ISSUE 98 | MARCH 2014

The Specialist

THE NEWSLETTER OF THE ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

ASMS
TOI MATA HAUORA
www.asms.org.nz

DHBs FAILING over distributive clinical leadership

ASMS 25 YEARS OF ENGAGEMENT 1989-2014

Late last year the ASMS surveyed DHB-employed members on distributive clinical leadership in DHBs. This followed an earlier survey which awarded most DHBs an abysmal E-Grade when it came to committing to time for non-clinical duties to support clinical engagement by senior doctors and dentists. Our most recent survey aimed, among other things, to further explain this poor state of affairs.

Entrenched shortages, time and leadership deficit

Let's be clear: DHBs' failure to improve distributive clinical leadership is mainly because of the broader political failure to invest in the specialist workforce. Entrenched specialist shortages have become the norm, and the Government and DHBs are exploiting this.

Senior doctors lack the time to be involved in engagement over and above their clinical practice. We are well short of the workforce capacity to achieve the full quality and cost effectiveness benefits that their engagement would provide. This failure to invest compounds the precariousness of our public hospital system in the medium to long term but does meet immediate short-term imperatives.

Our health system lacks the leadership to address this critical challenge, and DHBs have been telling the Government what they think it wants to hear.

The second survey was completed by 1,060, or 30%, of our DHB-employed members and it examined the performance of chief executives, senior managers, middle managers and human resource managers. While not as rigorous as a professional opinion poll, the survey nevertheless provides important insights.

Overall DHB performance is poor but two people in particular stand out as top performers relative to their peers: David Meates, Chief Executive of Canterbury and West Coast DHBs, and Warrick Frater, Hawke's Bay DHB Chief Operating Officer. South Canterbury DHB's new Chief Executive Nigel Trainor also performed strongly, although he has some challenges to address in the levels below him. Hawke's Bay Chief Executive Kevin Snee has improved since the 2010 University of Otago survey of ASMS members, although the poor result in last year's survey on provision of time for non-clinical duties remains an indictment.

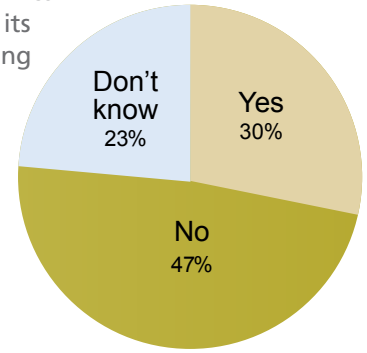
The better performing DHBs were (north to south) Lakes, MidCentral, Canterbury, West Coast and South Canterbury.

But there are clearly DHBs in serious trouble with Wairarapa, Hutt Valley, Southern, Bay of Plenty, and Auckland the most obvious. The first two share the same Chief Executive (Graham Dyer).

David Meates Chief Executive of Canterbury and West Coast DHBs

DHBs overall

Do you believe your DHB is genuinely committed to 'distributive clinical leadership' in its decision-making processes?



Members were asked to assess their DHB's level of genuine commitment to distributive clinical leadership in its decision-making processes. Just 30% of respondents felt their DHB was genuinely committed to distributive clinical leadership, while 47% felt their DHB was not genuinely committed, and 23% didn't know.

PO Box 10763
Wellington
New Zealand
+64 4 499 1271
asms@asms.org.nz

ISSN 2324-2787

Do you believe your DHB is genuinely committed to 'distributive clinical leadership' in its decision-making processes?

Rank	DHB	Yes	No	Don't know
1	Canterbury	62%	23%	15%
2	Lakes	56%	28%	16%
3	West Coast	44%	22%	33%
4	South Canterbury	40%	50%	10%
5	MidCentral	40%	48%	12%
6	Tairawhiti	37%	37%	26%
7	Counties Manukau	34%	31%	35%
8	Waitemata	32%	55%	13%
9	Whanganui	31%	54%	15%
10	Hawke's Bay	29%	42%	29%
11	Northland	25%	53%	22%
12	Capital & Coast	25%	48%	27%
13	Taranaki	24%	48%	29%
14	Waikato	23%	51%	26%
15	Nelson Marlborough	20%	45%	34%
16	Auckland	18%	53%	29%
17	Bay of Plenty	16%	67%	16%
18	Southern	15%	68%	17%
19	Hutt Valley	10%	55%	35%
20	Wairarapa	0%	86%	14%
	National Average	**30%**	**47%**	**23%**

In just two DHBs did more than 50% believe their DHB was genuinely committed – Canterbury (62%) and Lakes (56%). The next three best performers were West Coast, South Canterbury and MidCentral. On the other hand, the worst results were recorded for Wairarapa (0%), Hutt Valley (10%), Southern (15%), Bay of Plenty (16%) and Auckland (18%).

When DHBs are ranked by negative responses, Wairarapa DHB 'topped the poll' with 86% of surveyed members there saying 'no', followed by Southern (68%), Bay of Plenty (67%), Hutt Valley and Waitemata (both 55%), and Auckland (53%). The small differences between the 'yes' and 'no' rankings are due to the variability of 'don't knows' (for example, Hutt Valley was 35% compared with Waitemata at 13%).

Meanwhile, just 22% of West Coast DHB members said 'no', with the next best being Canterbury (23%), Lakes (28%), Counties Manukau (31%) and Tairawhiti (37%).

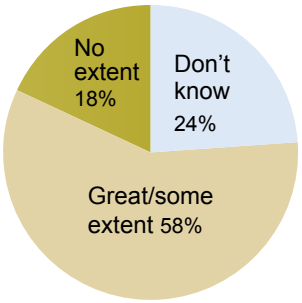
Warrick Frater

Nigel Trainor

Graham Dyer

Rating chief executive performance

To what extent do you believe that your Chief Executive is working to enable effective 'distributive clinical leadership' in your DHB's decision-making processes



Rank	DHB	Great/some extent	No extent	Don't know
1	West Coast	89%	11%	0%
2	Canterbury	84%	3%	14%
3	South Canterbury	80%	0%	20%
4	Hawke's Bay	78%	3%	19%
5	Lakes	75%	9%	16%
6	Whanganui	69%	23%	8%
7	Tairawhiti	68%	11%	21%
8	Waitemata	66%	11%	23%
9	MidCentral	64%	24%	12%
10	Nelson Marlborough	61%	32%	7%
11	Wairarapa	57%	29%	14%
12	Southern	56%	27%	17%
13	Waikato	53%	14%	33%
14	Northland	52%	17%	31%
15	Counties Manukau	49%	14%	37%
16	Bay of Plenty	49%	28%	23%
17	Auckland	48%	21%	31%
18	Hutt Valley	44%	33%	23%
19	Capital & Coast	41%	22%	37%
20	Taranaki	24%	38%	38%
	National Average	**58%**	**18%**	**24%**

ASMS members were asked to rate their chief executive's commitment to enabling effective distributive clinical leadership in their DHB's decision-making processes. Overall, 12% believed their chief executive was working to a great extent to do this, 46% believed to some extent; and 18% to no extent. 'Don't knows' were a significant 24%.

The standout was David Meates, one of two chief executives heading two DHBs. The vote to a great extent was 56% and 43% for West Coast and Canterbury respectively (33% and 41% respectively to some extent). He was the only chief executive where 'great extent' exceeded 'some extent'. Other chief executives were streets behind, with the next three being Jim Green (Tairawhiti), Nigel Trainor (South Canterbury) and Dale Bramley (Waitemata), with ratings from 16% to 21%. A total of 12 chief executives (Graham Dyer twice) were ranked less than 10%; rather grim.

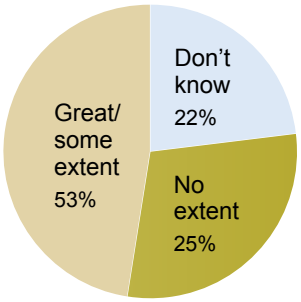
When the 'great' and 'some extent' categories are combined, the top chief executives are from West Coast (89%), Canterbury (84%), South Canterbury (80%), Hawke's Bay – Kevin Snee (78%) and Lakes – Ron Dunham (75%).

