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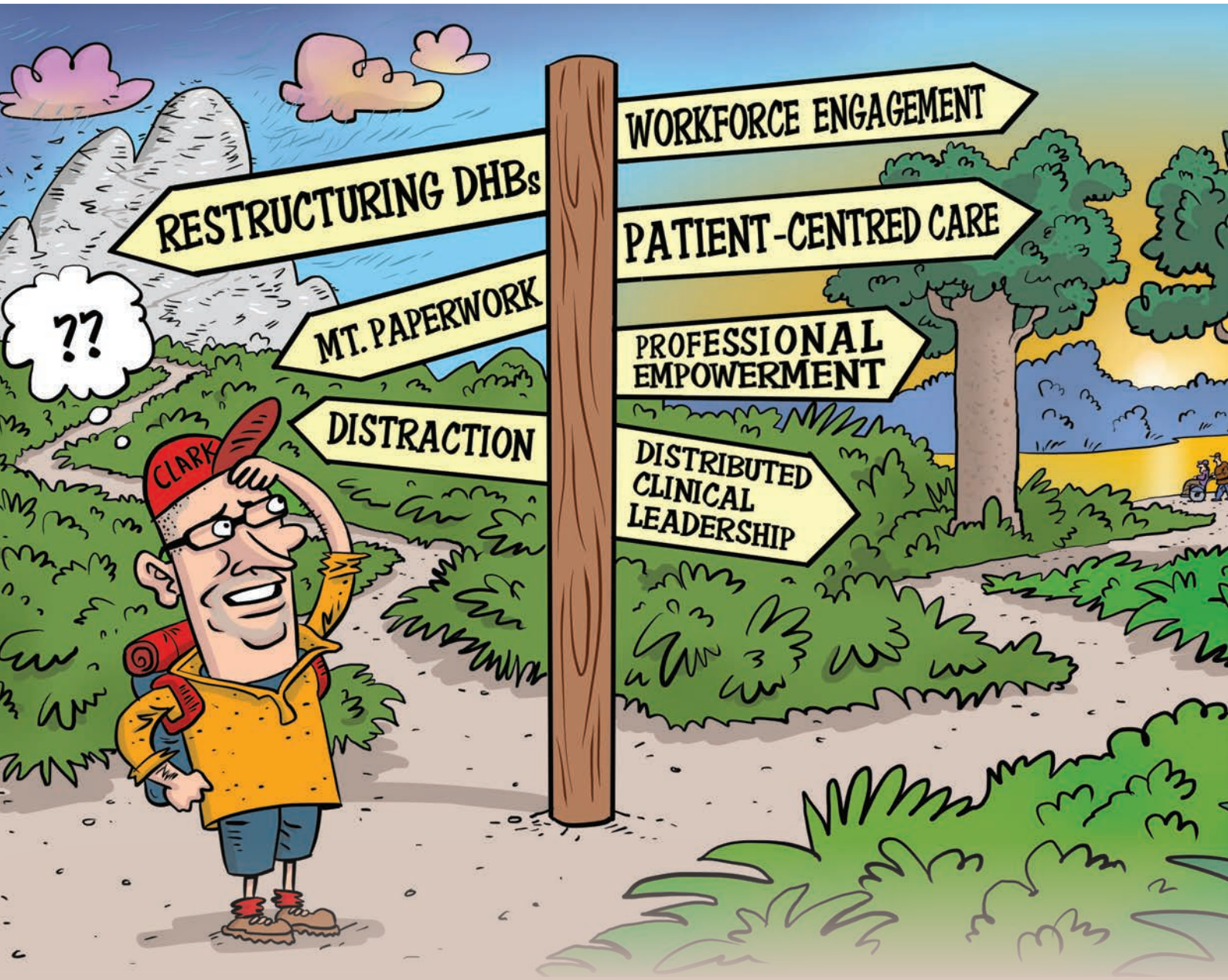

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WHICH WAY, MINISTER CLARK?

IAN POWELL | ASMS EXECUTIVE DIRECTOR

New Health Minister Dr David Clark has announced a highly significant and wide-ranging review of health and disability services. It includes district health boards but goes beyond them to include primary health organisations (PHOs) and the wider primary sector. The draft terms of reference are broad and open to public consultation, a positive approach which compares well with past government initiatives.

The Chair is Heather Simpson (the rest of the review group is yet to be appointed). Given her role as the highly influential senior adviser to Helen Clark in her different roles, especially as a three-term Prime Minister, this appointment is open to political attack.

But it must be remembered that in a previous life she was an academic health economist. Further, she was centrally involved in the construction of the current legislation that created DHBs and replaced the commercial business model that had previously governed our public health service. She knows the principles our current Act is based on more than most, and no one, including political opponents, criticises the quality of her brain cells.

This doesn't mean ASMS will not have differences with some of the things her taskforce proposes. We may well do. But whatever that might be, it is likely to be considered, and not lacking in intellectual grunt.

The review deserves to be welcomed, but with caution, depending on which way the review and the Health Minister's expectations go (hence the cover cartoon in this issue of *The Specialist*).

New Zealand's public health system, compared with universal systems around the globe, performs very well. It punches above its weight. But there are difficulties, much of which are due to sustained under-funding in a sector affected by continuing and increasing demand (especially acute and chronic). The Government advises us that it intends to address this during its occupancy of the Treasury benches. It is off to an encouraging start, but one year of reasonable funding does not make up for eight previous years of under-funding.

New Zealand's public health system punches above its weight but there are difficulties, mostly due to sustained under-funding.

The review should consider making explicit in the legislation an obligation on DHBs to ensure workforce empowerment and the well-being and health of those they employ.

RELATIONAL COMMUNITY AND HOSPITAL CONTINUUM OF CARE

There are processes and leadership culture that also constrain the effectiveness of our system. There is too much focus on primary and secondary care as somehow something being organically separate, leading to narrow constructs of 'primary-led' and 'shifting services' from the former to the latter. The focus is structural, rather than relational. Instead, the emphasis should be relational based on the continuum of care between community and hospital.

The most mature example of this is the several hundred health pathways between community and hospital (broader than just primary and secondary) at Canterbury DHB. These have been developed and agreed through effective clinical leadership (not just doctors) in both community and hospital. As a result, the outcomes are much more robust, despite serious workforce capacity issues (shortages) amongst specialists at least.

Centred on distributed clinical leadership, good relationship-based networking and patient-centred care, they have led to considerable gains both in the quality and accessibility of patient care and financial performance. This includes the unparalleled experience of bending the curve of increasing acute demand.

This doesn't mean that we don't have disagreements with Canterbury DHB over engagement; we do. But this experience confirms the importance of this low transaction cost relational approach instead of the high transaction cost contractual and structural approach. Critical to its success is the leadership culture developing these pathways (distributed clinical leadership), its networking approach and the focus on patient-centred care.

The Minister's review needs to focus on improving processes through a relational lens (sometimes called alliancing). This is not just through the networking approach between community and hospital, but also between DHBs sub-regionally, regionally and nationally. Clinically developed and led networks between public hospitals have achieved proven success in Scotland and New South Wales. We have made some progress in New Zealand but are way short of realising the potential.

For this to happen, however, we need to increase the capacity of the health professional workforce. This includes specialists who face (through leadership neglect from government to DHB) a crisis as they suffer worsening chronic shortages, burnout, presenteeism and retention loss. The review should consider making explicit in the legislation an obligation on DHBs to ensure workforce empowerment and the well-being and health of those they employ (**https://www.odt.co.nz/news/dunedin/campus/university-of-otago/crampton-protect-nz-health-staff**).

AVOID THE STRUCTURAL FOCUS PLEASE, MINISTER

But there are some alarm bells. Dr Clark has intimated in a couple of public utterances on a more structural approach; specifically, the number of DHBs. Further, medical sociologist Professor Peter Davis has argued in the *New Zealand Herald* (**https://www.stuff.co.nz/national/health/104612468/health-review-should-consider-making-doctors-visits-free-to-all**) that we should go back to the short-lived structures of four regional health authorities of the mid-1990s when the government of the day tried to run our public hospitals as commercial businesses competing with themselves and the private sector. These four authorities controlled the funding for this competitive model that subsequently collapsed under its own ideological absurdity.

I suspect Professor Davis is not proposing a return to this failed business model. It would be contrary to his own previously articulated views on this failed attempt to create a commercial market in a universal public health service. But, simplistically, he seems to be advocating for reducing our 20 DHBs to four, presumably based on the four regional groupings of DHBs we currently know as Northern, Midland, Central and South Island.

There are several problems with this approach. DHBs are responsible for defined populations. These four populations are too big and dispersed for a DHB to have an effective operational focus in both community and hospital care. It is too big an ask. Look at how difficult the relatively new Southern DHB (the result of a top-down driven merger between Otago and Southland) is finding addressing the health needs of the most geographical dispersed defined population of all our 20 DHBs.

If the objective is to improve integration in the continuum of care between community (why would it not be otherwise), then smaller is better. Where there is more than one general practice voice or PHO in our 20 DHBs, it has proven very difficult to achieve the gains that have been made in the Canterbury DHB (which has the added advantage of one GP voice to engage with; Pegasus). Creating four mammoths will severely impede this objective.

Structure is not the determinant of clinical collaboration between DHBs. There are already good examples of this happening now. One that hits me in the eye is the very small West Coast DHB and the very large Canterbury DHB, separated by a huge mountain range. There are longstanding historical roots to this collaboration but in recent years it has qualitatively advanced beyond Canterbury specialists doing lists or clinics on the Coast. Services on both sides of the Alps function in a more integrative way than before, with an encouraging Transalpine feel emerging. A big brother-small brother relationship would not have allowed this.

This is still a journey but the road map is good. But it is being achieved under two DHBs rather than through a merger (although they share some senior management functions). If it had been a merger, it most likely would have fallen short. What has been important is that by having its own DHB, the West Coast and its SMOs have had a greater voice which has benefited all.

Our current four regional boundaries are somewhat artificial. Largely historical, they do not neatly capture natural clinical synergies between DHBs. For example, while Whanganui DHB has a need to consider a close relationship with its near neighbour MidCentral, particularly vulnerable smaller services and sharing critical mass, in respect of patient referrals its clinical synergies are further north in Auckland and further south in Wellington.

Merging DHBs does not of itself save money, or at least not enough to be worth the considerable hassle and disruption. Didn't the top-down driven merger of the former Otago and Southland DHBs into the new Southern DHB work well financially with its sustained high level of debt? The politically driven failed attempt to merge by stealth the three lower North Island DHBs – Wairarapa, Hutt Valley and Capital & Coast – led only to uncertainty and a level of havoc.

The practical outcome of this review focusing on the number of DHBs will be a distraction from what is really needed to improve our public system. It would create uncertainty over the future for many working in DHBs, particularly the smaller and medium-sized ones, even greater than the poorly judged Health Benefits Ltd initiative of the former Government. The political risk of such an approach, with the next election in 2020, is high. Only policy wonks with their heads in the clouds and their feet well away from the clinical front line would contemplate going down such a short-sighted direction.

NATIONAL AND LOCAL HEALTH SYSTEMS

A feature of all universal health systems is the tension between their internal local and national systems. All health systems struggle with getting the balance right between what works best locally, regionally and nationally. Arguably, universal health systems are too dynamic to get the balance right. But it is not the struggle that is the issue. Instead it is the quality and robustness of the struggle; the better this quality and robustness, the better for our system overall.

