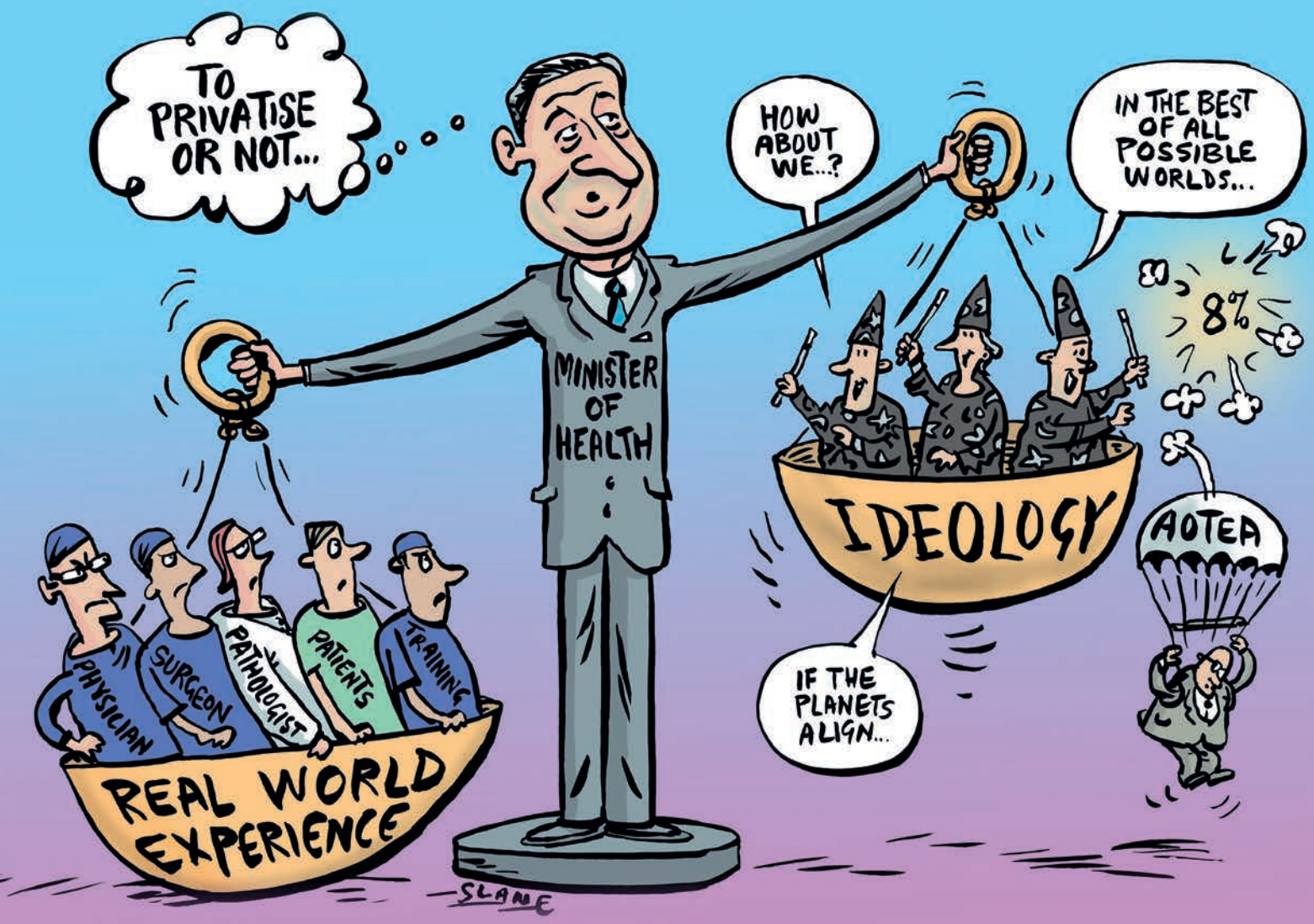
THE SPECIALIST

THE MAGAZINE OF THE ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

ISSUE 102 | MARCH 2015



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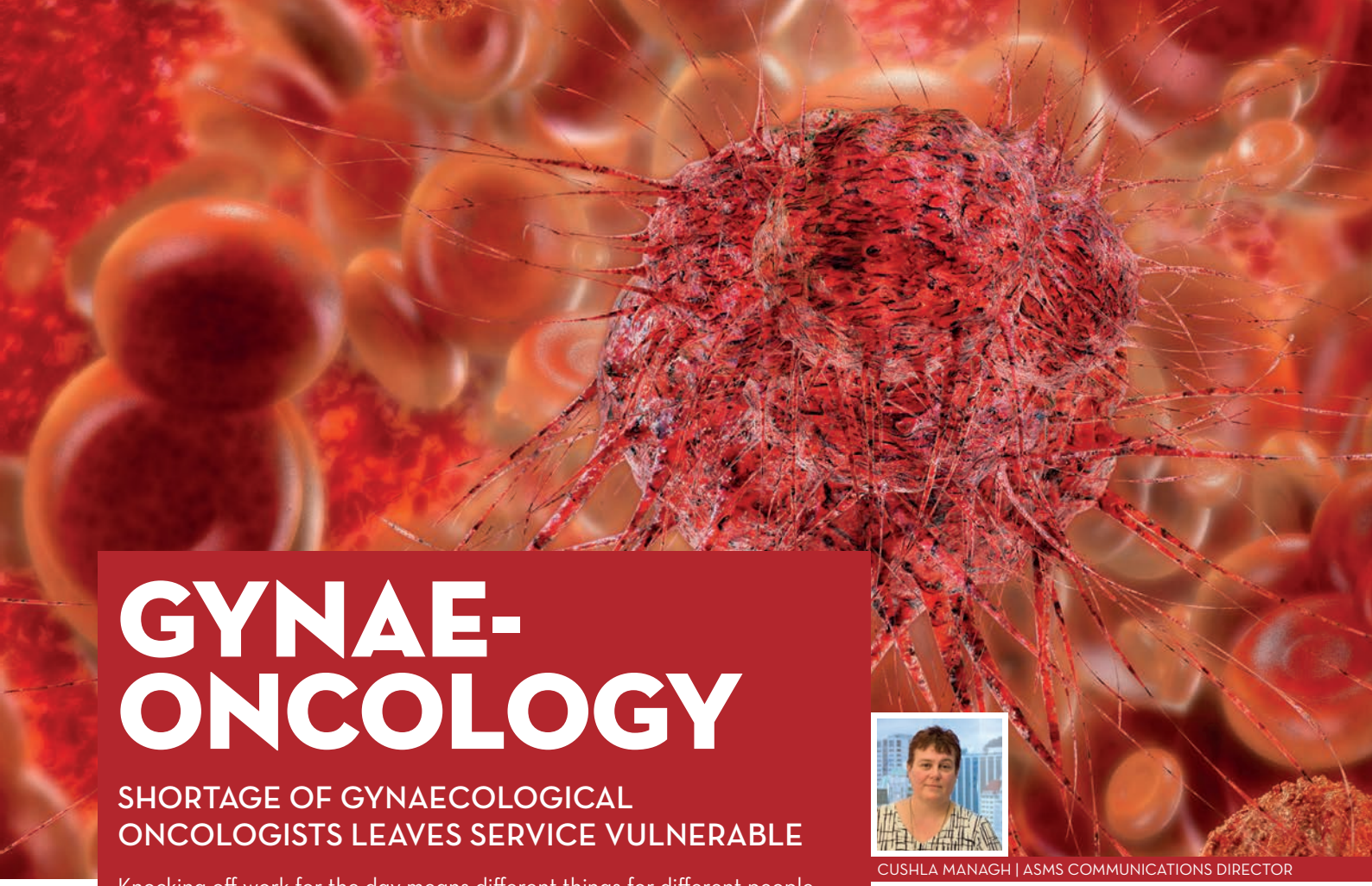
The Specialist is produced with the generous support of MAS.

ISSN (Print) 1174-9261
ISSN (Online) 2324-2787



GYNAE-ONCOLOGY

SHORTAGE OF GYNAECOLOGICAL ONCOLOGISTS LEAVES SERVICE VULNERABLE

Knocking off work for the day means different things for different people – time to catch up with family or friends, to go for a run, read a book (or write one), plan a trip, or tackle the mountain of laundry that's grown in our absence. The boundary between work and personal time is not always clear-cut, of course, but for many of us there comes a point in the day when we are able to shake off the tethers.

CUSHLA MANAGH | ASMS COMMUNICATIONS DIRECTOR

For Cecile Bergzoll, however, the work day often just blurs into the work evening. When the sun goes down and the clocks tick over and the buildings begin to cool, she rolls up her sleeves to do all of the things she couldn't get to earlier: correcting letters, analysing data for business cases, contributing to annual reports, polishing presentations.

And on some of her days off, she operates on patients.

"There is so much to do," she says.

Dr Bergzoll is a gynaecological oncologist based in Wellington, and one of a handful scattered around New Zealand. For a country of this size it has been estimated we need at least 11 gynaecological oncologists distributed across Auckland, Wellington and Christchurch. Instead, we have just 7 of them, and they're struggling to cope.

Dr Bryony Simcock, Gynaecological Oncologist, Canterbury:

"Gynaecological oncology in New Zealand provides a world class service in less than world class conditions. We need to be staffed appropriately.

> *"It's not exactly rocket science. If any one person fell, then the system would topple. It's that vulnerable."*

Associate Professor Peter Sykes, Canterbury:

"It takes a while to train a sub-specialist, and there's an international market."

About a thousand New Zealand women a year are diagnosed with a gynaecological cancer, most commonly uterine cancer (about 40%), followed by ovarian cancer (34%), cervical cancer (18%) or vulval/vaginal cancer (7%). Up to 70% of women with gynaecological cancer require radical surgery and/or specific radiation therapy procedures.

Historically the treatment of these cancers fell to general gynaecologists but in recent decades a new sub-specialty has emerged to bridge the medical words of oncology and gynaecology – known as gynaecological oncology, and nested within its parent specialty of obstetrics and gynaecology.

The sub-specialty first appeared in the United States and Australia during the 1960s/70s, and by the 1980s both countries had solid training programmes in place. It was slower to take root in New Zealand – affected at least partly, says Peter Sykes, by the fallout from the 'Unfortunate Experiment' at National Women's Hospital in Auckland, which was exposed by Sandra Coney and Phillida Bunkle in 1987. Significant public mistrust made obstetrics and gynaecology (and its fledgling offshoot) a less attractive option for many doctors.

