SUMMARY OF SUBMISSIONS

Director-General of Health's Commission on Competitive and Sustainable Terms and Conditions of Employment for Senior Medical and Dental Officers Employed by DHBs

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Introduction

The Director-General of Health has established 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. The Commission will recommend to the Minister of Health (through the Ministry of Health), district health boards and the Association of Salaried Medical Specialists, a national recruitment and retention strategy that will provide a sustainable pathway to competitive terms and conditions of employment for senior medical and dental officers (SMOs).

Establishment of the Commission recognises New Zealand's potential vulnerability as a relatively small, geographically isolated, country in:

- retaining current SMO employees
- recruiting and retaining medical and dental officers trained in New Zealand
- recruiting and retaining international medical graduates.

In reaching its recommendations, the Commission will have regard to, but not necessarily be bound by, other national conversations and work programmes, including tripartite initiatives and the work of the Medical Training Board. In its deliberations the Commission will take into account:

- drivers of demand for the SMO workforce, including population health need and models of service delivery
- national and international supply of SMOs, including opportunities for employment, and the terms and conditions of employment for SMOs in Australia and other countries
- employment opportunities available for SMOs in both the private and public health sectors
- margins between specialist salary scales and the relative remuneration resident medical officers (in particular senior registrars) and SMOs
- changes and trends in factors that affect the supply of SMOs to the New Zealand public health system
- the Government's priorities and health targets
- any other factors it considers relevant.

Under its Terms of Reference the Commission is due to report to the Director-General on 31 March 2009. The Director-General has indicated his support for later reporting deadlines should the Commission require more time to complete its deliberations.

Submission process

To inform its work the Commission is reviewing available literature and consulting with stakeholders and a number of key informants. As a part of the consultation process the Commission invited written submissions. The open invitation was communicated through key stakeholder groups. There was no set format for submissions although a list of indicative questions was provided. A copy of the invitation and indicative questions is attached as Appendix One. The closing date for submissions was 15 December 2008 although late submissions were considered.

Summary of submissions

A total of 19 submissions had been received by 12 February 2009. Ten were from district health boards or district health board employees. The remaining submissions were from a diverse range of organisations. A list of respondents is included as Appendix Two to this report.

Content from the submissions is summarised below, under the following headings:

- Retaining the current SMO workforce
- Training the future SMO workforce
- International recruitment and registration
- Issues for small and rural hospitals
- Other comments.

In reporting key points from the submissions, the Commission has endeavoured to represent all viewpoints without assigning greater weight to any particular view. The views represented in the submission summary are not necessarily those of the SMO Commission or individual members of the Commission.

Retaining the current SMO workforce

Valuing SMOs

Several respondents said that being valued was a more important factor than pay and conditions in recruitment and retention of SMOs, with one respondent remarking that feeling valued is probably the single most important retention and recruitment tool that the health service has available to it.

It was suggested that a priority should be re-establishing relationships of trust between medical staff and management, where SMOs have a real voice in quality and clinical governance and actively participate in setting the parameters for patient care, including access.

Lack of participation in clinical governance was a strong theme in many submissions, with SMOs reporting that their influence in decision-making has been considerably eroded in recent years to the detriment of service delivery and teaching. It is suggested that potential service/operational improvements recommended by clinicians are not being implemented, and other well-intended changes are being implemented that are counter-productive and which might have been avoided with clinical input at the design stage.

SMOs shortages are reported to have a significant impact on the wider health workforce that is not always recognised in resource allocation decisions.

One writer proposed that clinical governance might be more effective if there were fewer non-clinical management positions and fewer DHBs.

Healthy workplaces

The working environment was mentioned in several submissions as an important factor in retention and recruitment. One writer noted that successful recruitment is often achieved as a result of word-of-mouth networking and recommendations, so reputation is important.

In addition to staff relations and participation in clinical governance mentioned above, the following desirable attributes were identified:

- a positive, cohesive and supportive 'can-do' culture within a hospital and its departments
- up to date technology and IT systems that enable modern medicine to be practised
- processes that are welcoming and make it easy for new recruits to integrate into the workplace and wider community.