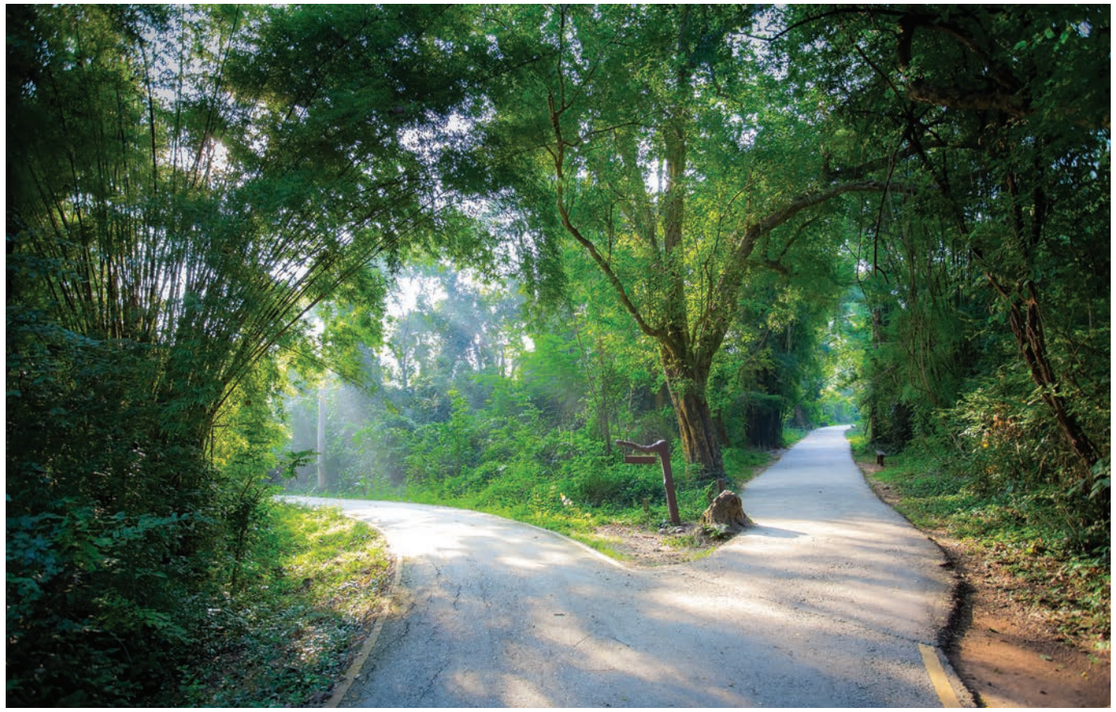
The reality is that we have defined geographic populations with variable diversity of needs as part of a national system. Each depends on and interacts with the other. It is logical, given its defined population, for example, to speak of a Northland health system. Conversely, it is illogical to speak of a northern health system comprising the three quite diverse metro Auckland DHBs and Northland.

In this context, the review would be better placed to consider how the operational role of the Ministry of Health might be better refined to facilitate (perhaps even direct) DHBs to focus on clinically-led relational-based networking within and between DHBs, and across the community-hospital continuum.

REVIEW MUST NOT BECOME RATIONALE FOR PROCRASTINATION OR DELAY

There is also a risk of the Government allowing shorter term exigencies to either be dumped in the bucket of the review's scope or continuing to be ignored. These include the crisis facing the DHB specialist workforce referred to above, and the lost opportunities caused by the failure to advance distributed clinical leadership. Both of these were glaring omissions from David Clark's first Letter of Expectations to DHBs in April. It is imperative that if the Minister is to be genuinely rather than rhetorically transformational, that he focuses on addressing them post haste.

The review deserves to be welcomed, but with caution, depending on which way the review and the Health Minister's expectations go.



A positive aspect of the Minister's Letter of Expectations to DHBs was the strong, unambiguous commitment to public provision of hospital services (and by direct contrast, his opposition to privatisation). This is also evident from his abandonment late last year of Public Private Partnerships in the South Island. It took a long time for the penny to drop but Taranaki DHB eventually realised the obvious and reversed its plan to privatise its hospital laboratory. But there is much more for Dr Clark to front foot on this. With the various services, clinical and diagnostic, that have been privatised over the years, there is a need to plan for returning these to public provision as each contract comes up for renewal. But this should not have to wait until the Simpson review has concluded. It does not need to be part of this review because the policy direction is already established. It should start now.

FUNDING MECHANISMS

The Population Based Funding formula is a matter that deserves attention but need not wait until the Minister's review. There is general acceptance that a population based funding system (with appropriate qualifiers) is sound, especially when compared with activity-driven alternatives.

But some sharply focused work is required by those with expertise in this area on fine-tuning the qualifiers, reviewing whether PHO enrolments might be a more robust method of assessing population than the five-yearly census based on smaller numbers, recognising that PBF is unreliable for addressing unexpected cost increases due to natural disasters, and making the whole process transparent instead of the current secrecy.

Major capital works funding could also be addressed more immediately instead of waiting until the review is completed. Its impact on the operational budgets of DHBs is profound and distortionary. Why not use the expertise that already exists in DHBs, particularly through the chief finance officers, to advise on this? They could look at a national risk pooling system of funding major capital works that takes the pressure off operational funding. One thing that could be done immediately is significantly increasing the decades old absurdly low threshold ($10 million) for capital works spending for triggering Government approval and Treasury monitoring.

POSITIVELY TRANSFORMATIONAL OR NEGATIVELY 'DESTRUCTIONAL'

If the Minister of Health and his review is going to lead to something positively transformational, it needs to steer away from structural change. Instead, it should focus on improving clinically-led networking processes between community and hospital, and between DHBs at all levels, on explicitly directing DHBs to be enabling workforce empowerment (distributed clinical leadership for much of what they are responsible for), and explicitly requiring DHBs to be responsible for the health and well-being of their workforce.

If they allow themselves to divert down the structural dead-end pathway, then, rather than being positively transformational, the predictable outcome will be negatively "destructional' (no such word, I know, but it fits).

THE DR BAWA-GARBA CASE: CRIMINAL LAW AND HOW IT SHOULD BE APPLIED IN HEALTH CARE

DR ROB HENDRY | MEDICAL DIRECTOR AT MEDICAL PROTECTION SOCIETY (MPS)

The case of Dr Bawa-Garba in England has created concern amongst the medical community worldwide. Doctors are afraid that if their care of a patient is judged to be seriously deficient, this could result in them being the subject of a criminal prosecution and even imprisonment. This concern is shared by New Zealand doctors.

Dr Bawa-Garba was convicted of gross negligence manslaughter (GNM) in 2015, following her part in the death of six year old Jack Adcock in 2011. She was given a two year suspended sentence and was subsequently suspended from the UK medical register for one year by the Medical Practitioners Tribunal Service (MPTS). The UK General Medical Council (GMC) appealed the Tribunal's decision and sought agreement from the High Court to instead erase her from the medical register. The appeal was supported by the High Court. MPS instructed a number of the country's top QCs to represent Dr Bawa-Garba in these hearings, and we were extremely disappointed at the outcome.

The collision that followed between the medical community and the criminal justice system has sent shock-waves around the world. 'Could it happen here?' and 'Is a career in a high risk speciality wise?' are questions many health care professionals in New Zealand are asking themselves.

A large degree of the outrage within the profession in the UK was triggered by the GMC's decision to appeal the MPTS' determination and seek to have the doctor struck off. It underscored that

The Dr Bawa-Garba case has been something of a watershed in the history of professional accountability.

those who hold doctors to account are far from developing the open, learning culture promoted as essential to patient safety. In New Zealand, it has also understandably prompted the question of what the Medical Council of New Zealand (MCNZ) would do in the same situation.

Many are also concerned by the decision to prosecute Dr Bawa-Garba for GNM in the first place, and here it is worth reflecting on some of the issues this case has brought into focus, how this area of criminal law has developed in different ways in different countries, and how (for some) it may develop in the wake of this case.

THE POSITION IN NEW ZEALAND

In New Zealand there is a statutory definition of GNM that mirrors the English legal test. Manslaughter by gross negligence is a statutory offence under the Crimes Act 1961 making it possible for New Zealand courts to treat the circumstances giving rise to the Dr Bawa-Garba case in a similar fashion to the English courts. However, for over 20 years there have been no GNM prosecutions in New Zealand and the system for holding doctors to account has developed in a very different way. Two distinct bodies unique to New Zealand, are worth considering because their influence, in my opinion, significantly reduces the likelihood of such prosecutions occurring in New Zealand.

The Accident Compensation Corporation (ACC)

When the ACC was set up in the 1970s it introduced a form of no-fault compensation for personal injury and since then an adversarial approach to medical error has not developed. Due to the scheme's statutory ban on bringing civil proceedings against medical practitioners for injury, injured parties can instead seek compensation through a bureaucratic process. This means there are fewer barriers to doctors being entirely candid with patients when things go wrong. That said, if the ACC identifies a risk to the public health and safety, they may refer the matter to the MCNZ to consider a doctor's competence.

The Health and Disability Commissioner

Health care professionals may not be accountable through the Civil Courts in New Zealand but they can be held to account by the Health and Disability Commissioner (HDC) if it is thought that they have infringed patient rights, as set out by the Code of Patient's Rights. Where the HDC has serious concerns about an individual's conduct or performance they can refer them to the Health Practitioners Disciplinary Tribunal and the MCNZ.

Professional failings are therefore usually regarded as a regulatory, rather than criminal matter. The main purpose of criminal prosecution is to punish the offender, the other is to serve as an example in order to minimise the risk of recurrence. In New Zealand, the MCNZ and the HDC effectively fulfil both theses purposes as they are afforded broad discretion in investigating, prosecuting and disciplining medical professionals accused of negligence. Hence, while the ACC does not afford medical practitioners immunity from criminal proceedings, criminal prosecution in the absence of ill intent is seen as purposeless.

THE POSITION IN ENGLAND AND WALES

GNM is a common law offence in England and Wales and has evolved from the same set of tests that apply to the civil test for negligence. In order to secure a conviction, firstly it must be shown that the individual doctor in question owed the patient a duty of care; secondly, that the doctor breached that duty of care and thirdly, that the breach of duty caused the patient harm. In civil cases these tests are used to establish whether compensation is payable to redress the harm. In the criminal arena, if the harm caused was the patient's death then the possibility of a GNM prosecution arises. The final hurdle that needs to be cleared to secure a conviction is that the jury must be satisfied beyond reasonable doubt that the level of negligence is 'gross'.

"This case has highlighted the tension between the open, learning culture we wish to see and an adversarial and punitive approach to medical errors."

"'Could it happen here?' and 'Is a career in a high risk speciality wise?' - questions many health care professionals in New Zealand are asking themselves."

So what gives rise to such cases appearing in front of a criminal court? There are two essential components which lead from the death of a patient, to the criminal court. Firstly, those investigating the death are required to obtain an independent medical expert opinion on the actions of the doctor. If, in the opinion of the expert, the care was not just sub-standard but a serious departure from the proper standard of care, the question of the doctor being blameworthy to a criminal extent may arise. It is important to stress that the standard the doctor is being measured against at this stage is one set by another doctor, not by a lawyer or the police. Without a very critical independent medical report, criminal prosecution will not get off the ground.

Next, when the matter has been fully investigated and such medical expert opinion is forthcoming the case may be referred by the police or Coroner to the Crown Prosecution Service. The prosecutor must decide whether or not a prosecution is in the public interest and if there is a reasonable prospect of a conviction.

THE POSITION IN SCOTLAND

Interestingly, the criminal law in Scotland has developed rather differently to that in England and Wales. Scotland has a separate legal system; manslaughter is not a term that features and the nearest comparable offence is culpable homicide which is defined as the killing of a person in circumstances which are neither accidental nor justified but where the wicked intent to kill required for murder, is absent. In short, the unlawful act giving rise to the death must be intentional or, at least, reckless and/or grossly careless.

The other crucial difference in Scotland is that if a charge of culpable homicide was considered against a medical practitioner, the country's most senior law officer who sits on the Scottish Cabinet is required to approve it. It is possible therefore that they would take a wider view regarding public interest than in England and Wales.

It is widely accepted that a culture of openness and low blame should be promoted in the health service, in order to learn from mistakes. Is it then in the public interest to pursue criminal prosecutions of individual healthcare professionals? While such prosecutions are rare, their effect on staff perception and morale is greatly magnified.

The culpable homicide law, and its application in Scotland, has seen one attempted prosecution resulting in acquittal.

CONCLUSION

The Dr Bawa-Garba case has been something of a watershed in the history of professional accountability. It has highlighted the tension between the open, learning culture we wish to see and an adversarial and punitive approach to medical errors.

The few health care professionals who wilfully set out to harm patients, or are reckless, should face criminal charges. However, the vast majority of health care professionals - who make mistakes while working under difficult and complex conditions – should not be labelled as criminals.

In England and Wales, MPS has provided evidence to the UK Government's rapid review into GNM in healthcare. At the heart of our recommendations, is a call for the legal bar for a GNM conviction in England and Wales to be raised; moving towards the Scottish position where charges are only brought against doctors if an act is proved to be intentional, reckless or grossly careless and is shown to be in the public interest. Many other recommendations are aimed at improving the way in which GNM cases are handled by the police, courts and the UK GMC[1]. The outcome of the UK Government's review is due to be published in the coming months and I know it will be closely scrutinised across the New Zealand medical community and beyond.

