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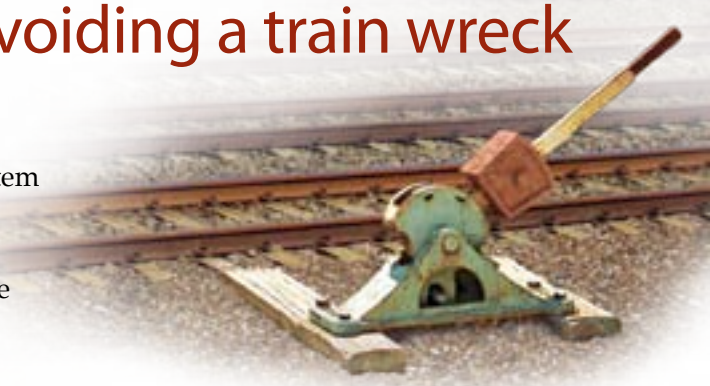
The Specialist

The newsletter of the Association of Salaried Medical Specialists

The costly distraction of avoiding a train wreck



The government has embarked upon a path affecting clinical support services that, unless the public health system is sufficiently vigilant, risks becoming a train wreck. The likelihood, in fact, is that the train wreck will be avoided because of this vigilance. But the more realisable risk is the destabilisation it is likely to cause.

This is because of the uncertainty this process is creating and the valuable time and effort of those with expertise (clinical, finance, IT and procurement for example) that has been required to date, and will continue to be, in order to prevent the wreckage. These effects will be a major disruptive distraction for the DHB sector.

The risk stems from the government's unfortunate, artificial and populist distinction between frontline and back office staff in a way that denigrates the latter and disregards the exigency of them being highly integrated.

The means – HBL

The means is Health Benefits Ltd (HBL), a crown entity which, following the government's generally sensible and practical restructuring of central agencies in 2009-10, is responsible for handling the rationalisation of so-called 'back office' functions of DHBs. Previously HBL was responsible for the funding of general practitioner benefits but lost this function some years ago when this task was devolved down to DHBs. HBL has its own board which reports directly to the Ministers of Health and Finance.

HBL is required by government to make savings in DHBs of $700 million (cumulative) over five years – this period has already commenced. HBL has embarked on a process of developing 'indicative cases for change' (a business case without much business in it by another name). Earlier this year HBL prepared its first 'indicative case for change' which was on 'finance, procurement and supply chains' for each of the 20 DHBs who then had to make their own individual responses. One immediate difficulty facing DHBs was the 'high level' (or lack of specificity) of the 'indicative case'.

The next stage for HBL is to prepare draft 'business cases' on finance, procurement and supply chains for each of the DHBs. This will be a two-phase process. The first, which has been done, looks at possible pathways to go down (eg, scenarios) in order to identify what are 'go' and 'no go' areas. The second phase will follow the DHBs' responses to the first in which HBL develops a more specific draft business case for each of them. This process is expected to go right through to August at least.

In isolation it is a mature process. But it can't be seen in isolation. At some point while all this activity is going on, HBL will dump a second 'indicative case' on the DHBs – this time on 'facility management and support services'.

Overwhelming a good change management framework

The ASMS has a constructive relationship with HBL staff, including the chief executive. Further, the health unions and DHBs have developed and agreed a good formal consultation process known as the 'change management framework', with HBL. It is deliciously ironical, nevertheless, that DHBs were able to use the various union negotiated consultation clauses (including in our MECA) as an argument for slowing HBL down even though some of them have not always been good adherents to compliance themselves. As Margaret Thatcher observed on the eve of her political execution, it is a funny world!

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But even the best consultation process can be overwhelmed. The problem is not HBL staff. Instead the problem is those driving HBL, its board and government. In particular:

1. The sheer scope and volume of what HBL has to address with DHBs is too large.
2. The pace required by government, through the Health Minister and HBL's politically appointed board, is too fast.

HBL, as a small organisation, does not have the internal staff capacity to provide the expertise necessary to do its work. Consequently it has to engage external consultants who in the main lack the experience of the complexities of a universal public health system. They generate assumptions which at times are tenuous and then tie up DHBs resources and time in trying to sort them out (i.e. high transaction costs).

HBL has to engage external consultants who in the main lack the experience of the complexities of a universal public health system

The unsettled environment arising out of this potentially extensive restructuring is leading to uncertainty among key non-clinical staff (e.g. operational management, finance, IT) with skills that can be used outside the health sector. This inevitably risks encouraging some to leave DHB employment on their own terms rather than coping with the fear of being restructured out.

Those driving the HBL process forget what very large and highly complex 24/7 organisations DHBs are

The ASMS has had several constructive discussions with individual DHBs through our Joint Consultation Committees and it is fair to say that we are broadly on the same page on these matters with shared concerns. All show signs of serious anxiousness with Canterbury DHB firmly articulating their concerns the most.

Where simplicity clashes with complexity

Those driving the HBL process forget what very large and highly complex 24/7 organisations DHBs are. The process creates risks by trying to put a simplified overlay over a large complex organisation. For some relatively less complex areas like banking, insurance and possibly big multiple purchases, it is reasonable to assume that there would be advantages through economy of scale. In terms of insurance it would also spread the risk across the country.

But for the likes of suggestions such as a single rostering system across all DHBs it is simply impractical. Endeavours to rationalise positions will be riddled with perils given the diversity of functions in their similar sounding titles between DHBs. Smaller DHBs utilise their finance ftes differently from bigger DHBs. Further, some DHBs have finance ftes allocated within departments while others do not.

There is confusion with HBL under pressure to force what they call 'back office' mergers. This is a demeaning and unhelpful term that disregards the highly integrative nature and complexity of a DHB. Orderlies and cleaners, for example, are all essential parts of the clinical system and not some 'back office' non-entity. Nowhere is the value of 'back office' boilermakers appreciated more by clinicians than in Canterbury as a result of their incredible work during the February 2011 earthquake in getting the hospital up and running again and maintaining its functioning.

There is a better way

The government is requiring $700 million cumulative savings over five years. It has been reported that in the first year $55 million has been saved which, on the surface given its cumulative nature, appears encouraging. But there are two qualifications – these savings have to be continued (they can't be one-off) as well as increased and much of these savings have come from the DHBs' own processes, not HBL's. I have no doubt that the $700 million savings will be made; the only doubt is the proportion that is achieved 'creatively'.

It seems to be generally accepted that there are savings to be made in some of these areas. It would have been better, however, if government allowed HBL to narrow its scope (eg, procurement), give it more time flexibility, and allow it to second appropriate DHB staff with expertise in these areas (eg, clinical, IT, finance) to investigate and advise.

Nowhere is the value of 'back office' boilermakers appreciated more by clinicians than Canterbury as a result of their incredible work during the February 2011 earthquake

But the massive distraction of constantly challenging potentially risky tenuous assumptions (few things are more irritating) due to a flawed process risks avoidable and destructive destabilisation at a range of levels in DHBs, nowhere less than the clinical frontline.