By the 1990s, however, the new sub-specialty had begun to make its presence felt, and in 1997 Peter Sykes returned to New Zealand after a period of sub-specialty training overseas. He was this country's first certified gynaecological oncologist.

But while the number of sub-specialists has grown in stops and starts since then, securing funding for training and positions, and then recruiting to them, has been very difficult.

"There's been no funding for training in this country," says Peter Sykes.

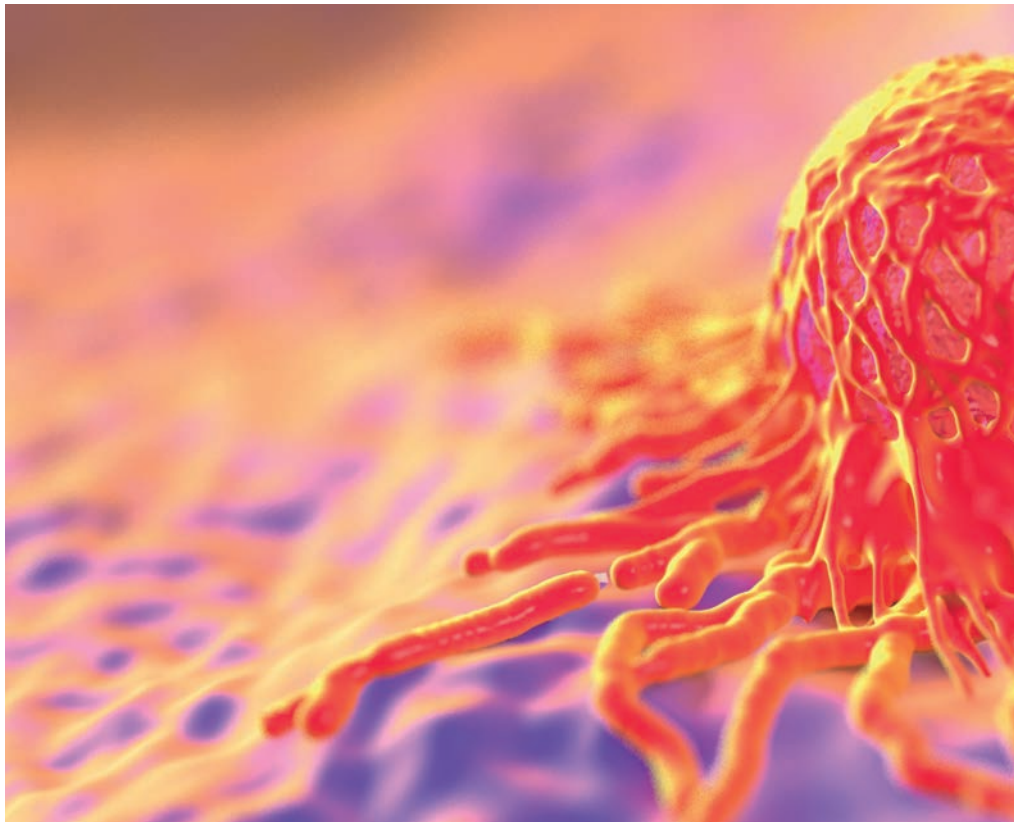
> *"All the O&G has been focused on obstetrics roster cover so gynaecology oncology has been a Cinderella, less of an immediate need than other things."*

In addition, the lure of Australia and other countries has been strong. Three years of sub-specialty training is provided in Australia – and many of the registrars who have gone to Australia to train have subsequently decided to stay there.

That's hardly surprising, says Peter Sykes. The Australian gynae-oncology centres are bigger,

DR CECILE BERGZOLL

ASSOCIATE PROFESSOR PETER SYKES



ASMS CONCERNED BY INADEQUATE RESOURCING

"The ASMS is very concerned by the inadequate resourcing of gynaecological oncology in this country," says ASMS Executive Director Ian Powell.

"We're talking about very small teams of dedicated and highly skilled professionals who are dealing with very heavy workloads and doing everything they can to ensure that women in their regions receive the best possible treatment for gynaecological cancer.

> ***"Burnout is a real concern for this group and such heavy workloads are not sustainable. It's not sensible to have a situation where the service is made vulnerable by the absence of any one specialist."***

"This service needs to be properly funded and resourced to ensure it is sustainable. If it collapses due to inadequate resourcing, that would be a disaster for the medical specialists and other dedicated health professionals who have spent years training and working in this area, and also for the many women who stand to benefit from their expert treatment and care.

> ***"The shortage in this area is part of a bigger picture of entrenched shortages in the medical workforce which needs to be addressed."***

more developed and better supported. The workload is less onerous because there are more specialists, and people are able to earn more.

> ***"It's not just about the money. It's about the mix of things. Here you might be working on your own, having to set up a service.***
>
> ***"It's tough yakker doing that. I did it for the South Island at one point. I was in the hospital seven days a week, and I did that for a decade. People are working very hard to make sure the service works."***

New Zealand sub-specialists have also struggled to get proper recognition of the need for their service from district health boards (DHBs), he says.

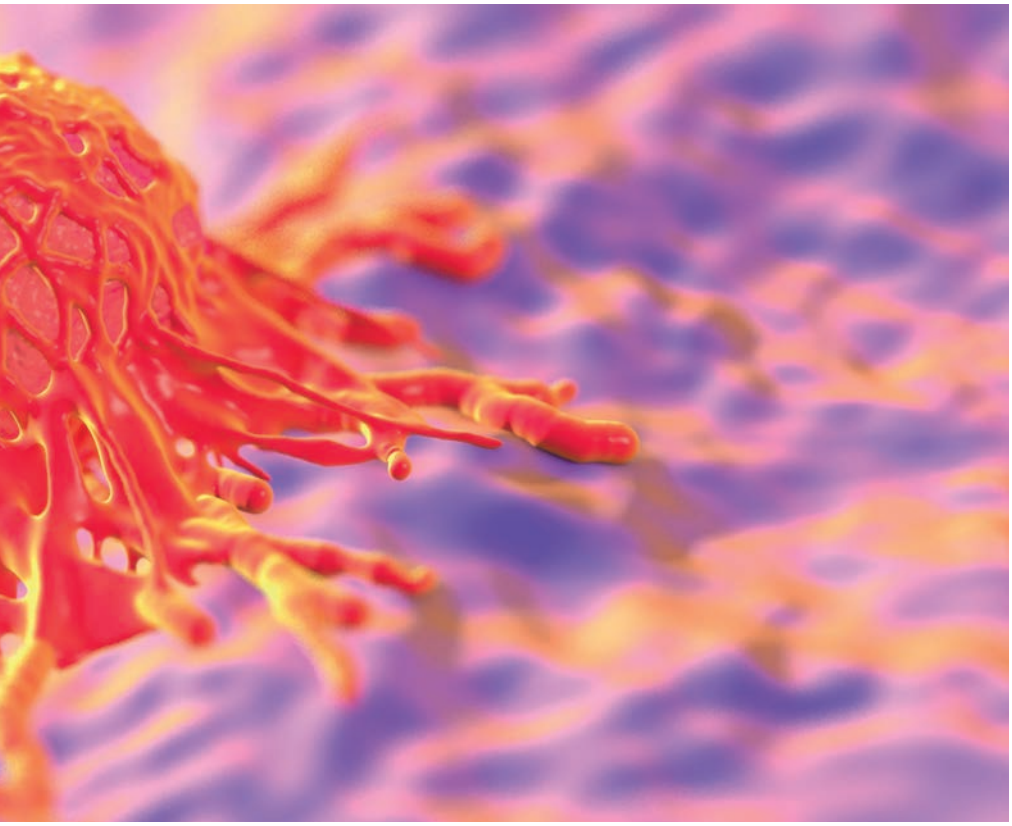
In 2010 the Ministry of Health asked a group of doctors, nurses, managers, patient representatives to audit gynaecological cancer care services in New Zealand. Their report, *'It Takes a Team'*, was submitted in July 2011 to the New Zealand Gynaecological Cancer Group (NZGCG) and is available online at http://www.health.govt.nz/publication/it-takes-team. The group proposed a national service plan for gynaecological oncology to improve equity and access to treatment. The preferred model of care involved a multi-disciplinary team, led by two or three gynaecological oncologists, in four expert centres spread around New Zealand.

Peter Sykes says the Ministry has indicated approval for three centres of expertise – Auckland, Wellington and Christchurch – but these do not come with central funding attached. It is now up to DHBs to provide adequate resources, hence the business cases that the Wellington team, led by Cecile Bergzoll, has been working at night to prepare.

"My workload involves three full-time days of administration, which I don't have time for, so I do it in the evenings," she says.

It has been estimated that Wellington requires three gynaecological oncologists for the 240 women diagnosed with gynaecological cancer each year in the central region, which covers seven DHBs from Wellington to Hawke's Bay and Taranaki. Instead, the region has just Cecile Bergzoll as 1FTE and Howard Clentworth who works part-time and is due to retire within 18 months.

"We are short on the ground. We are not able to deliver the care we would like at all levels, and working in isolation as a specialist is not good," says Dr Bergzoll.



"The team in Wellington has been struggling for years with limited theatre time, nursing time and literally no administrative support. Every member of the team is working very hard to give the best care they can, given the circumstances."

All three specialists agree that Wellington is hardest hit by the shortage.

"If Cecile left Wellington, there would be a major problem," says Peter Sykes. "It's very fragile. There could be major problems with service provision. She desperately needs help."

Capital & Coast DHB has approved temporary funding to appoint a locum gynaecological oncologist for 12 months. It's not a proper fix but, given the circumstances, this will buy some time until a permanent solution is secured.

Bryony Simcock says the workload pressures are being felt all around the country, and she cites the example of a Fellow who pulled out after one year of her fellowship because of the size of the workload.

"At the international gynaecology cancer meeting, which is held every two years around the world, one of the speeches was on the rate of burnout among gynaecological oncologists, especially among women who are trying to do so many things," she says.

"You're working, working, working. You wouldn't do it if you didn't have a complete passion for it. You're dealing with women whose quality of life is threatened or their lives are at risk. We love it, absolutely, but it's very demanding."

Peter Sykes says DHB chief executives have signed off on the model of three centres of gynaecological oncology expertise.

"It's just middle management getting all wrapped up in the business cases and the money. If the DHBs really recognise the need for this, they will fund it. They have to."