MPS has a wealth of experience in supporting doctors faced with GNM charges. Though it seems unlikely due to the differences between the New Zealand system and the England/Wales equivalent, if a doctor in New Zealand was to be charged with GNM as a result of an adverse patient outcome, MPS has access to the most experienced lawyers and barristers in the country to instruct in defence of our members.

In addition, MPS is constantly monitoring the New Zealand medicolegal environment, and if we noticed a change in how the general public and relevant authorities approach the question of criminal prosecution against medical practitioners, we will use our influence and resources to challenge those who blame and castigate hard-working doctors and we will continue to protect the interests of members.

REFERENCE

1. https://www.medicalprotection.org/uk/about-mps/our-policy-work/consultation-responses/consultation-responses/evidence-to-the-professor-sir-norman-williams-review

L-R, Back: Drs Julian Vyas, Paul Wilson, Seton Henderson, Julian Fuller, Tim Frendin.
Front: Andrew Ewens, Angela Freschini, Murray Barclay, Katie Ben, Annette van Zeist-Jongman, Hein Stander.

YOUR NATIONAL EXECUTIVE AND BRANCH OFFICERS

THE ASMS NATIONAL EXECUTIVE FOR THE THREE YEARS TO 2021 IS:

- Murray Barclay, National President, gastroenterologist, Canterbury
- Julian Fuller, Vice-President, anaesthetist, Waitemata
- Paul Wilson, National Secretary, anaesthetist, Bay of Plenty
- Hein Stander, Immediate Past President, paediatrician, Tairawhiti
- Julian Vyas, paediatrics, Auckland
- Andrew Ewens, emergency medicine, Waitemata
- Annette van Zeist-Jongman, psychiatry, Waikato
- Tim Frendin, geriatric medicine, Hawke's Bay
- Angela Freschini, anaesthesia, Tairawhiti
- Seton Henderson, intensive care, Canterbury
- Katie Ben, anaesthesia, Nelson Marlborough.

YOUR ASMS BRANCH OFFICERS FOR THE SAME PERIOD ARE:

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Nelson	Katie Ben	Gareth Harris
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Canterbury	Geoff Shaw	Siobhan Cross
South Canterbury	Matthew Hills	Peter Doran
Otago	Chris Wisely	John Chambers
Southland	Roger Wandless	Leonard Chia

Thank you to everyone who put their hand up for either the National Executive or Branch Officer positions. We appreciate your willingness to advocate and support your medical colleagues, and this shows the Association is in good heart. We would also like to acknowledge those members of the National Executive and Branch Officers who decided not to stand for re-election, and thank you for your efforts and ongoing commitment.

RESPONDING TO THE CHALLENGES AHEAD

PROF MURRAY BARCLAY | ASMS NATIONAL PRESIDENT

Becoming President of ASMS is not something I imagined when I was approached six years ago to join the National Executive. As I came to grips with the Executive functions, I became increasingly involved in the research activities of ASMS, particularly senior doctor understaffing, and the well-being issues of burnout, bullying, and presenteeism. My research background meant that I was keen to see good data on these important issues to help drive improvement. I was therefore very supportive of increasing the research capacity of ASMS with highly competent staff. We certainly have those now.

For those who don't know me, I work as a gastroenterologist and clinical pharmacologist at CDHB. I am also a Clinical Professor with the University of Otago. I grew up in small town New Zealand, Balclutha, went through Otago Medical School, have a grown family and live on the rural edge of Christchurch. My leadership experience includes being President of the New Zealand societies of gastroenterology and clinical pharmacology, and clinical directorship.

What is apparent from the ASMS research and member feedback is that the New Zealand senior medical workforce has some major problems that need addressing urgently to enable New Zealanders to get the medical care they deserve. When asked to be ASMS President, it was the findings of the research that convinced me this might be worthwhile as it was clear that further work needed to be done to both define these problems, but more importantly to attempt to bring about improvements.

I have found that the ASMS team and national executive are exceptional in their approach and passion. All are dedicated to improving the lot of senior medical staff in New Zealand, and improving the quality and equity of health care in NZ. This makes working with them a pleasure that generates enthusiasm and hope that positive changes can be made.

WHAT WE KNOW

In 2013, New Zealand ranked near the bottom of OECD countries for number of medical specialists per head of population (figure 1). Updated data is being sought but requires validation.

Medical staff burnout is topical globally but in New Zealand our frankly tragic burnout rate of 50% (figure 2) looks to be higher than in other countries where burnout has been studied. The consequences of burnout are serious for these senior doctors and for their patients who fail to get the health care benefits that result from proper engagement with their doctor. High workload is at least one of the factors predicting burnout.

More recently, we have documented high rates of bullying in the New Zealand senior medical workforce, including 38% experiencing this at least weekly and 67% witnessing bullying at least weekly. Again, high workplace demand was strongly associated with risk of bullying

The New Zealand senior medical workforce has some major problems that need addressing urgently to enable New Zealanders to get the medical care they deserve.

ASMS needs to take a strong role in advocating for the quality and equity of health care for patients in New Zealand.

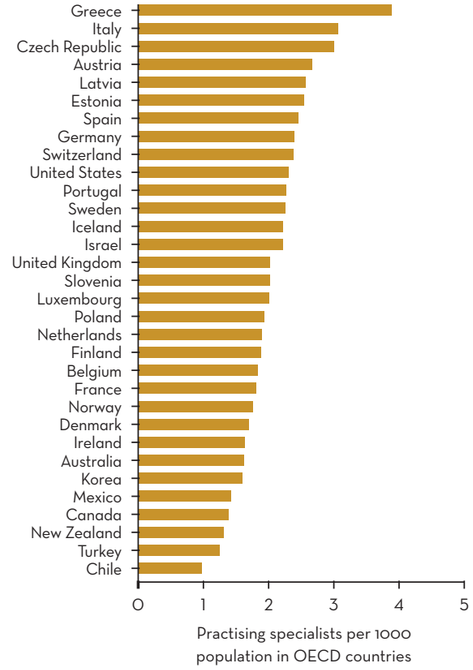


Figure 1: Practising specialists per 1000 population in OECD countries in 2013

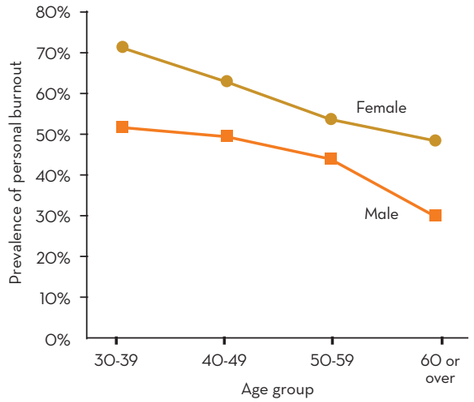


Figure 2: Prevalence of burnout related to age group and gender

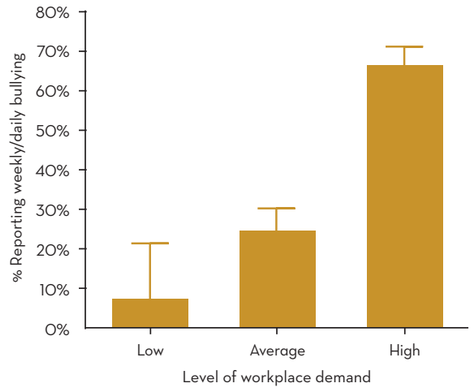


Figure 3: Bullying prevalence related to workload demands

(figure 3) along with reduced support from peers or non-clinical managers.

Disturbingly, burnout and bullying are clearly even more of a problem for female senior medical staff (figure 2) with, in particular, a burnout rate 20% higher than males at each age band (70% in young female senior doctors) and a bullying rate of 40% versus 32%.

WHAT FOR THE NEXT THREE YEARS?

At the time of MECA negotiations, the role of ASMS needs to be to negotiate for the best possible conditions for members. In between MECA negotiations, however, it seems clear that ASMS needs to take a strong role in advocating for the quality and equity of health care for patients in New Zealand. In relation to senior medical staff, the most obvious thing that needs to occur is a sharp increase in senior doctor numbers to combat unmanageable and dangerous workloads. Senior staff also need adequate time to consider service reconfiguration that provides better, more manageable health care for patients.

The ongoing series of DHB clinical director surveys on workload and FTE requirements appears to be showing consistently that New Zealand needs 25% more senior doctors per head of population just to deal with current workload expectations, let alone to provide optimal health care following full consideration of unmet need.

Our current best tool in the MECA for addressing departmental FTE requirements is regular job-sizing. In parallel, it may be that service-sizing that takes into consideration unmet health need may further define and address requirements. Service and job-sizing requires significant resourcing from DHBs and ASMS but the outcomes should more than compensate. ASMS will be helping to drive these initiatives whenever and wherever possible.

The gender inequity highlighted in our surveys over the past two years requires further exploration and definition with a view to providing some solutions for our female senior medical staff. I believe this is now a high priority for ASMS.

ASMS is a mature organisation, almost 30 years in existence, and its activities have grown beyond contract negotation. We now deal with issues around health advocacy, climate change, healthy eating, doctor well-being, gender inequity and others. Feedback from members has been positive in respect of these ASMS directions but it is probably a good time to reflect on priorities. ASMS will therefore be seeking views from members within the next year to help fine-tune priorities.

So there is plenty to do, but also some very good people doing it at ASMS. During my time on the Executive so far I have been fortunate to observe the great leadership styles of Drs Jeff Brown and Hein Stander who have brought a solidity, good humour and strength of purpose to the role that I hope I can, at least partly, replicate. And I look forward to the next three years with the hope that we can help bring about some significant improvements in health care in New Zealand, and in particular, better working conditions and job satisfaction for members.

PREPARING FOR A TOUGH WINTER IN HOSPITAL EMERGENCY DEPARTMENTS

In New Zealand, the summer months are historically a time of relative quiet but not this year, with a number of emergency departments feeling under pressure even over summer (*https://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=12004291*). Whilst there is usually a 4-6% increase in presentations year on year in Waikato Hospital, there was a 19% increase in presentations in February/March compared to 2017.

"It's going to be pretty torrid this winter," says Waikato Hospital emergency physician John Bonning, who's also the New Zealand faculty chair of the Australasian College for Emergency Medicine (ACEM).

"We're going to be flooded in particular with older people, particularly with chronic illness, as well as children. Not just at Waikato – hospitals all around the country are in a similar situation. Hospitals have been operating well above 80% inpatient bed capacity and demand has gone right up.

"At Waikato Hospital's emergency department, there's been a nearly 50% increase in presentations between April 2011 and April 2018. We're talking over 58,000 presentations pa to Waikato ED in 2010, increasing to over 63,000 in 2011 (8% increase) after the new ED opened, to well over 85,000 in 2017.

"That is a nearly 70% increase over 7 years. At the same time, the population hasn't grown by anywhere near that proportion over that period so the increase is really due to increased burden of chronic disease, diabetes, heart and respiratory illness, more trauma, more cars on the roads, older people living longer, more falls, and higher levels of unmet health need. We'd arrive at work at 8 o'clock in the morning and there would be over 20 patients waiting for inpatient bed spaces which were not available. And that was just in April before winter had started."

He says people with minor complaints are not the cause of the clogged hospital system.

"We're not busy because patients can't see their GP for something minor or because they'd stood on some Lego. We're dealing with a lot of very sick people, and it's going to increase.

We're not busy because patients can't see their GP for something minor or because they'd stood on some Lego. We're dealing with a lot of very sick people, and it's going to increase.

When pressure goes on ED, every part of the hospital system becomes stressed.

DR JOHN BONNING

"Ambulance ramping (being unable to unload patients from ambulances due to no physical space being available in ED to put them) will happen again this year (having happened in NZ for the first time in 2017 and happening in Australia for a decade) and we'll see people languishing in ED corridors again. It will be tough to find a bed and people will end up staying many hours in ED.

"When pressure goes on ED, every part of the hospital system becomes stressed, and EDs are not the place to manage patients ongoing health needs for hours on end once their acute needs have been met."

He says patients can help by taking some responsibility for their own health care, ensuring that they are vaccinated, don't smoke, that they drink alcohol in moderation, and are aware of their sugar intake. Clinicians and patients also need to be aware of the *Choosing Wisely* initiative (**www.choosingwisely.org.nz**) to ensure limited health care resources are used rationally.

"We all need to help to manage our limited health care resource as best we can."