The government needs to allow HBL to slow-down and ensure that there is sufficient time to second DHB expertise (including clinical) to methodically work through what is sensible and doable and what is not.

Ian Powell
Executive Director

PRESIDENT'S COLUMN

Critical thinking – the mistakes we will make

Try as I may, strive as I might, I will continue to make mistakes. Yes, continue. Some will be the same mistakes I have made before, some will be new ones. Some I will realise before they cause harm. Some I will never recognise.

I do not set out to make mistakes. I do not go to work to err, to be other than human. My doctor's brain has been trained as thoroughly as many a medic, decades of decision making have honed my clinical experience. Yet I have to admit that the more I strive to correct my wayward thoughts, the harder it seems to be. The more I work to keep up with evidence based practice, to stay abreast of each new development, to audit each encounter, I am not sure that I make fewer mistakes. I seem to depend as much as ever on those around me to detect my slips and constructively correct them.

Searching for correction has taken me to experts outside of medicine such as psychologist Daniel Kahneman who won the 2002 Nobel Prize in Economics and last year published "Thinking, Fast And Slow", and Michael LeGault whose 2006 book "Think: Why Crucial Decisions Can't Be Made in the Blink of an Eye" is the antidote to Malcolm Gladwell's "Blink" but not such a best seller. Jerome Groopman, Professor of Medicine at Harvard, did produce a best seller in 2007 with "How Doctors Think" but the most persuasive and clear protagonist for critical thinking in medicine I have met is Pat Croskerry, an Emergency Physician from Nova Scotia who practices and preaches the necessity for us all to understand how we make the decisions we do. For healthcare safety's sake.

Dual process theory has come to the fore in psychology to explain how we come to decisions. Most of what our brains do they do intuitively with fast automatic thinking. It is how we can drive to work without having to think about every action and reaction along the route. It is also how we do most of what we do at work, even as doctors and dentists. In fact we train our brains to act intuitively by perfecting pattern recognition and familiar iterative questioning to get to the most likely most of the time. Most physical, clinical and diagnostic skills take about forty hours to achieve the level of expertise to push them from slow deliberative thinking into the regions of the brain that react automatically within a few hundred microseconds. So that we can free up the slow, deliberative analytical parts of our brain that take several seconds to process.

We like to believe, as highly trained medical professionals, that we come to most of our diagnostic decisions with our slow deliberative analytical thinking. Unfortunately studies continue to show that diagnostic error occurs about 15% of the time. Across all disciplines. No matter how much we exhort ourselves and each other to know more, remember more, act more evidentially. Of these errors, only 7% are truly no fault. One in five is related to system failures alone. Our own cognitive errors account for 28%. And 46% are due to a combination of cognitive and system errors. That means around three in four could be amenable to better critical thinking. To us accepting that it is not what we don't know, it is how we think that matters.

Because as much as the comfortable numbness of intuitive thinking helps us live, we can train and educate our intuition with forcing functions and clinical decision rules, from paper to lists to electronic aids, online or on our person, built into our systems or bolted on top of them.

We can also promote reflective practice. We can teach and train and improve performance in the analytical mode. We need to. The uncomfortable truth is that on the spectrum of six levels of critical thinking (unreflective, challenged, beginning, practising, advanced, accomplished) most doctors are functioning at stage two.

The good news is that while our brain tries to default to intuitive fast automatic thinking (system 1), especially when conditions allow or enable us to, executive override can occur and permit slow analytical deliberative thinking (system 2) to dominate. Most diagnostic errors occur in system 1, so that forcing our brains into system 2 will reduce our chances of error.

We can educate and train intuition. We can also develop cognitive forcing strategies, promote reflective practice, learn our main cognitive and affective biases and adopt de-biasing strategies.

We can raise awareness of the conditions that may affect decision making and allow dysrationalia to override. Such as stress, fatigue, sleep deprivation and cognitive overload. We can recognise these predisposing conditions, in ourselves and our colleagues, and do something about them. Before more patients are harmed.

We all work hard to eliminate social biases such as racial, gender, obesity, and ageism. But we act as if toughening up will counterbalance ambient affective biases such as stress, fatigue, sleep deprivation and cognitive overload, while accepting work-arounds for environmental and ergonomic factors (eg. no electronic access to patient results at the bedside).

We are often unaware of the power of cognitive biases that lead directly to cognitive error, such as anchoring (in irrelevant information), search satisficing (calling off the search once something is found), representativeness (matching profiles to templates or classic patterns), and more than a hundred other biases. We ignore the influence of age.

I think I understand a bit more about the why I make the mistakes I do. My slow analytical deliberative mind can devise some strategies to begin, practice and even advance my own critical thinking. But I will need to work alongside colleagues who have the time to install these strategies into our everyday professional lives, together. Time to challenge me. Time for quality thinking. Pat Croskerry guarantees that if we improve our critical thinking the outcome can be measured in patient lives and health dollars. Surely two targets worth aiming for.

Jeff Brown
National President

EXECUTIVE DIRECTOR'S COLUMN

It started with a graph

In April I had the opportunity to listen to a financial update from conversational Treasury officials on the state of the economy along with other representatives of health unions, DHBs and the Ministry of Health. Contrary to stereotype these Treasury officials were not dour and did not have pimpled faces.

In summary, they reported that:

1. Economic growth was slower than at the government's Pre-Election Financial Update last year.
2. The rebuild of Christchurch was slow although the impact of the earthquakes has not affected exports.
3. Economic growth was in line with other trading partners' growth.
4. The net debt was around 24%. Consequently the surplus was likely to be smaller than forecast in 2014.
5. Government spending will increase $5 billion by 2015 (this may be modified by Finance Minister Bill English's admission that we will have a zero budget this year).
6. Health wages and salaries in DHBs have moderated over the past two years.
7. Wage and salary growth needs to be resourced by productivity gains.

Raising the fur

This was all interesting and generated some good discussion. But what really caused the fur on the back to stick up was the inclusion in Treasury's presentation of a graph of doctor and nurse productivity in public hospital medical and surgical services. Their graph contrasted inputs (expenditure on nurses and doctors, interestingly 25% of which is from locum doctors and bureau nurses) with outputs (those things that can be counted) and revealed that the latter fell well behind the former. In other words, the productivity of doctors and nurses had declined (by 5%).

In the somewhat scratchy discussion that followed the criticism included:

- The measurement of outputs was confined only to those things that could be counted, primarily discharges with some case weighting for emergency departments. Outpatient clinics were counted during the period covered but when this commenced was unknown. But much of what happens in DHB health services are not counted including mental health, community health and chronic illnesses. District health nurses reduce productivity because the care they provide for patients at home is not counted; if these patients were treated in hospitals then although this would reduce quality of life and be more expensive, it would increase productivity. How loopy is that!
- It counted investing in the health professional workforce as, by definition non-productive, and was about outputs instead of outcomes.
- It was false to call the data productivity when it was simply a narrow range of throughputs.
- There was a basic contradiction between the government and DHBs (and professional groups) saying that quality improvement enhanced productivity and the graph saying that investing in time for quality improvement was anti-productive.

