ASMS

ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

TOI MATA HAUORA

# Submission to the Governance and Administration Select Committee on the State Sector Crown Entities Reform Bill

**28 March 2018**

## Introduction

The ASMS is the union and professional association of salaried senior doctors and dentists employed throughout New Zealand. We were formed in April 1989 to advocate and promote the common industrial and professional interests of our members and we now represent nearly 4,800 members, most of whom are employed by District Health Boards (DHBs) as medical and dental specialists, including physicians, surgeons, anaesthetists, psychiatrists, oncologists, radiologists, pathologists and paediatricians.

Over 90% of all DHB permanently-employed senior doctors and dentists eligible to join the ASMS are in fact members. Although most of our members work in secondary and tertiary care (either as specialists or as non-vocationally registered doctors or dentists) in the public sector, a small but significant number work in primary care and outside DHBs. These members, mainly general practitioners, are employed by the New Zealand Family Planning Association, ACC, hospices, community trusts, Iwi health authorities, union health centres and the New Zealand Blood Service.

The ASMS promotes improved health care for all New Zealanders and recognition of the professional skills and training of our members, and their important role in health care provision. We are committed to the establishment and maintenance of a high quality, professionally-led public health system throughout New Zealand.

The ASMS is an affiliate of the New Zealand Council of Trade Unions.

## Code of conduct for Crown entity boards

Owing to limited time and resources, our submission is confined to the matter of enabling the State Services Commissioner (SSC) to apply a code of conduct to Crown entity boards and board members (Clause 7). It relates specifically to the boards of district health boards (DHBs).

We note the collective and individual duties of Crown entity board members under the Crown Entities Act are to ensure that the entity "performs its functions efficiently and effectively, in a manner consistent with the spirit of service to the public, and in collaboration with other public entities; and the entity operates in a financially responsible manner". Briefly, the individual duties of members include to: act with honesty and integrity; act in good faith and not at the expense of the entity's interests; act with reasonable care, diligence and skill; and not disclose information apart from in the performance of the entity's functions.[1]

We support Clause 7 for the following reasons:

As explained by the State Services Commission in its Supplementary Analysis Report, applying a code of conduct to board members:

- Is inherently the right thing to do. There is no reason from a public transparency and accountability perspective to treat board members differently to staff or contractors. If anything, public expectations are higher in terms of the behavioural standards by governors of these entities, given their senior positions and the impact of breaches on the reputation of both the entity and the broader state services.
- Would support the legislative expression of board members' collective and individual duties and guide them on how to give effect to these duties.
- Would catch up with international practice.
- Is necessary for reconnecting the system around a unifying ethos of a spirit of service to the community.

The above points are especially relevant with regard to the way DHB boards sometimes plan and make decisions that can have a major impact on clinical safety, quality and efficiency (as well as downstream cost) but without engaging with senior doctors in the process. Where it does occur, engagement is usually a cursory tick-box process with a hand-picked few.

A study on the governance of DHBs, which included surveys of DHB board members supported by interviews with chief executives and individual board members, found:

*Both Chairs and CEOs commented on the importance of clinicians for a range of high-level DHB activities such as risk management and priority setting. Sixteen CEOs specifically mentioned the importance of clinicians to overall financial sustainability.*[2]

However, only 51% of board members surveyed agreed/strongly agreed that their board had a positive relationship with senior clinicians, with statistically significant differences between DHBs.

*… there is little evidence the senior clinicians are engaged with governing boards other than through invited presentations at board and committee meetings. This may be appropriate as the primary relationship for clinicians is with management, but their significance to DHBs is such that there is a strong imperative for them to be more positively engaged and hold organisational as well as clinical perspectives.*

While this study, published in 2007, focused on the formative years of DHBs, our members' experience today indicates little has changed. Of course, board and management perspectives do not always align with senior doctors' perspectives, but that is all the more reason for strong clinical engagement, to ensure decisions are based on the best knowledge, evidence and practical experience available. It is well recognised that in complex systems such as health care, a wrong decision can have far-reaching unintended consequences, including financial as well as clinical.

Among the most significant decisions that some DHB boards have made in terms of impact on clinical services has been the privatisation of hospital laboratory services, which we focus on in this submission as an example of the lack of engagement and transparency in decision-making processes, though we emphasise that the experiences described here are typical of the approaches taken by many boards and executive managers relating to decisions affecting services generally.