He is optimistic the situation will improve over the next five years, given the Ministry's support for a three-centre model. The others are less sure, but remain hopeful.

Cecile Bergzoll:

> *"If we can make this work in the central region, it will be great. It will be a real system improvement that could help women. We're not asking for the moon. If I could just get a colleague and a secretary and a dedicated nurse in Wellington, then patients could get adequate treatment faster and consistently."*

IMPROVING THE NATIONAL GYNAE-ONCOLOGY SERVICES

The report 'It Takes a Team' prepared for the Ministry of Health and submitted in 2011 outlines a proposed national improvement plan for gynaecological cancer services. The full report can be read at: http://www.health.govt.nz/system/files/documents/publications/it_takes_a_team-_national_plan_for_gynaecological_cancer_services_22_july_2011.pdf

The report's findings include:

- All women with gynaecological cancer should have timely and equal access to appropriate multidisciplinary specialist cancer services, but this was not the case in New Zealand.
- Gynaecological cancers comprise about 10% of all cancer cases and 10% of all cancer deaths in New Zealand.
- Evidence shows that women generally have better outcomes if they are treated by a sub-specialist trained gynae-oncologist and reviewed by a multidisciplinary team.
- A review had found that, on average, women with ovarian cancer treated by a gynae-oncologist as part of a multidisciplinary team lived an additional 11 months.
- The New Zealand Cancer Registry shows that Maori and Pacific women have a significantly higher incidence rate of endometrial and cervical cancers than non-Maori and non-Pacific women. Maori women also have poorer survival rates for cervical and endometrial cancers.
- Gynae-oncology in New Zealand is a small, vulnerable but essential service for women and their families. The report identified the following challenges with service provision:
  - building a sustainable workforce
  - achieving equitable access to evidence based services
  - aligning the funding and purchasing framework with optimal provision
  - collecting data on quality and outcomes.
- There was a strong rationale for improving national coordination and planning of services. However, no one at that time had the mandate or capacity to agree on the best way to develop and use New Zealand's gynaecological cancer resources. There was no clear decision mechanism to ration access to gynae-oncologists.
- The lack of national coherence also meant there was no standard set of referral pathways and no nationally agreed clinical guidelines.

THE RISKS OF PRIVATISING THE WELLINGTON REGION'S LABORATORY SERVICES

APPROVAL FOR THE PROPOSAL TO PRIVATISE THE HOSPITAL LABORATORIES AT CAPITAL & COAST AND HUTT VALLEY DHBS ULTIMATELY RESTS WITH THE MINISTER OF HEALTH.

(L) DR JEANNETTE MCFARLANE | CLINICAL HEAD, ANATOMIC PATHOLOGY, LABPLUS, AUCKLAND HOSPITAL
(R) DR ANJA WERNO | MEDICAL DIRECTOR MICROBIOLOGY, CANTERBURY HEALTH LABORATORIES

At the time this article was written for publication, his decision was not known. However, concern about the clinical and operational risks of privatisation was so strong, the ASMS asked Drs Jeannette McFarlane and Anja Werno to outline the essential points the Minister must consider when reaching his decision.

The Wellington region DHBs (Capital & Coast and Hutt Valley) are attempting to merge the community and hospital laboratories, and privatise the latter. Local clinicians, including pathologists, were excluded from the privatisation decision, and no details are yet available, but it appears likely the successful bidder will be a subsidiary of one of the two large Australian laboratory companies, Healthscope and Sonic Healthcare (45% shareholding of Aotea). Both companies are listed on the Australian Securities Exchange.

> *Subsequently, however, Aotea has withdrawn its bid, citing strong criticisms of the DHBs' process. If the privatisation proceeds the hospital laboratories would be run by Healthscope.*

As specialists committed to the long term future of laboratory services in New Zealand, we hope the Minister of Health will reflect very carefully before supporting this recommendation. He should consider the long term consequences and take into account other DHBs' experiences of private laboratory services elsewhere in the country before succumbing to the siren song of short term cost savings that may not be maintained once a private company is in a sole regional provider position.

Laboratory services are at the centre of health care, and neither the hospital or community health service can survive without them. If the Wellington privatisation goes ahead, the three DHBs will have ceded control of an essential function to an outside entity whose raison d'etre is to maximise profit for its overseas shareholders – an economic short-sightedness at best as this does not constitute financial re-investment into the New Zealand market.

Once public hospital laboratories become privatised there is effectively no back up if parts of the service fail, and no way to reinstate pathology in the public health system. Small, highly specialised services such as immunopathology will be very vulnerable and may collapse entirely. The private company's bid will cover only the most basic investigations, and all of the extra unfunded work that public laboratories currently do will be lost. Highly specialised and innovative tests might not be offered, or they might be sent to public laboratories at other DHBs within New Zealand, provided they are not already privatised, or the tests will be sent to an overseas provider at substantial cost with diminished control over quality. Alternatively, there is a significant risk that patients will be asked to pay for these investigations themselves.

There are very strong incentives for Healthscope to under-price their bid for the contract in the expectation that they would be able to renegotiate later. Once ensconced and the other laboratories closed, the DHBs would in practice have very little control or governance role.

In other regions, the privatisation of laboratories and changes of contracts between private providers have proved much more problematic than expected, and there are continuing issues that will take many years to resolve.

> *In some instances, DHBs have had to engage in lengthy and costly legal action, money that was effectively taken away from patient care.*

Seemingly simple matters like achieving compatibility between computer software systems have required substantial investments that had not been allowed for.

We appreciate that the DHBs need to spend their budget responsibly and should be looking for ways to improve efficiencies, but have serious concerns that any short term savings will not be maintained and that there will be unforeseen long term costs that will not be in the best interests of our patients. If New Zealanders are to have access to the highest standards of healthcare in years to come, it is essential to invest in the laboratory services that underpin advances in treatment. The money that would be taken overseas as profit under a private company would be better spent on new technology and long term investment in the laboratories.

There is a major part of the pathology services' function that is invisible on the DHB's balance sheets – the close working relationships between the laboratories and their end users. Communication, discussion and advice from pathologists to clinicians are largely hidden from hospital management but behind the scenes we are deeply involved in the care of individual patients. Wellington and Hutt Valley pathologists are also integral to the teaching and training of medical students and resident doctors from a wide range of clinical departments.

> *Any change of ethos if the laboratories are contracted out to a private provider risks losing the hospital culture that underpins those working relationships.*

We believe that this proposal is an inherently high risk venture that will destabilise the health services of the wider Wellington region for years to come and, in reality, is unlikely to achieve the savings promised by those promoting privatisation.

We would strongly urge the Minister of Health to evaluate all options for the future of laboratory services in the Wellington region and take the advice of local specialists before making any decision.

OTHER READING

- ASMS Health Dialogue – Proposed privatisation of hospital laboratories: weighing the risks of unintended consequences (Wairarapa, Hutt Valley and Capital & Coast DHBs). http://www.asms.org.nz/wp-content/uploads/2014/11/Health-Dialogue-Laboratories-Privatisation-CCDHB-HVDBH-WDHB_162600.3.pdf
- Auckland Region District Health Boards: Review of transition to new community laboratory services provider – a report by Graeme Milne and Jens Mueller, 30 September 2010.

DR HEIN STANDER | ASMS NATIONAL PRESIDENT

NEW ZEALAND PUBLIC MISSING OUT ON BASIC HUMAN RIGHT

Saturday 20 December 2014, and I find myself alone in Auckland. I'd arrived a day early for the Jethro Tull concert the following evening, and friends were due to join me the next day. Later that afternoon, I strolled down Queen Street to the Viaduct area and spent some time there while observing big-city-Saturday-evening-human-behaviour. I noticed Aucklanders display, and also tolerate, a wide spectrum of human behaviour.

About 9pm I wandered along to an upmarket restaurant, where I was informed that there was an hour-long wait for a table. I decided to while away the time in the restaurant's lounge/bar. The bar counter stretched across the room, with seating for two at one end. The perfect place to sit while waiting for a table-for-one. As I walked across I found the spot was already occupied by a gentleman in his late forties, who clearly shops at 3 Wise Men. He was winning the battle with a $400 bottle of gold label Dom Perignon.

I seated myself alongside, ordered a drink and gestured to the man's bottle of bubbly.

"Celebrating?"

He replied: "Yep, closed a business deal earlier today". We started chatting and it turns out he is also an out-of-towner. He left 20 minutes or so later, having successfully defeated the Dom Perignon.

I turned my attention to the cocktail-ordering patrons and the bartender who was doing his best impression of Tom Cruise in the movie 'Cocktail' while using mountains of crushed ice for his creations. A stylish couple placed their order just as "Tom Cruise" ran out of crushed ice. He sent his helper to replenish the supply, but not wanting to slow down the service, he took a clean white towel, placed it on the work surface, filled it with ice cubes, rolled it up and proceeded to bash it with a small club shaped like a baseball bat. When he stopped, the woman watching said: "That reminds me of my granny in China, washing our clothes on a rock in the river".

> *That's when it hit me. The inconvenient truth. Something we all know but find it is best to ignore while we go about our daily lives. The fact is this: the human experience of life on earth covers a wide spectrum.*

Some of the news headlines at that time went through my head. The devastating effects of Ebola, leading to death and complete disruption of families and society. Young children attending school in Pakistan and never getting to go home because the Taliban decided to target their school that day. These and other sobering thoughts put a damper on my evening, and by the time my table became available, I felt privileged and guilty sitting down to a delicious medium rare grass-fed fillet steak in a stable country like New Zealand.

Thoughts on the inequality of human life continued over the following days, and spurred me on to research and read on the topic. I stumbled across a real eye-opener of a documentary called "Inequality for All". In it, Robert Reich, a former Labour Secretary for the USA, discusses the gap between rich and poor. He reviews the history of how this gap developed and predicts it will continue to widen with grave consequences unless a change occurs. Highly recommended viewing.

I quickly realised that to prevent complete information overload and my brain exploding, I needed to concentrate on the New Zealand situation. I found two excellent publications both by Max Rashbrooke: "Inequality: A New Zealand

Crisis" (279 pages) and also a shortened version of the original book, "The Inequality Debate: An Introduction", which consists of the original book's first two chapters, updated by Max Rashbrooke. I read the latter and found the information quite disturbing.