It is also worth noting the perversity that this approach to productivity gives no value to improving quality, places no value to saving lives (if this takes too long, productivity falls), and recognises patient deaths improve productivity – that is, if patients die in hospital the day after admission productivity goes through the roof (providing they are discharged that same day).

Bureaucrats, heal yourselves

The proponents of this line might want to look at the broader approach undertaken by researchers at Victoria University who reveal that hospital productivity in New Zealand rose by 3-5% between 2007 and 2009.

But back to the meeting where the last word should be left to Treasury. After listening to this criticism the officials neatly pointed out that the offending graph was not theirs. In fact, it was taken from the Ministry of Health's Annual Report leaving Ministry officials red faced.

The nonsense negative message of this graph has been severely critiqued for years. It is time for the Ministry of Health to cease this misleading rubbish and for Treasury to cease repeating it.

Ian Powell
Executive Director

ASSISTANT EXECUTIVE DIRECTOR'S COLUMN

Physician Assistants: The final report on the Counties Manukau DHB demonstration

The final evaluation of the physician assistant pilot at Middlemore Hospital is now available on the Health Workforce New Zealand Website. *www.healthworkforce.govt.nz*

Some of you will remember that in 2010 Health Workforce New Zealand set out to trial the role of physician assistant in New Zealand. The project was variously referred to as a trial, a pilot or a demonstration. Two American trained physician assistants worked in one of the General Surgical teams at Counties Manukau DHB for 12 months. An initial evaluation focusing on the setting up of the pilot was done by Pam Oliver Associates (available on the ASMS website). The contract for the final evaluation was withdrawn, for unclear reasons, from this company and given to an Australian based consultancy. The evaluation was promised by the end of 2011; in the event it was released in March this year.

Essentially the evaluation found that the physician assistant 'pilot/demonstration' at Middlemore showed that physician assistants would be a useful addition to the New Zealand health system. Unsurprisingly, teams that had the addition of a physician assistant had better results than those that did not. These positive results were attributed by the evaluators to the physician assistants training in the medical model and 'would not have been seen with the addition of another house-officer, nurse or nurse practitioner.' Evidence is not provided to justify this conclusion.

Despite the views of the majority of interviewees that the findings of this trial could not be generalised to dissimilar settings the evaluators conclude that similarly positive results would be expected to occur in other sites as the results were a consequence of the PAs training. One house surgeon's view, that the current system is unsafe and that she and house surgeon colleagues were leaving for Australia (where the decision has been not to adopt the profession) but would stay if physician assistants were introduced immediately into the New Zealand system leads on to the evaluators identifying an immediate need to import US physician assistants. Making the system safe in some other way is not discussed or even identified as an urgent problem.

All interviewees that had worked with the physician assistants (the only exception mentioned was the radiologists at Middlemore) were reported as thinking that the profession should be used in New Zealand but stakeholder groups such as ASMS, NZNO, RDA and the Medical Council were reported as sceptical. This is a puzzling conclusion as ASMS views were directly taken from the consensus reached by our members who were involved in the trial after a robust email debate

The evaluation repeats some of the criticisms that have been made, dismisses them, but does not answer them. One of the critical points was that the salary level in the trial was substantially better than that which would be offered should the profession be introduced on a permanent basis, suggesting that recruitment and retention might be a problem particularly of US trained PAs.

The evaluation does not discuss the failure of the Australian pilots to lead to the introduction of the profession in Australia and the closure of the PA training schemes in Queensland and South Australia.

NZNO has been highly critical of the evaluation. They make the very valid point that it would be extraordinary if an extra experienced clinician did **not** make a difference to the results of a team which had them added as an extra member; they question inserting a 'programme logic' approach eight months into a one year programme and point out that the Australian evaluators do not understand the New Zealand regulatory system as they appear to believe that prescribing rights are provided under the Health Practitioners Competence Assurance Act (HPCAA) rather than set out in the Medicines Act.

The next step, according to the evaluators, is to demonstrate to the sector groups the value of the role by robust engagement, by setting up a series of demonstrations in areas such as primary care or by taking stakeholders on a trip (to look at physician assistants working overseas). Provided stakeholder support (particularly in primary care) can be obtained then the next step is to 'remove the regulatory barriers to PAs practicing at the top of their license'. This may already have been partly signalled with the planned changes to the Medicines Act but implies registration under the HPCAA. PAs should then be recruited from the US to work as educators and mentors and New Zealand students sent overseas to train. If the demand is sufficient at DHBs, New Zealand should establish training courses, and or accredit Australian training courses and consider employing graduates of the University of Queensland course.

The evaluators see a role for physician assistants in emergency departments, general medicine, acute and elective surgery, orthopaedics and preoperative assessment clinics. If the stakeholders remain obdurate then they suggest a number of short demonstrations using US trained and registered PAs over a range of settings.

Already plans are underway to trial physician assistants in primary care.

Angela Belich
Assistant Executive Director

Branch Officers' day

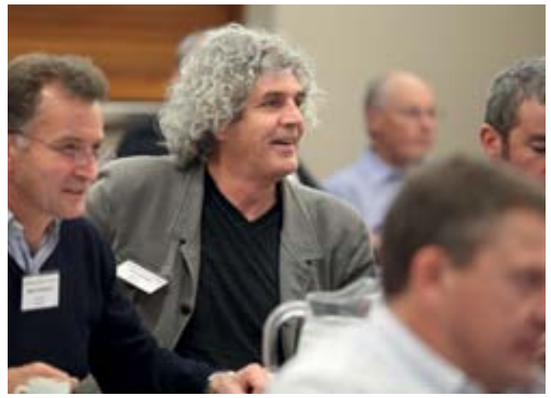
The presidents and vice presidents of local ASMS branches met with the National Executive on 2 May 2012 for a stimulating day of sharing ideas and experiences. Fifteen branch presidents, eighteen vice presidents and three stand-ins met in Wellington with the majority of the ASMS Executive and ASMS National office staff to discuss the successes, failures and barriers to distributive clinical leadership, ideas for negotiating the MECA and any other issues that the branch officers regarded as burning issues at the local level.

The day was so successful that the ASMS National Executive has decided to have a further day on Wednesday 26 September mainly to discuss the MECA negotiations due to start next year.

Dr Andrew Klava, *Rotorua Branch Vice-President*

Dr Roger Wandless, *Invercargill Branch Vice-President*

Dr Kai Haidekker, *Hawkes Bay Branch President*



Dr Seton Henderson, *Christchurch Branch President*, and Dr Clive Garlick, *Nelson Branch President*

Dr Peter Doran, *South Canterbury Branch Vice-President*

Dr Graeme Lear, *Tairawhiti Branch President*

Dr Ywain Lawrey, *Waitemata Branch President*

Dr Guy Rosset, *Whakatane Branch President*

Dr Christian Hirling, *Whakatane Branch Vice-President*

Dr Jeff Brown, *ASMS National President*

Dr Chris Wisely, *Otago Branch President*

Dr Tim Mackay, *Invercargill Branch President*

FROM THE INDUSTRIAL TEAM

Frequently asked questions on CME

The following are the questions that have been identified by the ASMS industrial team on Continuing Medical Education (CME). Further information is in the *Standpoint on Professional Development, September 2011* which is available on the homepage of our website (www.asms.org.nz) under 'Latest Publications' *(see right hand column alongside the latest issue of The Specialist)*. If you have further queries please call the industrial team on 04 4991271 or email us at asms@asms.org.nz.

