

# The Specialist

THE NEWSLETTER OF THE ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

## Preparing for the National DHB MECA negotiations

Who can forget the acrimony and trauma of our last multi-employer collective agreement (MECA) negotiations with the 21 DHBs? Commencing in April 2006 and finally concluding with membership ratification in May 2008, they included three unprecedented events – very well attended national stopwork meetings, nearly 90% of respondents voting for industrial action in a national membership ballot, and up front ‘hands-on’ direct involvement by the then Minister of Health which helped avert industrial action and produced an outcome.

### Resolving the last MECA negotiations

A key factor affecting these negotiations was the large increase in salaries in Australia. The original ASMS claim back at the commencement of these negotiations took into account what was with hindsight a relatively modest salary increase in New South Wales (compounded 28% over four years) but did not appreciate the significance of the subsequent much larger increase in Queensland (depending on location between 27% and 58% over three years).

But the impact of the Queensland settlement was quick on both other Australian states and New Zealand. At the same time as the DHBs were adopting an inexplicable adversarial position in negotiations,

...our members were receiving (and still are) very attractive job offers, particularly from but not confined to Queensland.

including counter-claims that would have enhanced managerial power over senior doctors and dentists and eroded some existing conditions of employment, our members were receiving (and still are) very attractive job offers, particularly from but not confined to Queensland. Many of those whose family and other circumstances permitted took up these offers while a number of others who had financially attractive opportunities in the private sector pursued them.

It was not practical to increase our claim to the new Australian levels during the negotiations. The gap between the ASMS's relatively modest claim and the DHBs at that time was already great and considerably widening it would have made a negotiated outcome unachievable.

Consequently, in May 2008, settlement was finally reached with the current MECA which expires on 30 April 2010. Negotiations will commence early next year and the ASMS will have to develop its strategic direction including our claim. However, there are two major difficulties we are faced with.

### Challenges for next year's negotiations

First, a significant circuit-breaker in the settlement of the current MECA was the agreement to form a commission (which became known as the SMO Commission) to recommend a sustainable pathway to competitive terms and conditions of employment. However, while the Commission's report is now out

## NATIONAL EXECUTIVE UNANIMOUS RESOLUTIONS

That the Association promotes the right of equal access for all New Zealanders to high quality public health services. Both access and quality are threatened by the medical workforce crisis in our district health boards. Critical to resolving this crisis are:

- a clear pathway to competitive terms and conditions of employment for senior doctors and dentists;
- recognition that district health boards are competing in an Australian medical labour market; and
- recognition that the Government is responsible for resolving the crisis.

That the strategic direction for the next national district health boards collective agreement negotiations be formulated by the Annual Conference 2009.

## ASMS

Executive Director  
**Ian Powell**

Assistant Executive Director  
**Angela Belich**

Senior Industrial Officer  
**Henry Stubbs**

Industrial Officer  
**Lyn Hughes**

Industrial Officer  
**Lloyd Woods**

Executive Officer  
**Yvonne Desmond**

Membership Support Officer  
**Kathy Eaden**

Admin Officer  
**Joanne Jourdain**

Admin Assistant  
**Ebony Lamb**

Level 11  
The Bayleys Building  
Cnr Brandon St & Lambton Quay  
PO Box 10763  
Wellington  
New Zealand  
Ph 04 499 1271  
[www.asms.org.nz](http://www.asms.org.nz)

Continued next page

and includes several useful recommendations, it did not fulfil its terms of reference. There is no sustainable path to competitive terms and conditions of employment identified (this is discussed in more detail separately in this issue). Consequently the ASMS will have to develop and endeavour to negotiate around this path.

Second, there is the international recession. The most devastating effect of the recession is increasing unemployment. One of the consequences is labour market shortages. However, the labour market is not homogeneous. Instead there are multiple labour markets and not all are affected in the same way. In the case of the DHB medical labour market significant shortages continue and Australia continues to seek to recruit to fill its vacancies. DHBs still have to recruit and retain in a highly competitive medical labour market unlike many other parts, if not all, of their workforce.

Even in the recession Australia remains a threat to New Zealand with settlements comparable to Queensland being achieved in Western Australia and South Australia (even a, by comparison, modest settlement in Victoria of New South Wales proportions, has served to widen the pay gap across the Tasman). Further, more recent actual and provisional settlements (New South Wales and Queensland again) suggest a pattern of further salary increases of around 4% per annum which have the effect of further widening the pay gap (currently between 35% and 49%).

### Shaping our strategic direction

The ASMS Annual Conference (3-4 December) will be central to shaping the ASMS's strategic direction for next year's negotiations. The ASMS National Executive has already identified key factors that should help Conference discussion (resolutions published on front page).

First, in order to provide an accessible and quality public health service for patients, DHBs need a pathway towards competitive terms and conditions. Second, for reasons such as shared training systems, close economic and related relations, and proximity, DHBs have to compete in an Australian medical labour market. Third, the government, which itself recognises that DHBs have a medical workforce crisis, is responsible for ensuring its resolution.

Within this framework the Annual Conference will have the important task of shaping our strategic direction in what is shaping up to be an even more challenging negotiation than (but hopefully without the adversarial DHB conduct of) the previous one.

**Ian Powell**  
Executive Director

### ASMS services to members

#### As a professional association we promote:

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

#### As a union of professionals we:

- provide advice to salaried doctors and dentists who receive a job offer from a New Zealand employer
- negotiate effective and enforceable collective employment agreements with employers. This includes the collective agreement (MECA) covering employment of senior medical and dental staff in district health boards which ensures minimum terms and conditions for around 3,000 doctors and dentists, over 90% of this workforce
- advise and represent members when necessary
- support workplace empowerment and clinical leadership

### Other services

#### [www.asms.org.nz](http://www.asms.org.nz)

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

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

#### ASMS job vacancies online

#### [www.asms.org.nz/system/jobs/job\\_list.asp](http://www.asms.org.nz/system/jobs/job_list.asp)

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

Substantial discounts are offered for bulk and continued advertising.

#### ASMS email broadcast

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

If you wish to receive it please advise our Membership Support Officer, Kathy Eaden in the national office at [ke@asms.org.nz](mailto:ke@asms.org.nz)

### How to contact the ASMS

Telephone	04 499-1271
Facsimile	04 499-4500
Email	<a href="mailto:asms@asms.org.nz">asms@asms.org.nz</a>
Website	<a href="http://www.asms.org.nz">www.asms.org.nz</a>
Postal Address	PO Box 10763, Wellington 6143
Street Address	Level 11 The Bayleys Building Cnr Brandon St & Lambton Quay Wellington



## Regarding rocks, and other places

Aspirations and goals may be the reasons we achieve, the drivers of success. They may also be the seeds of failure. When we have an aim, but do not achieve it, we can feel we have failed. The very expectations we engender can lead to disappointment when we miss our mark.

So when we contemplate the collective recommendations of the divers reports lying on the Minister's desk and asking for public and private comment, how do we frame our feedback? How do we formulate our Association's aspirations? What response do we publicise regarding our wishes for the structure of the system and the training of the workforce? What forecast for the future do we project, while making certain we do not ignore the imperatives immediately in front of us?

The current MECA expires next April. Before then we need to collectively work out what and how we prepare for the next. We need to decide our aspirations and goals. We need to decide what our more than 3000 members want to gain from the effort and heartache of negotiations. What will individuals settle for? What will they concede?

In a climate of political posturing it may be hard to argue for bridging the Tasman divide. But if we do not work towards some closure, the Aussie allure will continue to drain us of our colleagues. Already New Zealand is the greatest exporter of medical graduates in the OECD, as well as being the greatest importer. The latter is plundering of other health systems, robbing them of their investment, and a dangerous dependency which may evaporate in an instant. The former is woefully wasteful of multi-million dollar medical education.

Increasing the supply of graduates is imperative, is happening, and needs to be even further augmented. But this will take years to produce a specialist, and will require more time and effort from current specialists to provide the necessary apprenticeship training and supervision for the greater number of students and graduates.