Some facts and figures from the book:

- How much does an individual have to make in a year to get into the top 10 percent of income earners in New Zealand - $200,000, $500,000, $1 million? The answer is just $76,000.
- The wealthiest 1 per cent of New Zealanders together owns three times as much as is owned collectively by the poorest 50 percent of the population.
- About 790,000 New Zealanders live below the poverty line, including more women than men, and a great many children.
- One major report on children's welfare ranked New Zealand 28 out of 30 developed countries, better only than Mexico and Turkey.
- 13,000 New Zealanders have incomes over $250,000.
- One possible factor, beyond globalisation and productivity, for stalling work incomes is the workforce's declining power. Union membership in New Zealand fell from nearly 70 per cent of all workers in 1980 to just over 20 per cent by 1999. Over the same period, the share of national income going to wage and salary earners dropped from 60 percent in the 1980s to a little over 45 per cent by 2002. This is lower than in almost any other developed country.

Max Rashbrooke covers many a topic in this book, as well as the dynamics in inequality and comparative data with other countries, etc. The chapter "The Great Divergence" opens with the following paragraph: "In the two decades [80s and 90s] framing these changes, the gap between those at the top and bottom of the income ladder in New Zealand opened up more rapidly than in any other comparable society."

> ***I am not a politician and I don't understand economics. I am a salaried medical officer working in the New Zealand public health system.***

I asked myself: where does health and in particular, access to health care, fit into all of this? "Dirty Politics" aside, we live in a world that politicians (governments) create. They determine the regulations that govern our daily lives, the level of funding for public services and the laws we need to live our lives by. They set the taxes and, more importantly, how big business and the "filthy rich" get taxed. Treasury obviously has a big role to play. They can either create a convergent society (reducing the inequality gap) or a divergent society (increasing the inequality gap).

Digressing slightly, I sincerely hope they keep this in mind while, behind closed doors and with great secrecy, they negotiate the TPPA (Trans Pacific Partnership Agreement). I urge, no, beg you, to watch Eric Monasterio's presentation to the ASMS 26th Annual Conference on how the TPPA might adversely affect health care in New Zealand, viewable at https://www.youtube.com/watch?v=FYXndJVJbm8. Please read his article in this publication if you haven't done so already. You cannot sit on the fence on this issue!

Inequality? Where does the New Zealand Government stand on this? On 10 December 2014 during question time in Parliament, Prime Minister John Key defended National's track record on addressing inequality. An OECD report formed the basis of this parliamentary question/answer exchange. It became a 'it-got-worse-under-Labour-and-better-under-National' political spin contest of who did what and when and added nothing to reducing inequality. (http://yournz.org/2014/12/11/norman-and-little-versus-key-on-income-inequality/).

There is mounting evidence that the economic growth of countries where the inequalities gap is small or reducing is better than those with bigger or increasing inequality. The OECD report published 9 December 2014 (http://www.oecd.org/els/soc/Focus-Inequality-and-Growth-2014.pdf) states: New OECD analysis suggests that income inequality has a negative and statistically significant impact on medium-term growth. Rising inequality by 3 Gini points, that is the average increase recorded in the OECD over the past two decades, would drag down economic growth by 0.35 percentage point per year for 25 years: a cumulated loss in GDP at the end of the period of 8.5 per cent.

Rising inequality is estimated to have knocked more than 10 percentage points off growth in Mexico and New Zealand.

> ***My question remains: what is the inequality gap when it comes to access to health care in New Zealand?***

What do the New Zealand public and Government expect of a publicly-funded health care system? Where does access to health care rank as far as basic human rights are concerned. What do we see as adequate minimum standards of living? Access to clean water, food, shelter, clothes, education? Where do we draw the line on access to health care?

Amnesty International (www.amnesty.org.nz/makerightslaw/definitions) defines minimum standards of living as: "The basic needs and services such as health care, safe water, food, education, and housing that are necessary for an individual to survive."

Measures of Poverty:

- Measures of income - these are based on disposable income (what you earn minus your tax and any benefits), adjusted for family size and composition, used to measure if people fall above or below the adequate standard of living.
- Material Deprivation - a measure of material deprivation based on the number of families/children that 'go without' a given number of items due to financial constraints. Measures for material deprivation include going without fruit and vegetables, postponing doctor's visits and feeling cold because you cannot afford heating.

Poverty is not just a lack of income – it is the denial of adequate access to resources to survive, such as water, food and medical care. It is also a lack of the security and power that people need in order to live with dignity.

Timely access to health care clearly falls within the realm of minimum standards of living.

Is there inequality to access to health care in New Zealand?

We are all too familiar with the pressure that is being placed on the public health care system. I refer to my previous column where I discussed the iron triangle and the increasing pressure that is being placed on all three corners of the triangle: resource, time and scope, and increasing demand for improving quality and safety even further.

Is the increasing pressure on the public health care system reducing or increasing access to health care?

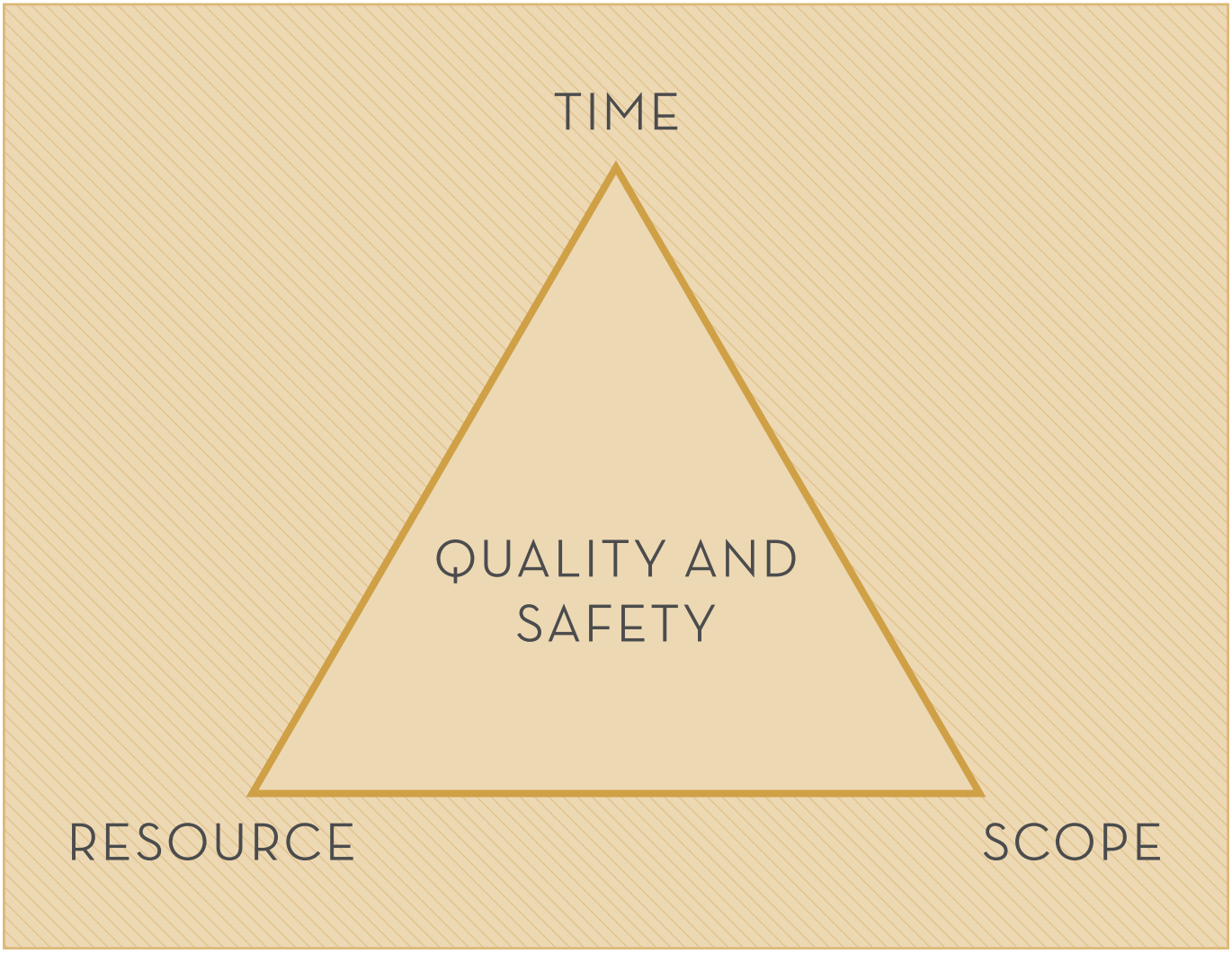
To enter the New Zealand health care system you do so through the primary care "door" but there is an "entrance fee" to pay. Should you require secondary or hospital care, a referral is made to secondary care where a complex process is initiated. This process is well described in a letter by Dr Barnaby Nye in response to a patient that felt she was missing out on treatment she deserved. (www.stuff.co.nz/life-style/well-good/inspire-me/66206884/Doctors-face-balancing-act-treating-patients). "We are tasked with drawing a threshold to treat patients in the public system and must weigh the benefits for each of these ... Our budget demands a certain number of cases be done per year but with limited operating time, operating on [one person] potentially denies more than 30 [other people] the chance of treatment."

If you are turned away from the public health system there are a few options available to you:

1. Accept your current health problem and go without being further assessed and/or treatment.
2. Wait for your health condition to worsen or become more urgent and, if you can afford it, pay your "entrance fee" again, hope that a fresh referral is made and accepted. During this process you become part of the 'unmet health need' pool (on which we have little and poor data).
3. If your long-term health problem becomes more acute, you can enter the public health system, free of charge, through your DHB's emergency department.
4. Alternatively, if you can afford it and/or have private health insurance, you can be referred to the private health system.

> ***Is there evidence that we do have inequality in access to health care? Well, yes.***

In the Ministry of Health report "Health of New Zealand Children" (http://www.health.govt.nz/publication/health-new-zealand-children-2011-12) one in 20 (or 44,000) sick or injured children missed out on after hours medical care due to cost. Rates are higher for Maori and Pacific children, with one in 10 Maori children missing out on after hour services. Surely not, with under-six-year-olds now entitled to free health care?



In 2011, 87% did receive free health care but this slipped to 83% in 2011-2012. One in seven adults missed out on receiving health care.

The system is complex and real life experience is documented in an article "Free Health Care - Yeah right!" (http://www.stuff.co.nz/the-press/news/8315208/Free-healthcare-Yeah-right). The fee for seeing a GP for children aged under six is at best confusing, varies by postcode, with poor public awareness of the "system" and entitlement.