The Taranaki, Hutt Valley and Wairarapa, Nelson Marlborough, and Bay of Plenty chief executives have much to work on given the high number of members who gave them a 'no extent' rating. Conversely, South Canterbury's Nigel Trainor should be pleased with his 0% rating in this category.

A word of caution about the Capital & Coast result: the survey was conducted in December when its chief executive had just started and was barely known by most members.

Senior management

To what extent do you believe that senior management (reporting directly to the Chief Executive) is working to enable effective 'distributive clinical leadership' in your DHB's decision-making processes?



Rank	DHB	Great/some extent	No extent	Don't know
1	Hawke's Bay	75%	6%	19%
2	Canterbury	74%	13%	13%
3	Lakes	72%	9%	19%
4	Nelson Marlborough	62%	27%	11%
5	Taranaki	62%	19%	19%
6	MidCentral	61%	29%	10%
7	Whanganui	61%	31%	8%
8	Wairarapa	57%	43%	0%
9	West Coast	56%	22%	22%
10	Counties Manukau	52%	14%	34%
11	Northland	50%	22%	28%
12	South Canterbury	50%	50%	0%
13	Capital & Coast	50%	25%	25%
14	Waitemata	48%	26%	26%
15	Tairawhiti	47%	21%	32%
16	Southern	47%	39%	14%
17	Auckland	46%	25%	29%
18	Waikato	43%	32%	25%
19	Hutt Valley	40%	40%	20%
20	Bay of Plenty	37%	40%	23%
	National Average	**53%**	**25%**	**22%**

Senior managers rank even lower than chief executives. Senior managers are second tier in the DHB's hierarchy and report directly to the chief executive with Middle managers reporting to them.

In the context of senior medical staff, this is usually the chief operating officer or someone in a similar operational position.

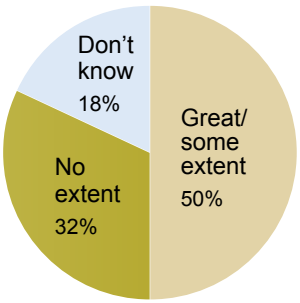
Only 8% of respondents said senior managers were working to a great extent; 45% to some extent; and 25% to no extent (22% recorded 'don't knows'). Again, West Coast and Canterbury were well ahead of the pack, with West Coast the highest at 33%. The only others having a commitment to a great extent rating above 10% were Counties Manukau, Hawke's Bay, MidCentral and Lakes DHBs. Significantly South Canterbury's rating for 'great extent' drops to 0% compared with 20% for the performance of the DHB's chief executive.

When the 'great' and 'some extent' categories are combined, the top senior management is from Hawke's Bay (75%), Canterbury (74%), Lakes (72%), Nelson Marlborough (62%) and Taranaki (62%), with Bay of Plenty a mere 37%. The national average is an uninspiring 53%.

In the 'no extent' category, South Canterbury should be sweating followed by Wairarapa and Hutt Valley, Bay of Plenty and Southern. On the other hand, Hawke's Bay should be pleased.

Middle management

To what extent do you believe that middle management is working to enable effective 'distributive clinical leadership' in your DHB's decision-making processes?



Middle management are ranked even lower than those they report to, with a mere 7% of members rating them at a great extent; 43% to some extent; and 32% to no extent (18% recorded 'don't knows'). Perhaps distributive clinical leadership is perceived as a threat at this level of management. On the other hand, perhaps reflecting their closer proximity to the medical workforce, middle management performs better than the other categories in the 'no extent' rating.

The top five DHBs at this level were Canterbury (17%), Lakes (13%), Counties Manukau (12%), West Coast and Tairawhiti (both 11%). Twelve were rated less than 10%, three of which did not get above 0%.

When the 'great' and 'some extent' categories are combined, the national average just hits 50%, with the top middle management from Hawke's Bay (87%), Lakes (74%), Taranaki (62%), Canterbury (61%), and Whanganui (61%) and with Auckland a mere 37%.

In the 'no extent' category South Canterbury again has reason for concern, followed by Waikato, West Coast, Waitemata and Wairarapa.

Human resource management

> *Human resource managers do even worse, with a national average of 2% for a great extent rating and a massive 40% to no extent.*

Human resource managers do even worse with a national average of 2% for a great extent; 19% to some extent; and a massive 40% to no extent. Even when the 'great extent' and 'some extent' categories are combined, it is a sorry picture with only one DHB (South Canterbury) getting over 50%. Alarm bells should be ringing loudest in Nelson Marlborough, West Coast and Auckland.

A major caveat, however, was the high 39% of 'don't knows', which may reflect the distance between HR managers and clinical engagement, or be more about the distance between them and the medical workforce. It might also reflect the overall (with some good exceptions) underwhelming performance of HR generally and the tendency to be excessively process driven. There is a further caveat for Capital & Coast DHB. For some time it has been without someone in the permanent HR general manager position, leaving the system fragmented. This situation is now changing.

Ian Powell
Executive Director

NATIONAL PRESIDENT

A challenge for the New Zealand health service

In May 2011 Atul Gawande (an American surgeon, journalist and public health researcher) delivered that year's commencement address at Harvard Medical School entitled Cowboys and Pit Crews. He stated that medicine's complexity has exceeded our individual capabilities as doctors. The era when doctors could hold all the key information patients needed in their heads, and manage everything required themselves is fading fast. He indicates that health care no longer requires cowboys (independent physicians) but pit crews (highly coordinated health teams).

This is not a new idea. WHO states that effective teamwork in healthcare delivery can have an immediate and positive impact on patient safety. A publication in Health Care Papers (2007:7, Clements et al) concludes that employers and workers might consider effective teamwork an asset, but for patients it is a prerequisite. In the health workplace, the evidence for inter-professional coordination and effective teamwork continues to grow. Even our own Health Quality & Safety Commission arranged a full-day symposium on teamwork and patient safety last March. Research and evidence on the topic is easy to find and I am sure you can think of many examples in daily practice where teamwork is essential and improves the outcome of a patient or where the lack of teamwork unfortunately can have the opposite effect.

Teamwork, however, does not happen overnight. It takes time for team members to get to know and trust each other. They need to get to know each other's strengths and, perhaps more importantly, weaknesses. Developing effective communication within and between teams can take even longer. Developing trust unfortunately cannot be rushed either, and is earned rather than given.

Furthermore a team needs a clinical leader and additionally it needs a membership that is not forever changing.

There is agreement that teamwork is a prerequisite for optimal patient outcomes and safety, and to be effective each team needs a clinical leader and a stable membership that knows and trusts each other.

I want to discuss these two aspects further (i.e. stable team membership and clinical leadership) and put it into the context of the New Zealand health care system.

A team's effectiveness and function will be severely affected by a frequent change in membership and clinical leadership. Forty-one of the 98 senior medical officers who resigned from the ASMS, because of their resignation from their DHB, responded to our exit survey conducted between 5 September 2013 and 11 February 2014. Of those respondents, 46% have taken up positions elsewhere in New Zealand and 46% have left the country (22% to Australia and 24% elsewhere). Please note that these numbers are for ASMS members only. The total figure of resignations will be a little higher.

The members that moved to Australia and beyond are a loss to New Zealand's health workforce but also, importantly, even the movement of senior doctors to another DHB can have a negative effect in that it causes disruption to the health team and teamwork in the DHB they departed as well as the DHB they joined. At their new DHB, they become a new team member that needs to settle in. It is not only the movement of senior doctors that causes such disruption, of course. The same can be said for nursing, administrative and other staff when they move across DHBs. The resulting disruption to the health teams inevitably impacts on their ability to function effectively.

Yet to be published figures from ASMS researcher, Lyndon Keene show that we continue to have a retention problem of senior medical officers (SMOs), especially international medical graduates (IMGs), who currently comprise 44% of our SMO workforce. The Medical Council's Annual Report for 2013 indicates this proportion is set to grow further, with 56% of new vocational registrants being IMGs.

