or head as a sign of grief. It means beating with a loud or deep sound (the 'plangent wave') or expressing sadness and plaintiveness. There is a little bit of this around as well in DHB land.

If we are to move forward and resolve these negotiations then what we need from DHB leaders is for them to *osmose*, a verb which comes from the biological term *osmosis* and means to gradually or unconsciously assimilate some principle or object (in this case the principles and tenor of the *Business Case*).

"If we are to move forward and resolve these negotiations then what we need from DHB leaders is for them to osmose,"

Through *osmose* they might get to *effloresce*, a verb with origins in chemistry and combines the Latin roots *ex-* (out of) and *florescere* (to blossom) and meaning to burst into bloom and blossom. At this point our DHB leaders, especially the chief executives, will realise the enormous quality and cost effectiveness potential offered by the blueprint that is the *Business Case*.

Ian Powell
Executive Director

ASMS 23rd Annual Conference

Thursday 17 – Friday 18 November 2011

Mark it in your diary now!

Illusions of grandeur

My only son is now a man
Has left the house he left the womb for
Going north in his mother's care
To farewell her arms on Takapuna beach
Before nestling into tertiary excitement

His stomach now his to stock
His brain now his to fill

I was once as old as he
Already fledged and forging aself
A twinkling later I study his toddler gaze
Hanging on the wall above the phone call
And hope that keen trust was not misplaced

That I gave enough to guide him
While serving others at his expense
Will he regret the path I took
Or see my roles in a kinder light
As nurturing the place we live
And the systems that care for us

I had no vaulting ambition to lead
It rather cloaked me like a soft snow falling
So I fear no Tahir Square
But fret over succession planning
For the always unfinished business

A balancing act against an inner advice
Not to dwell too long
No illusions of grandeur
Nor pretensions of power
More an Alexander beetle
Who chooses not to hide under the rock
But to stride out on behalf on those
Searching for the Pole

Leadership may need to be gently thrust
On those merely inclined not to duck
When resilience and humanity mark
Them as your future servants
In positions of honour and responsibility
To fairly lead a privileged band

Many more expert than myself
Most certain of their own solution
Yet often mired in the labyrinth
Of their selfless and selfish selves

Professionals often hardwired
To compete for perfection
But inherently wary of self-promotion
Especially in others

Whose corpus of knowledge
And oft-times wisdom
Needs divers heads but sometimes
A single voice
Somewhere between oratory and poetry

Only ever aspiring to father
Figurehood at home
To look forward not back
To a future not all ways better
Just different

Realising what I have known all along

I am jolted by a certain pride
Blending with the emptiness that I
Can't put my arms
Around a memory

Jeff Brown
National President

EXECUTIVE DIRECTOR'S COLUMN

Health Minister plonked in middle of MECA negotiations

Health Minister Tony Ryall has been plonked right in the middle of the ASMS's precariously placed national DHB MECA negotiations. But this is neither by design nor statutory responsibility.

It is not always appreciated but the Minister of Health has a different role in collective agreement negotiations to that of the Minister of Education or the Minister of State Services (slightly complicated because Mr Ryall is also the latter).

In education, while Boards of Trustees are the employer of school teachers (and other school employees) for the purpose of hiring, firing and general management, the State Services Commission has the legal designation of 'employer party' for the purpose of their MECA negotiations. The SSC, in turn, delegates this authority to the Ministry of Education which consequentially brings in the Minister.

In the case of DHBs the SSC does not have this designation and consequently the Ministry of Health is not a legal participant in collective negotiations. Instead this rests with the DHBs who have to work together nationally. This is also unlike Australian states where the departments (and government) are direct participants (sometimes the legal employer).

But it is not as simple as that in New Zealand. Health is necessarily labour intensive and its workforce is the key determinant of value. This depends on having sufficient workforce capacity which requires effective recruitment and retention. In turn, this costs money and the government is the funder of DHBs which means the Minister of Health can't be uninterested in what happens in negotiations.

More specifically Mr Ryall has been right on the button with two important challenges he has identified:

1 Genuine distributive clinical engagement and leadership in DHBs is critical for the achievement of comprehensive quality improvement and substantially improved financial cost effectiveness, including removal of wastage. One of the consequences of this was the excellent policy advice to DHBs on clinical leadership, *In Good Hands*.

2 There is a senior doctor workforce crisis in DHBs and it is the government's number one priority.

Completing the loop is the survey of ASMS members on the implementation of *In Good Hands*. conducted by Associate Professor Robin Gauld, University of Otago (reported in the March issue of *The Specialist).* It revealed a picture of DHB performance over achieving clinical leadership which ranged from poor to mediocre and reported that only 20% of respondents believed they had enough time to be involved in clinical leadership and in project/programme work.

There is now a blueprint for resolving this – *Securing a Sustainable Senior Medical and Dental Workforce in New Zealand: the Business Case* – which was jointly developed by ASMS and DHB representatives and subsequently adopted by both (although some within the DHBs are trying to wiggle out of it).

It provides the blueprint for engaging senior medical staff in distributive clinical leadership throughout all DHBs with strong emphases on quality improvement, removal of wastage, and substantially improved cost effectiveness. Further, to deliver on it there needs to be an investment in the remuneration of senior doctors and dentists to generate the workforce capacity to provide the time necessary to engage in distributive clinical leadership.