## Example: laboratory services

Laboratory services by their nature do not have the same public visibility as other hospital clinical services but the work of laboratories is critical to the safe and effective delivery of patient care and treatment across the public health system. More than 70% of all diagnoses involve pathology tests, predominantly for surgeons and physicians, and pathology plays a vital role in infection control and monitoring disease. To operate safely and effectively, laboratories must foster strong integrated relationships with the 'end users' in their hospitals who depend on their service. This includes the full range of surgical and medical hospital specialties.

The most recent laboratory privatisation occurred in services covering the Wellington region in 2015, and our comments below refer specifically to that experience, though it similar to that of the privatisation of laboratory services in Otago/Southland in 2007. Taranaki DHB is currently attempting to follow suit and, again, the familiar issues are arising. In summary, the processes have been marked by:

**Lack of clinical engagement:** 'Consultation' with staff has fallen woefully short of what is required for effective clinical leadership and engagement, as described in government policy and as agreed in several documents, including the multi-employer collective agreement (MECA) covering senior medical and dental officers. Where consultation has taken place, it has been of little value, restricting specialists to commenting on a limited range of matters determined by management, instead of enabling them to contribute their experience and expertise.

**Lack of expertise in proposal development:** People without much understanding about how hospital laboratories work, particularly from DHB funding and planning divisions of DHBs, have tended to be the main instigators of the proposals and dominate the advice provided to boards, which is discussed further below.

**Lack of transparency:** Much of the development of the proposals occurred in secret. Information of vital interest to the public and to those providing the services has been vigorously guarded, contrary to the principal underlying the Official Information Act (OIA) that "information shall be made available unless there is good reason for withholding it". In the Wellington case, intervention from the Ombudsman was necessary to obtain information about the rationale behind the planned privatisation. It showed many of the claims made publicly by the DHB were at best overstated and at worst lacking in any foundation, including stated 'savings' from the move. The risks outlined in the information, that had not been available to staff, included a 'high' risk that construction of the new facility could cause disruption so that areas "located in the Clinical Services Block cannot fully function and service delivery is impacted".

## Poor quality advice

An underlying issue experienced with these privatisation processes concerns the quality of advice provided to the boards by DHB officials. In the Wellington case, information obtained under the OIA revealed that many of the concerns raised by specialists about the potential implications of DHB plans had not been considered and that officials had seriously under-estimated the complexity of restructuring the service. The documents showed the DHB's publicly stated 'savings' that would be made from the move were in fact aspirational rather than calculated estimates.

Board members were repeatedly advised that clinicians had been consulted on the plans and supported them while our canvassing of senior doctors' views found the complete opposite on both counts. ASMS attempts to provide a more accurate perspective from clinical staff was effectively ignored by the board. DHB-employed pathologists were so concerned that they wrote a letter to the Minister of Health appealing for his intervention; a further letter raising concerns was sent by the Society of Pathologists (New Zealand Committee of the Australian and New Zealand College).

Attempts by some elected board members to learn more from the senior doctors' perspective were prevented by the Board Chair from contacting the ASMS once commercial contracting processes were underway on the spurious grounds of protecting commercially sensitive information. The board members were responsibly seeking information held by the ASMS; they were not proposing to give away commercial secrets, nor would we have expected them to. The ruling by the Chair not only maligned the integrity of these board members, it also prevented them from carrying out their duties to the community.

We recognise that all board members, included those elected by the community, are directly responsible and accountable to the Minister of Health, but as the Ministry of Health explains, "elected members have an important role in ensuring the community's voice is heard at the DHB board table".[3]

## Conclusion

The behaviour of some DHB boards in developing and deciding on proposed service changings, in the experience of our members, have at times fallen well short of their duties under the Crown Entities Act, to ensure their DHB "performs its functions efficiently and effectively, in a manner consistent with the spirit of service to the public and … operates in a financially responsible manner". The duties of individual board members to "act in good faith and not at the expense of the entity's interests; [and] act with reasonable care, diligence and skill".[4]

The attitude and behavior of some DHB boards with regard to accountability, engagement and public participation falls well short of the requirements of the Official Information Act and general public expectations of good governance.

A code of conduct for boards that helps to address these shortcomings is sorely needed.

## References

[1] SSC. Supplementary Analysis Report: State Sector and Crown Entities Reform Bill, February 2018.
[2] P Barnett, C Clayden. Governance in District Health Boards: Report No 2 on Behalf of the Health Reforms 2001 Research Team, August 2007, Health Services Research Centre, Wellington.
[3] Ministry of Health. District Health Board Elections 2016: Information for Candidates, June 2016.
[4] SSC. Supplementary Analysis Report: State Sector and Crown Entities Reform Bill, February 2018.