THE RISE IN ACUTES

ANGELA BELICH | ASMS DEPUTY EXECUTIVE DIRECTOR

At many of our Joint Consultation Committees, where ASMS members met with DHB management, members raised the issue of the rise in acute presentation which had not showed the usual summer lull but continued to be high. The bad flu season in the northern hemisphere also contributed to a gathering sense of doom. The following issues were noted (some meetings did not discuss the issue):

- Northland – acute demand increasing, no summer decline in presentations, theatres stretched, ED under pressure due to bed block
- Waitemata – winter planning to minimise the impact of flu, vaccinations a big emphasis particularly of staff
- Auckland - little room to accommodate surges as serves as acute hospital for the rest of the country; some services very vulnerable
- Counties Manukau - hospital at nearly full capacity with 21 lists being cancelled at the date of the JCC, 14% growth in acute demand over the last five years without corresponding increase in beds, resilience is complicated by low morale among staff, many of whom perceive the DHBs problems as management's fault
- Waikato - see accompanying article for John Bonning's assessment
- Lakes – very busy, higher number of presentations compared with last year; at the time of the meeting, four patients in ED under the influence of methamphetamine
- Bay of Plenty - surge in presentations at Whakatane, unanticipated number of patients using hospitals
- Tairawhiti - stress on services due to understaffing
- Taranaki - long-term consistent increase in demand, DHB blindsided by rise in demand over Christmas, number of nurses the critical factor; bed block had a negative effect on electives
- Hawkes Bay - second year in a row with no summer drop off, ED designed to take 27,000 patients in 2021 now seeing 46,000, nursing numbers insufficient for the level of acuity, primary care presentations greater than the degree of population growth
- Wairarapa – higher than average demand, shortfalls have meant the cancelation of electives
- Hutt Valley - hospital already full on a number of occasions as of February, optimistic that full complement of nurses this year, looking at an escalation plan for ED
- West Coast – pressure on primary care meant overflow pressure on ED.

WHAT SHOULD ASMS MEMBERS DO?

1. Get vaccinated and make sure your colleagues get vaccinated too
2. Participate as fully as you can in planning for this winter
3. If you are too tired or sick, or you see colleagues who are too tired or sick to work, take leave or take a break. If you cannot work safely, you cannot give patients safe care
4. Make sure you are familiar with the Medical Council Statement on managing in a situation of resource constraint **https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Safe-practice-in-an-environment-of-resource-limitation.pdf**
5. Schedule breaks, weekends, leave and keep to them, and support your colleagues to do so
6. Reiterate to your managers, your Chief Executive, your Board, the Minister and the Government that the solution is adequate staffing and decent accommodation, and that today's situation is the result of the under-resourcing of the past. Job sizing should be adequate to cope with surges, and this for many DHBs is the second or third year where acutes have risen faster than the population and there has been no summer lull.

You cannot run down health funding by $2 billion without consequences.

THIS YEAR'S BUDGET HAS STOPPED THE BLEEDING, BUT WHAT NEXT?

LYNDON KEENE | ASMS DIRECTOR OF POLICY AND RESEARCH

Council of Trade Unions (CTU) economist Bill Rosenberg described the Government's 2018 Budget as a 'stop the bleeding' budget, but warned that the body of public services is still in dire straits: "While the bleeding may have stopped, we still have to get the patient well again."

The Health budget is a good example. For the first time since at least 2010, Vote Health appears to have received sufficient funding ($863 million additional operational funding) to cover rising costs and demographic pressures, compared with the previous year, as well as pay for new initiatives such as reducing primary care fees for people on low incomes and extending free general practitioner visits to children under 14. At the time of writing there remains a number of unknowns, however, such as the outcome of pay negotiations with nurses, allied health staff and others, and the pay equity settlements such as for mental health care and support workers.

CTU-ASMS analyses of the Health budgets have estimated that years of funding shortfalls have accumulated to the extent that if this year's health funding was to be restored in real terms to 2010 levels (when CTU analyses began), it would have needed an additional $2.7 billion, so is nearly $2 billion short of that mark. No one would expect a funding shortfall of such magnitude to be addressed in a single budget, but whether the public health system is to operate more efficiently and effectively, whether it is to provide timely responses to New Zealand's growing health needs and address unmet need, whether it is to provide staffing levels that are safe for both patients and those providing the care, is all dependent on a restoration to 2010 funding levels – and more.

You cannot run down health funding by $2 billion dollars without consequences. The ASMS has long argued that years of funding shortfalls merely shift the costs, both financially and socially, downstream. Those downstream effects are now evident in the trends showing increasing health service use is far outstripping the rates of population growth, including public hospital admissions.

The number of public hospital inpatients (excluding mental health and addiction services) rose by 14.1% from 2010/11 to 2016/17 (13.2% when adjusted for 'caseweights'), while the population grew by 9.3%. This growth is due largely to a 20.0% increase in acute inpatients over that period – more than twice the population growth. When adjusted by caseweight, acute inpatients increased by 14.2%.

The rapid growth in acute cases appears to have squeezed out non-acute patients, whose numbers grew by just 5.3% over the same period. That becomes a 12.0% increase, however, when adjusted by case-weight, indicating the non-acute cases are becoming more complex, possibly an effect of the aging population.

The headcount growth of non-acute patients being less than population growth suggests a growing but unmeasured level of unmet need for people with non-acute conditions, which may in turn be contributing to growing acute service need. Hospital day cases (non-overnight stays) are not included in this data but other Ministry of Health reports indicate a 16.9% rise from 2010/11 to 2014/15 (the latest data published) – again, well above the population increase of 4.8% for that period.

Increases in Emergency Department (ED) presentations and the use of Mental Health and Addiction Services (MHA) are also far exceeding the growth in population. Waikato District Health Board's ED, for example, has seen an increase of presentations approaching 70% in seven years (see separate article in this issue of *The Specialist*). And the number of unique 'clients seen' by MHA service teams grew by 50% in the years 2008/09 to 2015/16. Further, many of those clients are seen more than once in any given year, as indicated in data showing 'new referrals' to MHA triage teams increased by 62% over the five years from 2010/11 to 2015/16 (earlier data is less robust).

The big increase in acute hospital service needs has occurred as primary care use is also growing ahead of population growth. Between 2008/09 and 2016/17, primary care consultations increased by 24.3%. Much of that is due to more nurse consultations, which grew by 115.1%, while general practitioner consultations grew by 12.6%. GP consultations increased by 1.5 million, while nurse consultation

The evidence indicates clearly that both primary care and hospital care services require significant boosts in resources.

Years of funding shortfalls merely shift the costs, both financially and socially, downstream.

increased by 1.8 million, though GPs are still seeing about 80% of the patients. The population grew by an estimated 11.4% over the same period.

WHY THE INCREASE IN 'ACUTES'?

There will be many factors contributing to the rise in acute hospital admissions. Overseas studies indicate common patient factors are related to aging, low socioeconomic status, lower educational attainment, chronic disease and multimorbidity. In New Zealand, additional factors will be high levels of unmet need for primary and secondary care and mental health care, along with underlying inequalities. Poverty, poor housing, high and growing rates of obesity are all well-documented issues.

Despite the increased use of primary health care, many people continue to face barriers to those services. The New Zealand Health Survey 2015/16 shows 29% of adults reported one or more types of unmet need for primary health. The most common reasons for this unmet need were being unable to get an appointment at their usual medical centre within 24 hours, and the cost of GP services. Cost barriers to primary health services for children have been reduced through increased subsidies to general practices. However, in 2015/16 nearly a quarter of children still experienced one or more access barriers, including difficulties in getting timely appointments. The location of a primary care practice (and the local ED), and the ability to get a convenient appointment with a primary care practitioner are commonly cited barriers to primary care both here and overseas.

HOW WILL THE GOVERNMENT RESPOND?

The data indicate growing pressure in every part of the system. The question now is how the Government will respond while it is highly constrained by 'Budget Responsibility Rules' limiting government spending and debt.

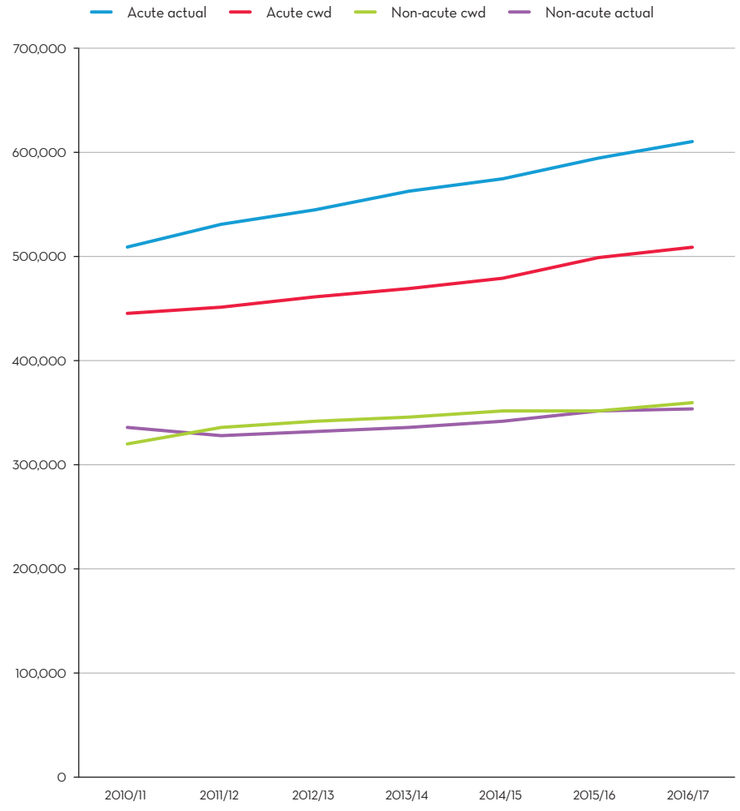
When Health Minister David Clark announced a major review of the health system recently, he stressed that the review would include "a strong focus on primary and community-based care. We want to make sure people get the health care they need to stay well. Early intervention and prevention work can also help take pressure off our hospitals and specialist services."

However, the evidence from New Zealand and overseas indicates that while measures to improve access to primary care are much needed, they do not necessarily reduce the use or need of hospital care. The dynamics are more complex.

If, under continuing budget constraint, the 'strong focus' on primary care is code for a 'rob Peter to pay Paul' approach to health service funding, the likely outcome would be an even tighter bottleneck to accessing non-acute hospital care, which in turn would create greater pressure on primary care and possibly, eventually, acute services.

The evidence indicates clearly that both primary care and hospital care services require significant boosts in resources. And studies looking at interventions to reduce acute hospital admission suggest a promising solution to reducing acute hospital admission is in improving the way the two parts of the health system work together. These issues will be examined further in future articles.

ACUTE AND NON-ACUTE HOSPITAL DISCHARGES (ACTUAL AND CASE-WEIGHTED [CWD]), 2010/11 TO 2016/17



Source: Ministry of Health Caseload Monitoring Reports (data extracted from Excel spreadsheets)

Increasing health service use is far outstripping the rates of population growth, including public hospital admissions.

WAGE-LED GROWTH: HOW LOW WAGES HOLD BACK PROGRESS

DR BILL ROSENBERG | COUNCIL OF TRADE UNIONS ECONOMIST AND POLICY DIRECTOR

We are frequently told "You can't raise wages before you raise productivity". But productivity is barely rising: employers are not investing to raise it. Why not? Perhaps they don't feel the need to because wages are kept low. Perhaps raising wages would encourage productivity to rise, funding new wage rises and creating a virtuous spiral of rising wages and productivity. As I show below, there is good logic and evidence that that could be true.

WAGES ARE IMPORTANT SOCIALLY AND ECONOMICALLY...

Wages (including salaries) are important socially as well as economically. They are easily the most important way that employees get a share of the income their work creates so they and their families can live decent lives. On average, 60% of the incomes of New Zealand households comes from wages (and even more in prime working age households).

...BUT LOW

It is widely accepted that New Zealand's wages are low compared with other otherwise high income countries. New Zealand's low share of income going to wages is one indicator, as the figure on the right shows. Another is the dominance of low wage industries in our economy, particularly in the export sector – agriculture and tourism. Qualifications, particularly vocational ones, are poorly rewarded in higher wages (eg, Crichton, 2009; Crichton & Dixon, 2011; Zuccollo, Maani, Kaye-Blake, & Zeng, 2013). We have too many working poor (four out of ten children living in poverty come from working families, according to Perry (2017, p. 144)), and we would have many more if not for income support: Working for Families, accommodation supplements and so on.