The Minister can not settle the MECA whose negotiations have become precarious due to unexpected DHB behaviour (erratic or unprincipled depending on one's point of view). But he can give consistent messages to DHBs, both privately and publicly, that the *Business Case* is the blueprint for meeting his challenges and moving forward that he would reasonably expect competent DHB leaders to adhere to. The wins are all round – government, DHBs, the senior medical workforce, taxpayers, and above all patients.

Go tell them Tony not to shoot a gift horse in the mouth! You have nothing to lose but non-achievement of your challenges!

Ian Powell
Executive Director

ASSISTANT EXECUTIVE DIRECTOR'S COLUMN

The Trans-Pacific Partnership Agreement: The end of Pharmac as we know it?

New Zealand is engaged with nine other countries including the United States and Australia in negotiations over a 'free trade agreement', known as the Trans Pacific Partnership Agreement (TPPA). The arcane terminology, confusing (and often unexplained) acronyms and major consequences of seemingly innocuous differences in wording make it a difficult area to analyse. The secrecy of much of the process is not a help. There are three main health related issues of interest to ASMS members.

Pharmac

US pharmaceutical companies are lobbying their government to put limitations on "generic and anti-competitive drug buying" through the TPPA.

The United States-Australian Free Trade agreement included a provision which required the parties to "recognise the value of innovative pharmaceuticals". Australia then moved to a system in which patented drugs with no generic equivalent could no longer be compared to generics. This has meant a 60% increase in the price of some groups of drugs.[1]

Pharmac's (New Zealand's pharmaceutical purchasing agency) purchasing strategy has made enormous savings and appears to have had cross party support. However, the Prime Minister has made clear that, as far as he is concerned, changes to Pharmac are on the agenda.

It would be easy to use the precedent set by Australia (the wording seems harmless) and undermine the entire purchasing system. This does not at present seem to be the New Zealand negotiators' position. (Their position paper was leaked last year). However it is easy to conceive that even a sniff of an easing in the United States protectionist policies on agriculture could cause a rapid change in New Zealand's position.

The United States lobby group, Pharmaceutical Research and Manufacturers of America (PhRMA) has targeted New Zealand's Pharmac as a problem that needs to be addressed in the talks. They say they want "the value of patented drugs reflected in the system" thus decreasing the power Pharmac has to negotiate over the price of some drugs. The approach at first sight contradicts a very similar approach to that of Pharmac that is taken by the United States' own Medicaid programme. The United States has made the distinction that this is at a state rather than national level.

As well, PhRMA is urging the American negotiators to include 12 years of data protection on drugs derived from living organisms (biologics). This is an addition to the free trade agenda.

As a result of this lobbying 28 U S senators have signed a letter to President Obama asking him not to sign a TPPA that doesn't include provision for protection for 'innovative medicines'. Part of the lobbying strategy by the pharmaceutical industry is to seek the support of clinicians for what they call improvements to the transparency of Pharmac, to include greater clinician involvement and to put in place an appeal process. ASMS members have sometimes been less than happy with Pharmac's processes so this may seem attractive. However, it would be naïve to assume that PhRMA or even the US government are concerned with the better health of New Zealanders or the more efficient operation of our health system.

Tobacco, Alcohol and Food

The convoluted rules that appear to be at work in 'free trade agreements' can allow companies to take action against governments that introduce measures that reduce the value of an investment or brand through something called "investor state disputes procedures". Philip Morris International has used this procedure to dispute Uruguay's right to have 80% of a cigarette packet display images of the consequences of smoking.

The Australian government has said it is not prepared to engage on "investor state disputes procedure" thus exempting itself from any future action by tobacco (or other) companies arguing that their investment has been devalued by government action. The New Zealand government has not.

New Zealand has joined with six other countries to dispute Thailand's right to put warnings on alcohol labels at the WTO (posted on the WTO website). This would suggest that New Zealand will not be exempting this sort of public health initiative from the TPPA. New Zealand's negotiators have also signaled their willingness to engage on "investor state disputes procedures".

ACC

The TPPA could make it impossible for any future government to reverse a private sector insurance companies take over of ACC functions (as happened in 1999) if it involves an international company without paying massive penalties. This could also be the case with any other privatisations. Earlier New Zealand Governments have 'reserved' (which means that they don't intend for such a provision to be included) on the proposal to allow a foreign financial investor to appeal the decision of a government to provide a financial service itself. It appears that this government is so far not intending to change that position so the threat of future New Zealand being unable to reverse such a decision has receded.

The TPPA was scheduled to be concluded by the APEC meeting in November but this now seems very ambitious. The next round of negotiations is scheduled for June in Vietnam.

Angela Belich
Assistant Executive Director

1. Faunce , Bal and Nguyen ' Impact of the Australia-US Free Trade Agreement on Australian medicines regulation and prices' Journal of Generic Medicine Vol. 7,1 18–29w

Understanding the crisis that can't be avoided: The *Business Case* as a blueprint for the future

Securing a Sustainable Senior Medical and Dental Workforce in New Zealand: the Business Case, jointly developed by the DHBs and ASMS, provides a blueprint for the future direction of a clinically and financially sustainable health system.