For further evidence of inequality that exists in health care in New Zealand it is worth reading: "Left Further Behind: how policies fail the poorest children in New Zealand" and "Indicators for inequality for Maori and Pacific people", August 2014, a working paper on public finance.

> ***At this point I want to look at solutions rather than just keep pointing out what most, if not all of you, already know.***

As part of the ASMS 25th anniversary celebrations last year, we invited one of the world's leading thinkers on the operation of health systems in times of economic austerity, Professor Martin McKee, to speak. He provided solid evidence that a country should invest in health care. It is money well spent. He described the significant economic and health gains to be achieved from governments investing in public health: (http://www.asms.org.nz/news/asms-news/2014/08/26/argument-investment-public-health/).

Politicians might argue there is a limit to the amount of money available and the financial constraints, etc. They fully understand and "we are doing the best we can". In an article in the Guardian entitled "Universal Healthcare: the affordable dream", several examples of countries that have moved towards or achieved university health care (UHC) are discussed: (http://www.theguardian.com/society/2015/jan/06/-sp-universal-healthcare-the-affordable-dream-amartya-sen). They successfully addressed inequality in access to health as well as improving health outcomes. In Thailand, where UHC was introduced in 2001, the infant mortality rate has dropped to 11 per 1,000 and is now shared between the poorer and the richer part of the country. The article is a very good read.

I think it is clear that we can do better in New Zealand if there is the political will to do so. Counter intuitively, in New Zealand the majority of the public needs to pay to be seen by a primary care physician.

To conclude, the time has come for politicians and the Treasury to change their language and mindset. Money being spent on public health care does not go down into a bottomless pit. Money invested in public health and the health of the population is money well invested that will pay dividends. The pressure being applied to the corners of the iron triangle with chronic under-resourcing is contributing towards increasing health inequality.

Evidence shows that a healthier population can contribute more to the economy, thereby enhancing economic growth. A reduction in inequalities in society will have significant and wide-ranging benefits, including a reduction in the socioeconomic drivers for poor health and further stimulating economic growth.

> ***Timely access to health care is a human right and missing out on this means that many New Zealanders do not attain a minimum standard of living.***

LYNDON KEENE | ASMS RESEARCHER

PUBLIC HEALTH SALARIES SEND NEGATIVE MESSAGE

New Zealand's economy grew by 3.5% in the year to June 2014 and is expected to grow at a similar pace in the next two years, making it one of the fastest growing in the western world. This economic recovery, following the global recession, has been underway since the June quarter of 2009 – in other words, for more than five years. But whose recovery is it?

'Recovery' for the public health service has become equated with real operational funding cuts conservatively estimated at half a billion dollars since 2009/10, when inflation and demographic changes are taken into account (see the ASMS publication *Health Dialogue Reality Check: The myth of unsustainable health funding and what the Treasury figures actually show,* available from www.asms.org.nz). Since most operational spending is to pay for the health workforce, inevitably it is the health workforce that feels the pinch when budgets are squeezed.

A recent State Services Commission (SSC) report, Human Resources Capability, confirms what many district health board employees have known for some time: their wages and salary rates have been slipping backwards.

The SSC report reveals that in 2013/14 the average pay increase for public health service employees was just 0.7% – less than half the 1.6% inflation rate for the year to June 2014. Further, the SSC says that over the four years from March 2010 to June 2014 public health service pay increased by 5.9% on average – 3% lower than the inflation rate over that period.

That gap will increase further by the time the next round of multi-employer collective agreements (MECAs) are negotiated. Treasury's inflation forecast for the year to June 2015 is 1.6%, and a further 2.0% to June 2016.

The SSC report also revealed another disturbing trend: that public health sector wages have fallen behind those of the general private sector workforce. The average 0.7% increase for DHB employees in 2013/14 compares with an average pay increase of 1.8% for the general private sector workforce. And over the last four years the 5.9% average increase for public health service employees compares with 8.4% for the private sector – and the gap has been widening.

This sends a clear message to young New Zealanders that working for the public health service is not well rewarded financially and that they would be better off pursuing careers elsewhere. This does not help with the recruitment and retention of staff, which is in urgent need of improvement in many areas.

Not everyone has fared badly in the public health sector, however. Most district health board chief executives have done well.

A separate SSC report on movements in the remuneration bands for DHB chief executives between 2012/13 and 2013/14, released before Christmas, shows the bulk of them received increases of between $10,000 and $30,000, representing rises of between 2.1% and 5.6%.

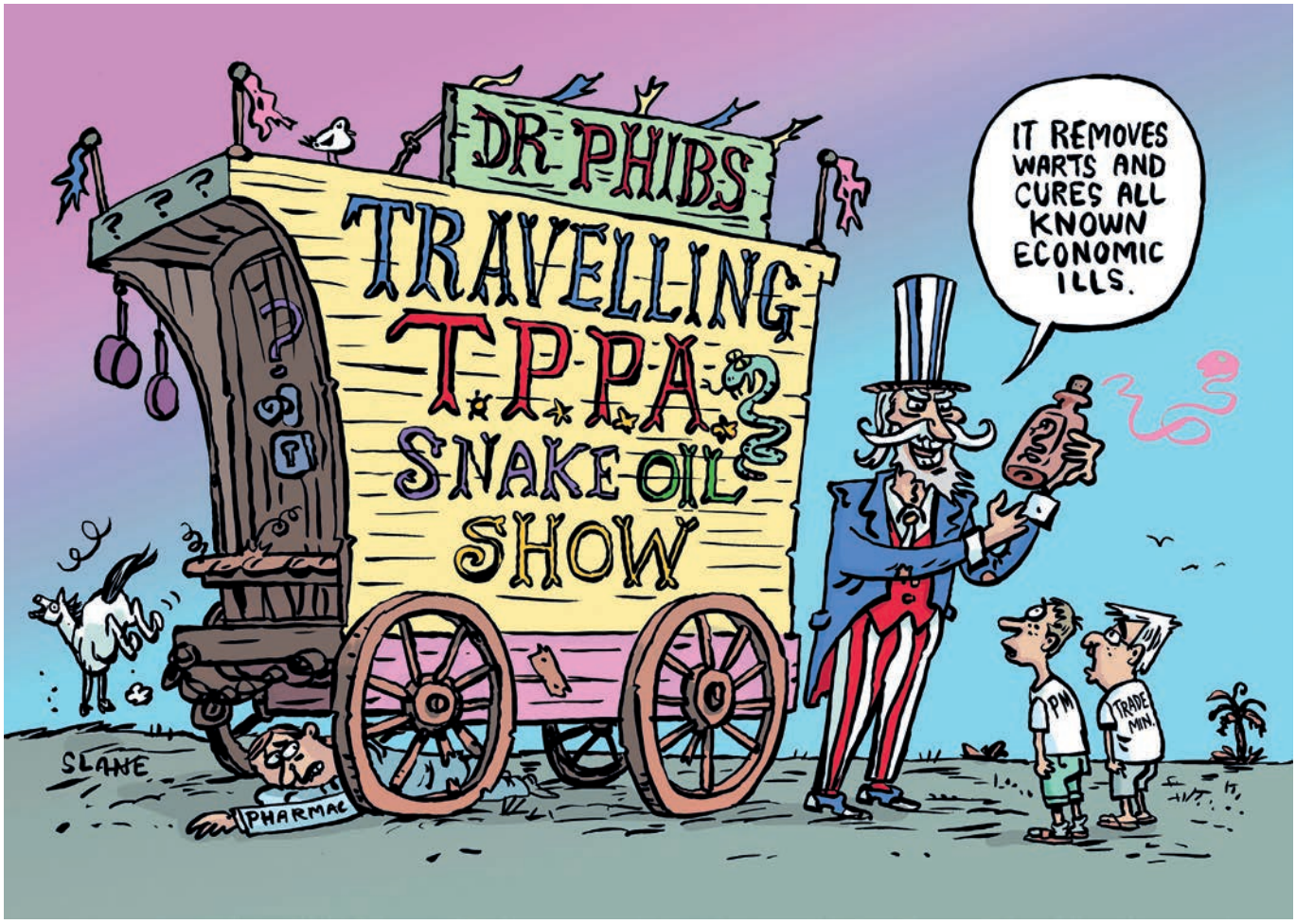
There were also several DHBs where chief executive salary package increases appeared much larger. However, DHB explanations published since the release of the SSC figures indicate these outliers were influenced by factors such as the timing of performance review payments, and that the level of their increases may be more in line with those of the other chief executives.

Of course, there is a competitive international market for chief executives and it is vital that our DHBs are able to attract and retain high quality people, and part of that is through offering decent employment packages.

The exact same argument applies to many health service staff, yet, without exception, the DHBs rejected even their relatively modest bids for pay increases in the most recent round of MECA negotiations. While they were paying their chief executives real increases in their employment packages, they were telling their staff they had to accept a real pay cut.

With many in the public health sector workforce approaching retirement, coinciding with growing service demand, the future-proofing of the public health system is more than ever dependent upon attracting and retaining younger generations of workers. Clearly the wage and salary trends of recent years are pushing against that desired state.

As for today's health employees, it is reasonable to guess they will be expecting fairer treatment, and recognition of their value, for the next round of MECA negotiations, both in relation to the increases gained by their bosses and those gained in the private sector. Securing a viable, well-functioning health system for the future may well depend on it.



THE TPPA ROADSHOW

EQUITABLE ACCESS AND COST OF HEALTH CARE IN THE BALANCE AS TPPA DECISION DRAWS NEAR

Dr Erik Monasterio, a consultant in forensic psychiatry, Deputy Clinical Director with the Department of Forensic Psychiatry at Hillmorton Hospital, Christchurch, and a senior Clinical Lecturer with the University of Otago, Christchurch School of Medicine.

What is the Trans Pacific Partnership Agreement (TPPA)? And how could this trade agreement put the lives of your patients at risk?

The TPPA is a proposed Pacific Rim regional trade agreement involving 12 countries, including New Zealand, Australia and the United States. It encompasses economies that account for more than 40% of global trade. Its ambition to reset global trade rules is without precedent. The TPPA is said to comprise approximately 29 chapters, which include legal rules covering issues such as investor protections, intellectual property rules and regulatory coherence along with more traditional trade issues such as the removal of tariffs.[1] As it is now in the final stages of negotiation, with US President Barack Obama and New Zealand Prime Minister John Key emphasising that a deal can be sealed within the first half of 2015, there is real urgency to consider its implications and address any issues that arise from it. The next round of negotiations is scheduled for March 2015.