In the meantime retaining the specialists we have, encouraging our trainees to stay in our system, and attracting medical immigrants to our country in preference to others, must be an imperative for the whole country. How much this imperative overrides the exigencies of systemic financial constraints is the very very hard question. When Mr English poses no pay increase for doctors, nurses, teachers, firemen and other public servants, pressing all to show restraint in these dire economic times, can we argue a special case for salaried specialists? Or do we see past the poses, past the cynical

nest-feathering perks and privileges, and conclude that justification is in the eye of the beholder of the purse.

I would like to think that I can speak for you all and stand firmly for our shared principles. But I feel that I may not find a rock so solid. That I may be stuck between a proud, if not perfect, footing, and GPS coordinates that struggle to triangulate the fallout from farcical financiers. The hard place to find may not be deciding what we stand for, but what we will not stand for. While keeping an open mind, paying attention to contrarians and unexpected events, and allowing for a broad spectrum of opinion and analysis.

Can we predict our aspirations, let alone our possible achievements? In the words of Yogi Berra, "prediction is very hard, especially about the future." Eminent economists and politicians disagree about where our financial fortunes are headed, and how soon we will get there. When experts disagree should we look for the "wisdom of crowds"? Such wisdom is not just mob mediocrity. Surowiecki argues that averaging the predictions of many pundits will typically outperform the individual predictions of the pundits from whom the averages were derived. Maybe the crowd of specialists the Association represents can provide the wisdom to guide our choices between rocks and other places.

Tetlock, analysing the predictors and what they can teach us, argues that "history rarely overtly repeats itself but it often rhymes". And that there is an advantage to those who can pick up the more subtle similarities. We have a history of negotiating MECAs. They have not been easy. They have taken us to the brink. This time however the circumstances are different, the drivers are divisive, the potential for collateral damage unknown.

As we head into uncharted waters, and look for foundations upon which to form our aspirations, I ask each and every one of you to voice your view. Tell your regional representative which rock you want us to take a stand on, which hard place you would select as your goal. In regions unknown your Executive could affix the label "here be dragons", or with your shared direction, find together a terra firma.

Guide us well.

**Jeff Brown**  
National President



## Chief Medical Advisers – there's a bright side to the 'dark side'

There was a time, before the formation of the ASMS in 1989, about which it is said the doctors were in charge of the running of our public hospitals. In those days there was no chief executive but instead a triumvirate comprising medical superintendent, head nurse, and head administrator. But when one probes those who worked in the system at that time you don't get a strong sense of nostalgia. Much depended on the personalities in the positions, particularly the medical superintendent. The impression I get is that it was largely top down and not particularly engaging. Of course, the medical workforce was smaller in those days which may have compensated for some of this distance.

This system was ditched with the creation of area health boards in the late 1980s and the move to generic management. Then we had the commercial model from 1993 to 1999 based on state owned companies called crown health enterprises running public hospitals. Since then the company structure was replaced with the statutory entities that we know as district health boards whose responsibilities included primary care.

### Emergence of the positions

Largely since the end of the commercial system and the formation of DHBs we have also seen the emergence of chief medical adviser positions in each of the 21 DHBs (also known in some DHBs as chief medical officers or medical directors). These positions have less power than the old medical superintendents. They are accountable to the chief executive. But they are potentially influential positions. In part they were created in response to the disengagement of senior medical staff in the 1990s and the need for DHBs to receive high level senior doctor advice and input. The current incumbents are generally impressive people of stature and have earned, or are earning, respect.

The realisation of this potential influence is dependent on some key factors. For example, it is important that the role is not seen as primarily a managerial position as it presently is in at least 2–3 DHBs. The potential will not be realised if the chief medical adviser position is seen as essentially that of a medically qualified manager. Chief medical advisers must have the confidence of both the chief executive (and other senior managers) and senior medical staff if they are going to succeed. Without one or the other (or both) they will fail.

The term of crossing over to the 'dark side' is sometimes called upon to describe chief medical advisers (sometimes rather depreciatingly by themselves). This overused term is

undermining the unique character of Darth Vader and by diminishing his evilness gives him a bad name. But its use is guaranteed where chief medical advisers only have the confidence of senior management.

### Enhancing and undermining credibility

What unquestionably enhances the credibility of a chief medical adviser among senior medical staff is whether or not he or she is still undertaking some level of clinical work (an exception is where the person concerned is winding down their career with retirement not too far away). Some chief medical advisers are fellows (or seeking to become fellows) of the college of medical administration. While this is a worthy qualification it does not address the issue at hand which is that credibility is enhanced if one is still working in the branch of medicine from which they were working in before taking up the chief medical advisor position.

What undermines credibility is when chief medical advisers are seen to be part of (or an adjunct to) the senior management team, particularly where this leads to being used to endorse management decisions. An example is the unfortunate practice that has emerged in the Auckland region where the three DHBs (Waitemata, Auckland and Counties Manukau) have issued statements involving contestable interpretations of MECA provisions which include the signatures of the chief medical advisers. This unnecessarily risks putting them in conflict or at opposites with their clinical colleagues. They are not the only DHBs to fall into this trap.

### Debate needed over role

Regrettably there appears not to be an obvious consensus of the role of chief medical advisers. Instead the role is dependent very much on the 'culture' of management and the personal characteristics of the individual. This is a pity because the ASMS's experience is that where chief medical advisers have credibility with the senior doctors and dentists, on the one hand, and management, on the other, the enormous positive potential of this role can be realised. Senior medical staff and management work in overlapping circles. To succeed chief medical advisers need to be supported and have the instinctive inclination to work in both.

A constructive debate over the role of chief medical advisers and how to realise their potential would be healthy.

**Ian Powell**  
Executive Director



Assistant Executive Director

## The Horn Report: here we go restructuring again

The report (the Horn Report) of the Ministerial Review Group (the Horn Group) headed by former Treasury Secretary and Business Round Table member Murray Horn was released on 16 August. The Horn Group was set up in January this year by the Minister of Health to:

- 'Assist the Minister and Ministry by providing advice on further progressing the Government's priorities around clinical leadership, productivity and quality patient services
- Review the existing systems for infrastructure and prioritisation and advise improvements
- Help meet serious Vote Health financial challenges by providing a fresh examination of health sector spending with a view to identifying low priority/poor quality spending that can be moved to improve frontline health services'.

It has ended up proposing a major restructuring while identifying very little in the way of concrete savings.

### Unpalatable early drafts

The Group apparently went through several drafts which were tabled in Parliament by the Minister of Health in response to opposition questions. As well some papers highlighting at least some of the groups thinking were leaked to the opposition. They reveal a number of issues that did not make it through to the final report probably because they were politically unpalatable. These include the suggestion that certain private hospitals be designated 'trial private hospitals' to test the premise that 'hospitals be funded on the basis of convenience to the patient rather than DHB management' and be placed on a 'level playing field with public hospitals', Primary Health Organisations' budget holding for diagnostic services, and medical tourism (foreign nationals coming to New Zealand for the purpose of having elective procedures as a money making venture by health providers).

The Horn Report's 170 recommendations will be considered by Cabinet over the next couple of months after considering input from the public. The initial deadline for input is 18 September.

## THE HORN REPORT

# THE GOOD, THE BAD, THE UNCLEAR & THE UGLY

### The good

- Enhanced national and regional DHB collaboration (including clinical networks)
- Clinical leadership
- Emphasis on national health planning (national health committee and investment committee with clinician involvement)
- Move towards rationalised DHB reporting

### The bad

- New national bureaucratic jungle
- Less accountable National Health Board
- Paralysis during major restructuring
- Attempt to avoid parliamentary (and public) scrutiny

### The unclear

- Quality Improvement Agency
- National Shared Service Agency
- Reduction in committees (replacement with expert panels)
- Access PHOs (areas of high primary care need)

### The ugly

- Goal posts shifting towards privatisation
- Risk of destabilisation and privatisation of diagnostic services (radiology and laboratories)

### Major restructuring again: three (or four or five or six) new health boards

The report proposes a major restructuring: its response to what it sees as the problems of integrating and funding health. The report recommends the establishment of three or four or possibly five new stand alone bodies (or even six if one includes the new scientific institute); the National Health Board (NHB), an independent quality improvement

agency, a body equivalent to Pharmac (this may be part of the shared services agency) for procurement and a national shared service agency for back office DHB functions. There is also the possibility that rather than being part of the National Health Board the National Health Workforce Board (or even just the Clinical Training Agency Board) would form a separate Crown Entity as recommended by another ministerial task force (see p17). There are also a number of subsidiaries proposed under the aegis of the National Health Board.