The first part of the document highlights the unsustainable nature of the health system recognised by no less that Minister of Health Tony Ryall who has acknowledged that we have a senior doctor workforce crisis in DHBs, that we need to maintain more of our "hospital specialists" and that addressing the crisis is his number one priority. The second part examines the potential substantial gains (including financial) by making an upfront investment in senior medical staff remuneration as part of the national DHB MECA negotiations.

Summarising the Crisis

The *Business Case* notes the following facts which reinforce Mr Ryall's assessment:

- New Zealand was short of well over 600 specialists (secondary/tertiary) in 2008 according to international benchmarks

> *"New Zealand was short of well over 600 specialists (secondary/tertiary) in 2008…"*

- Out of 26 specialties (and sub-specialties) where data is collected, 19 require workforce increases of more than 20% to meet the recommended specialist-to-population ratios. Eight require increases of more than 50% and four require increases of at least 100%.
- New Zealand has the second highest emigration of doctors in the OECD and, to attempt to fill the gaps, the highest dependency on overseas trained specialists (41% of the medical workforce).
- There has been a growth in the number of medical specialties on Immigration New Zealand's 'Long-Term Skills Shortage List' from eight in 2004 to 11 in 2009. This includes the largest secondary care specialties of anaesthesia and psychiatry along with key diagnostic specialties pathology and radiology, and intensive care specialties on which surgery is dependent.
- According to DHB data, over recent years the large majority of the around 300 new specialist registrations per year are being employed, at least in part, by DHBs but resulting in an average net loss of DHB specialists. The *Business Case* assumes that, allowing for fluctuations, the DHB employed workforce outflows equals the inflows.
- New Zealand has, in effect, become a medical training ground for other countries, especially Australia which each year attracts an estimated 280 New Zealand doctors (including international medical graduates).

> *"New Zealand has the second highest emigration of doctors in the OECD …"*

- In some specialties on the 'Long-Term Skills Shortage List' referred to above the international medical graduate (IMG) proportion is close to 50% (compared with the 41% average); for psychiatry it is approaching 60%. Over the last three years IMGs have comprised approximately half of new specialist registrations.
- Retention rates of IMGs are poorer than New Zealand trained specialists. Whereas around 84% of a cohort of New Zealand doctors with vocational registration are retained in the country nine years post-registration, only two-thirds of vocationally registered IMGs are retained over the same period.

> *"New Zealand has, in effect, become a medical training ground for other countries, especially Australia"*

- In 2007 and 2008 the number of IMGs lost in the first year following vocational registration was 20% and 16% respectively compared with an annual average of 8% in the years 2000 to 2006.
- In noting New Zealand's high dependence on IMGs, a 2006 OECD report concluded that given the relative small size of our health workforce and heavy reliance on immigration, "a sudden change in the international migration flows, which could result from policy changes in OECD countries beyond the control of New Zealand authorities, could have a dramatic impact on New Zealand."
- The same OECD paper also conservatively estimates 29% of New Zealand trained doctors are working overseas.
- Remuneration is becoming an increasingly important "push" and "pull" factor. While, 80% of a 2002 cohort of anaesthesia trainees' career intentions had intended to eventually work as a specialist in New Zealand, only 64.5% were working in New Zealand seven years later. In 2002 13% stated Australia as their preferred destination, but by 2009 26% were still working there. In this 2009 survey 75% of respondents currently working overseas agreed or strongly agreed that salary was an important influence in choosing their country of residence.

- In 2008 DHBNZ's official national vacancy rate was 20%. ASMS surveys have identified significantly more vacancies – up to 24% - as opposed to budgeted vacancies.
- Gender statistics for practising registrars indicate that the proportion of female specialists will continue to increase. Medical Council data shows women doctors work fewer hours than men doctors.
- There is a sharp drop-off in specialist numbers from age 50 years onwards. Within the next five years 21% of the specialist workforce will turn 50, and 17% will turn 55.
- The resident medical officer workforce has grown far more rapidly over recent years than the senior medical officer workforce leading to a marked increase in the latter's training and supervision duties at a time when clinical demands have also increased.
- Specialists' lack of adequate time to enable quality supervision of resident doctors is contributing to job dissatisfaction of the latter. The requirements of service delivery too frequently take precedence over RMO training.
- A high number of medical students plan to leave New Zealand within three years of graduating.
- Despite historically there being little support provided for senior doctors teaching resident doctors, increasingly universities and medical colleges are designing programmes to enhance senior doctor teaching responsibilities.

> *"Specialists' lack of adequate time to enable quality supervision of resident doctors is contributing to job dissatisfaction of the latter."*

- Adverse events were estimated in 2002 to cost New Zealand $870 million per year, of which $590 million was due to potentially preventable events. While a range of factors contribute to this, there are many examples indicating senior doctor staffing levels is an important factor.
- The implementation of the New Zealand Cancer Control Strategy Action Plan can't succeed without a highly motivated and skilled workforce. However, this is threatened by shortages including radiologists, colonoscopists, pathologists, radiation oncologists, medical oncologists, haematologists and palliative medicine specialists.
- A shortage of anaesthetists and registrars is one of the reasons New Zealand came bottom of a survey of seven comparable countries for heart patients' access to potentially life-saving surgery.
- The Health & Disability Commissioner has reinforced the need for emergency departments to be sufficiently staffed by specialists to enable appropriate supervision of resident doctors.
- Whereas New Zealand needs at least a minimum of 180 emergency medicine specialists to achieve an acceptable standard of care, there were only 103 in 2008.