Excessive workloads and high levels of stress were described in many submissions. There was a perception that demands were being managed at a high personal cost to SMOs and that this is not a sustainable situation.

One respondent also reported high anxiety generated by a "name shame and blame" culture and recommended a shift to a culture of improved health care through shared learning.

Pay and conditions

One writer observed that senior RMOs were often paid more than those at the bottom of the SMO pay scale, and proposed improving SMO pay and conditions to provide fairer relativity reflecting increased duties and responsibilities.

Several respondents noted that pay and conditions (including superannuation) within the public health system are not competitive with other countries - especially Australia. It is suggested that this reflects the extent to which SMOs are undervalued in New Zealand and contributes to an outflow of registrars and SMOs to countries offering better pay and conditions.

One submission included concrete recommendations regarding changes required to provide pay and conditions that are more competitive with Australia, as outlined below:

- current salary scales of $128,596 - $164,852 increased to at least $213,066 - $280,747
- continuing Medical Education reimbursement increasing to $20,000 initially and increasing to $30,000
- employer's superannuation contribution increasing from 6% to at least 9%
- payment for after hours and on-call increasing to double time or higher.

One respondent suggested that achieving parity with Australia would not be achievable without a significant injection of funding to DHBs. It was also suggested that there was considerable public support for increasing health expenditure.

Two writers challenged the validity of assertions that pay and conditions are vastly superior in other countries, and called on the Commission to place reliable data in the public domain to educate the public on this. It was suggested that the proportion of disposable income after tax, professional expenses (eg, insurance) and living costs would provide a better measure of relativity. It was also suggested that payment systems (eg, fee for service vs salary) would need to be taken into account in making cross-country comparisons. It was said that such information would be valuable when related issues are raised in the media and during industrial negotiations.

Several respondents expressed concern about the inconsistency in rates of pay and conditions between DHBs. The SMO MECA[1] sets out what is effectively a minimum, with

[1] MECA stands for Multi-Employer Collective Agreement.

most SMOs receiving allowances and benefits on top of the base salary. Larger DHBs are reported to have greater capacity to pay above the minimum, compounding the other recruitment disadvantages experienced by smaller DHBs. There was a call for national benchmarking to provide greater transparency around actual pay and conditions for SMOs.

One respondent advocated nationally standardised pay rates that are competitive with Australia. Another writer, however, suggested that the one-size-fits all approach of the MECA perpetuates shortages in smaller centres and in highly sought after specialties. They recommended at least two agreements or structured arrangements for urban and rural services that incentivise rural employment, to enable sufficient cover to maintain reasonable rosters, and enable SMOs to take leave and to participate in continuing medical education (CME).

Several respondents voiced caution about pursuing a course of improved pay and conditions for SMOs to address recruitment and retention concerns, remarking that:

- pay and conditions are not the major determinant of SMO job satisfaction
- improvements to pay and conditions will not address underlying problems
- significant improvements in SMO pay and conditions in New Zealand may contribute to further increases globally, thereby losing any relativity gains
- significant improvements in SMO pay and conditions would have a flow-on effect across the health sector (eg, to Resident Medical Officers (RMOs)), and other industries that are experiencing similar workforce issues (eg, police)
- significant improvements in SMO pay and conditions would have to be funded either through increased taxation or cuts in public expenditure such as education or indeed cuts elsewhere in the health sector.

One writer suggested that it is unrealistic to try and achieve internationally competitive pay and conditions, and suggested closing the gap somewhat but maintaining relativities in the future.

While the current MECA provides for non-clinical time, several respondents observed that clinical responsibilities often left little if any non-clinical time within rostered hours. The need for protected non-clinical time was frequently identified as a priority.

In additional to the pay and conditions traditionally negotiated under the MECA, one submission observed that relatively small things make a huge difference to working conditions such as office space, administrative support, typing services and secretarial support.