The figures are quite an eye opener. My observations tell me that the research and Medical Council figures are accurate enough to believe. I see new faces appear in the corridors and disappear again with regularity. In some specialties the problem is bigger than others.

How is it possible to build effective teams and establish trust and effective communication if the specialist or other team members change every so often? When this happens the team is weakened and needs to start rebuilding. This problem is much more exaggerated in smaller DHBs with smaller departments or services, where an SMO and a small team might be the only ones delivering that particular service. The team then needs to be rebuilt just about from scratch.

To exacerbate the problem even further, quite often the leaving doctor is replaced by an SMO that is new to New Zealand's healthcare system. He/she will be on a steep learning curve just settling in and finding their feet and getting used to a different healthcare system. It will take even longer for them to earn the trust of other team members and for the team to function effectively.

Clinical leadership

Where are we at with establishing effective clinical leadership, at all levels, i.e. distributive clinical leadership? Health Minister Tony Ryall and the ASMS agree that distributive clinical leadership is not only highly desirable but essential. In Good Hands was published in 2009. A recent survey conducted by the ASMS shows that 54.6% of respondents felt that the culture of their DHB did not encourage distributive clinical leadership. In one DHB 86% of SMO respondents felt that their DHB was not committed to distributive clinical leadership. Is this the best that can be achieved after nearly five years! Come on, surely this can and must be improved on.

We should not lose sight of the most important aspect of the above. While teams are disrupted and rebuilt, the service becomes less efficient and the risk to patients increases. Combine this with poorly established clinical leadership,

and efficiency and patient safety deteriorate even further.

Who is taking responsibility to address this?

In 1893, prior to the World's Fair in Chicago, the American Press Association asked some of America's best thinkers of the time to predict what the world might be like in 100 years. The predictions and essays are captured in the book by David Walker; *Today Then: America's Best Minds Look 100 Years into the Future on the Occasion of the 1893 World's Columbian Exposition*. Some predictions got pretty close to being accurate and some were way off the mark. Mary E. Lease, a political activist, predicted that three hours would constitute a long day's work by the end of the next century. Mmmm. John Ingalls, a lawyer, predicted: "Long before 1993, the journey from New York to San Francisco, and from New York to London, will be made between the sunrise and sunset of a summer day. The railway and the steamship will be as obsolete as the stagecoach."

One of the predictions caught my attention. Terence V. Powderly, a union leader, suggested: "Labour organisations will have disappeared, for there will be no longer a need for their existence". No unions? I remember thinking, boy did he get it wrong. I forgot about it until recently when I read an article in *North & South* titled "Can The Unions Save Us?" by Duncan Greive. He describes himself as a freelance journalist and critic. He certainly gets quite critical at times of unions, and unionists, which he divides into the 'traditionalist' and 'the modern union'. He is particularly critical of the 'traditionalists'. What raised an eyebrow was a discussion he had with Helen Kelly, President of the New Zealand Council of Trade Unions. During this exchange DHBs are held up as an example of employers which have a positive, productive relationship with their employees.

This got me thinking. What is the SMO workforce's relationship with DHBs really like? Who plans and 'looks after' the SMO workforce? What are the expectations of DHBs as employers rather than providers of health services? Who has the long-term vision of the SMO workforce?

During our last DHB MECA negotiations we were told Health Workforce New Zealand (HWNZ) believes there is no problem within the SMO workforce. In fact, HWNZ has gone a step further and recently advised Parliament's Health Select Committee that: "New Zealand is training enough doctors, and senior doctors constitute the most stable workforce in the country" *(briefing on Health Workforce New Zealand's work programme)*. They don't mention any 'compared to what?' detail or give actual figures.

HWNZ therefore is not going to make any effort to consider the specialist workforce as an area that needs attention currently or in the near future. The DHBs (as expressed by their negotiation team during the last round of MECA negotiations) made it clear that they fully support HWNZ's point of view.

This raises the question then as to who (other than the ASMS) has any interest in the senior doctor workforce as far as workforce planning is concerned.

How do I see the relationship between the ASMS and DHBs?

We are not dealing with a single entity, of course. There are 20 DHBs with their own chief executives and HR departments, and our relationship with some is better than with others. As a collective, however, I think we should look at actions rather than words to judge how DHBs view us.

The jointly developed (ASMS-DHBs) *Business Case* of November 2010, which provides a blueprint for the future direction of a clinically and financially sustainable health system, has become one of many documents collecting dust on DHB shelves. The manner in which the DHBs turned their backs on *The Business Case* during MECA negotiations in 2011 is still fresh in my memory.

The behaviour and opinion expressed during the most recent MECA negotiation ("We are not here to discuss your concerns about the workforce. If you want that addressed please talk to HWNZ") showed their attitude towards us and our real concerns. There was no interest displayed in our research and figures or concerns, and by now we know the opinion of HWNZ.

What the DHBs seem to ignore or easily forget is the fact that the ASMS is more than just a traditional (or modern) union. As an association the ASMS has two main roles in supporting better healthcare:

1. Professional and Policy

   In this role the ASMS:

   – promotes the right of equal access for all New Zealanders to high quality health services; and

   – articulates our members' professional concerns and interests to the Government and its various agencies, employers and the public at large;

2. As a union of health professionals (industrial) we will advise, represent and advocate members in respect of their employment agreements and workplace rights.

It is our professional and policy role that both the Ministry of Health and DHBs like to paint with the "they want more money" brush. Recent events in Greymouth's Grey Hospital clearly show that the unions do have a professional and policy role to play. In a show of unity all unions recently joined in a meeting at the hospital to voice their growing concerns over the $60 million new hospital project. This was not to "line their pockets" but to stand up for what they believe is right for the population of the Greymouth area.

In conclusion

The are several obstacles in the way of establishing and maintaining effective health care teams that can pride themselves on being "patient pit crews". The ASMS is concerned that there is no one taking responsibility for removing or minimising the obstacles or promoting and fostering teamwork.

DHBs and HWNZ have a choice. They can choose to continue to ignore our concerns and sit in the warm water as it slowly heats up or choose to truly engage with the ASMS and other health unions to work together towards building a better health service for all New Zealanders.

Effective team work is such an important aspect of patient safety that I would wlike to challenge the Health Quality & Safety Commission to become part of this conversation.

Our patients will thank us.

Hein Stander

EXECUTIVE DIRECTOR

Tale of two health ministers

Health Minister Tony Ryall's decision to retire from politics surprised many, including me. By the end of this parliamentary year he will share with his rival Annette King the record for being the longest serving health minister for several years – two parliamentary terms.

How should we assess his performance in this role, given he was so hungry for it (a positive) when in opposition? Let's deal with one (trivial) issue first, given that everyone else talks about it: his clothes sense. My partner would confirm I'm the last person to comment on this subject, given I have no such sense, but I reckon he did well. He apparently takes advice/instruction from his wife when it comes to his clothes. She's an interior decorator, and her exterior work is pretty good too in my humble inexpert opinion.

But talking about colour-coded clothing is as interesting as talking about car parking, although less frustrating. Let's get into the serious stuff. Tony Ryall's performance as Health Minister has been mixed. He got off to a very good start but after a couple of years, his performance became increasingly disappointing. You could say that it's been a game of two halves.

The good

Tony Ryall restored the right of doctors to elect some of their peers onto their registration body, the Medical Council. This right should never have been taken away by the previous government and it risked undermining the profession's confidence in the Council. Significantly, Mr Ryall also extended this right to nurses for their registration authority.

He recognised the vulnerability of the public hospital specialist workforce, describing it as a crisis and his number one priority to fix. Not only did he assert this when in opposition but also continued to affirm it in his first two years of office. For a while it seemed specialists and the Minister were on the same page over the brittle state of the workforce.

The Minister initiated a very good policy statement on clinical leadership in district health boards (DHBs), called In Good Hands, which was written by a working group led by former ASMS President Jeff Brown. The statement focused on DHBs empowering senior doctors and other health professionals in their workplace and within their wider organisations. It went well beyond formal positions of clinical leadership to the need for leadership and engagement with the wider professional workforce.