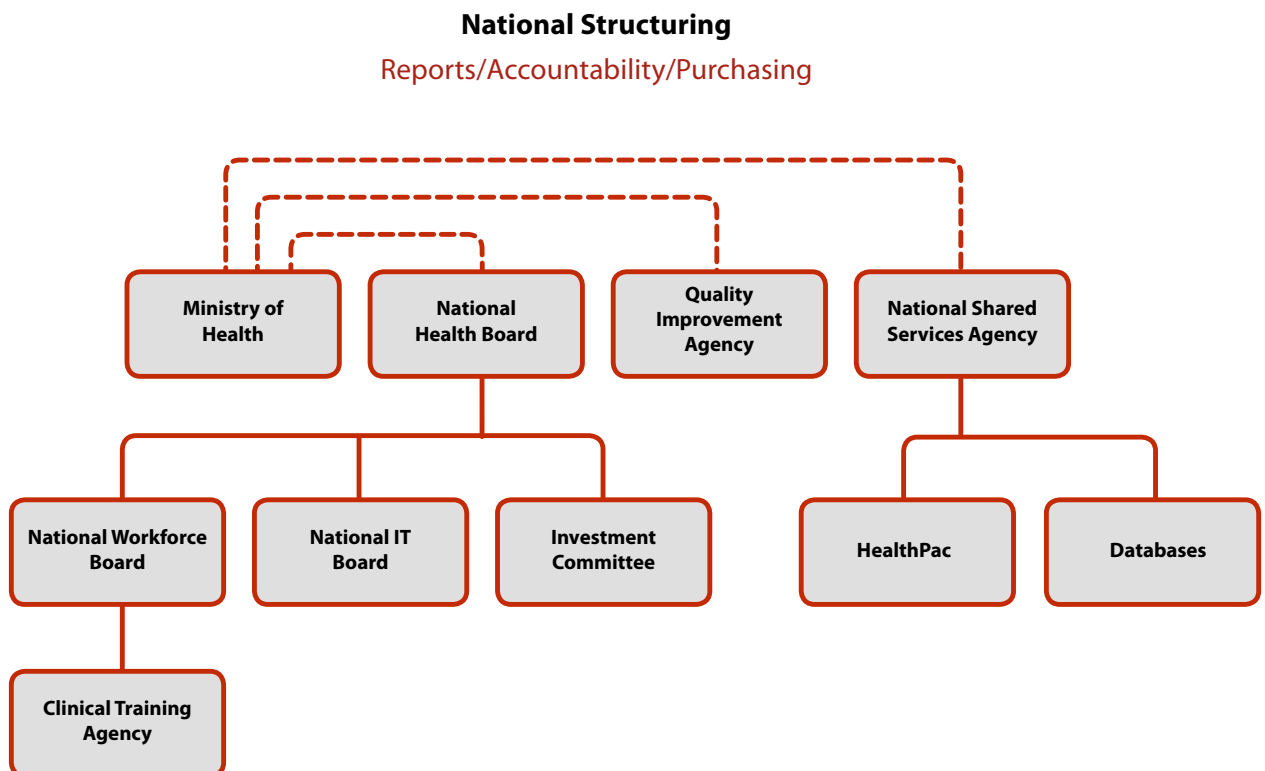
Most of these new structures carefully skirt around the current DHBs. However it is clear that setting them up will cause wide spread disruption as DHBs lose funding for services, lose some functions and possibly gain others. For instance the National Screening Unit would either be moved to the NHB or to DHBs within 12 months, services deemed national would skim off funding from some DHBs and give it to others causing redundancies at some DHBs and services like payroll and possibly human resources would move to another new central agency. In the process the usual paralysis that accompanies these restructurings would occur.

### The National Health Board (NHB)

The major feature of the restructuring is the National Health Board which will:

- strategically plan and plan the funding of future capacity such as information technology, workforce, capital and facilities;
- fund national services presently funded by the Ministry of Health and services deemed to be national. The first by taking control of the non-departmental funding presently administered by the Ministry and the second by taking money out of funding presently allocated to DHBs;
- monitor DHBs partly by requiring them to develop the top three or four productivity measures that are important to them; and
- arbitrate any dispute as to whether services are to be national, regional or local.

The NHB would include the National Workforce Board (it too would have its own governance structure) and would include the Clinical Training Agency Board (again with its own governance structure). As well the NHB would



include a National Health IT Board which would aim for 'safe, shared and transferable' patient records by setting a standard requiring IT systems to be able to transfer data to each other.

The proposed NHB would be similar to the former Health Funding Authority in terms of funding DHBs (an important background difference is that population based funding for DHBs did not apply then). But it would be expanded beyond this to include planning, overseeing and directing DHBs including on service provision. However, while the Ministry of Health could also perform this expanded role, the NHB as a crown entity would be more arms length and less accountable than the Ministry. The role of ensuring regional and national service planning by DHBs is commendable but an additional bureaucracy is not required to achieve it.

The Ministry of Health would be limited to policy and regulatory work although it would have the additional task of monitoring the NHB.

When a new crown entity is established enabling legislation is required. One of the important benefits is that it ensures parliamentary (and consequently public) scrutiny. The Horn Report proposes avoiding this by instead establishing the National Health Board by converting the Crown Health Funding Agency (a small crown entity of around 20 staff with the narrow function of being the DHBs 'bank' for debt management) into the National Health Board with far greater responsibilities and powers. There is some debate over the legality and appropriateness of this and it could be open to judicial review

The Horn Report says that as a crown entity the NHB would be "more distant from the Minister" which "should provide greater confidence about how the NHB would behave." This "reduces both the reliance on subjective factors and the scope for lobbying and special pleading."

In other words it seeks to insulate the health system from the inefficiencies of democracy and the decisions of democratically elected governments.

In other words it seeks to insulate the health system from the inefficiencies of democracy and the decisions of democratically elected governments.

The reference to lobbying and special pleading could reasonably be expected to include the ASMS, other medical organisations such as the colleges, and other health professional bodies.

## National Shared Service Agency

This agency is to take over back room functions of the DHBs and the national operations functions of the Ministry including HealthPac. It would also have charge of all the 'repositories and data bases' presently run by the Ministry. The suggestion is that these be run as a subsidiary (with a separate governance structure). It is unclear whether this would subsume, replace or be separate from DHBNZ, itself a shared service agency created by the 21 DHBs.

There is merit in considering a pooling of these sorts of resources although there is a 'magic wand' feel about some of it. For example, payroll is an obvious back office function but, in contrast with schools which have a national payroll system, it is very complex for bodies responsible for 24 hour, seven day services with a wide range of different occupations. The enormous difficulty of developing a common payroll system for the Waitemata and Counties Manukau DHBs is a case in point.

It is also suggested that human resources come under this new agency. Human resource management, especially in such a labour intensive sector, should be as close to the workplace and as focused on maintaining operational viability as possible. It is unclear whether these services would cover the NHB staff as well.