What happens if the current crisis continues

The *Business Case* describes how these problems will escalate with increasingly negative consequences if this crisis continues. In summary:

- The heavy dependence on IMGs will remain and increase, escalating the high turnover of senior medical staff and increasing the current level of wasteful expenditure by DHBs.
- New Zealand's health workforce (and therefore services) will remain vulnerable to the effects of the competitive overseas market and the vulnerability of New Zealand's health system, most severe on provincial DHBs and specialties where staff are already hard to find.
- Continued and increasing heavy reliance on locums, along with the associated increased costs, will worsen lack of continuity of services; put additional pressures on permanent staff; and limit any effects of improving training and supervision, and developing clinical leadership, multidisciplinary teams and clinical networks.
- Continued shortages of SMOs will nullify efforts to reduce adverse events. With preventable events estimated to cost $590 million a year, an opportunity to improve safety and quality while creating savings will be lost. In fact, an increase in adverse events may be seen in some areas.
- Some of the Government's key health targets will not be achieved on a sustainable basis as they depend on an adequate supply of specialists across the whole range of specialties, and government objectives will be compromised.

> *"Continued and increasing heavy reliance on locums, along with the associated increased costs, will worsen lack of continuity of services"*

- Lack of time outside of clinical duties for specialists will prevent the establishment of comprehensive clinical leadership. This will hinder development of multidisciplinary clinical networks, deter reconfiguring services with a more regional focus, inhibit creation of more innovative ways to deliver services, and prevent integration of hospital and community based services. The considerable potential for improved cost-effectiveness and service performance, as indicated in overseas research, will be lost, and the counterfactual of slow, inefficient services will ensue.
- The proportional imbalance within the medical workforce will continue, with insufficient numbers of senior doctors to train and supervise resident doctors. Job satisfaction will suffer further and continue to adversely affect recruitment and retention of seniors and potentially residents, resulting in potentially substantial financial losses.
- More specialists (and later resident doctors) will be lost to overseas competitors.
- Increased medical school intakes will have no appreciable impact as graduates will depart the country because of poor training and as they observe senior

doctors in New Zealand struggling to meet both clinical and leadership demands.

- New Zealand will continue to be the unsolicited training ground for other countries.
- Understaffing will mean some services will not be clinically and financially viable, and many others will struggle to meet increased demands efficiently, effectively and safely.
- Efforts to develop a generalist specialist workforce, which require an adequate supply of New Zealand trainers and trainees, will be jeopardised.

> *"Lack of time outside of clinical duties for specialists will prevent the establishment of comprehensive clinical leadership."*

- Efforts to integrate with primary care will not consistently succeed because of a lack of credible senior hospital doctors to collaborate on pathways.
- Government initiatives in place to deal with these problems will fail because an adequate credible stable senior doctor workforce is not consistently in place.
- Unnecessary extra effort will be required in order to improve services to substitute for an inadequate level of expertise and human capital.

> *"Understaffing will mean some services will not be clinically and financially viable"*

This crisis is fiscally wasteful and unethical when considering the costs of training doctors. The *Business Case* notes that the current cost of training a doctor up to their final year as a registrar is estimated at approximately $1.5 million per doctor ($500,000 as an undergraduate and at least $1 million postgraduate). Across the spectrum of undergraduate and postgraduate training, about $500 million of government investment is graduating each year.

The Government's plan to increase the number of medical school places by a further 200 over the next five years equates to an additional investment of around $300 million. The loss to New Zealand of a relatively small number of New Zealand-trained resident doctors (and specialists) represents a loss of tens of millions of dollars of government investment.

> *"This crisis is fiscally wasteful and unethical when considering the costs of training doctors."*

Future state: pathway to addressing the crisis

The *Business Case* then focuses on achieving a 'future state' centered on the importance of developing a sustainable senior medical workforce in DHBs and concludes that we need about 6,740 specialists in 2021 (a 52% increase on estimated current numbers) equating to a net annual increase of 232, mostly through improved retention.

It recommends that the future state should encompass the following components on the assumption that the majority of RMO graduates will be coming into the workforce when student numbers were increased between 2004-07:

1 Specialist numbers targeted at 1.4 per 1000 population as projected for Australia in 2021 (the current average for the OECD is 1.8).

2 High SMO:RMO ratios, increasing from current 1:1 to at least 2:1 and possibly 3:1 in some areas and specialties.

3 Consistent job sizing implemented for all DHBs.

4 Decreased reliance on short-term IMGs, and decrease in overall numbers of IMGs.

5 Current average non-clinical time for SMOs increased by 10% nationally.

6 Strong regional services and clinical networks delivered across regions.

7 Excellent recruitment and retention achieved through favourable working conditions, working environments and employment opportunities.

8 State of optimal time and opportunity achieved to deliver clinical time, quality improvement, teaching and training, research and clinical leadership.

9 Reporting of all errors and adverse events based on a culture of systems approach to error management.

10 Best patient outcomes.

11 Government objectives achieved and continuous striving for more ambitious government targets.

The benefits of realising these components are, in summary:

- Stronger clinical leadership recognising that when change is led by clinical leadership, the quality and cost effectiveness of care are improved, staff are energised by it and patients and the public more likely to support it.
- Integrated and collaborative models of care including improved patient journey, patient safety and service quality.
- Increased senior doctor role in the training of resident medical officers including improved recruitment and retention of both groups.
- Meeting of health targets and improved quality and safety.
- Substantial financial and economic benefits.