Tony Ryall strengthened the Ministry of Health's ability to support and better coordinate fragmented DHBs by creating a National Health Board (located within the Ministry). While the DHBs, established in legislation by then Health Minister Annette King, were a considerable advance on the commercial state-owned companies that ran our public hospitals in the 1990s whose legacy, among other things, was high fragmentation, there was still a need for some level of operational leadership. Mr Ryall's central government restructuring was a positive step forward and, after some uncertainty, he disregarded some of the ideological market-orientated advice in the report that his restructuring originated from.

Further, he established the Health Quality & Safety Commission and appointed the respected Professor Alan Merry to chair it. While there was an earlier version of the Commission in force before Tony Ryall became Minister, this initiative took it to a new level and enhanced its authority and status.

The bad

Since 2011, however, things have taken a turn for the worse. The Minister abandoned his commitment to address the vulnerability of the hospital specialist workforce by knowingly using dodgy misleading data. This u-turn led to him turning a blind eye to public hospitals struggling to function under entrenched specialist shortages. He sanctioned what he previously condemned.

In effect, Mr Ryall's switch of position destroyed the ability to implement the Business Case on the vulnerable state of the specialist workforce that had been jointly developed and agreed between the ASMS and DHBs. This was a tragic loss of opportunity that could have been a game changer in the public health service.

The Minister has increasingly financially squeezed public hospitals while demanding more of them. His defence is to compare our health system with countries such as Ireland, Greece and Spain, but the impact of the world recession was far greater on these countries than New Zealand. His government inherited an economy in a much better state, particularly in terms of unemployment and debt levels.

> *The Minister has increasingly financially squeezed public hospitals while expecting them to do more.*

In addition to pressures generated by the impact of demographic changes such as New Zealand's aging population, and poverty, Mr Ryall's government has increased the demands on public hospitals without looking at the other side of the equation – workforce capacity. DHBs have been told to do more with less.

The demonisation of the so-called back office staff has been particularly concerning. So much of what happens 'back office' involve critical support systems for clinical work. Public hospitals are among the most highly integrated complex organisations in

society; 'back office' and 'frontline' are inter-linked and inter-dependent. To denigrate one part insults both it and the other part. It is straight populism.

We have also experienced excessive political micro-management, including threatened financial penalties in order to achieve his elective targets. This is creating a punitive culture in public hospitals which inhibits innovation and creates additional stress for an already overworked workforce. Some describe it as a culture of fear.

The shared objective between Tony Ryall and ASMS of improved clinical leadership in DHBs has suffered a big set-back with the failure to deliver on the promise of *In Good Hands*. His failure to invest in the hospital specialist workforce in order to improve quality of patient care, patient safety and cost effectiveness has meant that specialists simply lack sufficient time to do much outside of their increasing clinical workloads.

> *Things have gone backward because of the failure to invest in an occupational group of natural problem solvers.*

If anything, the situation has gone backward since 2011 (and perhaps since 2009) because of the failure to invest in an occupational group of natural problem solvers. This has been a waste of potential. It has been made more difficult by the combined impact of intense financial pressures and growing punitive culture which has exposed serious deficiencies in the performance of DHB senior managers. This has become unconducive for enhancing senior doctor engagement.

The perplexing

Meanwhile, Mr Ryall has become entangled in a protracted commercial dispute in the deep south. He needs to explain why he asked for the advice of a confidant and head of a private health company (South Link Health) over who should chair the Southern DHB when that company and the DHB were in a huge financial dispute over how $5-6 million given to the private company was spent (about $15 million now with compounded interest). This is especially so given the advice that fraud may be involved (not involving the Minister, of course).

Mr Ryall rightly would not want his six year ministerial term defined by this left field controversy, but it risks becoming so. If he does ensure this, then good. But even without this controversy, his six years may be best described as a tale of two health ministers, with his clothing being the closest to a contemporary version of a Dickensian image.

Ian Powell

ASMS appoints Communications Director

Cushla Managh has been appointed to the position of Communications Director with ASMS.

She has more than 20 years' experience as a journalist, including working as a senior reporter, producer and presenter at Radio New Zealand, a stint in the parliamentary press gallery for the Dominion and the Auckland Star, and periods covering industrial relations and health for the Dominion and the Dominion Post.

She has previously been the Communications Manager for the Mental Health Commission and DHBNZ (concluding that employment just before the acrimonious blow-up in our DHB MECA negotiations in 2011).

Since 2011 she has worked as a communications contractor for both the Health Quality & Safety Commission and the National Health IT Board. She has a Master of Arts in Creative Writing (Victoria University) and a Bachelor of Applied Science in Psychology (Open Polytechnic).

Cushla Managh started work with the Association on 3 March and, as part of her orientation, she will be attending a number of JCCs to meet members and branch officers.

Cushla Managh | cm@asms.org.nz | 021 800 507

SENIOR INDUSTRIAL OFFICER

Recovery time – how long do *you* need?

After a tough night on-call? After a busy weekend?

Is night and weekend work getting harder or are ASMS members just getting older? Is it that clinical work is becoming more intense and demanding? Perhaps it's because patients are sicker and rarely admitted unless they are quite unwell. Whatever the cause, the effect of increasing after-hours' and weekend work on senior doctors and dentists is well known and requires longer recovery time before you are fully refreshed and ready to face the demands and challenges of your next period of duty.

Adding to the problem is the sad reality that many services have few experienced, or perhaps even no registrars or other resident doctors. Those who may be on-duty might not have the level of knowledge, skill or experience to confidently manage the presenting patient(s) from their admission until a specialist is available to see them 24, 36 or even 48 hours later.

So what to do? Call the specialist ... at all hours of the day and night, throughout the wee small hours and increasingly on weekends and on public holidays. More services are now based on a specialist-led model of care with fewer decisions being made without the direct input of a specialist present at the patient's side.

The pressure of such practice and models of care on an ageing workforce results in a need for longer recovery times following a tough night of call. It also highlights the importance of regularly having two consecutive days off as a 'weekend' and sufficient staff on the roster to allow two and perhaps three consecutive days off after a week of evening or nights shifts.

MECA endeavours

With these issues in mind, ASMS submitted a draft Recovery Time claim to the District Health Boards in the course of the last MECA negotiations.

Draft recovery time clause

Each service that operates a shift system or an acute after-hours on-call roster shall develop and adopt an agreed set of measures that will allow shift employees or those on the on-call roster to have agreed breaks or periods of rest between shifts or before commencing their next day's duty following a period of on-call.

We naively thought this simple clause would find favour with DHBs; how wrong we were. The DHBs rejected the claim.

This clause, without further negotiation and agreement would have cost DHBs nothing. It was, after all, simply an agreement to enter into further discussions about an important health and safety issue that affects staff and patients alike. We were disappointed the clause was not supported by DHBs, for two reasons:

- The clause **implicitly** recognised the potentially harmful health and safety effect of sleep deprivation while acknowledging the DHBs' **explicit** statutory obligation to be good employers, which includes looking out for their employees' welfare;
- Agreements arising from such a clause would have ensured senior medical and dental officers were less likely to be at work during periods of sleep deprivation, thereby reducing the risk of patients being exposed to poor decisions at critical moments in their care by cognitively impaired clinicians.

Care models are changing

Models of care within DHBs are changing; not so long ago it was rare to find senior doctors working shifts or overnight. That is now not uncommon and most intensive care units and emergency departments have models of care based on swing shifts of days and evenings, or three shifts rotating through a full 24-hour day.

Other services, such as the Waitakere paediatric service, roster SMOs to on-site evening shifts, (4pm to midnight) with the rest of the night on call; for several years now the obstetric service at Counties-Manukau has rostered and required SMOs to provide on-site cover overnight.

In other services with high levels of acute presentations, including many surgical specialties, anaesthesia, obstetrics, paediatrics and psychiatry, ASMS members are increasingly called upon to spend many more hours in the hospital "after hours" than in the past.

And for many years now, physicians' weekend ward rounds in general medicine have found them on-site for six to eight hours each weekend day, effectively halving the rest and recovery time for those SMOs on those weekends.