Emigration of New Zealand trained RMOs and SMOs

One writer commented that New Zealand trained SMOs should comprise 85 percent of the SMO workforce.

It was implied that an unacceptable number of RMOs and SMOs travel and settle overseas permanently, to pursue professional development and personal interests and/or in pursuit of better pay and conditions. One respondent identified a need to quantify and better understand this issue, proposing the establishment of a rigorous exit interview process for SMOs who resign. The respondent suggested that this could be run independently of DHB line management and possibly run by one DHB for the whole sector.

Respondents suggested a number of strategies for improving the proportion of New Zealand trained graduates returning to New Zealand to pursue SMO careers, including:

- every advanced trainee leaving New Zealand having a guarantee of employment on their return
- developing systems for maintaining ongoing contact with vocational trainees who are working overseas
- funding leave for professional development overseas, with or without bonding
- incentivise return by significant payment – time limited and binding – eg, $20,000 for return within 12 months and stay in position for three years
- developing exchange programmes with sister-cities/sites to encourage the development of knowledge capital and practice innovation
- signing SMOs up three years in advance so they can take time off for international experience, but are committed to return
- write off student loans over five years after vocational registration to encourage stability of tenure at this critical point (ie, when settling down).

Changing aspirations among generation Y

One writer noted that the prospect of staying in the same post for 30 years would not attract younger doctors to become SMOs, commenting that it was time to design career opportunities for further learning and development that allows a mix of lifestyle choices with a career in medicine. This issue was also touched on in other submissions, with one writer noting that changing aspirations were not confined to generation Y, although might be more marked among that population.

Other ideas for improving retention

Respondents identified a range of strategies for enhancing job satisfaction, and thereby SMO retention, including:

- retaining more RMOs
- ensuring that RMO support is available to SMOs in all departments
- further development of multi-disciplinary clinical governance models
- reviewing medical education core competencies (communication, administration, management, leadership) to better equip SMOs for leadership roles
- developing a national approach to providing a positive, collegial and safe culture
- making CME entitlements as of right, and able to be cashed-up where there has been insufficient non-clinical time to undertake CME within paid hours
- creating more part-time and supervisory roles for senior specialists to prolong their engagement in the workforce as they approach retirement.

Training the future SMO workforce

Addressing future demand

It was acknowledged that population growth and ageing of the population as well as changes in morbidity (eg, obesity, diabetes) will increase the need for SMOs in the future, which is unlikely to be offset significantly through efficiency gains. Several respondents remarked on the need for rigorous workforce planning and a programme of action to meet expected demands. One respondent pointed out the need, in view of current recruitment and retention issues, for workforce planning to take into account existing shortages and the

pressures that the current workforce are experiencing in estimating future workforce needs – as opposed to basing workforce projections on an assumption of maintaining the status quo.

Training for service need

Several respondents suggested that there are insufficient training positions and that these are not aligned with New Zealand's current and future SMO workforce needs (eg, not enough generalist training or sub-specialty training in maternal foetal medicine and gynaecological oncology), and already too great a reliance on international medical graduates. It was suggested that Colleges needed to review entry processes to their training programmes to ensure that access is fair, equitable and allows maximum access to appropriate schemes. Greater involvement of smaller and rural hospitals in training at all levels was also called for to give trainees experience of working in provincial centres and to enrich the working environment within those centres.

Some respondents called for a more proactive approach to planning and a closer partnership between the training providers and health service leaders. It was suggested that each region should be planning to train sufficient SMOs for positions in secondary and tertiary centres.

The importance of collection and use of workforce information was highlighted by several respondents, who suggested that:

- local or regional information could be used to inform national strategies
- a clear and useful national picture comparing current workforce with predicted need is needed to facilitate medium and long-term planning.

One writer proposed that doctors in training should make decisions about where they wish to work earlier (possibly prior to entering advanced training) to facilitate forward planning, which would also provide an opportunity for training to be tailored more specifically to the individual's career path, including experience in secondary centres.