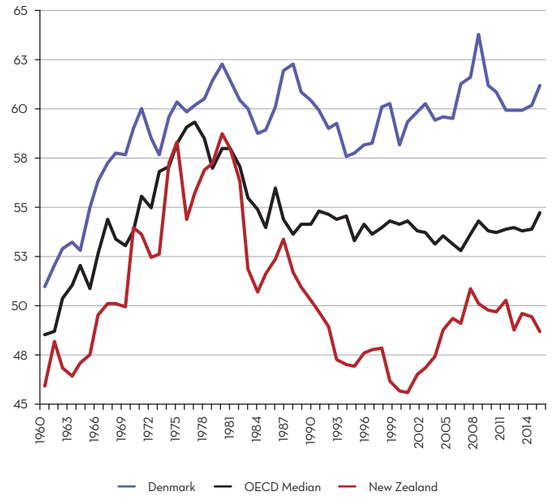
LOW WAGES CONTRIBUTE TO HIGH INCOME INEQUALITY...

The wage problem is also about how income is distributed: income inequality remains high in New Zealand (see Perry again). In the CTU's August ***Bulletin*** **(http://www.union.org.nz/economicbulletin192/)**, I summarised recent research showing growing wage inequality (Rosenberg, 2017). Gender pay inequality plays an important part too. Because wages are such an important part of people's incomes, raising wages and reducing wage inequality would have a powerful impact on overall inequality. There is ample evidence that deunionisation has been a significant cause of rising income inequality (eg, D. E. Card, Lemieux, & Riddell, 2003; D. Card, Lemieux, & Riddell, 2004; DiNardo, Fortin, & Lemieux, 1995; Jaumotte & Buitron, 2015; Koske, Fournier, & Wanner, 2012; Western & Rosenfeld, 2011). With low wages, the tax and benefit systems have much more work to do to redistribute income.

Inequality is highly correlated with, and likely contributes to many other social, mental and physical ills.

WAGE AND SALARY SHARE OF GROSS DOMESTIC INCOME COMPARED TO OECD MEDIAN

SOURCES: AMECO DATABASE, AUTHOR'S CALCULATIONS, SNZ



REAL COMPENSATION OF EMPLOYEES PER HOUR COMPARED TO SHARING THE LABOUR PRODUCTIVITY GAINS 1989-2016

MARCH 2017 DOLLARS, MEASURED SECTOR

...WHICH HAS BAD SOCIAL AND ECONOMIC EFFECTS

It's worth remembering some of the reasons high levels of inequality are bad.

- It can lead to social breakdown. There's evidence from both common experience and carefully designed experiments that people dislike unfair shares. With high inequality, people feel they are being treated unfairly, social tensions rise, cohesion as a society breaks down.
- Inequality is highly correlated with, and likely contributes to many other social, mental and physical ills. As Wilkinson and Pickett (2010) demonstrated in their book *The Spirit Level: Why More Equal Societies Almost Always Do Better,* "almost all problems which are more common at the bottom of the social ladder are more common in more unequal societies". They included lowered life expectancy, poorer mathematical achievement and literacy, worse infant mortality, more homicides, high imprisonment rates, more births to teenage mothers, lowered trust, more obesity, poorer mental health, drug and alcohol addiction, and decreased social mobility.
- It can increase financial instability and crises. For example, IMF researchers Michael Kumhof and Romain Rancière (2010a, 2010b, 2011) find evidence of increasing financial instability as inequality grows due to low and middle income earners becoming increasingly indebted in order to make ends meet. One of Kumhof and Rancière's solutions is restoring workers earnings through strengthening collective bargaining.
- It can worsen economic growth. As inequality rises, there is evidence for both more intermittent growth (eg, A. G. Berg & Ostry, 2011, 2011; A. Berg, Ostry, & Zettelmeyer, 2008) and for slower growth (eg, Cingano, 2014; Wade, 2013).

There are therefore strong economic and social reasons for improving wages in order to reduce inequality.

WAGES AND PRODUCTIVITY – REALLY?

The standard answer from employers and economists when people complain about our low wages is: "You can't raise wages before you raise productivity."

But wages have not kept up with productivity – see the graph above[1]. That is the case in the US and other parts of the world.

Productivity does need to rise for sustainable increases in wages in the long run – but there is nothing automatic about (real) wages following productivity. Since the collective wage setting system was largely destroyed outside the state sector in the 1991 Employment Contracts Act, that has not been the case. So to say wages must follow productivity is simplistic.

...AND PRODUCTIVITY GROWTH IS CHRONICALLY WEAK

But New Zealand has another problem: chronically weak productivity growth. There is no single simple answer as to why, but perhaps an important reason is low wages itself.

ARE LOW WAGES THE *CAUSE* OF LOW PRODUCTIVITY AS WELL AS THE RESULT?

Raising real wages can raise productivity at three levels.

MOTIVATING WORKERS

First, it works at the level of individual workers. Higher wages and fair treatment lead to better motivated workers who put more effort and thought into their work,

Wages are easily the most important way that employees get a share of the income their work creates so they and their families can live decent lives.

raising productivity and efficiency. There is a well-established body of research on the "Efficiency Wage" that explains why employers may set wages higher than would be predicted in a pure competitive market model.

MOTIVATING EMPLOYERS

Second, higher wages can encourage productivity increases at the firm level. Higher wages encourage employers to invest more in productivity-raising production processes including equipment and technology, and for investment to move to higher productivity firms. For example, Storm and Naastepad (2011, p. 208) list 17 studies, 15 of which show increases in productivity as a result of either increases in the real wage or improved worker rights.

CREATING AN ECONOMY THAT ENCOURAGES INVESTMENT

Third, higher wages can encourage productivity increases at the economy-wide level. If wage rises are widespread, particularly among lower paid workers who are more likely to spend their income, the increased spending creates greater demand for goods and services, encouraging employers to invest in their firms, install new technology and raise productivity and employment. Storm and Naastepad list 10 studies plus a review of 80 more that "find a causal link from demand growth to productivity growth".

How do we start this virtuous spiral of increasing wages raising productivity and thus funding more wage rises? Individual employment agreements cannot do it. The minimum wage rises are helpful, but have limited reach. To have widespread, coordinated increases we need widespread collective bargaining. Alongside these developments we need other policies such as increased research and development, improved vocational education and recognition in people's pay for attaining it, and government policy to support the development of higher productivity, higher wage industries.

By themselves, ambitious wage rises are not a silver bullet to high productivity growth. A number of policies need to be aligned. But shying away from higher wages, regarding them solely as a cost to employers, is short term, short sighted and poor policy. Higher wages are an ingredient which produces great social and economic benefits.

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CHILLING IMPACT OF POVERTY ON CHILD HEALTH

Children and young people living in the most deprived areas are three times more likely to die in childhood or adolescence than those living in the least deprived areas, says the Child and Youth Mortality Review Committee.

It released a report in April reviewing the deaths of children and young people for the period 2012 to 2016 – and Chair Felicity Dumble says the Committee's work shows poverty is a key driver of child deaths in this country.

"Children living in poverty may not be able to access health services in the same way as others, getting to the doctor and picking up or taking medicines can be harder," she says.

"Their homes may be damp and cold, food may not be plentiful, mum and dad may work one or two jobs and are unable to take them to the doctor. They may live in a crowded home where infection is spread easily or resources are stretched."

The Child and Youth Mortality Review Committee media release is on the Health Quality & Safety Commission's website at **https://www.hqsc.govt.nz/our-programmes/mrc/cymrc/news-and-events/media/3284/** and includes a link to the full report.

We asked three ASMS members for their view of the findings and their experience of the effects of poverty on child health. Here's what they had to say.

DR JEFF BROWN, PAEDIATRICIAN, MIDCENTRAL DHB

Poor kids are sicker in mind and body, die earlier, and it's not their fault

100% Pure is well known to be a marketing slogan and not the real truth. A much sadder myth is that Aotearoa New Zealand is a great place to bring up kids. It just might be – if you are not born into poverty. The reality of growing up in poverty, especially sustained poverty, is palpable in my everyday work as a paediatrician, and reflected in the harsh mirror of statistics whose visage must be impossible to ignore for all but the most cold-hearted politician.

So it gladdens my heart that there is a Child Poverty Reduction Bill in front of a Select Committee. We have a once-in-a-generation chance to cement measures and actions that endure beyond electoral cycles, provided the citizens of our country can embolden their MPs to be resolute and think beyond their own re-election.

We have a chance to address inequities that are persistent, systemic, and avoidable, and inherently unjust. Inequities that mean children growing up in the most deprived areas are three times more likely to be hospitalised, two to three times more likely to experience mental health issues, and three times more likely to die violently – by their own hand or that of others – than children in the least deprived areas. Around 45,000 children are admitted to hospital each year for conditions exacerbated by poor quality housing. Over 40% of children in social housing have fuel poverty, and major problems heating their home in winter. Families with children make up 53% of homeless New Zealanders.

And if they survive growing up in poverty, their physical and mental health as an adult is profoundly harmed, independent of their health as an infant (Dunedin longitudinal study). Accumulation of adverse events in childhood is directly responsible for a quarter of cardiovascular disease and cancers, half of mental health conditions, and almost two thirds of HIV and high risk sexual behaviours. Seven or more adverse childhood events takes 20 years off your life expectancy.

Many years ago we signed the United Nations Convention on the Rights of the Child. Over my career as a paediatrician, I have seen precious little evidence of us honestly applying what we signed up to.

I see coughing and wheezing kids from damp and cold houses. I see rotting teeth when I lift the lip of preschoolers, if they have not already had a full dental clearance of all their caried teeth. I see matted hair on maggot-infested scalps needing general anaesthetics just to clean and shave. I see primary school kids growing up in food swamps whose morbid obesity, hypoventilation and metabolic syndromes used to be the domain of adult physicians. I see rheumatic fever and bronchiectasis, 'third world' diseases of overcrowding and poverty, filling hospital beds and clinics in this rich country of milk and manuka honey.

When we surveyed families of children admitted in winter we found that half live in a damp house, just under half of their homes were insulated, one third all slept in the same room for warmth, and three quarters could not afford to heat their home.

No matter how good I am as a paediatrician, no matter how good our nurses are, no matter how good the inpatient care in hospital can be, I am discharging three in every four kids back to cold and damp homes. Which is the main reason they ended up in hospital in the first place. The solution to this is in others' hands – yet we know that insulating houses can have up to a 6:1 benefit-to-cost ratio for children and older people; and a 4:1 benefit overall.

Just maybe, with enough resolve, our political leaders can be convinced to draft a strong Child Poverty Reduction Bill 2018, a sustained Government commitment to reducing child poverty, which takes a step towards addressing the social and environmental factors affecting health outcomes for New Zealand children.

For no baby chooses to be born into poverty. And no child chooses to grow up in poverty. Yet they are the future of our nation, our true taonga.

PAEDIATRICIAN, ANONYMOUS:

Some observations from a provincial town. A personal view.

On the edge of town is a lattice of new roads, one-acre sections, pristine houses with smart colour steel roofs, sparkling European cars, sail boats in the car port. No children to be seen on a showery afternoon – must all be at school or in early childhood centres. A few minutes' drive to rows of peeling state houses, crumpled cars in driveways, dog shit on pathways, tattooed masculine arrogance and hostile adolescents. Like the weather patterns, the spectrum of social circumstances is widening with more common extreme events.

Many of the parents I see in the clinic are solo mothers. A child with complex medical needs has a mum who looks distracted. She is malnourished, front teeth missing. Couldn't come to the last appointment because she was in hospital. A three-year-old autistic boy has learnt how to unlatch the gate and runs off down the road. Most of the time there are enough people in the house to keep an eye on him... but not always. A 12-year-old with epilepsy on two drugs has failed to attend again. A three-year-old with eczema has another skin infection needing antibiotics – I can feel that no moisturiser has been applied, probably for quite a while. Mum says it's hard to find time to do it every day with long hours at work. A middle-aged couple has seven children in their care – grandchildren and their cousins. Three are developmentally delayed and need constant watching. Grandmother has given up work to look after them. A 15-year-old boy has a BMI of 63. He comes with mother and aunt who have similar body habitus. He's always hungry. We talk about diet and exercise. Surgery may be his only hope. I watch many obese children grow larger. The only child to lose weight was autistic and decided to stop eating. That wasn't good either. As I walk in town I pass a thin, dishevelled, ill-looking young man in his 20s, clutching a tattered bag. I recognise him as one of the graduates from the paediatric diabetes clinic.