In some centres, radiology, surgery and anaesthesia schedule weekend theatre and clinic sessions, to which ASMS members have been rostered, whether as a part of their call or as a regular session.

These new models of care may serve the public well but they come at a cost to the doctors who provide the care: they are called back more frequently, have their sleep interrupted more often and their weekends are cut short.

Where to next with recovery time

Although DHBs did not support our *Recovery Time* claim for the MECA, ASMS will now take up the related issues of *recovery time* and the impact of *sleep deprivation* on our members. We have embarked on a project to research the issues, investigate the extent of the problem and work with particular groups of members and their employers where the problems seem most acute.

As part of this project we invite members who are concerned and affected by these issues to contact us with their concerns and stories. That information will assist us to develop strategies and advice for you and your colleagues to obtain the rest and recovery time you need to practice safely. Please send your comments and concerns to your local industrial officer or directly to the national office at **asms@asms.org.nz.**

Henry Stubbs

DR ALAN DORIS, HEAD OF PROFESSIONAL SERVICES, MEDICAL PROTECTION SOCIETY

Indemnity cover for clinical trials

MPS

Clinical research drives progressive improvement in patient care, and is an interesting and rewarding professional endeavour for doctors. However, patients participating in clinical research, wittingly or not, can be in a very vulnerable position. In recognition of this, researchers must strictly adhere to a number of ethical and legal requirements. These include the principles of international agreements such as the Nuremberg Code, developed following the Second World War atrocities, and the World Medical Association's Declaration of Helsinki (now in its seventh revision).

Closer to home, the office of the Health & Disability Commissioner and the Code of Health and Disability Consumers Rights was established in the aftermath of the Cartwright enquiry[1] into treatment of cervical cancer and research carried out at National Women's Hospital.

In addition to medical researchers' duty to abide by the Code, there are other mechanisms to ensure participants are protected against harm, or properly compensated if harm is suffered as a consequence of involvement in research. When the research is a clinical trial of a new medication with commercial interests there are particular matters to consider.

Health Research Council

The Health Research Council (HRC) of New Zealand was established under the Health Research Council Act 1990 and is responsible to the Minister of Health. The HRC's Ethics Committee provides advice on health research ethical issues and the ethical review process.

The Committee accredits Health and Disability Ethics Committees (HDEC) and Institutional Ethics Committees. Clinical trials that involve use of a new medicine require approval under Section 30 of the Medicines Act 1981. Research applications involving clinical trials of new agents are assessed by the HRC's Standing Committee on Therapeutic Trials (SCOTT) which makes recommendations to the Director-General of Health on whether or not trials should be approved. The role of the HDEC is to ensure that a research proposal meets or exceeds established ethical standards as set by the National Ethics Advisory Committee (NEAC)[2] which have the principle aim of protecting participants. The HDEC does not provide legal advice or peer review the scientific validity of a proposed trial.

The NEAC issues guidance on interventional and non-interventional studies and provides advice in the general areas of adequacy of informed consent, respect for persons, justice, beneficence and non-maleficence, integrity, diversity and management of conflict of interests.

Relevance to ACC treatment injury system

A further task of HDEC is to determine whether the key beneficiary of a clinical trial is the manufacturer or distributor of a medicine. This is important as the usual mechanism of compensation for harm suffered while receiving care via the ACC Treatment Injury system may not apply.

Section 32 of the Accident Compensation Act 2001 defines "treatment injury". In relation to clinical trials, treatment injury will only be covered if:

(i) an Ethics Committee (approved by the Health Research Council of New Zealand or the Director General of Health) approves the trial; and

(ii) the trial is not to be conducted principally for the benefit of the manufacturer or distributor of the medicine or item being trialled; or

(iii) if the participant has not agreed in writing to participate in the trial.

If a clinical trial falls outside of the ACC treatment injury scheme, e.g. if the main beneficiary is a drug company, the HDEC has a responsibility to check that compensation would be available to at least ACC-equivalent standard, though HDEC is not expected to explore the detail of the arrangements and will rely on the actual researching agency to do this.

Industry sponsored clinical trials adhering to the Research Medicines Industry Guidelines on Clinical Trials Compensation for Injury Resulting from Participation in an Industry-Sponsored Clinical Trial [3] should lead the participant to be compensated by the sponsoring company. However, difficulties may arise as the broad ACC cover under a 'no fault' system may not be matched by cover from an insurance company where proof of causation may be required for compensation to be awarded. Additionally, drug companies sponsoring studies may exclude indemnity to the doctor for negligence or if the study protocol has not been adhered to, or treatment for an adverse event has not been adequately managed.

It is therefore possible that a participant injured in a clinical trial may not be covered by the ACC treatment injury scheme; be unsuccessful in taking action against the commercial sponsor or institution due to limits on the insurance cover, and so take action against the doctor when seeking compensation. This presents a risk that a doctor involved in a clinical trial could be sued for considerable compensatory damages.

Should a situation arise where a participant in a clinical trial seeks compensation for harm caused as a result of the trial, MPS would assist the doctor. A member of MPS involved in a clinical trial approved by an appropriate ethics committee has indemnity for acts or omissions regarding their professional work carried out as part of the trial. It is important, however, to check the insurance cover that the sponsoring company or institution has in place as MPS cover is for the individual doctor and does not extend to the company.

---

1 Cartwright SR. The report of the committee of inquiry into allegations concerning the treatment of cervical cancer at National Women's Hospital and into other related matters. Auckland: Government Printing Office; 1988

2 http://neac.health.govt.nz/publications-and-resources/neac-publications/streamlined-ethical-guidelines-health-and-disability

3 http://www.medicinesnz.co.nz/assets/Uploads/compensation-guidelines-0808-final.pdf

ASMS RESEARCHER

Greymouth Hospital:
a test case for the Government's commitment to clinical engagement

There is a wealth of international evidence that significant improvements to health services can be achieved when clinicians (most notably doctors) play an integral part in the shaping of those services. This is why the Government has given strong emphasis in its policy intent to develop clinical leadership and clinical engagement. As the Minister of Health stated in answer to a parliamentary question in November 2012, "clinical leadership and engagement are fundamental to improving patient outcomes".

The strength of commitment to that policy, however, is currently being tested on the West Coast of the South Island. Like other district health boards, the West Coast DHB faces some stiff challenges associated with growing service demand. In addition, the DHB is in urgent need of a new hospital in Greymouth, both as a result of general dilapidation of the current hospital buildings and identified earthquake risks. The decisions on what type of services are provided on the West Coast must take account of, among other things, the region's isolation and the risks for patients if they are forced to be transferred to another region owing to a lack of locally provided services.

An examination by senior clinicians of obstetric and gynaecological service needs, for example, found that between nine and eleven West Coast women or babies would suffer avoidable death or serious injury every two years if delays of more than two hours occurred in providing the necessary care. Clinicians have also estimated that more than 16 adult general patients could expect a similar fate over a similar period.

> *Between nine and eleven West Coast women or babies would suffer avoidable death or serious injury every two years if delays of more than two hours occurred in providing the necessary care.*

To take on the substantial challenge of developing a safe and sustainable model of care, a process of clinical engagement was established between West Coast and Canterbury clinicians, and senior management of the two DHBs. Over the course of nearly four years, to the credit of all those concerned, a new model of care was developed and agreed. Its key features include:

- 24/7 Emergency Department services.
- Primary and secondary birthing.
- 24/7 acute low and moderate risk obstetric service.
- 24/7 acute low and moderate complexity general surgery service.
- 24/7 low and moderate complexity anaesthetic service with two theatres and one additional procedure room planned for endoscopies, but able to function as a third theatre.
- 24/7 acute low and moderate complexity paediatric, medical and mental health service.
- Monday-to-Friday working hours operative acute orthopaedic service with out-of-hours non-operative acute orthopaedic service (out-of-hours operative acute orthopaedic service provided by CDHB).
- A critical care unit with Level 1 ICU.
- Low and moderate complexity elective general surgery, orthopaedic surgery and gynaecological surgery.
- On-site radiology, pathology and pharmacy services to support the service delivery above.