Another respondent recommended paying existing SMOs to train in certain sub-specialties (such as Electro-Physiology - Cardiology) as a more efficient strategy than trying to recruit in an extremely competitive international job market where there are very few if any potential candidates.

Support for the teaching role

One respondent pointed out that consultants engaged in teaching usually receive additional compensation recognising the role and time required to carry it out. Nevertheless, several writers noted that duties related to education, training and supervision are not explicitly set out in contracts or included in performance measures. They claimed that this can lead to an emphasis on performance of clinical duties, especially where there is an incentive to minimise public sector time in favour of more lucrative private practice. There was a call for greater clarity of obligations to ensure an appropriate balance, especially given a perceived tendency for DHBs to focus closely on direct service delivery, sometimes to the detriment of training and supervision. In this respect, one writer proposed that the Ministry of Health directive to DHBs needed to be more explicit about the importance of training the medical specialists of the future. It was also suggested that contributing to professional organisations and professional activities within the workplace should be given higher priority.

Taking a different perspective, one respondent remarked that piecemeal job sizing, where hours and obligations are set out in 10ths, is counter-productive, leading to fragmentation rather than continuity of care. For this reason they cautioned against further attempts to delineate activity by time intervals, or to move toward solidifying the notion of a 40 hour working week for doctors. Another respondent recommended that SMOs' normal hours should be extended across all shifts, claiming that SMO involvement outside the normal

hours has led to more effective and better supervision, including more timely assessment and discharge and less admissions.

It was also suggested that the public/private split need not be so marked, with potential for mutual benefit from shared appointments, resources and structures, co-location of services, and mechanisms for RMOs to be involved in both public and private sector service delivery.

Importance of the academic workforce and research opportunities

Two respondents reported that it has become increasingly difficult to recruit to academic posts, noting that academic pay and conditions had lost parity with the MECA over time, incentivising clinical over academic careers. It was suggested that parity with clinical pay and conditions needed to be re-established and maintained.

Another respondent claimed that lack of investment in the academic workforce could lead to huge problems in the near future. Proposed approaches for generating interest in academic careers included:

- giving RMOs exposure to academic medicine
- providing opportunities to work in academic medicine without necessarily having to commit to a long-term career
- involving RMOs in teaching, possibly with academic scholarships or fellowships
- paying a premium for higher qualifications such as PhDs.

A research-rich environment was also identified as critical to rewarding careers in both academic and clinical medicine. A number of approaches were proposed for strengthening research activity in New Zealand, including:

- making research funding more widely accessible to both academic and clinical staff, and not just major research programme grants
- providing research and training opportunities via tertiary and/or offshore partners
- Ministry of Health funding for fellowship positions that DHBs cannot afford to fund
- reducing bureaucracy around applying for and accounting for research funding.

Other comments on training

One writer considered medical training to be unduly protracted and recommended shortening both undergraduate and post-graduate medical training courses. Another argued that such proposals failed to recognise that the high skill level and accumulated knowledge that is sought cannot be gained quickly.

There was a call for central management and greater financial transparency around the use of Clinical Training Agency funding by DHBs.

Several respondents remarked on the emerging distance between RMOs and SMOs, which was seen as unhelpful to continuity of care and training. Some senior staff report no longer feeling connected to their junior team, and that this threatens a team approach to patient care.

One respondent attributed this to current work conditions – especially rosters. Another saw it as reinforced by there being different unions, different work practices and some strongly held hierarchical beliefs. It was suggested that the supply and demand for roles needs to be matched along the medical continuum from early training through to being a specialist. The current separation is seen as working against this.

A small number of submissions identified potential for new roles to be developed that complement and support the role of SMOs (and RMOs) such as so-called hospitalists.

Some writers expressed caution about this, and any proposals to delegate tasks currently undertaken by SMOs to other parts of the workforce, due to a fear that these approaches might be developed and implemented without a sound understanding of where the contribution of SMOs or particular specialists is essential.