## Other restructurings

The Quality Improvement Group (QIC) would be turned into an independent stand alone agency. This agency would report to the Minister directly and have its own staff. The proposal is that it is funded through the population based funding presently available

## The Ministerial Review Group

Group members were:

**Murray Horn**  
banker, Business Round Table member and former Secretary of Treasury

**Stephen McKernan**  
Director-General of Health

**Chai Chuah**  
Chief Executive of Hutt Valley DHB

**Dr Virginia Hope**  
public health specialist and elected member of Capital & Coast DHB

**Dr Tom Marshall**  
immediate past Chair of ProCare and semi-retired general practitioner

**Dr Pim Allen**  
Chief Medical Officer Southland DHB

**Hayden Wano**  
CEO of Hauora Taranaki Primary Health Organisation

**Sally Webb**  
former member of the Health Funding Authority

The group members were not unanimous.

to DHBs on the basis of the proportion of its time spent on DHBs and charges to private providers. Eventually it is to become entirely funded from charges for its services.

Eventually it (Quality Improvement Agency) is to become entirely funded from charges for its services.

A national agency is to be established for the procurement of supplies not managed by Pharmac. Medsafe would extend its brief to cover the safety of supplies as well as drugs and move to a cost recovery basis. The procurement agency (or Procuremac) is described as 'Pharmac-like'. Pharmac is a stand alone crown entity established under the New Zealand Public Health and Disability Act 2000. The structural diagram in the Horn Report however suggests that Procuremac will be part of the National Shared Service Agency.

There are some other fairly fundamental restructurings proposed such as restructuring one of the Crown Research Institutes to incorporate the National Radiation Laboratory,

making it more commercial and prefiguring a new 'one stop shop' for scientific services underpinning the health system. It is not clear whether this is to be yet another new agency but it appears likely.

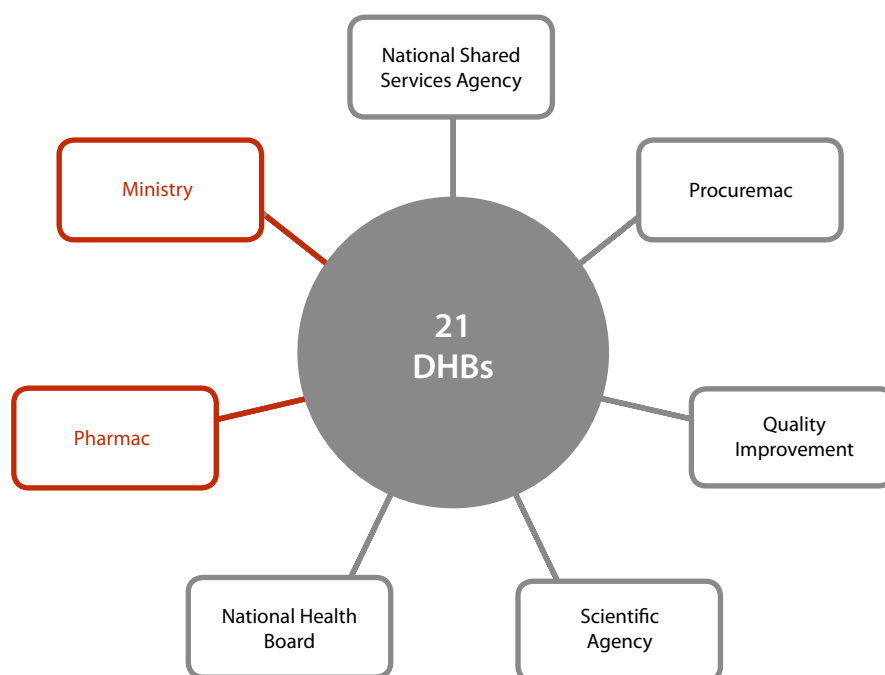
Despite the centralisation of back office functions for DHBs it seems that all of these new agencies (especially the NHB and its subsidiaries) will need their own management hierarchies and in many cases governance boards, accountability and financial systems, recruitment and human resource systems. If these are all centralised in some way it is hard to see how they can function as stand alone agencies in a nightmare network of clashing accountabilities unless a very contractual (and restrictive) model is followed. It is also likely that the Ministry will acquire additional work monitoring the new agencies.

### Clinical leadership

The Horn Report's recommendations on clinical leadership are overall commensurate with *In Good Hands* though they do not endorse the latter's call for national clinically focused productivity measures instead preferring measures be set independently at a variety of levels. One set of recommendations are very practical measures focused on making clinical leadership more attractive

## New Direct DHB Relationships

Existing relationships / Proposed New Relationships





and making clinical leaders more skilled. These include leadership awards, formal job descriptions including adequate time allocated for leadership, ways of ensuring re-entry to clinical work, formal training in clinical leadership both during professional training and on taking up a clinical appointment, mentoring, and opportunities for involvement in quality improvement.

### ...clinical leadership is not an end in itself.

The other set of recommendations focus on how clinical leadership should improve the system. The point is made that clinical leadership is not an end in itself. They include clinician leadership of the elective surgery initiatives, trialling new scopes of practice and workforce models, a national campaign on the prioritisation tools, clear terms of reference, time frames and goals for clinical networks, and suggesting the Ministry promote examples of good practice. The architects of this recommendation do not appear to have been fully cognisant of the recommendations of the rest of the report on the diminished role of the Ministry of Health.

### Cutting down reporting and committees

The recommendation that 157 identified health committees be reduced to 54, sets out in broad categories what committees could be disestablished. Mostly however this is done by replacing a committee with an expert panel which is to be activated as needed. The concept of expert panel probably more nearly reflects the requirements of the activity, but what detail is available suggests that, in reality, this will provide few savings and little actual change.

The Horn Report suggests that national framework for contracting, reporting, and accountability requirements should be developed by a working party with sector representation to align District Annual Plan, State of Intent (to Parliament) and other reporting. This is one of the recommendations that could be actioned by the Ministry without delay and could conceivably save money and conserve goodwill.

### Primary care

The proposal is to cut management fees to PHOs with fewer than 40,000 enrolled patients. There has been a dichotomy between large efficient PHOs and small PHOs with community involvement. ASMS GP members are largely in the small 'Access' PHOs providing services to very high needs populations at a very low cost. Their already marginal operations are likely to be dealt a death blow if the management fees are cut.

There are also suggestions of budget-holding for secondary services. Further, the Horn Report promotes shifting hospital services to primary care settings although this was also announced in the Minister of Health's Letter of Expectations to DHBs. What is meant by shifting services to primary care is ambiguous. At times it is about improved GP access to hospital laboratory services (a good idea) and at other times much more about control over a wider range of services. The focus is on devolution which involves taking from one place and giving to another compared with integration which is about working more collaboratively together.

### Strategic push toward privatisation?

The Horn Report falls short of an outright endorsement of privatisation or competition between public hospitals but shifts the goal posts toward privatisation. It puts in place mechanisms that would make the process easier when the review of progress after three years inevitably finds that the changes made so far have not brought the necessary benefits.

### The Horn Report falls short of an outright endorsement of privatisation or competition between public hospitals but shifts the goal posts toward privatisation.

Two areas where the Horn Report makes clear that privatisation is on the short term agenda are in diagnostic services and in shifting services to primary care where the terminology of 'level playing fields' between public and private provision mirrors the recent change in the protocols for provision of public funded services.

In the 1990s business era one of the ideological landmarks was that there should be neutrality in government support for private and public health providers. One of the consequences was the lack of commitment to building public hospital capacity. Returning to this is hinted in a section in the Horn Report on using PHOs to "develop new models of care". Specifically it states that DHBs should be responsible for dealing with new models of care, including by devolution to PHOs, and "in dealing with the full range of providers, DHBs will need to adopt a neutral position with respect to their own provider arm."

Elsewhere the Report criticises current arrangements that leave it to DHBs to contract with private hospitals to supplement public elective throughput. This is unlikely to make the best use of total public plus private capacity or provide the private hospitals with sufficient certainty to encourage additional investment. It then promotes a "more

---

neutral approach to funding public and private hospitals.” Later it promotes trialling the “allocation of some of the elective budget to a PHO that was willing to work with either private or public hospital specialists to deliver more elective services.”

A “neutral” approach to public and private provision of diagnostic services (laboratories and radiology) is also promoted raising potential threats to the future stability of current DHB hospital labs. The Horn Report has learnt nothing from the destabilisation of a number of hospital labs when Labour’s Pete Hodgson was Health Minister.