In December 2012, in what appeared to be an acknowledgement of the progress that the clinical engagement process had achieved, the Minister announced plans to fast-track the rebuild of Grey Base Hospital. The plans involved the setting up of a "Hospital Redevelopment Partnership Group" including representation from the West Coast DHB, the Ministry of Health and Treasury.

Any sense that the agreed model of care for the hospital was close to realisation was soon undermined, however, following a chance meeting of two doctors, previously unknown to each other, at a conference in Australia in October 2013. One was Paul Holt, ASMS branch president for the West Coast; the other was a Warkworth GP, Tim Malloy. During an informal conversation in which Dr Holt enthusiastically described the model of care, Dr Malloy's response (to Dr Holt's amazement) was to indicate that in fact the model would not be implemented because the cost was too great. Dr Malloy also indicated the clinical assessment of obstetric risk to women and babies had been reviewed and that the risk was considered to concern just one woman a year. He revealed that he knew all this because he happened to be one of the Minister's appointees on the "partnership group".

Owing to the nature of this exchange, the accuracy of the information was not able to be confirmed very easily but the ASMS saw it as an alert to closely monitor progress on the hospital rebuild.

On 9 January 2014, the *Greymouth Star* received (five months after the request was made) a copy of the business case for the new model of care that had been produced by the "partnership group" in May 2013, and which had been sent to the National Health Board. Many sections of the document had been withheld under provisions of the Official Information Act but it is clear that it supported the model agreed through the clinical engagement process. On its release however, the NHB's Acting Director, Michael Hundleby, noted that the eventual model of care would vary from that in the business case document. At this point the ASMS decided we must take urgent action.

Paul Holt wrote an opinion piece "Saving our hospital" in the *Greymouth Star* and the ASMS wrote to the chief executive of the Canterbury and West Coast DHBs, David Meates, raising our grave concerns about the apparent behind-the-scenes decision

to reject the agreed model. These concerns were about the risk of losing what is seen to be the only safe and sustainable option and also that it seemed the principles of clinical engagement and leadership had been over-ruled. We are still awaiting a reply.

The ASMS also got in touch with the other unions and organised a cross-union meeting for the evening of 21 January. The Minister was apparently unhappy and Mr Hundleby asked that we cancel the meeting. However, Mr Hundleby was unable to give us an assurance that the agreed model of care would be maintained and the meeting went ahead as planned.

The decision of the meeting was to send an open letter to the people of the West Coast. This was published on the front page of the *Greymouth Star* the next day, calling on the Minister and NHB to give an assurance that the agreed model would be retained. It specifically questioned the plans for obstetrics.

The Minister of Health and the NHB responded with a strong statement assuring that services would indeed be maintained. So far, however, these assurances have been lacking in specifics.

Subsequently, on 4 February, the Executive Director wrote to Michael Hundleby seeking an express confirmation of the specific details of the agreed model of care. At the time of publication we had yet to receive a reply.

It remains to be seen if we have won the battle for the agreed model of care, although Paul Holt reports that recent developments at West Coast have been encouraging. It is clear that if not for some surprising comments from Dr Malloy during a chance conversation, and revelations made in response to an Official Information Act request by the Greymouth Star, we would not have known that the agreed model of care was under threat.

> *There is a serious risk that senior clinicians, seeing this secret attempt to override an agreement achieved through clinical engagement, will lose confidence in the whole idea of clinical engagement.*

This issue, while particularly of concern for the West Coast DHB, has much wider implications. There is a serious risk that senior clinicians, seeing this secret attempt to override an agreement achieved through clinical engagement, will lose confidence in the whole idea of clinical engagement. Given that clinical engagement, in the Minister's words, is "fundamental to improving patient outcomes", it is vital that the right decision is made in this particular case, and that the commitment to clinical engagement at central government level is seen to be real.

Lyndon Keene

25 years of ASMS to remember and celebrate

There will be 25 candles on the birthday cake for ASMS this year and we think that warrants a celebration.

We are organising a special one-day national meeting for ASMS delegates in Wellington in August, with a top line-up of national and international speakers to stimulate our thinking about health care in New Zealand, and the challenges and opportunities for the specialist health workforce.

Professor Martin McKee from the London School of Hygiene & Tropical Medicine will be the keynote speaker at the national meeting, and he will talk about universal health systems and economic wellbeing in economically developed countries. Professor McKee has published extensively in the main international medical journals on this and other topics.

There will also be opportunities over the course of the day to take part in discussions and debate, and hear from a wide range of speakers as we reflect on our beginnings and also look ahead.

The meeting will be held at Te Papa, Wellington, on Tuesday 26 August 2014, and it will be followed by a national branch officers' workshop on the next day (27 August). ASMS will host an informal cocktail function on the evening of the national celebration meeting. More details about the venue and programme will be available soon.

ASMS 25 YEARS OF ENGAGEMENT 1989-2014

25TH ANNIVERSARY MEETING AND CELEBRATION

TE PAPA WELLINGTON

TUESDAY 26 AUGUST 2014

Register your interest today at ke@asms.org.nz

If you would like to attend as an ASMS delegate, please email an expression of interest for the 26 August celebration to Kathy Eaden at ke@asms.org.nz. Selection will be on the same basis as Annual Conference delegates, with the final decision resting with branch officers.

ASMS TOI MATA HAUORA

We look forward to seeing you there!

BILL ROSENBERG, ECONOMIST, NEW ZEALAND COUNCIL OF TRADE UNIONS

Health and the proposed Transpacific Partnership Agreement

In March 2013, over 400 health professionals wrote to the Prime Minister[1] about their concerns for health resulting from the proposed Transpacific Partnership Agreement (TPPA). In December, sixty prominent New Zealand health academics and practitioners wrote to the Minister of Health, concluding[2]: "We have serious concerns that the partnership agreement will cause patients to suffer and will load governments with additional, unreasonable costs for medical technologies (both new and existing)."

Many health sector organisations have raised similar concerns including the Public Health Association, New Zealand Nurses Organisation and the Global Asthma Network in New Zealand, the Public Health Association of Australia, and Médecins Sans Frontières (Doctors Without Borders) internationally. Alongside them are health academics[3], consumer groups[4], unions[5], environment groups[6], development organisations[7], innovative businesses[8] and others, often raising many issues in addition to its potential effect on health.

The TPPA is a proposed agreement governing commercial relations between New Zealand, the US, Japan, Australia, Brunei, Chile, Canada, Malaysia, Mexico, Peru, Singapore and Vietnam. While sometimes described as a free trade agreement, reportedly only 5 of its 29 chapters are about traditional trade. The remainder cover a broad range of areas including intellectual property rights, investment, the financial sector, services, regulation, government procurement, and constraints on public entities ('state owned enterprises'). Advocates and opponents agree that its rules aim to penetrate deep "behind the border" in constraining governments' options to regulate and act. One goal is to make it easier for corporations to use outsourcing and other international contracting and supply arrangements[9]. Many of the most contentious proposals are in intellectual property and investment, exemplified below. While the text of the agreement is being kept secret, there have been some leaks[10] and more can be deduced from other agreements the US (the dominant negotiating party) has signed and informed media reports. Widespread opposition to the secrecy includes legislators in many participating countries.

Below is an outline of the main concerns regarding health for New Zealand.

Dangers for PHARMAC

US pharmaceutical firms have long resisted PHARMAC's role in holding down prices and selecting pharmaceuticals[11]. A US objective will be to weaken this role. While PHARMAC will continue, its effectiveness could be significantly curtailed, increasing the cost of medicines and medical devices. The US proposals will affect pharmaceutical provision and prices in all TPPA countries and have been strongly resisted. Rather than withdrawing its demands, the US has proposed that for developing countries they be phased in. This would result in New Zealand being the most immediately and harshly affected.

Much cheaper generic pharmaceuticals could be delayed through lengthening patents, patent term extension (extending a patent by the time taken to get regulatory approvals), patent linkage (delaying the approval process and marketing of generic substitutes until the patent and legal actions on alleged infringements have expired), and data exclusivity (denying generic manufacturers access to test data that would speed up regulatory approval). The US also wants a 12-year period of biologic[12] exclusivity, far more than other countries impose; New Zealand has none.