International recruitment and registration

There was widespread recognition that New Zealand depends heavily on international recruitment to fill registrar and SMO positions. Several submissions referred to difficulties with international recruitment, and one writer argued that improvements to recruitment and registration processes were the highest priority issue to be addressed – ahead of remuneration and working conditions.

Recruitment processes

Using international recruitment agencies is costly, especially for smaller DHBs, with one writer citing agency fees of 30 percent of the agreed remuneration package including benefits. At the same time it was noted that agencies provide limited value for money. DHB medical staff still have to establish clinical practice levels and check references, which is a time-consuming process.

Respondents reported occasions when less scrupulous agencies forwarded CVs for people who were not qualified for available positions or had no intention of working in New Zealand. In some cases such candidates had been flown to New Zealand for interview – further wasting DHB time and resources.

It was reported that several DHBs can find they have been simultaneously competing for a single candidate, with each paying agency fees and sometimes meeting the costs of trips to New Zealand, and orientation to the services, in the expectation that appointment is likely.

Greater regional and national coordination around marketing and international recruitment was recommended, leveraging off special features which might include lifestyle opportunities, clinical practice, research opportunities, leadership opportunities, and local and off-shore professional development opportunities. Several respondents suggested that in rural areas there is scope for partnerships between public and private health service providers to achieve more effective and efficient recruitment outcomes for a location, and also to ensure rosters are less onerous.

Several respondents proposed the establishment of some form of regional or national recruitment service to support DHBs.

Immigration processes

One respondent suggested that Immigration Service processes were cumbersome and recommended that a dedicated staff member be appointed to facilitate DHB appointments, as well as removal of the requirement (form NZIS1113) for DHBs to have to re-establish their credentials as a viable businesses each time they seek to recruit internationally.

Registration processes

While one respondent observed that the New Zealand Medical Council provides an exemplary service in the registration of SMOs, international recruitment is reported by several writers to be adversely affected by delays in obtaining Medical Council registration. It was suggested that there is at least a four month delay while the Medical Council processes applications, follows up references and obtains recommendations from relevant professional colleges, by which time many applicants have changed their minds or accepted

other positions. It was suggested that this delays recruitment and wastes scarce resources. A fast track process for 'accredited' DHBs was proposed as one possible way of expediting registration of international medical graduates (IMGs).

While permanent long-term employees are generally preferred, it can be easier for IMGs to enter New Zealand as short-term locums. Sometimes short-term locums decide they would like to settle in New Zealand, at which point they may be required to sit exams or even leave the country in order to apply. It was reported that short-term locum tenens[2] registration is usually available to these SMOs so they come here for six month locum – sometimes repeatedly – but they cannot stay permanently unless they sit and pass local qualifications. It was suggested that these practitioners would be a much more valuable workforce if they were able to practice here indefinitely and that it seems illogical to allow them to use their specialist qualification to practice here in the short-term, but not to allow them to become fully productive and assimilated health service providers here.

It was suggested that Colleges could be less restrictive in their registration requirements for those who have trained and worked in first world countries where experience and standards are fairly similar to those of New Zealand. There was acceptance that there may need to be some form of orientation or assessment period, but concerns that the 12 month supervision period and the potential of having to sit exams when they have been through a similar process in another country is excessive.

Recognition of equivalent training and qualifications and/or development of a framework of global equivalence/medical passport were called for by several respondents.

It was accepted that a period of supervision was appropriate in some areas, such as Obstetrics and Gynaecology, where the new system can be very different, and a practice assessment is appropriate. Increasing use of on-site practice assessments was seen as respectful and appropriate.

One respondent suggested that the role of the Medical Council should be to support DHBs, and a need to clarify accountability for ensuring clinical competence was identified.

Another writer noted that there is commonly a requirement to have worked a certain number of hours in a previous year to obtain vocational registration, and suggested that this might be lowered, especially for non-procedural specialities such as physicians, psychiatrists, and non-interventional radiologists, in order to recruit senior specialists working reduced hours prior to retirement but with as much to offer as SMOs.