Q. Are all SMOs entitled to CME leave and expenses under the MECA?

A. No. You are not entitled to CME leave and expenses if you are employed as a locum or on a fixed term contract for 6 months or less.

Q. Are all SMOs entitled to 10 days CME leave each year?

A. No. Only full time employees (i.e. those with an agreed weekly job size of 40 hours or more) are entitled to the full 10 working days. Em**ployees w**ho work less than 40 hours are pro-rated accordingly.

Q. Are all SMOs entitled to receive $16,000 expenses each year?

A. No. Only full time employees and part time employees, who have no other income from medical practice, are entitled to the full $16,000. Part time employees with income from some other medical or dental practice will be pro-rated accordingly.

Q. Are any SMOs entitled to receive more than $16,000 expenses annually

A. Yes, but under quite limited circumstances. The MECA prescribes minimum entitlements which may be increased by negotiation between individual employees and their employer. Also, under the MECA there are three DHBs that do not prescribe a dollar amount or limit on CME expenses for their SMO employees. Currently these are Whanganui, Wairarapa and West Coast DHBs. We do not know how many (if any) SMOs actually claim and receive more than $16,000 in a single year, but some may if the C**ME** has been approved. Finally, the MECA allows SMOs who are enrolled in two or more MOPS programmes to receive up to an additional $500 p.a.

Q. What if I work for more than one DHB?

A. Your annual entitlement will be shared across the DHBs in accordan**ce w**ith the formula in clause 36.3(c) & (d).

Q. May I use my CME funds for premium economy or business class travel?

A. Most DHBs now have policies that allow this. Although there may be limits relating to length of the flight and arrival times before the event, but in all cases there must be sufficient funds and the expenditure cannot compromise your ability to satisfy your CME obligations or College or Medical Council recertification.

Q. May I use my CME funds to purchase a laptop or other electronic aids?

A. This is covered in MECA clause 36.1(c): Most DHBs now have policies (or agreements with ASMS) that allow such expe**nditure.** However you may need to show that the main purpose of the purchase is to support your CME. If you require a laptop for your work it should be purchased and paid for by your employer as a "tool of trade".

Q. Will the purchase of electronic aids incur extra tax?

A. Yes, in most cases. This is because you will own the item and IRD deem the purchase price as part of your salary, thereby attracting tax, which will usually be paid from your CME funds.

Q. May I use CME expenses to purchase books and journals?

A. Yes provided the purchases are accepted as being related to your CME or professional development by your DHB.

Q. May I use my CME funds to pay subscriptions for electronic journals or other publications?

A. Yes, if it is for your personal CME activities. DHB-wide subscriptions are considered as tools of trade.

Q. If I do CME on a weekend day or on a public holiday am I entitled to day(s) in lieu?

A. Yes

Q. May I accumulate any unused CME leave or expenses?

A. Yes, both your CME leave and expenses may be accumulated for 3 years and, by agreement, up to 5 years.

Q. Can I gift my CME to someone else?

A. No

Q. Do I have to book my travel for CME through the DHB assigned travel agent?

A. No

Q. Am I entitled to take my CME leave and expense balances with me when I leave the DHB?

A. No

Address to Marburger Bund, Autumn General Assembly

The following is a speech presented by ASMS Executive Director Ian Powell to the Marburger Bund Autumn General Assembly at Nurnberg on 19 May 2012.

Guten Tag

Kia ora, tena koutou, tena koutou. These words are from the language of New Zealand's indigenous population, Maori, and in this context roughly translates to hello, greetings, cheers and thank you.

The Association of Salaried Medical Specialists is delighted with the way our relationship with Marburger Bund has developed over the years. I have appreciated the opportunity to previously visit you in Berlin and we were very pleased to host you at our Annual Conference in New Zealand last November. Your representatives were struck by the number of your former members now working in New Zealand and attending our Conference.

I can also report that we followed with interest your form of limited strike action a few years ago, along with similar actions in the Netherlands, over the right to negotiate exclusively on behalf of your members. Again to use an indigenous Maori term I wish to mihi you; in other words, to greet and pay tribute for your successful campaign. In a major industrial dispute in 2007 we balloted our members on a similar strategy for strike action and received an overwhelming mandate of endorsement. As it turned out this ballot was sufficient to achieve a settlement.

Our country

New Zealand is a small country at the bottom of the world. To visualise it think of Italy upside-down although I like to think that our politics are not so upside-down. We were the first country in which women won the right to vote over 110 years ago; we introduced rights of union recognition and collective negotiations in 1894; introduced a universal social security (including health) system in 1938; and profoundly irritated the American government when we went nuclear free in 1984, including banning nuclear powered and armed ships into our ports.

It takes a unique country to have as its emblem a nocturnal bird that can't fly, hardly run and is not particularly bright.

Our population is four million, we have lots of sheep and quite a few cows, we make good films about hobbits and other subjects, and our coffee and wine are very good. We play rugby very well, as good as you play football. While I appreciate that our two countries do not share the same interest in rugby, we do share one common feature – we especially love beating the English and the French on the sports field.

Our national emblem is the indigenous bird, the kiwi. It takes a unique country to have as its emblem a nocturnal bird that can't fly, hardly run and is not particularly bright.

Our health system

New Zealand's universal public health system is predominantly publicly funded through general taxation with also a high level of public provision. Secondary and tertiary care is largely publicly provided while primary care, although largely privately provided. is government regulated and subsidised. We have 20 statutory district health boards of various sizes responsible for both primary and secondary care (in the main, funding the first and providing the second).

As evidenced by a recent Commonwealth Fund survey, our public health system is by international standards relatively inexpensive and cost effective. Overall our outcomes compare well suggesting that we punch above our weight. The universal nature of our health system, including its high level of public provision, contribute to this as does the general practice gate-keeper system for access to secondary care, our unitary political system, and relative lack of transaction costs.

There are positive moves to further encourage primary-secondary collaboration and clinical networks led by health professionals. On the other hand, there are threats in the form of too much financial pressure on the system while government expectations continue to increase, the calibre of senior management to avoid unilateral short-sighted decision-making, serious specialist shortages in public hospitals, lack of effective workforce planning and, periodically, privatisation.

We have a public hospital specialist workforce crisis in New Zealand. We are a small geographically isolated island nation. These factors create our vulnerability. New Zealand has, by a long way, the highest proportion of overseas trained doctors in the OECD and this has been increasing over several years (our closest neighbour Australia is the second highest). This is because we can't retain enough of the doctors we train. A country the size of New Zealand needs a significant emphasis on the generalist nature of specialists. But we largely recruit internationally from larger countries (including Germany) that logically have a greater emphasis on sub-specialisation. The more we depend on international recruitment the more the balance between generalism and sub-specialism gets out-of-hand. We will not overcome this until we are better able to recruit more of those that we train.