Achieving the sustainable 'future state'

Achieving the sustainable future state requires a financial investment in the senior doctor and dentist workforce in DHBs. However, this investment is modest - $200 million staged over three years is recommended by the *Business Case*. Or, to put it in perspective, 0.4% of current DHB funding levels in the first year, 1.2% in the second, and 2% in the third.

> *"Achieving the sustainable future state requires a financial investment in the senior doctor and dentist workforce in DHBs"*

The benefits identified in the *Business Case* for addressing what the government has identified as a crisis and its major health

priority from this modest investment are profound both through a quality and financial lens.

Some of these returns are 'bigger ticket' issues. In particular:

1. Adverse events

The *Business Case* cites a retrospective two-stage review of 6,579 patient records from a cross-section of 13 New Zealand hospitals in 1999 found 850 (12.9%) adverse events. Of these 538 (63% of adverse events; 8.2% of all admissions) were deemed preventable by the reviewers.

Adverse events were estimated in 2002 to cost the health system $870 million, of which $590 million is treating preventable events. Only 20% of these are outside hospitals. The *Business Case* concluded that up to 30% of public hospital expenditure went toward treating adverse events (20% towards preventable adverse events). The average cost per adverse event was $10,600.

The Government's Ministerial Review Group (2009) assessed that using the 20% figure (and adjusting for inflation) suggested potential savings of $800 million. The *Business Case* assumes therefore that a high level of savings should be possible over time predicated on preventing harm currently occurring in public hospitals.

> *"… up to 30% of public hospital expenditure went toward treating adverse events (20% towards preventable adverse events)."*

2. Specialist-led initiatives

The *Business Case* notes approvingly what has occurred in Canterbury where the DHB has identified savings of $30 million per annum due to specialist-led initiatives within the hospital based on 'lean thinking' principles which have led to improvements within hospital care alongside increased clinical complexity. Canterbury was, prior to the February earthquake, the DHB in the strongest position for recruitment and retention of senior medical staff. If this initiative was replicated nationally it would result in savings of $300 million per annum.

3. Hospital beds

It also notes that if all public hospitals were able to meet the current average length of stay, this would save 382 beds, effectively the costs of building an entire new hospital along with the associated ongoing capital charges and depreciation.

4. Further Examples

The *Business Case* also provides examples of smaller scale but cumulatively significant financial savings.

- An example is given of the potential savings that can be made. The implementation of the Central Line Associated Bacteraemia bundle embraced in one large DHB after tangible outcomes were demonstrated led to documented financial savings of $260,000 in 2008 alone.
- The *Business Case* identifies areas of wastage. For example, DHBs spent in excess of $6 million on specialist recruitment and relocation during the 2009-10 financial year. By improving retention this level of annual expenditure can be significantly reduced.
- Further, DHBs spent in excess of $50 million on senior medical/dental officer locum costs, mainly to cover vacancies. With a fully staffed SMO workforce locum expenditure could be significantly reduced by up to 50%.
- With improved clinical leadership and supervision of resident doctors, requesting patterns of diagnostic tests could easily be reduced by 5-10%. Expected savings of $5 million to $10 million on variable costs could easily be achieved.
- Investing more specialist time in close supervision and training of registrars will improve resident doctor chances of passing college examinations at their first attempt. As an example approximately 200 registrars sit the Fellowship of the Royal Australasian College of Physicians each year. The current first-time pass rate is 61% with 79% the final pass rate. If the difference of 18% passed first attempt, then potential savings would accrue from approximately 30-35 senior registrar salaries (and other associated costs). Approximately $150,000 per registrar equates to $4.5 – 5 million. This does not take account of the potential for overall enhanced pass rates.

The benefits for patients and for the financial sustainability of DHBs provided in the blueprint that is *Securing a Sustainable Senior Medical and Dental Workforce in New Zealand: the Business Case* are immense and far outweigh the cost of the investment in the senior medical workforce necessary to achieve it. The challenge is whether our DHB and political leadership have the insight and awareness to make it happen.

Ian Powell
Executive Director

MECA Timeline

2009

December	ASMS Annual Conference adopts resolution for direction of MECA negotiations
	Informal ASMS meeting with DHBs led by Northland Chief Executive & Chair of the DHBs Employment Relations Strategy Group Karen Roach