Two respondents perceived conflict of interest to be impeding international recruitment. They suggested that some stakeholders wanted to prevent increased competition for delivery of private sector services. Requiring appointees to obtain local qualifications to be eligible for full vocational registration, and impractical supervision requirements were given as examples of unnecessary impediments. There was a call for more consistent and transparent processes so that the New Zealand public health system is not compromised by such actions.

Standards not always maintained

Several respondents noted a trend for standards to be lowered where DHBs were desperate to recruit, and concern was expressed regarding the potential impact on quality of care provided as a result – especially if this practice becomes more widespread. There was a call for the minimum competency standards set by the Medical Council to be maintained.

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[2] Locum tenens is temporary employment for physicians, usually while a permanent position is waiting to be filled.

It was also suggested that doctors immigrating to New Zealand are formally oriented to the New Zealand system, including a cultural orientation, and that a formal system is put in place to ensure this.

One writer observed that engendering a culture within DHBs that values training highly would ensure that international medical graduates with generalist registration were not deployed in specialist areas without appropriate supervision.

Issues for small and rural hospitals

Recruitment more difficult

Several respondents reported that recruitment for small or rural hospitals is more difficult than for larger centres. Factors considered to contribute to this included:

- limited career opportunities for SMOs and their family members
- reduced scopes of practice and insufficient work volumes for sub-specialists
- lack of collegial relationships and support with the DHB
- limited career paths
- onerous on-call rosters because of working in small teams
- limited opportunity to work in private practice
- limited DHB resource for recruitment initiatives
- limited DHB resources to fund clinical and educational experience
- limited cultural support networks within the local community
- permanent full-time positions may be required by DHBs.

It was noted that rural DHBs are particularly reliant on international recruitment, with one respondent reporting that only 20 percent of their SMO workforce had been trained in New Zealand. The cost of international recruitment is difficult for smaller DHBs to meet. Wider workforce implications were also identified. For example, if SMOs are not vocationally registered they may not be eligible, despite being extremely capable, to supervise provisional registrants or junior staff.

It was suggested that regions needed to aggressively market the benefits of working and living in provincial centres. Incentivising rural employment was also proposed in a few submissions.

One respondent proposed that provincial centres develop relationships with larger centres giving provincial staff the option of providing some regular service in larger centres, and that inclusion of a major centre in training programmes should be mandatory to encourage long-term recruitment.

Supervision hard to arrange

Onerous supervision requirements for achieving vocational registration came up in several submissions, and were identified as the number one priority to be addressed by one writer. Some DHBs, especially small and rural DHBs, have difficulty providing required levels of on-site and off-site supervision. It was suggested that a systematic approach be developed for accessing SMOs from a range of DHBs to enable required supervision to be delivered – preferably one that does not place DHBs in the position of having to beg favours of each other. Exploration of options for tele-supervision was recommended by one respondent.

Severe impact of SMO shortages

Workforce was reported to be the major determinant for the healthy survival of provincial hospitals. Respondents said that in small or rural hospitals vacancies impose a further burden on remaining staff, compounding the effect of small team numbers to begin with. Moreover, prolonged vacancies are said to result in reduced ability to access

CME and undertake other professional development due to the heavy clinical workload.

One writer observed that sustained SMO shortages can stress service delivery to the point that the viability of small or rural hospitals is threatened, noting that if a hospital's survival is tenuous it either needs to be supported to survive or changes/closure carefully planned and managed.

Greater need for generalists

Several respondents observed an increasing trend for specialist training to be provided in main centres, and a commensurate trend toward sub-specialisation. They noted that in smaller and rural hospitals, of which there are many, there is a greater need for generalist SMOs than sub-specialists, but that this service need does not appear to be reflected in SMO training programmes and seems likely to exacerbate recruitment problems for smaller and rural hospitals.