While it is cheaper to retain more of those we train, the government and our district health boards turn a blind eye leaving taxpayers to fund medical training for developed overseas countries.

Our excessive and increasing dependence on overseas recruitment is an example of irresponsible financial wastage. While it is cheaper to retain more of those we train, the government and our district health boards turn a blind eye leaving taxpayers to fund medical training for developed overseas countries. New Zealand has two medical schools. Such is the level of this excessive dependence on international recruitment that, through a narrow financial lens, it would make more sense to close one of them down. This is something we point out but don't advocate!

Our vulnerability evolves into crisis partly because of the cumulative effect of not addressing the vulnerability, but also due to the magnet of Australia and, by international standards, poor salaries. Since 2006 Australian specialist salaries have leaped ahead of New Zealand's. The migration between the two countries is overwhelmingly one way. Aside from proximity, the attraction of Australia is that we have the same training system stemming from the fact that our colleges generally cover both countries. Regretfully our political and managerial decision-makers can only think in the short-term and have a belief in magic bullets and spreadsheet rather than real doctors. Before it was elected our government agreed there was a hospital specialist workforce crisis. Now that it is elected it says that there is not, even though little has changed.

Our collective bargaining

Finally I want to comment briefly on our system of collective bargaining as I know how you negotiate is an important issue for this conference. Unions in New Zealand, including in the health system, generally negotiate on their own on behalf of their own members. In the main we do not have centralised settlements achieved by unions negotiating under the same umbrella (we also do not have arbitration). Our national agreement, for example is negotiated by us on our own. This is also the same for the nursing national collective agreement. The reason is that the more you try to combine with other parts of the workforce, the more it becomes difficult to address the specific issues of the workforce you represent. The relative importance of the specific issues diminishes. There are important differences and needs between the professions as well as between the professions and trades.

There was an exception in 2009 when the other health unions affiliated to the Council of Trade Unions and our district health boards agreed on a centralised settlement for a modest salary increase. The main factor that led to this was the impact of the global recession. However, our union did not participate because, in contrast with the other health professional workforces, the medical workforce faced serious shortages. This was accepted positively by both the health unions and employers. It would simply be impossible for us to address the issues we need to address if we were part of a wider negotiating process. Attempts to repeat this combined process with the other health unions late last year failed because of the differences, in part at least, because the needs and priorities of the professions and trades were too great.

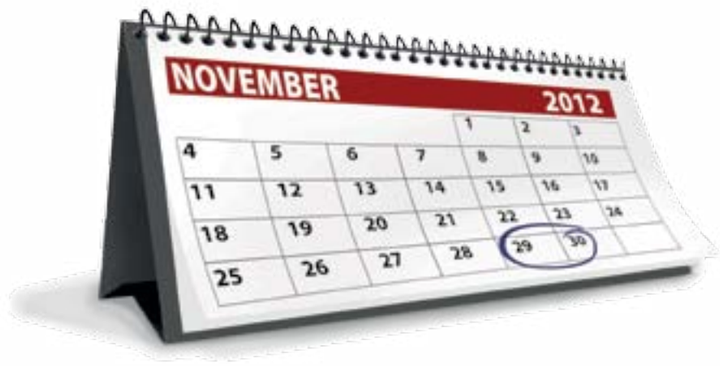
I can fully understand your strong opposition to the attempt of the German Federation of Employer Associations to seek a law change so that the collective agreement of the union with most members in the enterprise should have precedence over all other collective agreements. This would introduce labour market inflexibility. Fortunately this does not form part of New Zealand's industrial law and, further, many of our collective agreements have different expiry dates and therefore are negotiated at different times. We would vehemently oppose such a move in New Zealand.

I can fully understand your strong opposition to the attempt of the German Federation of Employer Associations to seek a law change so that the collective agreement of the union with most members in the enterprise should have precedence over all other collective agreements.

In conclusion, I commend another Maori word to you – rangatira. Again in context I wish you a successful Assembly which will further enhance the esteem and nobleness of your union to your members and of your members to their patients. Rangatira also includes being revered. It would be an extraordinary union to be revered by its members but best wishes for your Assembly assisting this aspiration.

24th Annual Conference

29–30 November 2012



Mark it in your dairy now!

The risks of Private-Public Partnerships to the Health System

This article has been kindly written for 'The Specialist' by Dr Bill Rosenberg, economist for the Council of Trade Unions. The implications are wider than Canterbury DHB as the government has advised that 'Private-Public Partnerships' could be considered for major hospital rebuilding in other DHBs. The motivation of government is to avoid the costs of rebuilding appearing on its balance sheet.

The Canterbury District Health Board has been instructed by the government to consider using a "Private-Public Partnership" (PPP) to rebuild Christchurch Hospital following the earthquake damage it sustained. Medical specialists at the hospital have publicly expressed their concern at this development. Dr Mike Beard, a former clinical director of haematology and general medicine at Christchurch Hospital, looked at the U.K. experience (called the "Private Finance Initiative" or PFI there) and found that "the way PFI has been introduced in Britain verges on a gigantic scam".[1]

Haematologist Dr Ruth Spearing, chair of the Canterbury Hospitals' Medical Staff Association, concluded that "We hope those considering the future of our Canterbury Health System don't make the same mistakes of our British cousins and other countries by locking us into expensive, inflexible and inefficient private arrangements, which primarily serve the interests of financiers not patients." [2]

"We hope those considering the future of our Canterbury Health System don't make the same mistakes of our British cousins and other countries by locking us into expensive, inflexible and inefficient private arrangements, which primarily serve the interests of financiers not patients."

Dr Ruth Spearing

PPPs take a variety of forms, but in general hand over the financing, design, construction, maintenance and operation of a facility to a private operator. What "operation" means can vary. It provides services that are in theory not related to health, leaving health professionals and managers to provide the medical services. But it is often difficult to draw hard lines: cleaning, catering and orderly services can all have important impacts on patient health, safety and recovery for example. Operators often control retailing and vending machines in the building, with implications for advertising and the health impacts of food and other goods sold.

Controversial UK experience

PPPs have been hugely controversial in the U.K. Introduced in large numbers into many areas of the public sector including health, education, prisons, courts and roads by Tony Blair's "New Labour" government, it is significant that they are now being severely criticised by conservative politicians and media as a waste of public funds. The *Daily Telegraph* reported in December for example[3] that Andrew Lansley, the Health Secretary in the Conservative led U.K. government, had complained that hospitals are "being forced to spend extortionate sums on private contractors rather than spending that money on helping sick patients get better". The *Telegraph* reported that "Official figures show that taxpayers are committed to pay £229 billion for new hospitals, schools and other projects with a capital value of just £56 billion. Much of the additional spending goes on expensive maintenance contracts." It gave examples: "North Staffordshire NHS trust paid £242 to put on a padlock while North Cumbria University Hospitals NHS trust paid £466 to replace a light fitting and £75 for an air freshener. A trust in Salisbury paid £15,000 to 'install a laundry door following feasibility study'."