2010

12 February	Second informal ASMS-DHBs meeting held; agreed to hold four joint workshops on underpinning issues
28 April	First joint workshop on the state of the senior medical workforce (recruitment and retention)
30 April	Current MECA expires although extended by statute for further 12 months
14 May	First day of formal negotiations (ASMS claim deliberately excluded major financial issues, including salaries, due to the workshops)
18 May	Second joint workshop on Australian medical labour market
17 June	Third joint workshop on clinical leadership
18 June	Second day of formal negotiations
22 July	Fourth joint workshop on SMO-RMO relationships and roles
28 July	Third informal ASMS meeting with DHBs led by Karen Roach to discuss conclusion of workshops; DHBs propose working together to develop a joint business case to support a MECA settlement (timing to fit in with Budget cycle); also agreed to consider a 'variation' under the Employment Relations Act to the current MECA
2 August	Third day of formal negotiations
8 September	Fourth day of formal negotiations (constructive progress continues with most issues resolved)
10 September	National Executive agrees to go down Business Case and MECA Variation path [DHB chief executives also agreed although some unhappy]; variation to MECA subsequently signed which included commitment to Business Case approach, 2% salary increase effective February 2011, and agreements reached to date during negotiations
Sept-Nov	DHB and ASMS representatives collaboratively work together developing and completing *Business Case*; forwarded to DHB chief executives and ASMS National Executive for approval
November	DHBs receive advice from government of their funding allocations for the 2011-12 financial year (subsequently confirmed in May Budget).
17 November	ASMS National Executive supports *Business Case* (ASMS Annual Conference endorses National Executive decision two days later)
29 November	DHB chief executives accept *Business Case* in principle with only two qualifications – further work wanted on a supplementary document fleshing out further details ('operationalising' it) and would not refer it to the government because they would fund the *Business Case* out of their baseline funding rather than seek additional funding; decision confirmed in 1 December letter to ASMS
	[Significantly, no concerns raised over funding investment required for *Business Case*]

2011

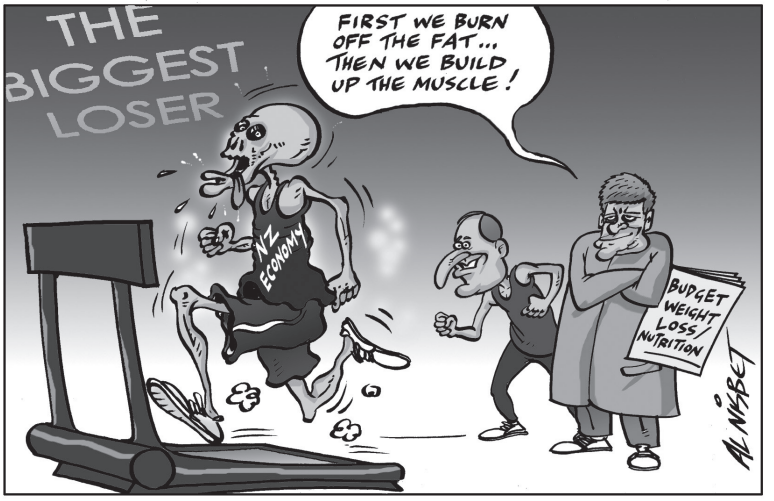
9 February	Formal negotiations resume for a fifth day; includes start of discussions on implementing funding allocated in *Business Case* for MECA settlement ($40m, $80m and $80m over three years from 1 July) through costing scenarios
8 March	At national meeting of Ministry of Health, DHBs and health unions (Health Sector Relationship Agreement Steering Group), the Ministry passed on Minister of Health's advice that the Christchurch earthquake would not change their funding allocations for the 2011-12 financial year (and advised last November)
15 March	Formal negotiations resume for a sixth day including costing scenarios; DHBs state desire to resolve negotiations (subject to ratification) by end of April (ASMS agrees); two salary scale scenarios (one from DHBs and one from ASMS) are costing with both within financial allocation of *Business Case*
	Later in day DHBs' negotiating team advises that they can't continue because they are uncertain of their mandate from the chief executives

23 March	Informal crisis meeting held between ASMS and DHB representatives (led by Karen Roach and Hutt Valley Chief Executive Graham Dyer); agreed to form small joint group to work on supplementary 'operational document' and to resume formal negotiations in late April; agreed objective to conclude negotiations by end of April (subject to ratification)
31 March	Small joint DHBs-ASMS group meets to work on 'operational document' and relationship with MECA; DHBs team led by Graham Dyer; DHBs agree that *Business Case* is not to be called a 'discussion document'; ASMS advises DHBs that we needed to forward the *Business Case* to members and asked whether they had any problems (DHBs advised no problems and that they understood our position)
10 April	Second informal meeting of joint DHBs-ASMS group; 'operational document' virtually agreed; agreement reached on proposal over implementation of *Business Case* for inclusion in MECA to recommend to ASMS negotiating team and DHB chief executives (ASMS again advised DHBs that we would soon forward the *Business Case* to members; no concerns raised)
18 April	ASMS negotiating team endorses recommendation of 10 April informal meeting; chief executives meet concurrently; formal negotiations resume for seventh day following both meetings; DHBs proposed variations to 10 April recommendation which are unacceptable to ASMS (due to too much conditionality and chief executives shifting goalposts)
19 April	Informal meeting with DHBs which successfully progresses small number of unresolved non-fiscal issues in negotiations
26 April	ASMS forwards jointly developed *Business Case* electronically to members (and on website) with an accompanying positive description in ASMS Direct
27 April	Major turning point in the negotiations occurred when DHBs (Karen Roach) on National Radio (Radio NZ) endeavoured to distance themselves from Business Case by claiming (for the first time) that it was unaffordable and demeaned it as only a "discussion paper"; also reported as being surprised at ASMS release of it
28 April	DHBs cancel eighth day of negotiations scheduled for following day; argue that they needed more time to develop a proposal for settlement; highly disruptive for members of ASMS negotiating team
5 May	On morning of National Executive the ASMS receives a proposal for settlement of the MECA from DHBs (details reported to members in ASMS Bargaining Bulletin) which radically departs from *Business Case*, calls for more working parties and is unanimously rejected by Executive Later DHBs' representatives led by Graham Dyer join Executive for 'free and frank' discussion
6 May	ASMS writes to DHBs outlining concerns over recent developments, calls for further negotiations picking up from where informal discussions on 10 April left off, and seeks meeting with Gregor Coster (Chair of DHBs national chairs group) and Kevin Snee (Chair of DHBs national chief executives group)
Late May	ASMS obtains professional public relations advice for a longer term campaign over the implementation of the *Business Case* in the MECA settlement according to its tenor
16 June	ASMS Executive Director, President and Vice-President (Ian Powell, Jeff Brown and Julian Fuller) to meet Gregor Coster and Kevin Snee
23 June	ASMS National Executive to further consider strategic direction.