> *"The TPPA's ambition to reset global trade rules is without precedent."*

As for the proposed Trans Atlantic Trade and Investment Partnership (TTIP) between the European Union and the US, serious concerns about the health impacts of the TPPA have been highlighted in the medical literature and by civil society. While US-based industry advisors have been granted privileged access to secret negotiating documents for the TPPA and the TTIP, health agencies have been forced to rely on leaks for information.[1]

The concerns include unprecedented expansion of intellectual property (IP) rights that are likely to prolong and extend monopolies on pharmaceuticals, as well as reducing access to affordable and life-saving generic medicines. Effective medicine price regulation, in particular the ability of PHARMAC to use market competition to drive down medication cost, will be undermined.[1,2] Interfering with these bargaining powers can have disastrous consequences. For example, a provision in the US Medicare Prescription Drug Act 2003 prohibited the US Government, the largest buyer of drugs in the world, from bargaining for prices on drugs. It is estimated that this has cost the government half a trillion dollars over 10 years

(US$50 billion/yr.) and is one of the main drivers of the current US deficit.[3]

> *"Public health policies, including tobacco, food and alcohol regulation, are likely to be adversely affected by corporate interests."*

On 28 January this year, Nobel Prize-winning economist Joseph Stiglitz urged foreign negotiators not to give in to demands by the United States for strict IP standards for medicines in the TPPA, as this would result in the deaths of thousands of people who would not have access to affordable medicine; "... we're talking about thousands and thousands of people who will die and thousands and thousands of people who will have a different quality of life as a result of what you decide in the next couple of days", he said.[4]

Public health policies, including tobacco, food and alcohol regulation, are also likely to be adversely affected by corporate interests. It is important to note that many of the impacts will be differentially distributed. People in low income countries and disadvantaged groups within participant countries, particularly those of low socioeconomic status, indigenous people and those with chronic illnesses and disabilities are likely to be disproportionately affected.[1]

On 28 November 2014, at the conclusion of the 26th ASMS Annual Conference in Wellington, senior doctors and dentists voted overwhelmingly in favour of an independent assessment on the impact of the TPPA on health, and opposed the TPPA on the grounds that health care will suffer from the loss of national autonomy that may result. There has been no formal response from the Government.

The voice of ASMS adds to a growing chorus of international concern about the impact of these new generation trade and investment agreements, which are likely to threaten the ability of governments worldwide to provide affordable health care and to put in place health and environmental laws that protect public health and mitigate health inequity.

The UN Special Rapporteur on Health and Human Rights, Anand Grover, in his final report to the UN General Assembly (in August 2014) went to particular lengths to highlight how these trade and investment treaties have consistently undermined the right to health: "While transnational corporations have the ability to influence international and domestic policies, States have been unable to regulate those corporations to prevent them from violating the right to health."[5(p.3)]

> *"The voice of ASMS adds to a growing chorus of international concern about the impact of these new generation trade and investment agreements."*

His concerns echo those of the WHO Director-General, Dr Margaret Chan, who months earlier in her address to the World Health Assembly, cautioned that: "One particularly disturbing trend is the use of foreign investment agreements to handcuff governments and restrict their policy space."[6] The neutral and independent health organisation Doctors Without Borders has issued a stark warning that "...the TPP agreement is on track to become one of the most harmful trade deals ever for access to medicines in developing countries."[7]

The controversial Investor State Dispute Settlement (ISDS) provisions allow investors to sue governments if policy changes or even court rulings significantly affect the value of their investment, yet do not allow governments to sue investors for breaching the right to health.[8] ISDS processes constrain governments' abilities to regulate on the basis of the precautionary principle, or even to implement health policies based on established evidence.

Given recent landmark legal cases by the US Department of Justice, which have highlighted the extent to which the largest drug companies have repeatedly and systematically engaged in illegal activities to promote drug sales, it seems particularly unwise to restrict governments regulatory controls. Common recent crimes have included illegal marketing of medications for off-label uses, misrepresentation of research results, withholding data on harms, and Medicaid and Medicare fraud.[9]

> *"The uncertainty and legal costs... will have a chilling effect on governments' efforts to address key health issues such as alcohol, the obesity epidemic, and climate change."*

In a recent interview for TVNZ's Q+A programme, Trade Minister Tim Groser advised the public not to get overly concerned about the possibility of increased prices for medicines and the risk of being sued by corporations (under ISDS provisions) for laws which restrict their trade, saying he had an experienced team of negotiators who were " not dummies" and he and they would work in New Zealand's best interests.[10] However, this contrasts sharply and naively with the evidence from more than 400 investor-state disputes filed since 2001, where Investors have won nearly US$3 billion from taxpayers in arbitral awards, with another US$15 billion in claims still pending[11]

Some of the more egregious examples include Eli Lilly and Company, using ISDS provisions under the North American Free Trade Agreement (NAFTA) to seek compensation of $500 million Canadian dollars from the Canadian Government in response to a patent ruling made in a Canadian federal court and Philip Morris Asia using a similar clause in an investment treaty between Hong Kong and Australia to sue the Australian Government over the introduction of tobacco plain packaging.[8,11] Recently, Indonesia and South Africa have terminated bilateral investment treaties citing concern over ISDS clauses. In April 2014 Germany also told the European Commission that the TTIP must not have ISDS mechanisms.[12]

The uncertainty and legal costs associated with ISDS provisions (the average cost of proceedings is nearly US$8 million, although costs in a single case can exceed US$50 million)[11] will have a chilling effect on governments' efforts to address key health issues such as alcohol, the obesity epidemic, and climate change.[1] This is likely to have already contributed to delays in the introduction of plain packaging tobacco laws in New Zealand.[1,8]

Taken together, the information available from a wide range of reputable sources about the implication of the TPPA is alarming. Tim Groser, in the TVNZ Q+A interview, also suggested that some of the opposition to this deal is being "whipped up by people who are ideologically opposed to trade agreements and it's time for people to come out and tell the truth here", and he dismissed any concern about the secrecy of the process.[10] This contrasts sharply with the position taken by the European Union, which in response to a ground swell of concern is making some of its negotiating position on the TTIP available to its citizens.

In my opinion it is no longer tolerable to accept that any concerns raised are ideologically based and speculative, and that we should accept that trade negotiations which affect us all must be conducted in absolute secrecy. It is tantamount to demanding that patients forgo informed consent before medical procedures and accept complex decisions made on their behalf.

> *"We are standing at a crucial crossroads."*

In considering these new generation trade agreements it may be that we are standing at a crucial crossroads, where the wrong turn will affect not only access and cost of healthcare, but most crucially our Government's sovereignty to prioritise health care policy to protect and improve the health of citizens for generations to come.

So, what can you do? Please consider writing to your local MP and the Minister of Health Jonathan Coleman, attending protest marches and raising the TPPA issues with colleagues and friends.

Dr Monasterio discussed the pharmaceutical industry's conduct and the TPPA at the ASMS Annual Conference in November 2014. His address can be viewed at https://www.youtube.com/watch?v=FYXndJVJbm8.

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IAN POWELL | ASMS EXECUTIVE DIRECTOR

REVISITING HEALTH FUNDING

It is time to revisit the funding of our impressive public health system and, in particular, the statutory bodies responsible for the provision of health care (both through direct provision of services or through funding of services) – district health boards. This is looking ahead but with a nod to past endeavours.

PBF AND ECONOMIES OF SCALE

First we have the Population Based Funding (PBF) formula. There is a tendency to demonise the PBF which distracts from the real issues. The PBF is not perfect. How could it be given the diversity and complexity in and between DHBs! But the PBF is superior to what it replaced, which was a system largely, if not completely, based on historical precedent. Since its inception, the PBF has been refined and refined. Further refining will probably be the order of the day.

But the PBF only becomes a strain for some DHBs if funding in general is inadequate. The better overall DHB funding, the less the pressure is on those DHBs with low or no population growth which receive a smaller allocation of funds under the PBF.

There is still a problem with PBF on critical mass issues. Even smaller DHBs such as Tairawhiti, Whanganui, Wairarapa, West Coast and South Canterbury have to provide relatively comprehensive 24/7 hospital services. They miss out on economies of scale because of the disproportionately higher critical mass they require in order to provide these services. This also applies to those DHBs which have two base hospitals. Southern (Dunedin and Invercargill) is in the worst position in this respect but Nelson Marlborough and Bay of Plenty are also affected.

There is a case for establishing an initial 'foundation stone' in the funding formula based on the necessary funding for secondary and tertiary services that DHBs are expected to provide. (This is less applicable to the more dispersed and smaller primary care services) DHBs could be located in different categories reflecting factors such as size and number of base hospitals. The PBF would not apply to this, which might act like an 'economies of scale adjuster'. To some extent this happens already but there is a case for making this foundation more explicit and a bigger proportion of DHB funding, with the reduced balance determined by the PBF.

WORKFORCE INVESTMENT STRATEGY

But a much bigger issue than this deserves debate. Last August ASMS brought Professor Martin McKee from London to New Zealand as part of our 25th celebration to speak on the importance of investing in health in developed economies for economic wellbeing. He reported International Monetary Fund analysis showing that for every government dollar spent on health, there was a $4.30 dollar benefit (an even higher benefit of $8.20 was identified for education). I would add that, in the New Zealand context at least, the priority for investing in DHBs should be its workforce capacity.

> *In the absence of a workforce investment strategy we are forced to focus on the negative picture that the data provides.*

This is starkly summarised by the following:

- From 2009/10 to 2014/15, total health operational funding as a proportion of Gross Domestic Product fell from 6.56% to 5.99%.
- Treasury estimated a real fall in health funding (after costs and population growth) of -0.6% in the year ended 30 June 2014. This is not a one-off. Treasury's estimates for subsequent years to June are for further cuts – -2.3% in 2015; -3.7% in 2016; -3.6% in 2017; and -3.1% in 2018.
- In the Government's Budget for the 2014/15 financial year, total health spending would have received an estimated additional $1.4 billion in operational funding if its allocation had matched the proportion of GDP of 2009/10.

- In 2014/15, DHBs were underfunded by $94 million just to cover increased costs and demographic changes. When the costs of new services DHBs are expected to provide are taken into account, the shortfall is likely to be well over $100 million.