Unfortunately, these are by no means unique. There has been a series of critical investigations by the Public Accounts Select Committee of the U.K. Parliament. In 2011 it reported that "In the present public expenditure climate there are legitimate concerns being expressed about the continuing financial cost of PFI for public organizations such as NHS [National Health Service] Trusts. Some of government's case for using PFI has not been based on robust analysis, but on ill-founded comparisons and invalid assumptions… At present, PFI deals look better value for the private sector than for the taxpayer."[4]

The Treasury Select Committee found "Private finance has always been more expensive than government borrowing, but since the financial crisis the difference between the costs has widened significantly. The cost of capital for a typical PFI project is currently over 8% –double the long term government gilt rate of approximately 4%. The difference in finance costs means that PFI projects are significantly more expensive to fund over the life of a project. This represents a significant cost to taxpayers. We have not seen clear evidence of savings and benefits in other areas of PFI projects which are sufficient to offset this significantly higher cost of finance. Evidence we studied suggests that the out-turn costs of construction and service provision are broadly similar between PFI and traditional procured projects, although in some areas PFI seems to perform more poorly. For example we heard that design innovation was worse in PFI projects and we have seen reports which found out that building quality was of a lower standard in PFI buildings."[5]

UK Treasury Select Committee: The difference in finance costs means that PFI projects are significantly more expensive to fund over the life of a project. This represents a significant cost to taxpayers.

A Nuffield Trust report looking at the financial pressures on the U.K. National Health Service, "Can NHS hospitals do more with less?" noted the inflexibility of PFIs: "PFI schemes can commit trusts to substantial annual payments for up to 30 years. They usually cost more than the equivalent public provision – perhaps because they provide a higher standard of service … The Audit Commission (2006) has identified an association between large new building projects (mostly PFI schemes) and financial deficits in the NHS. There is relatively little flexibility in PFI contracts, and because of this it has been suggested that there will be pressure to concentrate hospital activity on PFI sites at the expense of non-PFI sites if there is contraction" [6].

This last point is a poignant one in the current circumstances. PPP contracts are typically for 25–30 years. They give the PPP private consortium a 25–30 year monopoly over the operation of the buildings which enables it to charge extraordinary amounts for minor changes requested after the building has been completed. The government is legally obliged to pay regular instalments on the contract in the same way as a household must pay interest on a mortgage. During recessionary times like the present, governments try to reduce spending by reducing maintenance and closing or making more efficient use of underused facilities. However these contracts are in effect privileged: payments cannot reduce, leaving less government revenue available for other services.

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Even if there is no longer a need for a facility, payments must continue. According to another U.K. newspaper investigation in 2010, "Balmoral High School in Belfast closed six years after it was built, when pupil numbers halved. However, the Northern Ireland Department of Education owes the contractor £370,000 a year for the next 18 years" [7]. As the U.K. government makes severe cut-backs, privatises increasing parts of the health services and moves care out of hospitals says the *Telegraph*, "experts fear that PFI-built hospitals could be left half empty while trusts still have to pay millions every year in interest payments on the 'mortgages'" [8].

Alleged advantages of PPPs

One of the advantages of PPPs is said to be that the risk of building and owning facilities is shifted to the private sector. As has been seen, it may shift some of the risk around availability but not all risk. In any case, ultimately all risks in practice remain with the government which cannot simply walk away from the failings of what remains in the public's eyes a public hospital. The government will be forced to intervene as it did in New Zealand in failed privatisations such as rail, Air New Zealand and banking which were similarly supposed to transfer risk to the private sector.

In fact, over a three-decade contract, the risks of underuse or major change of use are high because changing medical practices, technology, demography and local health and population pressures change the nature and size of facilities that are needed. In addition, while a force majeure such as the Christchurch earthquakes may be insured against and provided for in PPP contracts in a general sense, it is almost impossible to anticipate and provide for all consequences such as the loss of population from Christchurch, and the change in its distribution. A government could be left paying the cost of a hospital facility which is being used far below its planned capacity – or have no choice but to increase the capacity of a hospital controlled by a private operator.

Undoubtedly we will be told that in New Zealand we will learn from previous mistakes. But the evaluation of PPP deals is biased here as it was in the U.K. In comparisons of public versus PPP provision, the cost of public provision is required to be based on private sector interest rates (which are much higher than those available to the government) in the interest of "neutrality", and public provision has an additional cost loading (usually 20%) for so-called "deadweight costs" of raising taxes, regardless of whether the public is happy with paying taxes for a satisfactory health system[9]. Thus when we are told that the saving on the recently let PPP for Hobsonville School was "about 1% over the [25 year] contract period" it is likely that in practice it will be significantly more expensive[10].

PPP contracts can be designed to anticipate many possible contingencies, and we would hope they do learn from international experience. However because of the complexity of the facilities being created and the very long period of the contract, they are hugely complex contracts. The new PPP prison in Auckland, at Wiri, will cost $21 million before construction even begins[11]. The cost of setting up the Hobsonville School PPP has not been released but could have been as high as $6 million according to Castalia[12]. A PPP for the London Underground which ultimately failed to get underway cost £445 million in negotiating the contracts[13]. Lawyers and accountants clearly are winners in these deals. But ultimately, everything cannot be anticipated, there will be loopholes, unforeseen circumstances and difficulties in enforcement.

While some staff may initially welcome the new facilities and the fact that they no longer have to worry about maintenance and other day to day tasks, in the longer run many regret the waste, loss of flexibility and impact on their patients.

Lawyers and accountants clearly are winners in these deals. Everything cannot be anticipated, there will be loopholes, unforeseen circumstances and difficulties in enforcement.

From a cost effectiveness point of view, it seems inevitable PPPs will be regretted. In the end that must rebound on the availability of funding for the rest of the health sector.

PPPs and the Trans Pacific Partnership Agreement

With large sums like these at stake, it should be no surprise that arrangements like PPPs are likely to be encouraged by 'free trade'

such as the Trans Pacific Partnership Agreement (TPPA) currently under negotiation between New Zealand, the United States and seven other countries. A number of provisions could affect our ability to control and back out of PPP arrangements in future. A government procurement chapter is likely to include PPPs, and DHB and Ministry of Health contracts would fall under it unless specifically exempted. In bidding for contracts over a certain value (and public hospital PPPs would almost certainly be over the threshold), overseas suppliers from the TPPA countries would have to be treated at least as well as local suppliers. The design, project management, maintenance and operation of facilities which are all likely to be part of a PPP contract, would be subject to the services chapter of the TPPA. Even if health as such is exempted, these services are unlikely to be. Once they are open to commercial provision, we have to allow any commercial operator with an operation or subsidiary somewhere in the TPPA countries

The Trans-Pacific Partnership Agreement could affect our ability to control and back-out of PPP arrangements in future... including the design, project management, maintainence and operation of facilities.

equal rights to run them. These requirements would prevent us favouring local providers – whether part of a PPP or not – let alone requiring public provision.