A woman pregnant for the fourth time and weighing 120 kg isn't interested in taking metformin or insulin. Ultrasound shows a growth-retarded baby, so we anticipate major problems. Another baby born to a gestational diabetic weighed well over 5 kg and needed IV glucose for more than a week. A bad start in life. I sit with the mother of a wheezy infant with high flow oxygen blasting up his nose. Of course she smoked during pregnancy, but now they smoke outside, so that's okay, except when he stays with his grandmother at weekends because they all smoke over there. Another adolescent has threatened suicide and needs a constant watch on the ward. Rush to find extra staff to cover. A momentary lapse and she's gone out the window – police search the neighbourhood. An infant previously ventilated for bronchiolitis is readmitted in the early hours with a temperature of 35 and cyanosis. Ventilated again, he eventually goes home, this time with foster parents. Head injuries, scalds, near drowning, dog bites...

In health care, we try to do our best. The families we work with try to do their best too, but this can be an unending struggle. We are privileged to have the chance to help. But we are limited in what we can do.

One of my mentors knew about the effects of poverty 30 years ago. She talked about not only lack of money. There is poverty of education, of ambition, of opportunity. It is well known that deprivation is associated with poor health. We see this most starkly in areas with politico-economic instability and war. And we know that when the rich get richer, the poor get poorer. This is a global issue.

In a developed country like New Zealand, we can make choices – do we pursue economic growth and enable a small section of the community to accumulate wealth, or do we adopt a caring philosophy where government policy is aimed at improving the education, welfare and health of its poorest? We can't do both – 'trickle down' doesn't work.

If we choose to act positively it will still take more than a generation to undo the damage done by the racial and economic inequality that we, as a society, have allowed to grow.

DR JULIAN VYAS, RESPIRATORY PAEDIATRICIAN, AUCKLAND DHB, AND ASMS NATIONAL EXECUTIVE MEMBER

Poverty is good...at self-perpetuation.

If you set out to design a 'perpetual engine,' you could do a lot worse than use poverty as your model. The personal and societal detriment that poverty causes includes breakdown of community, disaffection, crime, exploitation, poor living conditions, poor nutrition, poor education, as well as harming health and wellbeing. For those afflicted by poverty the cumulative effect can often mean a loss of dignity and hope. Many specific poverty related-problems will impinge on other poverty-related problems to reiterate and reinforce a cycle of systemic disadvantage. This can then further consolidate the near impossibility of breaking free from this 'perfect storm'.

The trenchant vignette "...from a provincial town" (v.s.) will come as no surprise to anyone whose work involves clinical contact with families or whanau living in poverty. Globally, the inextricable link between poverty and poor health is long established, and is further demonstrated by the recent Health Quality & Safety Commission report by the Child and Youth Mortality Review Committee.

Although summarisation risks over-simplification of the data, there were several key findings that are worthy of emphasis. The report catalogues causes of mortality from 2012 to 2016 for New Zealanders between 1 month and 24 years of age; and categorises cause as: medical (38% total), unintentional harm (27%), intentional harm - injury by another person and self-harm (25%), and sudden unexplained death (7%). Overall, there were 2621 deaths during the time studied. There has been a trend for the total annual death rate to fall in the past 15 years, which is to be applauded. However, the report goes on to identify alarming differences between groups of young Kiwis.

- Deprivation index stratification showed that those children and young adults in Decile 10 were three times as likely to die than those in Decile 1. Those in Decile7 – 9 were approximately twice as likely to die as those in Decile 1 and 2.
- The death rate was significantly affected by ethnicity. Highest rates (per 100,000 population) were seen in Maori (52), and Pasifika (45), yet were markedly lower in Asian (19), Middle Eastern/Latin American/ African (24) and European/Others (25). To crudely contextualise this, using UN Development Programme rankings, this is akin to Maori and Pasifika children living in a country that ranks approximately 60-70th in the world, whilst all other New Zealanders live in a country ranked in the top 20. There is no shame wherever a country sits in international comparative rankings. What is shameful is that such a profound dichotomy between groups of citizens exists in the same country.
- Also of huge concern are the observations for intentional injury. In the study period, 38 children between 10 and 14 years killed themselves; and for older adolescents, suicide is the commonest cause of death. Of 19 people under 15 years who were murdered, 15 were pre-schoolers.

These and other aspects of the report make for sobering reading, and surely only the hardest-hearted of New Zealanders would not feel a desire to rectify this glaring inequity. The recent budget has shown some promise of intent to tackle this problem. However, whilst the KiwiBuild initiative, and increased funding for health and education will doubtless help address the underlying problems behind the CYMRC Report findings, they are not a panacea for this schism in our country.

The Child Poverty Action Group has proposed other changes to the welfare system that will also help alleviate household poverty. These include index linking of benefits (as happens with NZ Superannuation), increasing the earning cap to $165 per week, and a reduction in the abatement rate for moneys received over and above the maximum available via Working for Families. Hopefully the newly convened Welfare Expert Advisory Group will be empowered to provide expert instruction to the Government to overhaul the welfare system. Further analysis from the Council of Trade Unions and ASMS also underscores the fact that the current budget is a good start, but should be regarded as 'step 1' in a longer journey to correct the cumulative underfunding in state sector services.

Solving the problems of living in poverty is to unpick a Gordian knot. Pressing facets of this systemic problem, eg the deplorable differences in child and youth mortality discussed here, must be tackled as a matter of urgency. To do so without also addressing the wider, generic issues that underpin and propagate ongoing poverty risks longer term failure. This is something this Government must do all it can to avoid. For the sake of all Kiwis.

FIVE MINUTES

WITH JUSTIN BARRY-WALSH

DR JUSTIN BARRY-WALSH IS A CONSULTANT FORENSIC PSYCHIATRIST WITH TE KOROWAI WHĀRIKI (REGIONAL FORENSIC AND REHABILITATION SERVICES), CAPITAL & COAST DHB. HE IS ALSO ASMS' WELLINGTON BRANCH PRESIDENT.

WHAT INSPIRED YOUR CAREER IN MEDICINE?

It's just something I ended up doing. I had an aunt who was a nurse and a grandfather who was a GP. I can recall at a young age thinking I would like to be a doctor. I was always interested in sciences so it was a question of what to do with that interest.

I studied at Otago Medical School. I was interested in having a good time, primarily, but I did develop several other interests during that time. I was leaning towards general medicine but later on I became interested in psychiatry. I was very privileged to have Professor Paul Mullen come to the university when I was there. He was a stark contrast to the rest of the psychological medicine department, an extraordinary man who provided captivating lectures. Later on I ended up working with him in Australia when I was doing forensic psychiatry, and he became both a mentor and a friend.

Anyway, I discovered in my trainee intern year that I was good at psychiatry. I won the prize for psychological medicine in 1986, and it made me sit up and take notice that this could be a good specialty for me, that I could flourish in it. Psychiatry was, and remains, an underdog and a Cinderella specialty. I looked at the exams for general medicine and also the exams for psychiatry, and chose psychiatry.

Most of my registrar training was in Wellington. When I finished as a senior registrar, I began my consultant career in Victoria, Melbourne. I returned to Wellington in 2003, and I've been here since. I specialise in forensic psychiatry, forensic means anything to do with the law.

We love to see people who offend as being part of the other, but we need to recognise that they are actually people, and they are very disadvantaged.

Working with people over a period of years, however long it takes for them to grow and recover, and then move back into the community, is very rewarding.

My public work involves the assessment and treatment of offenders, mostly mentally ill offenders. I write a lot of reports, mostly but not exclusively for the criminal courts, and I give evidence when required. I also provide ongoing treatment.

WHAT DO YOU LOVE ABOUT YOUR JOB?

Forensic psychiatry still holds the same interest for me. It's a specialty that takes you into places that I think everyone should experience and know about, prisons and the courts, as they are such critical parts of our system. It's important to understand what awful places prisons are and why it's a national disgrace that we have such a high rate of imprisonment, especially for Māori. We love to see people who offend as being part of the other, but we need to recognise that they are actually people, and they are very disadvantaged.

There are so many social determinants involved in offending, and we're familiar with many of them. Addressing them would be a start. We need to do that, and change our thinking about offending. At the macro level, when we talk about being tough on crime, all we're doing is letting people who have power make us feel afraid, which then helps them to maintain that power.

One of the things I've always liked about my specialty is that the knowledge base is so broad. There is so much value in reading across other disciplines, everything from philosophy through to the social sciences.

I don't often get thanked directly for what I do, and that's just life. But I do often see that my involvement makes a big difference in terms of the outcomes in the courts, which is a separate system from the prison system and as a result is usually more receptive because it's not about punishment at that point. I work with people who have often done the most awful things in the context of severe mental illness. Working with them over a period of years, however long it takes for them to grow and recover, and then move back into the community, is very rewarding.

WHAT ARE SOME OF THE MOST CHALLENGING ASPECTS OF PRACTISING MEDICINE?

What I enjoy and what challenges me are pretty much the same. It's important to maintain a non-judgemental and professional approach to things, especially when confronted with behaviour or issues that most people would respond strongly to. You can't do some of the work I do without putting judgements aside.

There are also some fundamental ethical questions that arise when you work in a court system or a prison as a doctor or healer, You are used to putting the interests of your patients first and yet you're working in a system that has an interest in justice or punishment. One of the ethical problems we have is where we end up with more than one role, and whether that represents a real or imagined conflict of interest.

I've ended up with a real richness of understanding around a population that is the most disadvantaged and stigmatised. I've also been given opportunities to engage in other areas of work that are really interesting. Currently I am developing a fixated threat assessment service, with Police, the Ministry and Parliamentary Security. It involves screening concerning communications, and identifying those of that require further intervention. The fixated are people who are likely to be mentally ill. The area overlaps with extremist violence and counter-terrorism, but a its core, it is about improving the outcomes for people. That's typical, I guess, to start working on something and then finding that I am drawing on a variety of different discourses from criminology, political science, and the philosophy of everyone from Zizeck to Foucault. It's one of the things I really love about my work.

I am an advocate for what I do. I always emphasise the value of being professional in what you do so that people can have a positive experience of psychiatry. I had a few jibes when I started in psychiatry but that doesn't happen now. Colleagues understand the value of the specialty, although it's still a Cinderella among medical specialties because of the stigma around mental health.

WHY DID YOU DECIDE TO BECOME ACTIVELY INVOLVED WITH ASMS?

When I returned to New Zealand from Melbourne, I was returning from a senior role that involved some leadership, and at first I didn't have that in my role here. I've always preferred to engage with the service I'm in, so I looked for a way that I could become involved. I'm not someone who is happy to just do my job. If you see problems, it's much better to be in a position where you can engage with people over those things.

The opportunity came up to work alongside Derek Snelling as the deputy president, and I loved it. It's a role where you have to look across the entire DHB, which in turn increases your interaction with other colleagues and specialties. I became a clinical leader around the same time, about 2008/9, and that brought me more into contact with a wide range of people too.

In addition, I've always been a strong supporter of unions. Noam Chomsky says they're an important democratising influence in a country, and certainly I wouldn't want to live somewhere where unions are weaker than they are in New Zealand.

WHAT HAVE YOU GAINED OR LEARNT FROM YOUR ASMS INVOLVEMENT?

I guess it's really emphasised the importance of unions. I acknowledge that because doctors are part of an elite, we're in a privileged position and so belong to a union that is privileged. As a result it's important that we do what I mentioned earlier, we have to look beyond our own silos and see ourselves as part of a DHB and part of the bigger picture.

BREASTFEEDING AND RETURNING TO PAID WORK; ISSUES FOR ASMS MEMBERS

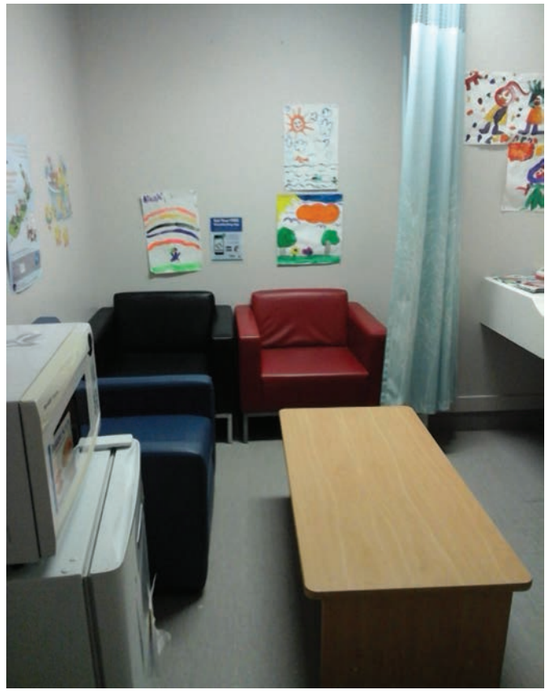
For mothers who wish to breastfeed, returning to paid work following the birth of children can present significant challenges. Research suggests that many women stop breastfeeding upon the return to paid work due to structural factors such lack of facilities and time to feed or express milk, as well as attitudinal factors such as the lack of support and understanding from colleagues and managers. This is despite the fact that breastfeeding is legislated as a right and breastfeeding upon return to paid work is explicitly supported by section 6 of the Employment Relations (Breaks, Infant Feeding, and Other Matters) Amendment Act (2008). In addition, women have the right to breastfeed and are protected from discrimination for breastfeeding under the Human Rights Act (1993).