IS THE ISSUE $11.5B OR $300M?

There is a serious lack of a workforce investment strategy in DHBs. Along with technology, the workforce (especially when both are wrapped around by distributive clinical leadership) is the main driver of quality and financial improvement in health systems. Because of this investment deficit the debate over health funding narrows down to the financial deficit discussed above.

In practical terms DHBs received about $11.5 billion funding in last year's Budget (2014-15). This includes an increase of about $300 million.

The consequence of the absence of a workforce investment strategy means the focus is on the inadequacy of the $300 million increase, rather than the effectiveness of the $11.5 billion.

Each year the Council of Trade Unions produces a robust analysis of Vote Health in the Government's Budget (last year with ASMS assistance). Focusing on the inadequacy of the increase is where the absence of a workforce investment strategy logically takes you.

WE CAN BE SMARTER THAN THIS

Patients and taxpayers who fund the health system deserve better. In reality we don't know whether either $11.5 billion or $300 million are adequate or inadequate. We can only conclude that, based on the intense pressures at the clinical and diagnostic front lines, both are seriously inadequate.

In November 2010, the DHBs and ASMS jointly concluded in a document known as Securing a Sustainable Senior Medical and Dental Officer in New Zealand: the Business Case [http://www.asms.org.nz/wp-content/uploads/2014/07/The-Business-Case-Nov-2010.pdf] that (a) there was considerable financial waste in DHBs and (b) millions of dollars could be saved by investing in the capacity (numbers) of DHB specialists to enable them to engage in process improvement initiatives (as well as the benefits of a stabilised workforce). This endeavour fell over because of unprofessional conduct by a small number of individuals in the national leadership of DHBs, linked to the settlement of our national collective agreement (MECA).

But there is now no linkage. Our MECA will not be renegotiated until 2016. It is time to return to these principles and flesh them out in a way that we make much more effective use of the $11.5 billion. In 2010-11, the leadership of the DHBs was not up to the challenge. Financial pressures are much greater now than then (especially when compounding effects are factored in). Despite being betrayed by disingenuous behaviour in 2010-11, the ASMS is still up to the challenge. The two questions are whether DHBs are up to the challenge and whether the Government is prepared to push them to meet it.

> ***If not, then we are back to debating the inadequacy of the $300 million or so each year. This is not smart; it is wasteful.***

FIVE MINUTES WITH IAN PAGE

DR IAN PAGE | CLINICAL HEAD OBSTETRICS AND GYNAECOLOGY, NORTHLAND DISTRICT HEALTH BOARD, AND ASMS NORTHLAND BRANCH PRESIDENT

What inspired you to become a doctor?

I was inspired by a family GP carrying out a home visit for my younger brother. I was about four at the time and living in Newcastle, and the visit made such an impression on me that I told my mum I was going to be a doctor like Dr Turner. My parents were aspiring and upwardly mobile, and nothing else leapt out at me in the same way as medicine while growing up. I was probably fairly naïve about what was involved with medicine, but I remained comfortable with the idea of becoming a doctor.

After training in London and working as a consultant in England for eight years, I moved to New Zealand in the year 2000. It was a time in my life when I could move halfway around the world, and I settled immediately in Northland, where I've stayed since.

Northland is a lovely place to live. It's warm and easy to get out into the countryside. It's a place with a lot of history. This is my home now. I was president of the local amateur theatre company for six years and I'm still on the committee. I've built the stage and set, sold the tickets, acted in productions, and I hope to get back into acting this year.

From a professional point of view it has the challenge of being relatively deprived so we are able to help people a great deal.

What do you love about your job?

Medicine is always different and interesting. The individuals you come into contact with are unique. It's people-focused and very much a team-oriented profession. I enjoy the collegiality with others, and the opportunity to work alongside other professions.

> *"Medicine is always different and interesting. I enjoy the collegiality with others, and the opportunity to work alongside other professions."*

In gynaecology, we're doing a lot to improve the quality of life for people. It's not usually life and death as such, but it's very much about the quality of life people are having. On the obstetrics side, it's about trying to make childbirth safer and with as little intervention as possible. It's always a balance of risks and the challenge is to get that balance right.

IAN PAGE, ACTING IN THE PANTOMIME ROBIN THE HOOD, WITH GEORGIE BIDOIS.

What is the most challenging aspect of practising medicine?

Getting it right for the patient and trying to stay in tune with what your patient wants as an individual, and the wishes of their whanau. A lot of people aren't empowered to make their own decisions but there's a family approach. I found that challenging when I arrived from England. I still work hard to get my head around it, and it really highlights the importance and value of good communication.

There have been a lot of changes to the way medicine is practised. I grew up on a one-in-two roster, which would not be tolerable to most people today. So one of the broader challenges involves reshaping the provision of medicine with the changed approach of doctors in terms of how they wish to work. And it's not just the young, new doctors – more people generally don't want to work a one-in-two roster.

It's challenging for patients, too. They have to let go of the idea of having their own doctor, especially in general practice, and accept that they're being looked after by the whole practice rather than a single GP.

Why did you decide to become a branch officer for the ASMS?

While working as a consultant in England, I was a branch secretary for the British Medical Association and had managed to resurrect the Lancastershire branch of the BMA, which had become moribund. I'm a very benign unionist. I believe we should be responsible and also be militant when needed – but employers also need to be responsible.

I've always believed that things needed to be done and I've got reasonable organisational skills which could be put to good use.

> ***"If nobody else is going to stand up and take on the task, then I'll put my hand up."***

I'm always happy, though, if someone else wants to stand for a branch role.

What have you learnt from this experience so far?

It's a very slow process to see any achievement. Communication is the key for local issues. More recently, we've seen an increasing need for SMOs to resolve issues amicably within a department rather than going out and involving management. A collegial approach can be very effective, rather than a managerial approach.

HENRY STUBBS | ASMS SENIOR INDUSTRIAL OFFICER

RESPONDING TO COMPLAINTS OR A SUMMONS TO A MEETING

All too often, tension that arises in the workplace is the product of a volatile mix of heavy workloads and inadequate time and resources to deal with them. Unfortunately, it's a sad reality that tension and stress are frequently behind intemperate outbursts of frustration, irritation or anger that in turn generate complaints and reports that management is then obliged to investigate and resolve.

The ASMS has an experienced team of industrial officers ready to advise, represent and otherwise support members who are the subject of complaints and 'invited' to attend a meeting to explain themselves.

Pause, breathe deeply and seek advice.

In our experience, the reaction of members who receive complaints and are summoned to a meeting with management varies. Some are dismissive and indignant, others outraged and angry, while yet others become anxious and worried. Some of these reactions are understandable, and none may be unreasonable, but once we get past the initial response the most sensible and safest thing to do is to pause, breathe deeply and seek advice.

Hasty explanations fired off in anger or in person are always unwise and will generally make things worse. Going to a meeting on your own where you speak too much, or defiantly seek to shift the blame to the complainant or attempt to justify what you've done by complaining about others is not a good idea and, in our experience, is likely to make things worse.

Here is a simple checklist of advice from ASMS to use if you are requested or required to attend a meeting:

- You are entitled to know what the meeting is about and who will be present BEFORE you attend.
- If it's to discuss a complaint or report, you are entitled to receive and should insist on being given a copy of the complaint or report BEFORE you attend.
- Do NOT attend the meeting on your own, if you know someone from human resources is present to support your manager.
- Nothing is ever so important that you need to attend a meeting at short notice.
- Take time to think and seek advice from a trusted colleague, friend or ASMS.
- Some informal meetings may result in a safe or informal outcome but many do not.
- Don't assume an informal meeting is just for a chat 'to quickly clear things up' because it will seldom be so.
- An 'informal meeting' does not mean it is off the record.
- Before you do anything you may regret: pause, breathe deeply and seek advice.
- The worst that will happen is that matters will take a few more days to resolve.
- Better to be safe than sorry.

HENRY STUBBS | ASMS SENIOR INDUSTRIAL OFFICER

AT THE ED WORKING GROUP MEETING. LEFT TO RIGHT; ANDREW MUNRO (NELSON-MARLBOROUGH), JOHN BONNING (WAIKATO), HENRY STUBBS (ASMS), AND ANDRE CROMHOUT (CAPITAL & COAST).

POLICY & GUIDELINES

FOR SHIFT WORKERS IN EMERGENCY DEPARTMENTS

The MECA and earlier collective agreements were largely designed for full or part-time hospital specialists who attended the hospital or workplace during the day and whose 'after-hours' work, for the most part, arose from their rostered on-call commitments. There was little, if any shift work (particularly prior to the growth of emergency medicine as a specialty in New Zealand), and A&E departments were run by nurses and staffed by one or two medical officers or GPs who called house surgeons and registrars in off their regular ward duties, as required.

Today the old A&E departments have been replaced in all hospitals by large and busy emergency departments, open 24 hours, that are the front doors of the hospital. Furthermore, rostered 'shifts' have become the main stay of several hospital services, principally EDs, ICUs and anaesthetics. In other services, notably obstetrics and paediatrics, clinical demand has resulted in their being 'specialist-led', with senior medical staff rostered on-site overnight and on weekends.

To meet the challenges posed by these changes in working conditions and models of care, ASMS is developing policies and practical advice to members about both recovery time and shift work. Previous issues of *The Specialist* have included items about our ongoing work on sleep deprivation and the need to build into an SMO's job size and hours of work adequate recovery time. The Association has now put together a working group to develop policy and guidelines for shift workers principally (but not exclusively) in Emergency Departments.

The ASMS industrial team recently convened a meeting of three senior Emergency Department members and industrial officers Henry Stubbs and Steve Hurring to begin this work. The group met in the Association offices on 12 February to begin the work of gathering information about medical staffing numbers (specialist, medical officers and RMOs) in emergency departments around the country, length and rotation of ED shift, allocation of non-clinical time, weekend frequency, on-call arrangements, total hours of work, remuneration packages and numbers of presentations, etc. Over the next few months, from this material, we will produce a report for distribution and wider discussion among our ED membership.

Our goal is to produce a set of national guidelines and standards for staffing levels, hours of work and remuneration for our members around the country, whether in metropolitan or provincial hospitals (large and small).