These are all steps to take the public health system further along the path to public funding but private provision.

Changing structures has a poor history of delivering better healthcare in New Zealand: clinical leadership seems a far better bet.

### A better way

Changing structures has a poor history of delivering better healthcare in New Zealand: clinical leadership seems a far better bet.

What is proposed for the new National Health Board could be more effectively handled by a re-jigged Ministry of Health. Despite several justified criticisms of the Ministry over the years it is more readily adaptable to perform these functions and has stronger statutory accountability.

The Horn Report alleges the Ministry has too many diverse responsibilities and should focus on its ‘core’ tasks of “policy and regulation” which would force greater clarity. This appears to confuse form with function. In a country of around four million people two large central bureaucracies (plus some extra smaller ones) seems excessive. This mishmash is much more likely to ensure lack of clarity than the current Health Ministry. The experience of the disbanded Health Funding Authority included duplication and competitive tensions between the two structures.

Given the views expressed in the leaked papers, it could be logically concluded that the structure is being set up so that the review, recommended in the Horn Report, in three years will find that the structure has failed to deliver and will further the role of the NHB as the agency holding funding that is contestable between public providers and between public and private providers.

**Angela Belich**  
Assistant Executive Director

---

## Where to Find the Report

**Meeting the Challenge:** Enhancing Sustainability and the Patient and Consumer Experience within the Current Legislative Framework for Health and Disability Services in New Zealand.

[www.beehive.govt.nz/sites/all/files/MRG%20Report%20Meeting%20the%20Challenge.pdf](http://www.beehive.govt.nz/sites/all/files/MRG%20Report%20Meeting%20the%20Challenge.pdf)

[www.beehive.govt.nz/sites/all/files/Annex1%20Current%20and%20Proposed%20Structures.pdf](http://www.beehive.govt.nz/sites/all/files/Annex1%20Current%20and%20Proposed%20Structures.pdf)

[www.beehive.govt.nz/sites/all/files/Annex2%20Clinical%20Leadership%20and%20Quality.pdf](http://www.beehive.govt.nz/sites/all/files/Annex2%20Clinical%20Leadership%20and%20Quality.pdf)

[www.beehive.govt.nz/sites/all/files/Annex3%20Infrastructure%20capacity%20and%20planning.pdf](http://www.beehive.govt.nz/sites/all/files/Annex3%20Infrastructure%20capacity%20and%20planning.pdf)

[www.beehive.govt.nz/sites/all/files/Annex4%20Value%20for%20Money.pdf](http://www.beehive.govt.nz/sites/all/files/Annex4%20Value%20for%20Money.pdf)

[www.beehive.govt.nz/sites/all/files/Annex5%20Commerntary%20on%20Enhancing%20Clinical%20Leadership.pdf](http://www.beehive.govt.nz/sites/all/files/Annex5%20Commerntary%20on%20Enhancing%20Clinical%20Leadership.pdf)

[www.beehive.govt.nz/sites/all/files/Annex6%20Report%20Recommendations.pdf](http://www.beehive.govt.nz/sites/all/files/Annex6%20Report%20Recommendations.pdf)



Assistant Executive Director

## The SMO Commission disappoints<sup>1</sup>

Critical to the resolution of our last MECA negotiations was the establishment of a Senior Medical Officers' Commission to recommend to three parties – government, ASMS and DHBs – a sustainable pathway to competitive terms and conditions of employment for senior doctors and dentists employed by DHBs. The Commission arose out of one MECA negotiation and was supposed to feed into the new MECA negotiations when the current MECA expires in 2010.

The SMO Commission report<sup>2</sup> was released on 3 July 2009. Unfortunately it did not identify a way forward to competitive terms and conditions for senior doctors and dentists employed by DHBs. Instead it concluded that though the pay gap between New Zealand and Australia is “clearly a relevant factor” with regards to retention of SMOs, that New Zealand cannot be competitive. The reports states “...New Zealand must rely on other strengths in order to recruit doctors into New Zealand’s health services at less than international salary levels”.<sup>3</sup>

It reaches a “tentative”<sup>4</sup> conclusion – based mostly on the commissioners’ impressions received during their meetings with SMOs – that SMOs’ frustration with management and their general work environment are more important determinants of decisions to leave New Zealand than the lure of better pay and conditions elsewhere.

### The key findings are that:

- There is a collective specialist pay gap of around 35% between New Zealand and Australia.
- There are “significant data gaps”<sup>5</sup> and a lack of reliable workforce management information, which compromised the Commission’s “ability to make decisions based upon good evidence”.<sup>6</sup>
- Shortages in the DHB specialist workforce have made the system “vulnerable” and retention is deteriorating.
- According to the Commission the main retention issue is disengagement of senior doctors and dentists from DHB management, which it attributes to “significant, detrimental influence” of managerialism that developed in the 1990s commercial business era.
- Recruitment and retention solutions lie in measures to improve the efficiency and effectiveness of the system, including improving the workplace culture so there is better engagement between specialists and managers, giving specialists more influence in how services are organised, developing more innovative practices, and reconfiguring services to provide better regional and national coordination.
- DHB managers and clinical leaders agree that “pay and conditions offered in other jurisdictions, and

Australia in particular, have reduced their ability to recruit in a competitive global market”<sup>7</sup>. But...

- In carrying out its brief to recommend a recruitment and retention strategy that “will provide a sustainable pathway to competitive terms and conditions of employment” for SMOs, the Commission has interpreted “sustainable pathway” to include financial sustainability and therefore...
- It expects current shortages to continue for at least the next 20 years, and suggests that New Zealand cannot afford to offer competitive terms and conditions of employment to fill the gaps.

Partly because of the weight it gives to “affordability”, none of its recommendations directly address the provision of “a sustainable pathway to competitive terms and conditions of employment”, and the extent to which most might contribute indirectly – if at all – to providing that pathway is debatable. Consequently, the Commission has not provided a coherent strategy to that end and has failed to fulfil its terms of reference.

Partly because of the weight it gives to “affordability”, none of its recommendations directly address the provision of “a sustainable pathway to competitive terms and conditions of employment”

### The influence of Australia

The Commission notes that Australia employs around 1640 doctors who obtained their first qualification in New Zealand. This represents about a sixth of the New Zealand medical workforce.

Despite an ASMS survey showing that New Zealand lost at least 80 specialists to Australia in the 18 months to July 2007, the Commission says “there is no data we have seen which shows large numbers of New Zealand SMOs currently relocating to Australia”<sup>8</sup>.

---

It adds that “Australia has limited capacity to absorb large numbers of New Zealand SMOs, especially given that it has greatly increased its internal production of SMOs.”<sup>9</sup> The Commission provides no evidence to support this. As the Commission report itself says, “Australian states [are] competing with each other for scarce skills.”<sup>10</sup> As in New Zealand, the increased medical training capacity will not impact on the SMO workforce for many years.

### The pay gap with Australia: between 42–49% we say

The Commission identifies a pay gap of around 30%–35% between current SMO salaries in New Zealand and Australia. The commission selected four states – Victoria, New South Wales, Queensland and South Australia for its comparison. All of these states have salary scales that are shorter than those in New Zealand. The Commission compared the top step with the top step and didn’t take into account the advantage that a shorter scale offers of getting to a high salary more quickly. It also excluded Western Australia where a large settlement was recently negotiated. If the correct step comparisons had been made the pay gap would have been around 42% and if Western Australia had been included the pay gap would have been 49%.<sup>11</sup>

The Commission contends the gap largely reflects a 28% gap between Australian and New Zealand wages in general, but concedes that there may be a factor of 5% where New Zealand SMOs are behind in relation to the rest of the New Zealand population, compared with Australian SMOs and the Australian population. The Commission says this is a matter for consideration in the next MECA negotiations.

With our common training system New Zealand specialists are more integrated into Australia than most other occupations.