Budget 2011–12

The Budget from Finance Minister Bill English for the 2011-12 financial year is predicated on optimistic forecasts that the government will return to surplus in 2014–15 and debt will begin to reduce in the following year.

Part of the reason for this is the governments intention to take an election victory this year as a mandate to sell part of the electricity companies, Air New Zealand and Solid Energy, put in place abatements to 'Working for Families', make changes to the student loan scheme affecting part-time students and students over 55, and make changes to KiwiSaver entitlements.



The predictions are also based on what some commentators have called 'optimistic' growth projections with the only real stimulus coming from the rebuilding of Christchurch and/or the hope that diary farmers will spend more. It is interesting that so much of the Budget depends on benefitting from a devastating human tragedy that everyone wishes had never happened.

Attention has also been drawn to IRD estimating lower revenue than that estimated by Treasury and the Ministry of Social Development estimating higher numbers on benefits than Treasury. It is worth noting that Budget 2010 forecast wage growth of 2.6% for 2010/2011. Actual wage growth in that year was 1%.

Budget 2011 Projections

March Year	2012	2013	2014	2015
Real GDP [1]	1.8	4.0	3.0	2.7
Unemployment rate [2]	5.7	4.8	4.8	4.6
Wages [3]	4.1	4.1	4.2	4.0
CPI [4]	3.1	2.4	2.5	2.6

1. Real production GDP, annual average % change
2. Percentage of labour force, March quarter, seasonally adjusted
3. Quarterly employment survey, average ordinary-time hourly earnings, annual % change (March years)
4. Annual % change (March quarter)

Canterbury

The cost of the two Canterbury earthquakes is being estimated at $8.8bn – of which $3.3bn is Earthquake Commission and ACC costs and $5.5bn is direct costs to the government. A Canterbury Earthquake Kiwi Bond will be created to fund a portion of this cost.

The State Sector

Government expenditure is planned to be flat for the next two years. This means a decrease in real spending after inflation. Health, Justice and Education get increases, but not enough to keep up with rising costs and population. These increases are paid for by cuts in spending in most other areas of government. The specifics of cuts are left to the individual government agencies to make but most won't take effect until 2012.

The government has also stopped funding superannuation payments made to state sector employers for KiwiSaver and some other state sector retirement schemes centrally. From 1 July 2012 state sector employers (including DHBs) will have to pay for these out of their own budgets.

One of the interesting issues that emerged once the budget documents had been digested was a performance measure for the State Services Commission (SSC) that public sector wage growth was to be the same or less than private sector wage growth. At present the State Services Commissioner has limited ability to directly influence this at DHBs.

Health

Health services are underfunded by approximately $127 million, despite $452 million in new funding, according to the estimates made by CTU Economist, Dr Bill Rosenberg (see the paper *'How much funding is needed in Budget 2011 to avoid the condition of the Health System Worsening?'* in the *"In Depth"* section at www.asms.org.nz. This is on top of an estimated $111 million shortfall in the 2010/2011 year.

Before the Budget, announcements were made of an additional $33.2m over four years for maternity services and $21.3m over four years for WellChild services to first-time mothers.

Further new initiatives in health over the next four years match expected priorities of the government with $18 million for the placement of 40 extra medical students, $80 million for widened access to medicines, $68 million for additional funding for elective surgery, $40 million for mental health and $130 million for disability support services. $80 million is coming out of DHBs for GP subsidies and $14 million for low cost subsidies and under six year old visits. All of these figures are for expenditure over four years and are less generous when annualised.

Many of the Budget lines under the heading 'national health services' stay at the same levels but there is a budget reduction for services contracted nationally by the Ministry of Health. This is an area where the government expects to make savings: services such as mobile surgical services (the 'surgical bus'), sexual and reproductive health services (probably NZ Family Planning), and services associated with the Oral Health and Cancer Control Strategies.

The Budget line for loans to capital projects has been cut dramatically from $202 million to $68 million

Cuts in 'real' funding played out in cuts in some services last year. The impact differs in DHBs with increasing population compared to DHBs with static or falling rates of growth or historic deficits. Meanwhile the supplementary estimates reveal that in 2010/2011 $208.1 million less was spent than was budgeted - $97.3 million of this remains in Vote Health while the remaining $110.8 million disappeared back into the consolidated account.