The writers suggest a shift in training emphasis away from the main centres to ensure there are sufficient SMOs with good generalist skills to meet New Zealand's future workforce requirements. This would also provide SMOs working in smaller and rural hospitals with a wider scope of practice (ie, increased training and supervision component), which will increase job satisfaction and thereby assist with retention. A need to work with the Medical Council to encourage the development of generalists was identified.

Other comments

More efficient deployment of SMOs

It was noted that SMOs are too few and spread thinly. It was suggested in one submission that better use needed to be made of clinical networks – regional, national and cross-Tasman. The writer also proposed that those with specialist expertise focus on their areas of expertise while supporting generalists to do less specialised work.

SMO locums – competition and safety

It was noted that there is an increasing dependency on locums, particularly at RMO level but also at SMO level. The levels of remuneration available to RMO locums and some SMO locums were seen as disincentivising the uptake of permanent full-time SMO positions.

Concern was expressed by one respondent that some SMOs are using their leave entitlement to locum elsewhere in New Zealand and in Australia, and that resulting fatigue raises clinical safety issues and is likely to produce burn-out. The writer urges the Commission to address this issue.

Onerous rosters

As mentioned above, onerous rosters affect smaller and rural hospitals in particular, but larger hospitals are also affected. It was observed that some specialists are required to participate in more than one roster (eg, surgical and maternity rosters) exposing them to more onerous on-call expectations.

Modest remuneration for on-call work was seen by some writers as failing to recognise the extent of the burden that rosters impose or to value the contribution being made by SMOs. Increased remuneration for on-call work was proposed by several writers. One writer advocated the need for appropriate recovery periods to be rostered following an on-call and the need to remunerate SMOs during these recovery periods.

One respondent advocated increased funding to DHBs to take account of the need to provide 10 to 16 weeks cover for planned absence including annual leave and CME etc for each full time equivalent (FTE) medical position.

Another recommended greater use of part-timers as a possible strategy for reducing onerous rosters, with rosters shared among a larger number of people thereby enabling people to better manage public and private sector work commitments.

Recognising the role of midwives

It was noted that midwives play a central role in the orientation of obstetrics and gynaecology specialists who are new to New Zealand, where the system of care may be dramatically different to what they have previously experienced. The importance of their role is particularly great where existing medical staff have limited opportunity to provide close training and supervision. It was suggested that the role of midwives be formally acknowledged to facilitate collegial respect and ongoing positive inter-professional relations.

Public private interface

It was suggested that some SMOs need to work in both public and private systems to meet continuing requirements of their scope of practice, so it is important for any consideration of SMO issues to recognise the complementary and linked nature of the two sectors. The writer added that the private sector will need to be used to meet the training needs of increased numbers of medical students.

Some respondents expressed a view that full-time work in the public sector was important and needed to be supported, possibly through some form of incentive.

One respondent was critical of the Commerce Act, which is said to restrict the hours that can be worked in the private sector. They noted that there were impacts on earning potential and lifestyle that may drive some specialists offshore with a flow-on effect from the loss of these specialists' contribution to the public sector.

Conclusion

There were not a great number of submissions, but this is not surprising as stakeholders also had the opportunity to speak directly with the Commission during its consultation process. The views presented in written submissions are largely consistent with those expressed in the face to face meetings.

The information from submissions will inform the Commission's ongoing work to develop a national recruitment and retention strategy that will provide a sustainable pathway to competitive terms and conditions of employment for senior medical and dental officers.

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Appendix One: Invitation and indicative questions

Dear ……….

Director-General Commission on Competitive and Sustainable Terms and Conditions for Senior Medical and Dental Officers employed by District Health Boards (the SMO Commission)

As you will be aware, the Director-General of Health, Stephen McKernan, has established a commission to recommend a national recruitment and retention strategy that will provide a sustainable pathway to competitive terms and conditions of employment for senior medical and dental officers (SMOs).

On 23 October, the Director-General announced the appointment of Len Cook (Chair), Ross Wilson and Dwayne Crombie as Commission members.