PRO 105/1

DEPARTMENT OF LABOUR

P.O. BOX 3705
Wellington 1
New Zealand
Phone 737-800
Telegraphic Address
"SECLAB"
Your Reference

Our Reference

HO 64/1/40

31 March 1989

The Secretary
Association of Salaried Medical Specialists
PO Box 156
WELLINGTON

Dear Sir/Madam

The complete amendment of your Union's Rules, including the name change, has now been recorded. A signed copy of the document and a new Certificate of Registration are attached for your retention. Please note that the Certificate is original proof of your registration under the Labour Relations Act 1987. It should not be lost or damaged.

Yours faithfully

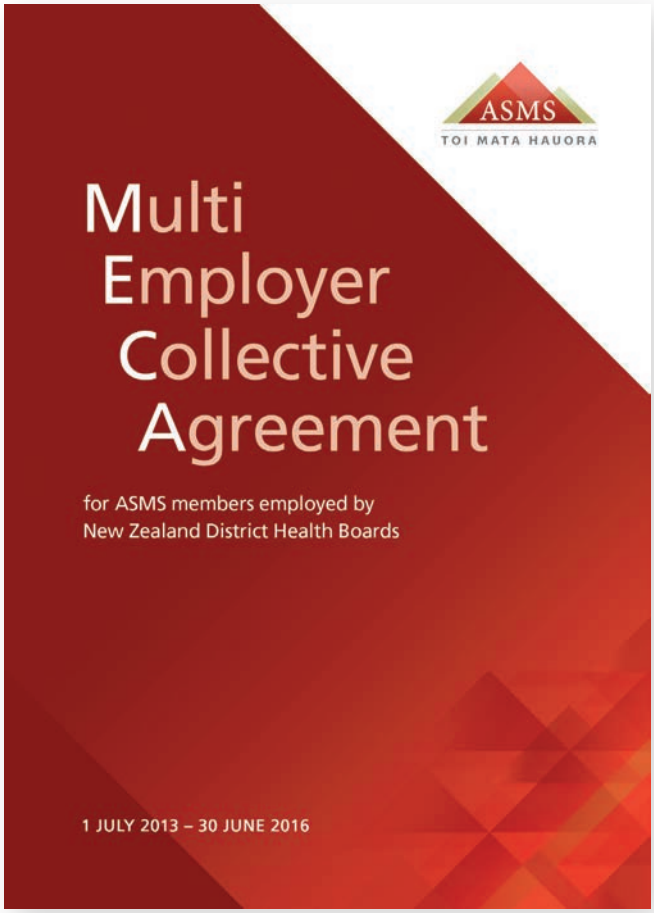
C D Fuller
Registrar of Unions

HISTORIC MOMENTS

WE'VE BEEN LOOKING THROUGH SOME OF THE DOCUMENTS AND PHOTOGRAPHS WHICH RECORD IMPORTANT MOMENTS IN THE HISTORY OF THE ASMS.

We'll publish something from the vault in each issue of *The Specialist* to highlight the history of your organisation. You can also find more documents on the ASMS website under 'About Us'.

This issue: a letter from the Department of Labour confirming ASMS' registration as a union under the Labour Relations Act 1987.



KNOW YOUR MECA

Specific MECA clauses that you may not be familiar with are highlighted in each issue of ASMS Direct, a national e-newsletter sent out to all members at regular intervals. These clauses are also promoted on the ASMS website (www.asms.org.nz) – and reprinted here for your information.

DID YOU KNOW...

... about your leave entitlement for professional meetings?

Did you know you are entitled to leave on full pay if you are elected, seconded or appointed to colleges and professional associations?

More information is in Clause 29 of the DHB MECA: http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-three/clause-29/.

... about part-timers and reimbursement of CME and work expenses?

Work-related (eg, annual practising certificate) and continuing medical education (CME) expenses for part-timers (ie, with a total job size of less than 40 hours per week) will usually be calculated on a pro-rata basis. However, if you're a part-timer with no other income from medical or dental practice, you are entitled to the same reimbursement as a full-timer, ie, 100%.

More information is available in the DHB MECA:

- Work-related expenses are covered in Clause 21: http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-two/clause-21/.
- CME expenses for part-timers are covered in Clause 36.2(b) of the DHB MECA at http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-five/clause-36/.

... about leave during the illness or accident of a close family member?

If you are employed by a DHB you're entitled to reasonable leave on full pay if a close family member becomes ill or has an accident.

That's right, Clause 27 of your DHB collective employment agreement provides for sick leave not just when you're sick, but when someone important to you is also unwell or injured.

More information: http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-three/clause-27/.

... about job descriptions?

The DHB is required to consult you whenever it plans to employ a senior medical or dental officer in the same service or on the same roster.

Clause 52.1 of the DHB MECA says you are to be consulted on the need for the appointment, the nature of the role, and the skills and so on required.

More information: http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-six/clause-52/.

... about bereavement leave?

If you are employed by a DHB you're entitled to reasonable leave on full pay "on the bereavement of someone with whom you have a close association".

Your entitlement is found in MECA Clause 27.1 and is not limited in time (eg, to only three days) or to the death of a close or immediate family member. Each case should be considered sensitively and recognise your particular culture and family responsibilities.

More information: http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-three/clause-27/.

CASE STUDY

The case that follows from Australia is an unusual but interesting case which highlights the importance of good handovers.

In 2009, a 78-year-old frail Aboriginal man called Peter Limbunya was taken to Katherine Hospital in the Northern Territory of Australia with pneumonia.[6]

Eight days later, he was discharged and flown, with no escort, to an isolated airstrip some distance from his home. His paperwork was faxed to the local community health centre, advising them of his discharge. However, the fax was not seen, so the community health centre was not aware of Peter's return.

There was no checking system to confirm that the discharge paperwork had been received; the hospital assumed that the fax would be acted on and someone would be there to collect Peter from the airfield when he was dropped off, when in fact, no-one was aware of his return.

He tried to walk home but was found dead from pneumonia and dehydration three days later, only 400 metres from the airstrip.

Following this tragic case, the Northern Territory government took steps to improve its handover procedures. Furthermore, the World Health Organisation (WHO) Patient Safety Alliance designated Australia as the lead country to implement standardised solutions to improve clinical handovers, as part of the "High 5s" Initiative.[7]

Lessons can be learnt from Peter's case that can be mirrored all over the world. The state of handovers in the Katherine Hospital was later deemed to be "unstructured, informal and error prone, with the majority of doctors noting that there is no standard or formal procedure for clinical handover".[8]

All doctors have a duty to ensure that their hospital cannot be accused of similar failings.

PASSING THE BATON

DR ROB HENDRY | MPS MEDICAL DIRECTOR

GOOD HANDOVERS PROVIDE CONTINUITY OF CARE AND CAN HELP TO AVOID ERRORS

Whether you work in a public hospital or in private practice, the same principles apply when transferring patients to the care of another doctor.

When handing a patient over to another doctor for treatment – either between shifts, between phases of care, or between community and hospital care – problems can occur which put the patient's safety at risk. The effectiveness of handovers will depend on the timeliness, accuracy and completeness of the information given, and whether it is understood by your colleagues.

A lack of consistent processes, absence of best practice guidelines and limited use of protocols mean that handovers can be fraught with risk. Poor handovers create discontinuities in care that can lead to adverse events, avoidable harm and complaints. They can be associated with:

- inaccurate clinical assessment and diagnosis
- delays in diagnosis and treatment
- delays in ordering investigations
- medication errors
- inconsistent or incorrect translation of results
- duplication of investigations
- increased length of stay
- increased in-hospital complications
- decreased patient satisfaction.[1]

A poor handover can have a significant downstream impact on the management of a patient, and MPS continues to see complaints arising from this. The following risk areas can often contribute to handover complaints:

- lack of clear leadership or responsibility when complications arise
- failure to effectively communicate a patient's condition when seeking advice from a colleague
- lack of an agreed care plan.

Patients can experience many changes in a care team over a day, and successive poor handovers can lead to miscommunication where information becomes continually degraded or changed. Most handovers are done with the best intentions, but quite informally. People are often distracted and trying to do several things at once, which can affect levels of concentration.

GOOD HANDOVERS

The Medical Council of New Zealand's (MCNZ) guidelines require doctors to inform patients why and how information about them is shared with other health professionals, and seek their permission to do so.[2] If the patient does not agree, information should not be passed on unless disclosure is necessary to ensure appropriate ongoing care.[3]

Once permission has been sought, a good handover should be a two-way process where information is exchanged and opportunities are given to ask questions and reaffirm that the information exchange has been successful. It should be structured and focused on making suitable arrangements for the patients' medical care, with minimal interruptions.

Checklists can help with the management of common conditions. For example, a successful handover requires:

- a senior clinician to lead the handover
- a shared understanding of the plan of action, who is responsible for each aspect of the patients' care and exactly what is required
- designated handover time within working hours (at least 30 minutes for large hospitals)
- involvement of all health professionals, as more information is needed for high-risk patients
- a clear method of contacting the doctor responsible for a particular patient
- awareness of potential risks
- informing the patient of who will be responsible for their care going forward
- clear documentation.[4,5]

What is perhaps most important about improving the quality of care, is to continually examine how it is delivered. Changing an existing process is not easy, but just focusing on one or two things in your handovers might make a lot of difference to you and your patients.

REFERENCES

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Improving measurement in clinical handover, Quality and Safety in Healthcare (2009)

2. The Medical Council of New Zealand
Good Medical Practice, 'Right 4(5) of Code of Patient Rights'

3. Medical Council of New Zealand
Good Medical Practice, sections 46, 47, 49 (2013)

4. Royal College of Surgeons
Safe Handover: Guidance from the Working Time Directive Party (2007)

5. Medical Council of New Zealand
Good Medical Practice, sections 50, 51 (2013)

6. Northern Territory Magistrates Courts
Inquest into the death of Peter Limbunya Darwin, NTMC 057 (2008)

7. World Health Organisation
Action on patient safety – High 5s (2009)

8. Bomba DTPR
A description of handover processes in an Australian public hospital Australian Health Review (2005)

ASMS SERVICES TO MEMBERS

As a professional association we promote:

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

As a union of professionals we:

- provide advice to salaried doctors and dentists who receive a job offer from a New Zealand employer
- negotiate effective and enforceable collective employment agreements with employers. This includes the collective agreement (MECA) covering employment of senior medical and dental staff in district health boards which ensures minimum terms and conditions for 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.org.nz

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

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

ASMS job vacancies online www.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*.

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

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E asms@asms.org.nz
W www.asms.org.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.org.nz**

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