With our common training system New Zealand specialists are more integrated into Australia than most other occupations and therefore the 35% gap is a real gap rather than a gap discounted by 28%. A 5% salary increase would, for example, do nothing to allow New Zealand to compete against Australia for overseas specialists and would do little to stop the loss of specialists from New Zealand to Australia.

The relativity between senior registrar remuneration and that of a new consultant is mentioned.<sup>12</sup> The Commission

offered no comment on this other than to say it was a matter that could be easily addressed in negotiations.

### Significant data gaps

In the same way the Association discovered data gaps during the compilation of our own submission<sup>13</sup>, the SMO Commission found “significant data gaps”<sup>14</sup> compromising “our ability to make decisions based upon good evidence”.<sup>15</sup>

The “critical information lacking” includes:

- Changes to vacancy rates over time
- Rates of turnover
- Exit interview data
- Comprehensive information on the use of locums

The Commission points out at the start that:

*“the nature of much of the available data requires a cautious approach to its interpretation.”*

A number of inaccuracies and inconsistencies in the report suggest the authors themselves appear not to have heeded their own advice as they appear to have derived some key assumptions and drawn some quite firm conclusions from this questionable data. As well value-judgements appear to have been made on what evidence was useful and what could be disregarded. This includes:

- Failure to address a possible shift in employment to the private sector over the last few years.<sup>16</sup>
- Asserting that around 40% of SMOs who work at least some of the time in public hospitals do not work rostered on-call hours.<sup>17</sup> Closer examination of the data sourced from MCNZ reveals that this data reveals nothing about the number of SMOs on call at all.<sup>18</sup> Our information from members suggests most SMOs undertake on-call duties.

### Vacancies and shortages; around 23% in 10 DHBs

The Commission has accepted DHBNZ’s measurement of a 9.5% SMO vacancy rate as a general indication of the level of workforce shortages.

An examination of the data on vacancy rates provided by DHBNZ reveals major discrepancies in the base SMO workforce figures, both in comparison to MCNZ’s statistics and to DHBNZ’s own quarterly workforce statistics. We believe that the stated rate does not reflect the true level of shortages. Our survey of clinical leaders regarding vacancy rates in the 10 surveyed DHBs reveals a rate of around 23%.

Other indicators of shortages such as the specialist-to-population ratios recommended by the colleges, and demand-driven projections based on demographic and health status projections, were not examined because “they are estimates based on assumptions that we do not have

information about"<sup>19</sup>. The accuracy of DHBNZ's stated vacancy rate as a true reflection of workforce shortages is not treated with the same circumspection, despite the vacancy data provided to the Commission from the ASMS survey showing a much higher vacancy rate and despite an acknowledgement in the report that "there is considerable variability in how establishment numbers are determined" and "vacancies will be affected by the capacity to replace staff who are needed".<sup>20</sup>

The Commission does, however, acknowledge that a deficit of around 10% is "more likely to be an underestimate of the structural gap we now have..." which it describes as putting the system in a "vulnerable situation"<sup>21</sup> It is prepared to live with this in the long term: "Furthermore, we recognise this gap will remain a significant element of the health service in New Zealand for perhaps 20 years, until we have made a sizeable increase in the annual additions to the SMO workforce from New Zealand medical school graduates."<sup>22</sup>

### Push or pull?

The Commission highlights the disengagement of SMOs from DHB management, which it attributes to the managerialism introduced in the 1990s. Its strong criticism of managerialism, and call for change, is welcome. However it takes the view that "push factors" (poor relationships with management) are more important than "pull factors" (higher wages overseas) in SMO decisions to leave New Zealand. This view according to the Commission is based on "empirical and anecdotal evidence".

The Commission's anecdotal evidence rests largely on the feedback it received from SMOs during its consultation process. The Commission says many SMOs felt undervalued and ignored by DHB management and it was these factors that drove colleagues to leave and might drive them to leave rather than the attraction of better pay and

There are many examples around the world where the "pull" of increasing incomes is used as a key recruitment and retention tool.

conditions. It is not a surprise to the ASMS that many SMOs at the forums found it more comfortable to raise frustrations about management rather than dissatisfaction with their personal incomes. Any observer of the far larger stop-work meetings would certainly have received a different impression.

An examination of the "empirical evidence" shows it also is flawed. It is inconsistent with other empirical evidence, some of which was referred to in our submission, which was not considered in the Commission's report. This evidence, according to the Commission's paper, shows Canada "has a relatively low outflow of doctors compared to New Zealand, despite there being an absolute and relative improvement in living standards for SMOs associated with a move from Canada to the USA".

The evidence rests largely on one draft paper – a paper "not intended for citation, quotation or other use in any form"<sup>23</sup> – concerning migration of doctors between Canada and the United States, and by linking Canadian migration statistics with OECD data on American and Canadian physician incomes. There is other empirical evidence on Canadian physician migration that indicates the "pull" of higher incomes is indeed significant. We referred to several papers providing this evidence in our submission [pp81/82].

There are many examples around the world where the "pull" of increasing incomes is used as a key recruitment and retention tool, including the three countries we traditionally compare ourselves with, and are our main competitors for skills – Australia, Britain and Canada. The implication of the Commission's paper is that these and many other countries around the world are misguided.

The Commission's report in fact gives inconsistent messages on the importance of the pull of more competitive pay and conditions elsewhere. On the one hand it says:

*[Increasing global competition] could make the New Zealand-trained health professionals harder to retain, and attracting the potential pool of foreign recruits more difficult.*<sup>24</sup>

The Commission then indicates some uncertainty about the pull factor: *While acknowledging that good pay and conditions are important, the primary focus of [SMOs'] concern was frustration with an environment which does not appear to value and adequately support their key roles.*<sup>25</sup>

The Commission then indicates more certainty without providing further evidence to explain the change in view.

*While discussion around pay and conditions is properly the role of the parties... it is important the parties consider... the minimal impact it is likely to have on long term SMO retention relative to other measures that can be taken to address the push factors identified in this report [commission's emphasis].*<sup>26</sup>

"Pull" factors can exacerbate or even create "push" factors. In particular, the loss of staff overseas has a

consequence for those who remain, who are often faced with increased workloads, longer hours and, ironically, an increased dependency on locums and overseas recruits.

The Commission's strong statement on managerialism and the call for change is good. The ASMS will continue its efforts to gain traction for change. However, the Commission's comments highlight the extent to which managerialism has been entrenched in the system for many years. So even if one agreed with the idea that a changed management culture would reduce wage expectations, realistically it is not a solution to contemplate in the foreseeable future.

The Commission's strong statement on managerialism and the call for change is good.

### Taking into account fiscal sustainability

In trying to fulfil its brief to come up with a sustainable pathway to competitive terms and conditions of employment for SMOs, the Commission has interpreted "sustainable pathway" to include financial sustainability: "Any pathway must also take into account fiscal limitations."<sup>27</sup> It takes the view that New Zealand is not in an overall position to increase health expenditure without an overall increase in productivity and that New Zealand's spending is commensurate with our relatively low per capita income.

### Unanimous Resolution of National Executive on SMO Commission Report

That, while encouraged by a number of the recommendations of the Senior Medical Officers Commission, the Association is disappointed that it did not fulfil its terms of reference with regards to a sustainable pathway to competitive terms and conditions of employment for senior medical and dental officers.

Referring to the OECD's latest Economic Survey for New Zealand, the Commission says our health system fares quite well in terms of spending and population health outcomes.

However, the OECD report says New Zealand spends less per capita on its health system than many OECD countries and raises concerns about the sustainability of the health service delivery model in the face of rising demands and looming health workforce shortages. OECD data on international health status show New Zealand does not compare well with countries such as Australia, Britain and Canada, as detailed in our submission [pp22-23].

The Ministry of Health and a World Health Organisation paper<sup>28</sup> point out there is no "right" or "wrong" proportion of a country's GDP to be spent on health, and cross-country comparisons cannot determine what is right but rather simply what is commonplace.