The United States is also insisting on a new type of requirement that has not been in agreements New Zealand has signed before: one on State Owned Enterprises. It is not clear yet which parts of central or local government this would cover, but it would certainly cover DHBs if they are not specifically exempted. The aim of such a requirement in the agreement would be that if a government owned operation competes in any way with a subsidiary of a multi-national corporation with a presence in the US or any other TPPA country, it would have to compete on a purely commercial basis with no public interest, economic development or other non-commercial objectives. Provision of government funding – even capital at the low interest rates governments can borrow at – are likely to be disallowed. The parts of a DHB currently responsible for the maintenance and running of its hospitals would, once opened up by a PPP, be regarded as commercial competitors. They would have to operate on a for-profit basis from then on, increasing costs and compromising their public service ethos.

If a PPP began to go wrong the Government could be faced with hugely expensive actions against it before private international dispute panels of trade lawyers with potentially tens or even hundreds of millions of dollars at stake.

Finally, the US is insisting that the TPPA contains enforcement processes that would allow investors to sue the government if their profits or asset values were threatened. A contract like a PPP would be regarded as an "investment" under the wide definitions that are standard in these agreements. If a PPP began to go wrong – perhaps because a DHB wanted to change the use of the hospital, or because of unforeseen demographic changes or natural disaster – the government could be faced with hugely expensive actions against it before private international dispute panels of trade lawyers with potentially tens or even hundreds of millions of dollars at stake. Such actions have been used against public health measures like plain packaging of cigarettes, against failed water privatisations, and in many other cases involving government regulatory action including on toxic chemicals, protecting the environment, and following financial crises.

FOOTNOTES

1 "Learning from Britain's Mistakes", by Dr Mike Beard, The Press, 13 March 2012, available at **www.stuff.co.nz/the-press/opinion/perspective/6563725/Learning-from-Britains-mistakes.**

2 "Praise for Canterbury health system", by Dr Ruth Spearing, The Press, 20 April 2012, available at **www.stuff.co.nz/the-press/opinion/perspective/6777374/Praise-for-Canterbury-healt.**

3 "Hospitals being charged 'extortionate' sums by PFI sums to carry out basic DIY jobs", Daily Telegraph, 23 December 2011, available at **www.telegraph.co.uk/news/politics/8973557/Hospitals-being-charged-extortionate-sums-by-PFI-sums-to-carry-out-basic-DIY-jobs.html**

4 UK Public Accounts Committee 44th Report – "Lessons from PFI and other projects", 1 September 2011, Summary, available at **www.publications.parliament.uk/pa/cm201012/cmselect/cmpubacc/1201/120103.htm**.

5 U.K. Treasury Committee 17th Report, "Private Finance Initiative", Summary, available at **www.publications.parliament.uk/pa/cm201012/cmselect/cmtreasy/1146/114603.htm.**

6 "Can NHS hospitals do more with less?" by Jeremy Hurst and Sally Williams, Nuffield Trust, January 2012, p.57, available at **www.nuffieldtrust.org.uk/sites/files/nuffield/can-nhs-hospitals-do-more-with-less_full-report-120112.pdf.**

7 "IoS Special Investigation: How Government squanders billions: Jonathan Owen and Brian Brady reveal the staggering cost of PFIs – some £300bn – in the third and final part of our investigation into Whitehall waste", The Independent on Sunday, 24 January 2010, p. 30-31.

8 "Expensive PFI hospitals could be left half-empty, NHS managers warn", The Telegraph, 20 September 2011, available at **www.telegraph.co.uk/news/politics/8782620/Expensive-PFI-hospitals-could-be-left-half-empty-NHS-managers-warn.html.**

9 See "Guidance for Public Private Partnerships (PPPs) in New Zealand", Treasury, October 2009, p.14, **www.infrastructure.govt.nz/publications/pppguidance, p.14**; and "Cost Benefit Analysis Primer", Version 1.12, Treasury, December 2005 (updated 30 November 2011), p.18 and p.26ff, available at **www.treasury.govt.nz/publications/guidance/planning/costbenefitanalysis/primer.**

10 "Hobsonville schools PPP will bring wider benefits", Bill English, Anne Tolley, Rodney Hide, 7 April 2011, available at **www.beehive.govt.nz/release/hobsonville-schools-ppp-will-bring-wider-benefits.**

11 "Prison costs reach $21m before start", by Max Rashbrooke, New Zealand Herald, 13 September 2011, available at **www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10751332.**

12. "School PPPs in New Zealand: Will PPPs provide value for Money as a Method of Procuring Schools in New Zealand? Working paper No. 2, Cost Benefit Analysis", Castalia Strategic Advisors, May 2010, p. 17 produced for the New Zealand Government, released to NZEI under the Official Information Act, available at **www.educationaotearoa.org.nz/all-stories/2010/9/22/see-for-yourself-the%20-governments-business-case-for-ppps.**

13 "London Underground PPP: Were they good deals?", Report by the Comptroller and Auditor General, 17 June 2004, available at **www.nao.org.uk/publications/0304/london_underground_ppp.aspx.**

Urgent Care Physicians

For many senior hospital doctors the speciality of Urgent Care was not in existence when they were training and so they may be less familiar with the scope, skill set and particular challenges faced by colleagues working in this area compared to other branches of medicine. MPS Medical Adviser and Urgent Care Physician Dr Andrew Stacey provides an overview of the speciality and identifies some of the particular medicolegal challenges faced.

The College of Urgent Care Physicians (CUCP) was formed in 1992 by doctors working in community clinics and hospital emergency departments, and became an incorporated society, the Accident and Medical Practitioners Association (AMPA), in 1995. The New Zealand Medical Council recognised Accident and Medical Practice as a branch of medicine in 2000. In 2011, AMPA changed its name to College of Urgent Care Physicians Incorporated, the branch name to Urgent Care, and the doctor's designation to Urgent Care Physician.

There are currently 180 Fellows of Urgent Care, with Urgent Care ranking the 14th largest branch of medicine in New Zealand. Approximately 70% of Urgent Care Physicians work in community clinics and 30% in hospital Emergency Departments (the latter with a collegial relationship with a Fellow of the Australasian College of Emergency Physicians). The College also seeks to have strong links with other Colleges, particularly General Practice and Rural Hospital Medicine, and to work closely with related specialties to supply seamless and integrated care.

CUCP administers a minimum four-year post-graduate Urgent Care training programme leading to Fellowship of CUCP. Following the shift of Health Workforce New Zealand (HWNZ) towards 'generalist' branches, Urgent Care now sits within the top third of funding priorities for HWNZ. This year HWNZ will again provide funding for 20 new trainees, with a current total of 129 trainees.

The Medical Council of New Zealand defines Urgent Care as "…the primary care of patients on an afterhours or non-appointment basis where continuing medical care is not provided."[1] CUCP aims to have a training program which teaches doctors to deal with patients in this scope of care, and oversee the clinics which provide these medical services.

Standards New Zealand in conjunction with CUCP has developed benchmarks for community based urgent care clinics. CUCP has stressed that the key features that distinguish an Urgent Care Clinic from a general practice are the presence of x-ray on-site or within (covered) wheelchair distance, and extended hours e.g. 8am – 8pm seven days. Dedicated plaster and resuscitation rooms, specialised equipment, and orthopaedic clinics on-site are further indicators of Urgent Care Clinics.