> *While PHARMAC will continue, its effectiveness could be significantly curtailed, increasing the cost of medicines and medical devices.*

PHARMAC's processes including clinicians' assessments of the efficacy and cost-benefit of new products could be opened to pharmaceutical company lobbying and opportunities to influence and challenge decisions. An Annex on Transparency in Healthcare Technologies could require PHARMAC to disclose its criteria and calculations. Chapters on Regulatory Coherence and Transparency provisions could give industry further leverage and information useful in challenging decisions. Processes could be slowed, the agency and individuals involved in its processes could be exposed to pressure or bullying, and we could see more intense public campaigns to force changes in decisions.

The US is also seeking patents for diagnostic methods and surgical procedures, currently expressly excluded from patentability in other intellectual property agreements such as in the World Trade Organization's (WTO's) Agreement on Trade-related Aspects of Intellectual Property.

Public health, including tobacco control

The tobacco industry has used similar agreements to challenge tobacco control measures taken by Australia, Uruguay and Norway. In the case of Australia's plain packaging laws, the tobacco companies have failed in the Australian court system and are now assisting Ukraine and other countries to challenge Australia under WTO intellectual property and labelling rules[13] while Philip Morris is suing Australia directly under an investment agreement with Hong Kong (see below).

Illustrating the chilling effect of such actions, the New Zealand Government says it will not implement similar laws here until

the outcome of these cases are known although this is challenged by the Minister responsible, Tariana Turia, who has introduced enabling legislation, saying "our country has a sovereign right and a legal right to protect its citizens"[14]. Similar issues could arise with labelling requirements for alcohol, high-fat or high-sugar foods.

> *The tobacco industry has used similar agreements to challenge tobacco control measures taken by Australia, Uruguay and Norway.*

Public entities, government procurement

The US considers controls on 'State Owned Enterprises' to be vital in the TPPA, despite resistance from most other countries. Even the term's definition is unclear. It conceivably could extend broadly to include any public agency such as hospitals, blood banks, Health Benefits Ltd, ACC, research and educational institutions and PHARMAC. The US intention is that public entities that compete with other companies should act in a fully commercial fashion with no direct or indirect benefits such as low cost capital or use of public land.

Investment

One of the most contentious elements is the dispute process in the investment chapter. Investor-State Dispute Settlement (ISDS) allows investors to directly challenge governments before private offshore tribunals of handpicked lawyers on the basis that their laws, regulations, actions or court decisions have caused the investor significant loss of profits or asset value. Penalties can range from the millions to billions of dollars. The majority of cases to date have been against government actions to protect the environment (including on toxic substances) but have also challenged measures taken for health reasons, during financial crises and after failed privatisations, and South African government actions to redress apartheid era inequalities. A current action against Canada by Eli Lilly under similar provisions in the North American Free Trade Agreement (NAFTA) challenges court decisions that patents for two of its drugs were invalid because they failed to meet Canadian usefulness standards[15]. Tobacco transnational Philip Morris is suing Australia for its plain packaging tobacco control measures under a Hong Kong-Australia investment agreement providing ISDS. Meanwhile the tobacco industry is lobbying for strong protections in the TPPA[16].

Concluding remarks

The secrecy surrounding this agreement makes it impossible to be sure of its consequences. General assurances have little meaning because of the complexity of the proposals.

The parties decided the text of the agreement will not be released until after it has been signed. After signing, New Zealand's international treaty process[17] is that the Executive (essentially Cabinet) has absolute power to ratify the agreement, though it will send it to the Foreign Affairs, Defence and Trade Committee for a 20 sitting day non-binding examination. Only consequent legislation requires Parliament's approval, and large parts of the agreement can be implemented without legislation.

Negotiations are, according to Ministers, close to completion, currently blocked by disagreement between the US and Japan on access to Japan's agriculture and motor vehicle markets. If completed, the TPPA is designed to have profound effects on New Zealand and its other members which will be very difficult to reverse.

Members of ASMS wishing to receive regular information on the TPPA can contact Bill Rosenberg to be put on the NZCTU's TPPA Watch email list at **billr@nzctu.org.nz**

---

1 See http://www.scoop.co.nz/stories/GE1303/S00011/doctors-and-nurses-warn-prime-minister-over-trade-talks.htm.

2 See http://www.scoop.co.nz/stories/PO1312/S00053/health-specialists-urge-not-to-trade-off-public-health-tppa.htm.

3 E.g. Gleeson, D. H., Tienhaara, K. S., & Faunce, T. A. (2012). Challenges to Australia's national health policy from trade and investment agreements. Medical Journal of Australia, 196(5), 354–356. doi:10.5694/mja11.11635; Gleeson, D., Lopert, R., & Reid, P. (2013). How the Trans Pacific Partnership Agreement could undermine PHARMAC and threaten access to affordable medicines and health equity in New Zealand. Health Policy, 112(3), 227 – 233. doi: 10.1016/j.healthpol.2013.07.021; and Gleeson, D., & Friel, S. (2013). Emerging threats to public health from regional trade agreements. The Lancet, 381(9876), 1507–`509. doi:10.1016/S0140-6736(13)60312-8

4 For example Consumer New Zealand (http://www.consumer.org.nz/reports/trans-pacific-partnership), the Royal New Zealand Foundation of the Blind (http://fairdeal.net.nz/2012/07/royal-new-zealand-foundation-of-the-blind-copyright-and-accessibility) and Consumers International (http://www.consumersinternational.org/news-and-media/news/2013/11/tpp_reaction/).

5 For example New Zealand Nurses Organisation (http://www.nzno.org.nz/get_involved/campaigns/tppa), the New Zealand Council of Trade Unions (http://union.org.nz/tppa).

6 For example Greenpeace New Zealand (http://www.greenpeace.org/new-zealand/en/blog/tppa-not-a-trade-deal/blog/43257/), Sierra Club (http://www.sierraclub.org/trade/trans-pacific-partnership-agreement.aspx).

7 For example Oxfam (http://www.oxfam.org.nz/news/nz-should-demand-us-scale-back), World Vision Australia http://campaign.worldvision.com.au/news-events/international-fair-trade-day-aftinet-rally-melbourne/

8 http://fairdeal.net.nz

9 See for example Jacobi, S. (2011, September 10). A New Zealand business vision for TPP. Speech presented at the TPP Stakeholder Forum, Chicago. Retrieved from http://www.nzuscouncil.com/index.php/views/article/tpp_a_new_zealand_business_perspective

10 For example https://wikileaks.org/tpp-enviro/, https://wikileaks.org/tpp/ and https://wikileaks.org/Second-release-of-secret-Trans.html.

11 http://www.ustr.gov/sites/default/files/2013%20NTE%20New%20Zealand%20Final.pdf.

12 Biologics, pharmaceuticals created through biological processes, are an increasing proportion of pharmaceutical expenditure important for chronic, non-communicable diseases including diabetes and cancer.

13 Nebehay, S. (2012, May 23). Australia says big tobacco aiding WTO challengers. Reuters. Retrieved February 9, 2014, from http://www.reuters.com/article/2012/05/23/us-trade-tobacco-idUSBRE84M0IO20120523

14 Turia, T. (2013). Government moves forward with plain packaging of tobacco products. Wellington, New Zealand: New Zealand Government. Retrieved from http://www.beehive.govt.nz/release/government-moves-forward-plain-packaging-tobacco-products; and Rutherford, H. (2014, February 12). Cigarette plain packaging closer. Stuff. Retrieved February 12, 2014, from http://www.stuff.co.nz/national/politics/9712203/Cigarette-plain-packaging-closer

15 See http://infojustice.org/archives/30694.

16 Fooks, G., & Gilmore, A. B. (2014). International trade law, plain packaging and tobacco industry political activity: the Trans-Pacific Partnership. Tobacco Control, 23(1), e1. doi:10.1136/tobaccocontrol-2012-050869

17 See http://cabinetmanual.cabinetoffice.govt.nz paragraphs 5.73, 5.74 and 7.112 - 7.122, and http://www.scoop.co.nz/stories/PO1312/S00148/explanation-of-nzs-treaty-making-process.htm

ASMS RESEARCHER

Regional health service planning; has it worked? The Auditor-General's report

The call for evidence based policy

A recent report on the importance of evidence in the formation and evaluation of policy, by the Prime Minister's chief science advisor, Sir Peter Gluckman, drew attention to a "growing recognition of the need to be more rigorous both in the employment of evidence for the development of policy, and in the assessment of its implementation".[1]

> *…Where evidence is conflated with values, its power is diminished. Where evidence is not considered properly, the risk of less than desirable policy outcomes is inevitable.*

Sir Peter Gluckman also found the quality of assessment and evaluation of policy implementation among government agencies is 'quite variable'.