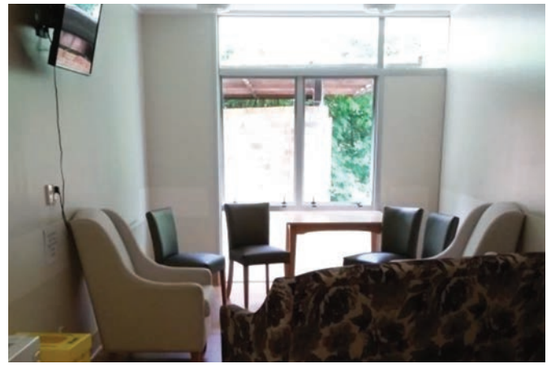
Recent research by the ASMS suggests significant barriers for female senior doctors with children who wish to continue breastfeeding upon return to paid work after parental leave. ASMS has published a *Research Brief* looking at some of the issues that breastfeeding mothers and specifically breastfeeding senior doctors may face upon their return to paid work if they wish to continue breastfeeding. It also addresses the legal rights of such women to request resources and support at work to facilitate genuine choice. The *Research Brief* first summarises relevant legislation before reviewing pertinent literature on breastfeeding and work and providing case-studies of ASMS members. It concludes by posing potential questions for employers that employees may like to raise.

For definitional purposes, breastfeeding at work is used as an umbrella term to refer either to situations where mothers may seek to breastfeed their infants or express breast milk during work hours.

The *Research Brief* is available on the ASMS website at (**https://www.asms.org.nz/wp-content/uploads/2018/06/Breastfeeding-research-brief_170113.1.pdf**).

ASMS has also asked district health boards if they have staff breastfeeding policies in place and suitable facilities available.





CLOCKWISE L-R, MIDDLEMORE HOSPITAL, LAKES DHB, WAITAKERE HOSPITAL

DOES YOUR DHB HAVE A STAFF BREASTFEEDING POLICY?*

DHB	POLICY
Northland	Unclear – DHB to advise
Waitemata	Yes
Auckland	Yes. Facilities at ACH and GCC.
Counties Manukau	Yes
Waikato	Yes, but not specifically for staff. Room available on level 1 Waiora.
Bay of Plenty	Work on a policy was done last year – not clear if policy has been rolled out. Departments identifying 'bespoke' solutions.
Lakes	Yes. A facility is available.
Taranaki	Baby-friendly accredited. A facility is available, although members have noted need for improvements.
Tairawhiti	Yes. No dedicated staff breastfeeding room, however. Facilities arranged on case-by-case basis as needed.
Hawke's Bay	No. No dedicated staff facility but work to develop one will start in July.
Whanganui	No policy sighted. Breastfeeding facility available, but it is not staff-focused.
MidCentral	No. Breastfeeding rooms are near the cafeteria and in the post-natal area.
Wairarapa	Yes. No dedicated facility but DHB advised that staff can breastfeed in maternity unit or in their workplaces.
Hutt Valley	Yes. Facility with key access available on the ground by Maori health.
Capital & Coast	Yes. Three breastfeeding rooms at Wellington Regional Hospital are available (two are public facilities and one is for staff) – near Vibe Café, level 3, ward support block. There is also a public facility at Kenepuru.
Nelson Marlborough	Yes. No specific facility available but individual solutions as needed.
Canterbury	Information to be put on staff portal. Not yet sighted. ASMS advised that arrangements are ad hoc.
West Coast	Yes. A specific room is available but most people make their own arrangements.
South Canterbury	Yes. Good facilities available.
Southern	No policy sighted. Facilities are provided.

*information correct as at May 2018

THE CAPITAL CHARGE: A FUNDING GIVE-AND-TAKE

LYNDON KEENE | ASMS DIRECTOR OF POLICY AND RESEARCH

Every six months district health boards (DHBs) are required to pay the Government a 'capital charge' on the Crown's capital (equity) funding received by DHBs. The charge, which is currently set at 6% per year, applies to any DHB operational surpluses as well as any new capital funding provided by Government. In 2017 the capital charge totalled $174.2 million (see table next page). The expectation is that the charges will be funded from DHBs' existing baseline funding.

The $750 million capital funding included in this year's Vote Health therefore comes with a 6% sting in the tail in addition to the existing charges. That sting will be more keenly felt over the coming years as Finance Minister Grant Robertson has revealed DHBs need more than $14 billion to upgrade their facilities over the next decade, due in part to deferred maintenance of hospital buildings and lack of investment in new facilities during years of funding constraint and, ironically, exacerbated by the capital charge.

DHBs have tried to reduce the impact of the capital charge by using government loans to finance capital projects because they carried lower interest rates. As indicated in the table, total interest on Crown loans was $58 million in the year to June 2017. But this avenue of funding was closed off last year when the then Government told DHBs they could no longer access Crown debt financing for funding capital investment. All Crown capital funding is now made via Crown equity injections, and DHBs have been directed to convert their existing Crown loans into equity, thereby making Crown debt financing subject to the capital charge.

DHBs are caught in a negative spiral where the capital charge on top of depreciation costs is contributing to financial pressures that are forcing them to defer maintenance.

The capital charge presents strong disincentives for DHBs to invest in capital, including maintenance.

CAPITAL CHARGE AND INTEREST ON CROWN LOANS FOR THE YEAR ENDING JUNE 2017

DHB	CAPITAL CHARGE ($M)	INTEREST ON CROWN LOAN ($M)
Auckland	39.4	7.4
Bay of Plenty	7.2	3.8
Canterbury	16.2	4.1
Capital & Coast	5.7	8.4
Counties Manuka	18.2	7.9
Hawke's Bay	5.9	0.8
Hutt	5.9	2.2
Lakes	2.9	1.5
MidCentral	7.7	1.6
Nelson Marlborough	6.4	1.6
Northland	8.1	0.5
South Canterbury	0.5	0.3
Southern	5.0	2.5
Tairawhiti	1.7	0.5
Taranaki	4.3	1.5
Waikato	15.2	5.1
Wairarapa	0.4	0.6
Waitemata	21.6	6.5
West Coast	0.7	0.3
Whanganui	1.2	1.0
Total	**174.2**	**57.9**

Source: Ministry of Health 2017. Totals may not add up due to rounding.

THE STATED PURPOSE OF THE CHARGE

The charge was first introduced into central government in the early 1990s (though later in the health sector) as part of a wider policy to emulate market forces within government. Bringing public sector capital accounting into line with private sector conventions in respect of returns on capital was an attempt to create a 'level playing field' by disguising the most significant difference between the two sectors.

In addition, the proponents of the charge, including Treasury and private sector interests, argued that public service agencies tended to view capital as a 'free good'. A capital charge would provide incentives for those agencies to improve their capital management and to dispose of surplus fixed assets (which then became available for purchase by potential competitors).

Despite the widely acknowledged failure of the market-oriented policies and the return to a more cooperative, non-

The $750 million capital funding included in this year's Vote Health comes with a 6% sting in the tail in addition to the existing charges.

competing public health sector model in 2001, with the establishment of district health boards (DHBs), the capital charge has remained. But the rationale and fairness of the capital charge regime, which effectively has the government playing shareholder and banker to DHBs, have come under question, including from the Auditor-General.

THE IMPACT OF THE CAPITAL CHARGE

Among other things, the Auditor-General has observed that challenging budgets over the years have led DHBs to focus on meeting immediate operating needs while there has been a consistent underspending against budget for capital expenditure. Ministry of Health data show DHBs underspent their planned capital spending by $200 million in the year to June 2017.

Aside from the pressures of funding constraint, the capital charge presents strong disincentives for DHBs to invest in capital, including maintenance. New and well-maintained assets generally have a higher value than older assets and so incur additional expenses (such as depreciation expense, as well as capital charges). By not spending on building and equipment, these additional expenses can be avoided in the short term.

However, in the longer term (and in some cases the 'longer term' is today for some deferred maintenance of the past), maintenance costs become higher. This has been the case, for example, for the Southern DHB, where a report from consultancy firm Sapere found financial pressure led to the 'false economies' of patching up buildings on top of earlier patches. Several buildings, including the nine-storey clinical services block, were assessed as being at the end of their service life and were in such poor shape that they were unable to be economically 're-lifed'. International studies show the long-term cost of deferred maintenance can be many times that of an early intervention cost.

The impact on services can also be costly, financially and in terms of the quality and safety of health care. As the Sapere report found, the "deteriorating physical environment is eroding quality of care, creating safety risks, and causing distress to patients and staff," as well as causing delays and "leading to an increased likelihood of adverse events for both staff and patients".

The literature strongly indicates poor maintenance can create health and safety hazards, including increased incidence of hospital-acquired infection, whether it is through damp and mouldy buildings such as revealed at Counties Manukau DHB in numerous media reports over recent months, or poorly maintained heating, air-conditioning or water systems. According to a report on Britain's National Health Service, patients with a hospital-acquired infection on average remain in hospital 2.5 times longer than an uninfected patient and incur hospital costs that are almost three times greater.

A SOLUTION?

In summary, the stated intention of the capital charge to create a level playing field for competition with the private sector is anachronistic – an example of the long-term distortions which the ideology-driven changes of the 1980s and 1990s continue to create for public services in New Zealand.

The evidence on the other stated intent of the capital charge – to achieve greater cost efficiency in the management of health service capital assets – indicates the unintended consequences of the policy are resulting in not only significant inefficiencies in capital management but also inefficiencies and safety risks in service delivery.

After media enquiries about the ASMS' *Research Brief* on the capital charge, released in May, Health Minister David Clark issued a statement to *New Zealand Doctor*, saying that he had asked for work to be done on the charge:

"Treasury itself admits the capital charge may have caused delays in investment leading to the situation today where we have infrastructure, including hospital buildings, which is past its use-by date. It seems very sensible to me that we have a hard look at the incentives in the system and consider whether there are better ways of doing things. This is particularly important work given our plans for substantial investment in capital projects across the health sector including construction of the new Dunedin Hospital. However, in the case of the new Dunedin Hospital, there's plenty of time for the capital charge issue to be addressed before the project is completed in 2026."

Meanwhile, the inefficiencies and safety hazards caused by the capital charge are worsening with time. DHBs are caught in a negative spiral where the capital charge on top of depreciation costs is contributing to financial pressures that are forcing them to defer maintenance, leading to service inefficiencies and increased capital costs – and additional capital charges – down the track.

On the weight of evidence, and considering the potential impact of the looming capital charges indicated for the next decade, there is a compelling case for their immediate abandonment.

The full *Research Brief* is available online at **https://www.asms.org.nz/wp-content/uploads/2018/05/Research-Brief-Capital-Charge_169877.2.pdf.**

ASMS
TOI MATA HAUORA

SPECIAL CIRCULAR 2018/6

TO: **All Financial Members of the ASMS**

SUBJECT: **2018 ANNUAL CONFERENCE, CONFERENCE REMITS**

Dear Member

I am writing to advise that the Association's 30th Annual Conference will be held in Wellington at Te Papa on 29-30 November 2018 (Thursday-Friday). Please schedule this in your diary. Delegates are also invited to attend a networking function on the evening of Wednesday 28 November. The function will be held at The Boatshed on Wellington's Taranaki Street Wharf and will be generously sponsored by MAS.

Any member or any branch (as well as the National Executive) may forward written remits for consideration by the Conference. Remits may include amendments to the Constitution, policy and other matters. Pursuant to Clause 10.4 of the Constitution, the respective deadlines for receipt of remits by the National Office are:

Constitution amendments
Wednesday
29 August 2018

Any other remits
Monday
29 October 2018

The Conference attendees comprise both National Executive members and branch delegates, although only the latter may vote. Each branch is entitled to one delegate per 25 members (with a minimum of one delegate per branch).