The College faces a number of challenges

Firstly many colleagues and Government departments are not aware of the existence of the College. Furthermore, both doctors and patients are not always aware of the role or scope of practice of Urgent Care Physicians. This leads to frustration from both parties as to what is appropriate to be seen at a clinic and what management can be achieved in this community setting. One of the key aims of the specialilty is to raise its visibility, and the College is currently seeking Royal endorsement.

Secondly, because there is no equivalent branch overseas, the CUCP has not been able to model the College on any international standard. The curriculum has been created from scratch, and the College has had to frequently adapt to changes in funding, legislation, and competition from other colleges.

Urgent Care sits between General Practice and Emergency Departments in terms of the facilities available and the acuity of the patients seen. The type of medicine practised by Urgent Care Physicians working in community clinics itself leads to problems.

Firstly, the no appointments system means that patient numbers can be unpredictable. It is not uncommon for an influx of patients to arrive at the same time. The unpredictable timing of patient presentations coupled with the extended evening and weekend opening hours can make rostering of appropriate staffing numbers difficult.

Secondly, although some community clinics are hybrid General Practice/Urgent Care Clinics with enrolled patients, many only see casual patients. The lack of access to a shared electronic medical record makes treating casual patients with complex medical issues difficult.

Thirdly, Urgent Care Physicians do not often receive discharge summaries for patients they have referred to secondary or tertiary services. This impacts on the ability of the doctor to reflect on their own management.

Fourthly, the emphasis of Urgent Care is stabilisation of the acute presentation and referral back to the patient's medical home for on-going care. For many patients this occurs in the setting of what is an unfamiliar doctor-patient relationship. The lack of a longitudinal relationship with the doctor which has been valued over time results in a higher rate of patient complaints in Urgent Care than in General Practice.[2]

There are also wider issues

There is a symbiotic relationship between Urgent Care Clinics and Emergency Departments. It is recognised that some groups of patients may be treated more expeditiously in Urgent Care Clinics and that this may be a more cost effective option. Many DHBs have various funding schemes in place to divert patients from the Emergency Departments to Urgent Care Clinics. It is however inefficient for patients with certain conditions (such as myocardial infarction) to present to clinics when they will still need to be seen at the

hospital. One challenge is in determining which groups of patients can be safely managed in Urgent Care Clinics, and the provision of appropriate resources to facilitate this.

With the introduction of any new speciality come the inevitable tensions arising from the delineation of the scope of that new area of practice. The new speciality may be seen to be encroaching on areas previously managed exclusively by another speciality. From time to time the Medical Protection Society (MPS) is made aware of critical comments by one clinician about another's care, and these comments are often the precipitant for patient complaints.

The Medical Council in a discussion document in May 2011 stated that opportunities for PGY1 and PGY2 doctors to practise medicine in a community setting, including Accident and Medical Practice (as it then was), would "…benefit them in the future when communicating with community care providers and gaining a general understanding of service integration across both community and hospital settings."[3] The Council's emphasis is on broad-based training for pre-vocational trainees and it is hoped that increased exposure of doctors to community medicine brings with it a heightened knowledge of the scope of Urgent Care.

Dr Andrew Stacey
Medicolegal Advisor for MPS and an Urgent Care Physician, member of CUCP and is on their executive committee.

FOOTNOTES

1 http://www.mcnz.org.nz/Registration/Howtobecomearegistereddoctor/Vocationalscope/Vocationalscopesofpractice/tabid/142/Default.aspx

2 Ely JW, Dawson JD et al, Malpractice claims against Family Physicians. Are the best doctors sued more? J Fam Pract. 1999; 48(1):23-30.

3 Prevocational training requirements for Doctors in New Zealand: a discussion paper on options for an enhanced training framework. Wellington: Medical Council of New Zealand. May 2011; 21.

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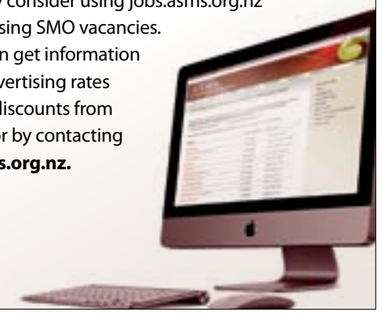

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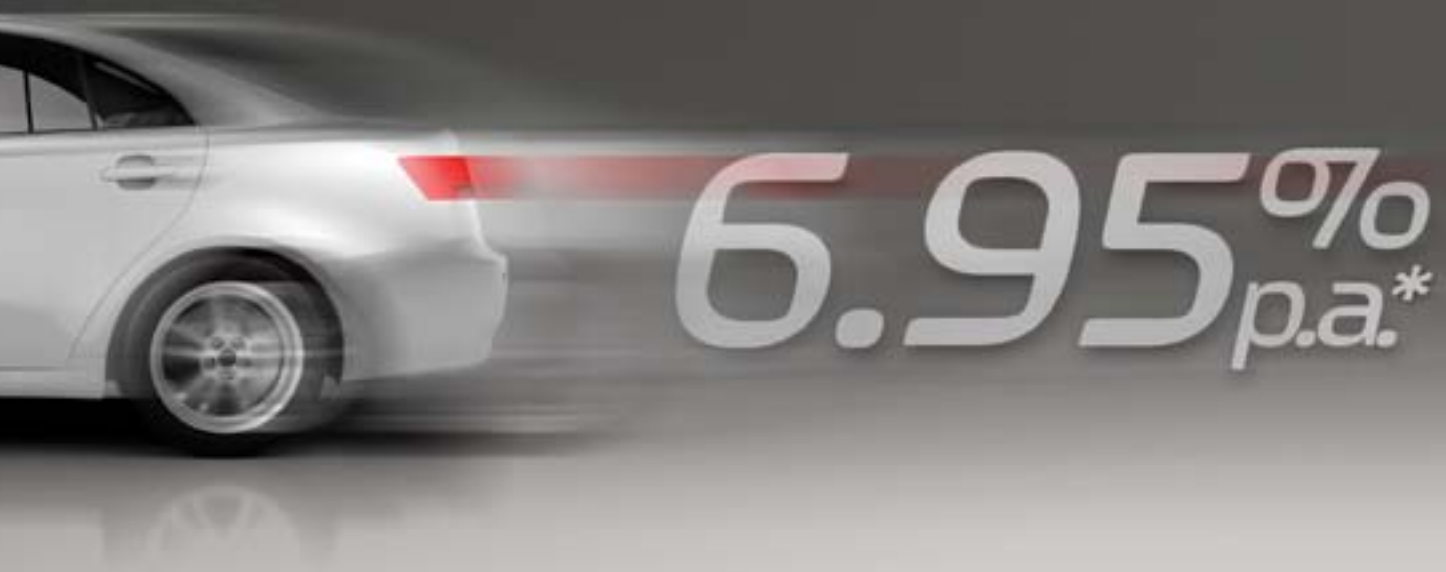

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