The Commission's interpretation of affordability appears to have become the overriding influence in its approach to producing this report

Surveys of New Zealanders have consistently indicated their desire to see the public health system adequately funded to meet their health needs.

The Commission's interpretation of affordability appears to have become the overriding influence in its approach to producing this report, to the point where the main focus is on a sustainable pathway to quasi-affordable terms and conditions, rather than competitive terms. For example:

*...New Zealand must rely on other strengths in order to recruit doctors into New Zealand's health services at less than international salary levels.<sup>29</sup>*

The confusion between being "competitive" and being "affordable" has resulted in a lack of clarity in the report, no more so than in the paragraph:

*Closing the [salary gap with Australia] raises financial sustainability issues in the current economic climate, which will impact on the gradient of the 'sustainable pathway' to competitive terms and conditions of employment.<sup>30</sup>*

This appears to mean that if we had more competitive terms and conditions of employment (in this case relative to Australia), it would be more difficult to achieve a "sustainable pathway" to competitive terms and conditions of employment. That is, the pathway may not be **sustainable** if it is **competitive**.

## Where to now?

Many of the Commission's recommendations, if they are implemented fully, have the potential to improve the working environment of SMOs in the longer term. The current workforce crisis, however, requires an immediate response which needs to deal with the recent rapid improvement in remuneration of specialists in Australia and recognition that international competition for SMOs is going to become more intense. Indeed many of the

none of its recommendations directly address the provision of "a sustainable pathway to competitive terms and conditions of employment"

Commission's recommendations require a workforce that is in a strong position and it is difficult to envisage many of the recommendations being implemented until the current shortages are addressed.

Partly because of the weight the Commission gives to "affordability", none of its recommendations directly address the provision of "a sustainable pathway to competitive terms and conditions of employment", and the extent to which most of the recommendations might

contribute indirectly – if at all – to providing that pathway is debatable. Consequently, the Commission has not provided a coherent strategy to that end and has failed to fulfil its terms of reference.

At its last meeting the ASMS National Executive (see p14 for the full text of the resolution) said that while some of the recommendations of the SMO Commission were encouraging, the Commission did not fulfil its terms of reference by failing to establish a path to competitive terms and conditions of employment for senior medical and dental officers.

The public health service is threatened by a medical workforce crisis that will only be resolved by recognition that New Zealand is competing in an Australian medical labour market and establishing a pathway to terms and conditions that are competitive in that market. Resolving this crisis (well recognised by the Government while in opposition) is clearly a government responsibility. Strategy for the next MECA will be discussed at the national conference in December. The SMO Commission has handed the problem back to senior medical and dental staff (and their union) and the government to resolve.

**Angela Belich**  
Assistant Executive Director

## Footnotes

- This article is taken from a paper that is being prepared as a response to the SMO Commissions report. Members who wish to comment please email ab@asms.org.nz.
- 'Senior Doctors in New Zealand: Securing the Future – The Report of the Director-General of Health's Commission on Competitive and Sustainable Terms and Conditions of Employment for Senior Medical and Dental Officers Employed by District Health Boards' available on www.moh.govt.nz/moh.nsf/indexmh/senior-doctors-nz-securing-the-future
- p49 SMOCR
- p65 SMOCR
- p2 SMOCR
- p27 SMOCR
- P64 SMOCR
- p65 SMOCR
- p65 SMOCR
- p64 SMOCR
- The contention that salary sacrifice in public hospitals delivers a maximum benefit of \$4000 (see appendix 8) was not the information we have had from members who have taken positions in Australia who report salary sacrifice up to 90% of salary. We will be researching this further.
- p36 SMOCR
- "Repairing the Leaking Bucket" on www.asms.org.nz
- p2 SMOCR
- p27 SMOCR
- Repairing the Leaking Bucket, pp93–94
- pp9,10 SMOCR
- as on-call hours are defined as on-call but not actually worked. On-call hours that entail actual work (i.e. call-out) are not included – they are instead reported separately as hours worked. This definition is provided as a footnote in Appendix 3 but is not included in the main body of the report. Furthermore the MCNZ's survey form allows information from just the most recent week to be used. The MCNZ does not collect data that enable the total number of SMOs that do on-call duties (i.e. on-call hours worked and not worked) to be calculated.
- p10 SMOCR
- p10 SMOCR
- p65 SMOCR
- p54 SMOCR
- Grepin K, *Brain Drain or Brain Train?* A longitudinal analysis of Canadian physician migration, working paper, Harvard University programme in Health Policy, May 2008
- p16 SMOCR
- p44 SMOCR
- p45 SMOCR
- p62 SMOCR
- Figueras, M McKee, et al, 2008. *Health Systems, Health and Wealth: Assessing the Case for Investing in Health Systems*. WHO 2008, Ministry of Health 2008. *Health Expenditure Trends in New Zealand 1996-2006*. Available at: www.moh.govt.nz
- p49 SMOCR
- p65 SMOCR

# Summary of SMO Commission recommendations

- 1 **DHBs and the Ministry of Health value the SMO contribution**, and jointly develop effective clinical leadership and participation through strong clinician–management partnerships. This will get the best value out of public health spending.
- 2 **The Government amend DHB mandates** to drive critical health system goals, such as workforce and clinical services planning, through shared accountability.
- 3 **The Ministry of Health** accelerate the development of a clear process for regional and national service planning, to enable aligned SMO workforce planning.
- 4 **The Ministry of Health require the Medical Training Board (or any successor) to review** and recommend medical student intakes at three-yearly intervals to align intakes with future service needs.
- 5 **The Government consider the recommendations** of the Medical Training Board report and Commission on the Resident Medical Officer Workforce, and agree to the rapid implementation of co-ordinated initiatives that will significantly strengthen medical training.
- 6 **The Ministry of Health lead a sector-wide process** to identify core SMO workforce management information and establish systematic ways of collecting, analysing and reporting that information to provide a common understanding of SMO workforce issues.
- 7 **DHBs and the Association of Salaried Medical Specialists develop an interest-based bargaining model** that is:
  - supported by reliable and accurate base information and analysis
  - led by experienced and senior representatives with delegated authority to reach agreement (subject to ratification)
- 8 **DHB boards initiate and monitor an ongoing programme** of SMO leadership development and report progress through their accountability documents. This will enable them to realise the contribution of potential SMO leaders.
- 9 **DHBs, the Ministry of Health and professional colleges work collectively** to use emerging national and regional service planning processes to determine the numbers and mix of general specialty and subspecialty training positions needed to match future service needs.
- 10 **The Medical Council of New Zealand and professional colleges adapt their processes** to provide the necessary support, responsiveness and facilitation to IMGs seeking vocational registration. This will ensure the wider public interest of appropriate SMO deployment across the New Zealand health system is met.

*If necessary, the Minister of Health may need to review the mandate of the Medical Council of New Zealand to enable this to be achieved.*
- 11 **DHBs establish regionally co-ordinated recruitment functions** that complement regional and national service planning, retaining the benefits of local strategies. This is a critical component of a national recruitment strategy.
- 12 **DHBs review current arrangements and take necessary actions to improve space**, tools and support for SMOs, recognising the importance of these factors to SMO retention.
- 13 **DHBs, the Association of Salaried Medical Specialists and the Ministry of Health strengthen existing bipartite** and tripartite processes to nurture an informed dialogue at all levels. This will contribute to a sustainable level of SMO staffing that is aligned to service needs.

*This will ensure negotiation is underpinned by expertise that is commensurate with the significance of SMOs to the health system.*



# The month of the many reports

The last few weeks have seen the publication of six reports on the health workforce and the report of the Ministerial Review Group (the Horn Committee or Horn Report) which proposes a massive restructuring of the public health system. Both the *Horn Report* and the *SMO Commission Report* are the subject of separate articles in this month's *Specialist*. However there are four other reports briefly summarised below. The full reports can be accessed on [www.govt.nz/moh.nsf/indexmh/health-disability-workforce-reports-aug09](http://www.govt.nz/moh.nsf/indexmh/health-disability-workforce-reports-aug09).