Should you be interested in attending the Conference please contact your local branch representative or Support Services Administrator, Angela Randall, at the national office: ar@asms.nz. Financial members are also able to attend as observers. The Conference programme, based on issues relevant to ASMS members, will be confirmed and advised later. To date the programme, in addition to normal business, includes:

- Minister of Health's Conference address followed by Q&A
- Presidential Address from Professor Murray Barclay

I will write directly to branches later advising of Conference information and remits for discussion.

Yours sincerely

Ian Powell
EXECUTIVE DIRECTOR

ASMS SUBMISSIONS

In the past few months, ASMS has made the following submissions to parliamentary select committees and working groups:

- Submission to the Tax Working Group: **https://www.asms.org.nz/wp-content/uploads/2018/05/Submission-to-the-Tax-Working-Group_169851.3.pdf**
- Submission to the Education and Workforce Select Committee on the Employment Relations Amendment Bill 2018: **https://www.asms.org.nz/wp-content/uploads/2018/04/Employment-Relations-Amendment-Bill-2018_169461.10.pdf**
- Submission to the Foreign Affairs Defence and Trade Committee on the Comprehensive and Progressive Agreement on Trans Pacific Partnership (CPTPP): **https://www.asms.org.nz/wp-content/uploads/2018/04/Submission-to-the-Foreign-Affairs-Defence-and-Trade-Committee-on-the-Comprehensive-and-Progressive-Agreement-on-Trans-Pacific-Partners_169784.2.pdf**
- Submission to the Social Services and Community Select Committee on the Child Poverty Reduction Bill: **https://www.asms.org.nz/wp-content/uploads/2018/04/Child-Poverty-Reduction-Bill-submission_169693.2.pdf**
- Submission to the Health Committee on the Health Practitioners Competence Assurance Amendment Bill 2018: **https://www.asms.org.nz/wp-content/uploads/2018/04/HPCA-Act-Amendment-Bill-submission-2018_169688.2.pdf**
- Submission to the Governance and Administration Select Committee on the State Sector Crown Entities Reform Bill: **https://www.asms.org.nz/wp-content/uploads/2018/04/Submission-Crown-Entities-Act-Amendment_169654.2.pdf**

VITAL STATISTICS

New referrals to psychiatric inpatient services increased by 70% between 2010/11 to 2015/16 (from 3,055 to 5,198).

New referrals to psychiatric outpatient services increased by 139% over the same period (from 1,055 to 2,517).

Workforce projections indicate an estimated 675 psychiatrists, or 13.2 psychiatrists per 100,000 population, will be practising in New Zealand by 2026. World Health Organisation and European Commission data indicate many comparable countries already have greater numbers of psychiatrists per capita, some by a wide margin. In 2015, eight European Union countries recorded more than 20 psychiatrists per 100,000 population.

SOURCES:

Ministry of Health. Mental Health and Addiction: Service Use – Series. Updated data (unpublished).

Ministry of Health. Unpublished specialist workforce projections.

WHO (2014). Global Health Observatory (GHO) data. ***http://www.who.int/gho/mental_health/human_resources/psychiatrists_nurses/en/***

Eurostat. Mental Health: How many psychiatrists in the EU? European Commission, October 2017. ***http://ec.europa.eu/eurostat/web/products-eurostat-news/-/EDN-20171010-1?inheritRedirect=true***

DID YOU KNOW

... ABOUT WORKPLACE REDESIGN

If your work or office space is being 'redesigned' or moved, you must be consulted before a final decision is made and throughout the process to ensure that what you get is of good quality, suitable for you needs and generally 'fit for purpose' (MECA clauses 53.1 and 53.2). If you and your colleagues are not being consulted, seek advice from an ASMS Industrial Officer.

...ABOUT VOCATIONALLY REGISTERED 'TRAINING' FELLOWS

If you are a 'Training' Fellow with vocational registration, even on a fixed term contract, both the law and the MECA require you to be paid as a specialist on the MECA's specialist scale (MECA clauses 11.3 and 12.2(a). If you or a Training Fellow in your service is being underpaid, you should seek advice from an ASMS Industrial Officer immediately.

... ABOUT ADVERSE WEATHER EVENTS

If an extreme weather event or natural disaster stops you getting to work, you may still be 'entitled' to salary for the day under your DHB's Natural Disaster (Adverse Weather) - Responsibility in Getting to Work Policy, which you might like to read. Your 'right' to receive salary in these events is not necessarily assured but the policy softens the general rule that, in return for your salary you have a responsibility to take all reasonable efforts to get to work on time.

... ABOUT SECONDMENTS

'The MECA clause 36.4 means you can apply for a secondment of two weeks, every three years. Secondments must be to a recognised unit for the purposes of your professional development and to upgrade your skills relevant to your duties and responsibilities. Contact your DHB for the process and application. If your application is declined then feel free to contact your industrial officer for further advice.

HISTORIC MOMENTS

EACH ISSUE OF *THE SPECIALIST* WILL FEATURE A PHOTOGRAPH OR DOCUMENT FROM THE ASMS ARCHIVES. YOU CAN FIND MORE SLICES OF HISTORY ON THE ASMS WEBSITE (**WWW.ASMS.NZ**) UNDER 'ABOUT US'.

NEW ZEALAND MEDICAL ASSOCIATION

PATRON: HER MAJESTY THE QUEEN 26 THE TERRACE, P.O. BOX 156, WELLINGTON. TELEPHONE (04) 724-741

Ref: AK TOP 132/4/3

29 March 1989

Mr G Travis
Industrial Relations Manager
Palmerston North Hospital Board
Private Bag
PALMERSTON NORTH

Dear Mr Travis

CONDITIONS OF EMPLOYMENT - OPHTHALMOLOGISTS

We are initially making an informal approach to alert you to the problems arising from the exceedingly heavy workload currently experienced by the three ophthalmologists employed by the Palmerston North Hospital Board.

It is quite clear that these specialists have been under a great deal of pressure and stress for the last 4 years since they have been caring for the patients from Wanganui as well as covering the full complement of patients from Palmerston North - in excess of 200,000 patients for 4.5 years whilst only being funded for 134,000. Although you have a small group of dedicated doctors, they have almost reached the end of their tether, and we feel it is in the interests of both our members and of the Board that this problem be investigated and alleviated as soon as possible.

Neither the union nor the doctors concerned want to take a personal grievance but it is possible that this may be the only way to resolve the serious workload problem currently existing. One of our representatives will be available to come to Palmerston North to discuss the problem at any time should this be of any assistance.

Yours sincerely
ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

J Thomson

Jill Thomson
Executive Officer
(Salaried Medical Officers' Services)

cc Dr T R Ellingham

AFFILIATED WITH THE BRITISH MEDICAL ASSOCIATION AND THE AUSTRALIAN MEDICAL ASSOCIATION

ASMS SERVICES TO MEMBERS

As a professional association, we promote:

- the 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 DHBs, which ensures minimum terms and conditions for more than 4,000 doctors and dentists, nearly 90% of this workforce
- advise and represent members when necessary
- support workplace empowerment and clinical leadership.

OTHER SERVICES

www.asms.nz

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

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

ASMS job vacancies online
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.

Substantial discounts are offered for bulk and continued advertising.

ASMS Direct

In addition to *The Specialist*, the ASMS also has an email news service, *ASMS Direct*.

How to contact the ASMS

Association of Salaried Medical Specialists
Level 11, The Bayleys Building,
36 Brandon St, Wellington

Postal address: PO Box 10763,
The Terrace, Wellington 6143

P 04 499 1271
F 04 499 4500
E asms@asms.nz
W www.asms.nz
www.facebook.com/asms.nz

Have you changed address or phone number recently?

Please email any changes to your contact details to: **asms@asms.nz**

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TOI MATA HAUORA
www.asms.nz

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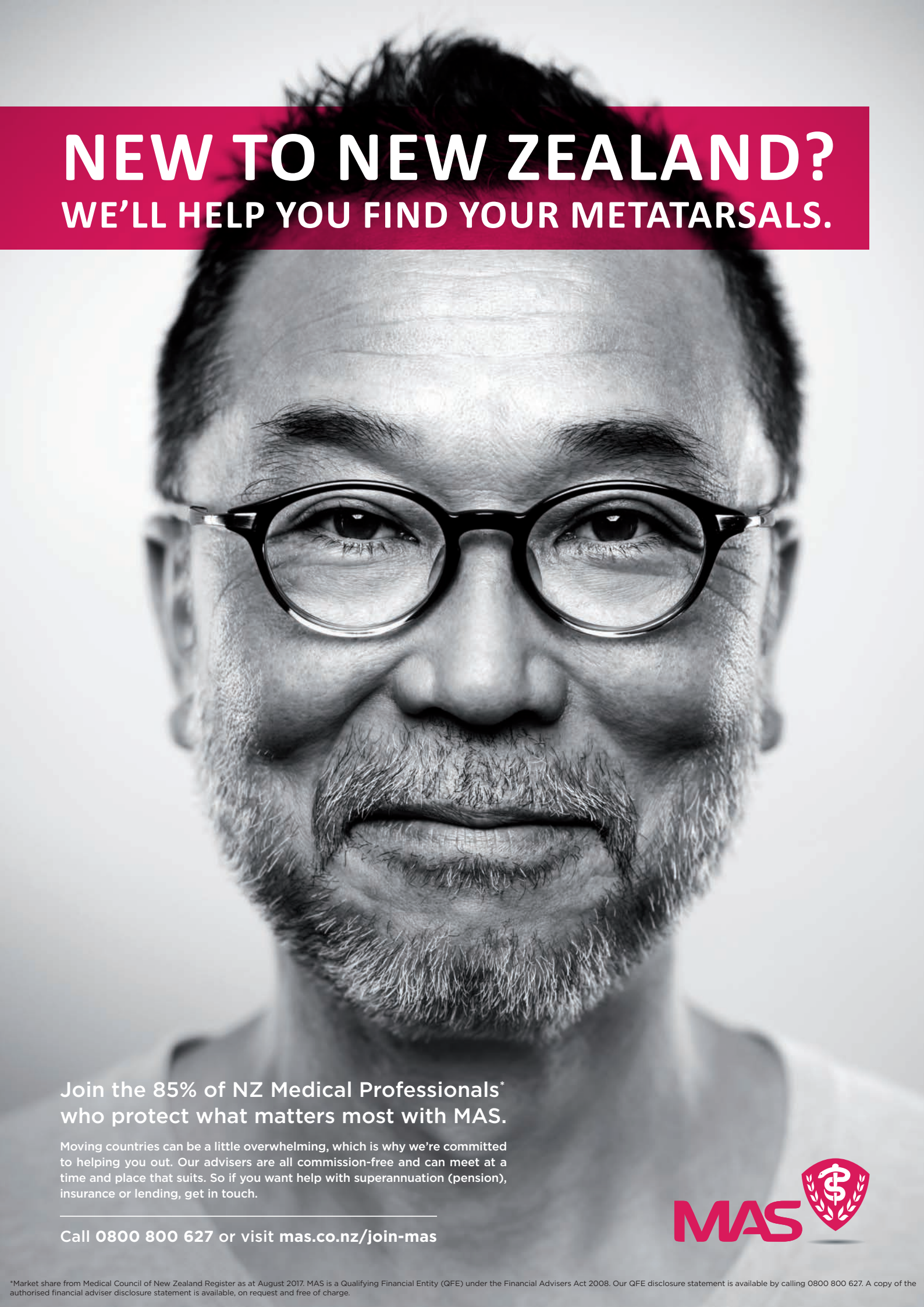
NEW TO NEW ZEALAND?
WE'LL HELP YOU FIND YOUR METATARSALS.
Join the 85% of NZ Medical Professionals* who protect what matters most with MAS.
Moving countries can be a little overwhelming, which is why we're committed to helping you out. Our advisers are all commission-free and can meet at a time and place that suits. So if you want help with superannuation (pension), insurance or lending, get in touch.
Call 0800 800 627 or visit mas.co.nz/join-mas
MAS
*Market share from Medical Council of New Zealand Register as at August 2017. MAS is a Qualifying Financial Entity (QFE) under the Financial Advisers Act 2008. Our QFE disclosure statement is available by calling 0800 800 627. A copy of the authorised financial adviser disclosure statement is available, on request and free of charge.