Kiwisaver

Minimum compulsory employee and employer contributions to Kiwisaver will increase from 2 to 3 percent in 2013. The 'Member Tax Credit' for employee contributions will be halved to 50 cents in the dollar with the annual maximum credit also halved to $521.43 per year from the year ending 30 June 2012. Perhaps of even more significance for our members the exemption from the Employer Superannuation Contribution Tax will be scrapped from 1 April 2012.

The likely outcome for ASMS members will be a decrease in the contribution that those in Kiwisaver receive from the employer. The ASMS is trying to get clarification from DHBs as to how they plan to handle these changes.

Angela Belich
Assistant Executive Director

MEDICAL PROTECTION SOCIETY

The value of reputation

Defamation can destroy reputations and, with the growth of the internet, another route to this has widened. Dr Alan Doris of the Medical Protection Society advises on the action you can take, should you fall victim

"A good reputation is more valuable than money"[1]

A damaged reputation can lead colleagues and patients to scorn or avoid the professional, causing damage to their career and livelihood.

Reputation, professional and private, is extremely important for any member of society and must be protected. Where an individual's reputation is harmed by a verbal statement or published material that lowers the standing of the person in the eyes of others, or may lead the person to be shunned or ridiculed, then that person may have been "defamed".

For health professionals, in addition to the personal hurt to the individual and their family, a damaged reputation can lead colleagues and patients to scorn or avoid the professional, causing damage to their career and livelihood. In some circumstances, a legal remedy may be available to put right this wrong. The common law and Defamation Act 1992 define defamation and outline when an action may be brought, as well as possible defences against such proceedings and legal remedies.

"Publication" does not need to be widespread and need only be to one other party. The principal defences to a claim of defamation are that the published statement is either true, is an honestly held opinion, or that the statement is protected by some privilege, eg, parliamentary privilege for statements made in Parliament.

In recent years, the internet, and in particular the expansion of online publications with blogs, internet fora, "Twitter", etc, has greatly increased the opportunities for people to make statements on all manner of things. While this has created greater opportunities for freedom of expression, exchange of ideas and social interaction, it has the potential for misuse and to cause harm.

As a plethora of information is easily available electronically, it has become increasingly common for patients, family members and prospective employers to check a health professional's online profile. Search engines such as Google or Yahoo! will return links to a professional's name, though there is no way of knowing whether the information retrieved is accurate. During the last year, several MPS members in New Zealand have become aware of unpleasant and potentially harmful material relating to them being published on the internet, and have sought assistance to remedy this.

It appears that the pseudoanonymity of the internet emboldens electronic writers and gives a sense of impunity, which leads to material appearing online that would not appear in conventional print or broadcast media. Such writers may be unaware that they are "publishing" statements at all, or believe that they are not covered by the legislation. This is not the case, and it is likely that the rules regarding making statements in traditional media will apply equally in cyberspace – and those making damaging statements will be vulnerable to legal challenge.

If an alleged defamation arises from a doctor's practice, and serious harm is likely to be caused to his or her professional reputation, then MPS advises on how best to rectify this situation. It may be enough to bring the offending material to the attention of the publisher and demand that it is removed or corrected. However, if the publisher does not take prompt, appropriate steps to remedy the situation then MPS may assist a member in proceeding with legal action. The decision to take such action would be at the discretion of MPS Council and would be considered after obtaining a legal opinion, and reviewed at each step in the case. It is unlikely that MPS would assist one member taking legal action against another.

If an action was successful, then there are various remedies available to the court. These include making a declaration that defamation has occurred and awarding costs to the plaintiff; ordering that a retraction, correction or reasonable reply is published in the same medium with similar prominence; and awarding damages or, when there has been a flagrant disregard for the rights of the plaintiff, awarding punitive damages.

It is important that doctors do not make malicious or unfounded statements about colleagues, whether verbally, in traditional media or on the internet. As well as being unethical, these could be regarded as defamatory. If a doctor is the named defendant in a defamation claim, MPS may assist if the matter arises from their professional practice. Such assistance may extend to an indemnity for legal costs and disbursements, but is unlikely to extend to the payment of damages. If making statements on behalf of an organisation, for example a professional college, doctors should ask for an indemnity for costs of any action taken against them to be provided by the organisation.

This is based on a feature published in MPS's January 2011 Casebook

References

1. Ascribed to Publilius Syrus, circa 100BC.

40 Years 2012
The Christchurch Experience

40TH ANNIVERSARY OF UNIVERSITY OF OTAGO, CHRISTCHURCH

(formerly Christchurch School of Medicine)

In February 2012, the University of Otago, Christchurch, will celebrate 40 years of research and teaching.

Events will be held in Christchurch 8 – 11 February 2012, beginning with a public lecture by a keynote speaker on Wednesday 8 February, and a University of Otago Alumni evening on Thursday 9 February 2012.

Celebrations will include:

- A series of social functions in the second week of February 2012
- The publication of a book covering the school's highlights and its future direction.
- The establishment of a research trust to fund fellowships and scholarships on the Christchurch campus.

If you would like to be part of the celebrations register your interest by going to **www.otago.ac.nz/christchurch** and click on the 40th icon. Bookmark this website. It is the place to come for updates on anniversary celebrations.

Alternatively, call the Senior Communications Advisor Kim Thomas
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or Virginia Irvine
03 364 0038 **virginia.irvine@otago.ac.nz**

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.

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www.jobs.asms.org.nz

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

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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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