## Treating People Well—the report of the RMO Commission

This is the report of the committee headed by ex State Services Commissioner Don Hunn. The other members of the committee were ex CTU Secretary Angela Foulkes and Professors Peter Crampton and Des Gorman.

The main recommendation of the report is that junior doctors should have a single employer while they are training. They consider four options - the status quo, a regional employment model, a stand alone national body, employment by the national training body - and favour a stand alone national body as the employer. The Commission was not of the view that the body with responsibility for training could also be the employer of RMOs because the two functions require different skills.

In his press statement when releasing the report the Minister of Health described the newly announced Clinical Training Agency Board as answering the Commission's call for a single national training body. He did not however endorse the reports recommendation for a single national employer and said he was referring this recommendation to DHBs for comment.

## A review of how the training of the New Zealand health workforce is planned and funded: A proposal for reconfiguration of the Clinical Training Agency

This report, by a Minister of Health's Taskforce of Professors Des Gorman, Margaret Horsburgh and Max Abbott, found that New Zealand had significant problems in recruiting, training and retaining an adequate health and disability service workforce and that these problems were likely to worsen. The report says the workforce situation is in crisis and says that 'career choice distortion' arises because of remuneration anomalies within New Zealand and between New Zealand and Australia and student debt.

The taskforce recommended the establishment of a single agency to fund or direct the funding for the training of all health and disability workers, plan their training and monitor their training. The agency should eventually be a crown entity separate from the Ministry of Health and expand its brief to disability workers. At some point the agency would have responsibility for the whole of the

education continuum for health and disability workers and for the whole health and disability workforce.

The agency is to have permanent reference groups for medicine and nursing but as needed reference groups for other parts of the workforce. It is also proposed that the new CTA set funding targets for the Tertiary Education Commission for health workforce training. The Minister is to approve all purchase intentions and current publicly funded workforce planning groups (such as HWIP) should be aggregated.

As he released these reports the Minister of Health announced the establishment of a Clinical Training Agency Board to be chaired by Professor Gorman and disestablished the Medical Training Board. The new CTA board will be established as part of the Ministry of Health pending the decisions that will follow from the Horn report.

## The final report of the Medical Training Board (MTB) called 'Foundations for Excellence'

This recommends a body called Medical Education and Training New Zealand to replace the MTB. Most of the functions suggested by this report could be incorporated into the Clinical Training Agency Board but it's clear that this approach and the 'evolutionary' approach suggested by the MTB have been rejected by the Minister. The danger for the medical profession is that incorporation in the overall Clinical Training Agency Board will make resources and funding, hitherto tagged to medicine, contestable.

## A report on Nursing Education

This report was written by Len Cook who headed the Medical Training Board and chaired the SMO Commission.

The report says that all nursing groups support the establishment of a nursing equivalent to the Medical Training Board. The recommendations however are couched in terms of asking the Minister to 'note' various issues in particular the need for high level governance for nursing education and the need to bring health professionals together more effectively to oversee roles, training and future needs.

**Angela Belich**  
Assistant Executive Director

---

# Disclosure of health information to third parties

*The following article is kindly provided by the Medical Protection Society with whom the ASMS has a close collaborative relationship. If ASMS members are not MPS members they are strongly recommended to seriously consider joining it for effective medical indemnity representation and support.*



Patient confidentiality is central to medical practice. However, in some situations disclosure of patient information to third parties is appropriate. Before releasing such information, doctors must ensure they are complying with their ethical and legal obligations.

Some laws decree that doctors **must** disclose information to third parties. For example, the Civil Aviation Act 1990 states that a doctor must inform the Director of Civil Aviation if he/she believes that a pilot is not fit to fly (after first informing the pilot of the intended notification).

## Accuracy in disclosure

However, even when disclosure is mandatory, the information must only be shared with the correct, named authority. In one MPS case, a member informed a local police officer that a patient was not fit to drive and was continuing to do so despite medical advice to the contrary. The doctor was required to inform the Director of the Land Transport Safety Authority in writing of his concerns for public safety, under section 18 of the Land Transport Act 1998. The Privacy Commissioner upheld the patient's subsequent complaint in part because the doctor disclosed the information to the wrong authority.

It is also important to ensure that the correct category of information is disclosed and the particular legal requirement may not always be clear. For example, under section 11 of the Social Security Act 1964, the Ministry of Social Development can require the provision of health information to the department. Often this is done to investigate suspected benefit fraud. However, an accompanying code of conduct states that only "administrative data" (eg, appointment times) can be requested from a doctor and not confidential information relating to treatment and diagnosis.

## Disclosure without patient consent

Other legal rules permit the disclosure of health information without a patient's consent. For example, Rule 11(2)(d)(i) and (ii) of the Health Information

Privacy (HIP) Code provides that compliance with confidentiality is not necessary if the doctor believes on reasonable grounds that the disclosure is necessary to prevent or lessen a serious and imminent threat to public safety. However, a doctor is required to meet a very high threshold if he/she intends to rely on this exception and the Medical Council suggests that it may be prudent for doctors to obtain legal advice if there is any doubt whether disclosure should be made.

Where there is discretion to release information without consent, doctors must also ensure that only information relevant to the specific purpose of the disclosure is released.

It is also often advisable to discuss an intended disclosure with the patient first. In another recent MPS case, a patient was under investigation by ACC and the corporation had requested information from the treating surgeon. ACC stated that an exception in rule 11 of the HIP Code applied, namely that the disclosure was related to one of the purposes for which the information was first obtained. While the provision of relevant information to ACC was justified on the facts of this case, MPS advised the member to discuss the intended disclosure with the patient first.

Doctors should note that where they have concerns about the safety of a child, the Children, Young Persons and Their Families Act 1989 allows (but does not require) the reporting of these concerns to a social worker or member of the police. Provided the disclosure is made in good faith, no civil, criminal or disciplinary proceedings can be brought against the person disclosing the information.

Often, however, there is no good faith defence if a doctor inappropriately exercises discretion to release information without consent. Inappropriate disclosure may result in an investigation by the Medical Council, the Privacy Commissioner and potentially proceedings before the Human Rights Review Tribunal.

Doctors should also be aware that MPS has been involved in cases where doctors, usually acting with the best of intentions, have been criticised for not disclosing information on the basis of the Privacy Act.

Decisions about what information to disclose to insurers is often challenging and doctors should familiarise themselves with guidance recently issued by the Privacy Commissioner on this subject (available at [www.privacy.org.nz](http://www.privacy.org.nz)).

MPS is always ready to provide assistance to members looking for advice when confronted with the very difficult issue of disclosure of health information to third parties.

**Dr Brendon Gray,**  
MPS Medico-Legal Consultant

## Support service for doctors

The Medical Assurance Society and Medical Protection Society have joined forces to bring their members an important support service.

The support service provides access to a free professional counselling service.

Doctors seeking help can call **0800 225 5677 (0800 Call MPS)**. The call will be answered by the Medico-Legal Adviser on duty who will then arrange counselling or support. The service is completely confidential.



# ASMS TWENTY FIRST ANNUAL CONFERENCE

Thursday 3 – Friday 4 December 2009, Oceania, Te Papa, Wellington

### Dinner and Pre-Conference Function

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

### Leave

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

### Registration of Interest

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

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

### DELEGATES REQUIRED

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



*We make it easy*

## It's much easier to find the right loan.

It's amazing – it's as easy as picking up the telephone and talking to us today. Our Members tell us how busy they are, so when they need a loan they need it quickly. Whether you're after a new vehicle, something for the house, practice equipment or just covering unexpected bills, it's now as easy as picking up the phone. In most cases, we can approve the loan on the spot. *It's that easy.*

PHONE 0800 800 MAS (627) EMAIL [society@medicals.co.nz](mailto:society@medicals.co.nz)

*Our friendly staff are standing by for your call.*

Medical Securities Limited's normal lending criteria apply for all credit and loans, and your application is subject to acceptance by Medical Securities Limited.