> *The required scrutiny can be devalued by agencies that assume their primary mandate is to implement political decisions. As a result, funding for evaluation is frequently trimmed or diverted.*

Auditor General's report on regional planning in the health service

Shortly after the release of Sir Peter Gluckman's report, Auditor-General Lyn Provost released a report on the effectiveness of the policy, introduced in 2011, for health service planning and delivery on a regional basis. Her report provides a case study on what Sir Peter had warned against. She quotes Sir Peter:

> *…without objective evidence, the options and the implications of various policy initiatives cannot be measured.*

Her report continues: "He went on to say that, without objective evidence, judgement is often based on opinion or belief. He recommended planned evaluation to ensure that the desired effects of the policy are being realised, especially where complexity makes forming policy particularly challenging."

The Auditor-General found that, due to a lack of monitoring and evaluation: "Three years on, the Ministry does not know whether regional service planning is working as intended."

Shifting resources from the back-room

Her report also reveals another example, albeit indirectly, of how the introduction of policy that is not grounded in evidence can lead to negative results. It relates to the now familiar slogan of shifting resources "from the back-room (a term suggesting lesser value) to the front line".

It was an idea that, in 2009, Health Minister Tony Ryall had asked a Ministerial Review Group (MRG) to provide advice on. He also asked for advice on ways to improve health service quality and performance, and to improve the health system's capacity to deliver services – from which the regional planning policy emerged.

Auditor-General Lyn Provost

While in principle few would argue with the notion of reducing administrative duplication from sharing some functions across DHBs, the policy of reducing back-room resources went well beyond that concept. The Government accepted the MRG's recommendations involving substantial cuts to administration jobs over three years in the Ministry of Healthand district health boards. It ignored warnings from the Public Services Association that the newly restructured Ministry, also emanating from the MRG's recommendations, could well require more staff to fulfil the roles expected of it, not fewer. The PSA also noted there was no evidence of any cost-benefit analysis on how reducing staff numbers at the Ministry will go towards enhancing 'front line' services.

In 2008/09 the Ministry had already been operating at around 200 FTEs below its capped staffing level of 1675 FTEs. By June 2013 staffing had been cut to just 1089 FTEs. It is not known to what extent, if any, this may have been partly offset by devolving functions to other agencies. Nor is it known how many DHB administration jobs have gone.

Auditor General's comments on the back-room

The Auditor-General makes a number of observations that relate in some way to the roles and functions normally associated with the so-called back-room, including monitoring and evaluation of policy. For example:

- 'When my staff looked closely at capital planning, they learned that there is a shortage of people with the right skills to support good governance of capital projects. This was particularly acute in business case development and in supporting board members throughout the health sector.'
- 'Good planning requires good information, based on data that is complete, reliable, consistent, and comparable. My staff found a wide range of problems when they looked at how data is used in planning services. The data we looked at was not always consistent, complete, or comparable – but this is important for planning and reporting purposes.'
- 'My staff expected and looked for evidence of outcomes that would not have happened without regional services planning. However, much of the evidence the health sector entities provided as signs of success was about getting ready to deliver outcomes.'
- It is difficult to find evidence of the extent to which regional planning is helping to improve performance in the health and disability sector.

- 'We saw no ministry monitoring of changes in cost by service arising from regional service plans.'
- 'Our research revealed that there are concerns about health data throughout the health system. Although we did not carry out a system-wide review of data, we found problems where we did look. … Good quality data benefits patients, for example, in diagnosis, treatment, and learning from what works and what does not… As funding and accountability systems become more complicated, the demand for good quality information – based on valid and reliable data – increases. Good quality data and information provides users and decision-makers with assurances about effectiveness, efficiency, and economy.'
- On timeliness, 'we looked for quantitative evidence of performance improvement from one year to the next…we saw few measures outside well-established work-streams.'
- 'To test whether the benefits were being redirected to the front line, we asked the regional offices for details of their costs, compared to the previous arrangements, but net of any savings arising from regional services planning. We were told that this information was not available.'
- 'We expected that, after putting regional services plans into effect, the Ministry would track the proportion of patients accessing regional resources outside their home DHB…We concluded that the Ministry was not tracking regional flows.'
- 'Neither DHBs nor the Ministry have in-depth expertise to project manage large-scale business cases for building projects. This means that they rely heavily on consultants, advisors, and experts.'

On the plus side

The Auditor-General's report is by no means all negative. It points out that the Ministry and DHBs have put effort into creating the conditions for success, and outlines some progress in various areas. The above examples are intended simply to draw attention to the question of whether the intention to improve efficiency and effectiveness has been thwarted, at least in part, by the implementation of a poorly informed policy to reduce 'back-room' costs.

It is unlikely we will get a full answer to that question, because the policy evidently is not being monitored or evaluated. For the same reason, we may never know whether the idea of shifting resources from the back-room to the front lines has, in reality, led to many tasks being shifted from the back-room to the front line.

The Auditor-General has made seven recommendations and expects to follow up on their progress in early 2016.
The Auditor-General's report can be accessed at:
www.oag.govt.nz/2013/regional-services-planning

Lyndon Keene

1 P Gluckman (2013). The role of evidence in policy formation and implementation: A report from the Prime Minister's Chief Science Advisor; Office of the Prime Minister's Science Advisory Committee, September 2013.

A new website for the ASMS

Our website is being updated to give it a fresher look and to make it easier for you to use.

The new ASMS website will include more industrial advice and answers to frequently asked questions, better archives for ASMS news and publications, and an improved search function.

You'll also be able to access it using your smart phone, tablet or computer so you will always have the latest information at your fingertips.

We're hoping to have the new website up and running by mid-year. In the meantime we will continue to provide you with the most up to date and relevant news and views via our existing website (**www.asms.org.nz**).

The ASMS web development team would like to know your thoughts about our website and the features you'd like to see. We would be very grateful if you could take part in a short survey, available at:
https://www.surveymonkey.com/s/2T7JV7H

How to contact the ASMS

Association of Salaried Medical Specialists
Level 11, The Bayleys Building,
Cnr Brandon St & Lambton Quay, Wellington

T 04 499-1271
F 04 499-4500
E asms@asms.org.nz
W www.asms.org.nz
P PO Box 10763, Wellington 6143

Have you changed address or phone number recently?
We're updating the ASMS database and would be very grateful if you could email any changes to your contact details to: **asms@asms.org.nz**

FSC

The Specialist is printed on Forestry Stewardship Council approved paper.

ASMS
TOI MATA HAUORA

You only need one tool to rebuild your house completely.

Unlike most house insurance providers, MAS isn't switching to capped sum insured cover. We think it's unreasonable to expect you to accurately calculate the cost of rebuilding your house in the event of a total loss. So we're doing what's right for our Members by continuing to provide full replacement cover for our house insurance policies.

This means you can rest easy knowing that we'll rebuild your house to the floor area you provide us with. You work out the area, and provide us with some basic information about your property, and we'll calculate the cost. It's that easy.*

To find out more about MAS house insurance, email us today at **info@mas.co.nz** or call **0800 627 659**.

*In limited situations we will not be able to offer full replacement cover where the property does not meet our standard underwriting criteria.

MAS