The Commission held its first meeting on 28 October 2008. Discussion focused on the scope and parameters of the Terms of Reference and identified a number of key elements of the work programme. We agreed that the Commission's work should be informed by the perspectives not only of senior doctors themselves, but those who work alongside them, or who have responsibility for influencing the conditions and way in which doctors engage in delivering health services. We wish to consult widely with a range of specialist groups and professional organisations within the health sector.

We would therefore like to invite your written submission on the recruitment and retention of SMOs. While we welcome contributions to the work of the Commission at any time during its existence, we intend to give submissions that are received by 15 December 2008 a formal acknowledgement and make every effort to ensure that our fullest attention is given to the information and concerns raised. Submissions and later contributions may be sent either by email to: Brenda_wraight@moh.govt.nz, or by post to:

Brenda Wraight
Director-General's RMO & SMO Commissions
Ministry of Health
PO Box 5013
Wellington

If you would like to meet with the Commission to discuss your submission, or other matters relating to the recruitment and retention of SMOs, please indicate that on your submission. Please note that a summary of submissions will be posted on the Commission's website, which can be found on the Ministry of Health website.

Yours sincerely

Len Cook
Chair
SMO Commission

Questions / prompts for submissions to the SMO Commission

- What do you see as the major issues with regard to recruitment and retention?
- What do you think the Commission should focus on to get a more credible outcome?
- What is unique about SMOs, the profession?
- What is the place of senior doctors in the health system? What are the hierarchies?
- What is the value of "place" and the wider working environment?
- What factors influence "place'?
- Do you have any comments on IMGs - numbers, planning, impacts?
- Whole of health system investment - how does the health system invest in specialists / technology / services? are these aligned, or coordinated locally / regionally / nationally?
- What is the impact of technology on service delivery & specialist employment?
- What possible strategies / solutions to help system?
  - Demand issues
  - Supply side
- Leadership – are we engaging senior doctors in the best way? Who are the leaders?
- Innovation – are there opportunities in the system? Where? Effectiveness?
- Resources – how are they currently used, and could we make better use of specialist resources? What options are there? Flexibility? Unlock the silos?
- Are there examples of where the system works well? What are the components of this?
- Do you have any comments on public/private balance?
- Sustainability – what does this mean? How to achieve it?
- What have been the key issues over the previous decade?
- What are the emerging issues over the next decade? 20 years?
- What do you see as the key drivers now and into the future?

Appendix Two: List of respondents

Assoc. of Salaried Medical Specialists	*Ian Powell, Executive Director, and incorporating input from:* • *Dr Himradi Seth, Waitemata DHB* • *Dr Sally Vogel, Auckland DHB* • *Dr Vanessa Beavis, Auckland DHB* • *Dr Judy Bent, Auckland DHB* • *Dr Helen Moore, Auckland DHB* • *Dr Stuart Barnard, Counties Manukau DHB* • *Dr John Bonning, Waikato DHB*
Australasian College of Emergency Medicine	*Drs Peter Freeman and John Bonning*
Bay of Plenty District Health Board	*Phil Cammish, Chief Executive*
Canterbury District Health Board	*Unsigned*
Capital and Coast District Health Board	*Ken Whelan, Chief Executive*
Clinical Training Agency	*Tony Gibling, Manager, Clinical Training Agency*
Council of Trade Unions	*Unsigned*
Lakes District Health Board	*Cathy Cooney, Chief Executive / Jenny Martelli, Manager, Medical Management Team*
Lakes District Health Board	*Darren Malone, Senior Medical Officer*
New Zealand College of Midwives	*Lesley Dixon, Midwifery: Practice Advice and Education*
New Zealand Medical Association	*Dr Peter Foley, Chair*
New Zealand Society of Anaesthetists	*Andrew Warmington, President*
Northland District Health Board	*Dr Gloria Johnson, Chief Medical Adviser*
Otago District Health Board	*Brian Rousseau, Chief Executive Officer, Otago and Southland DHBs*
Royal NZ College of General Practice	*Cathy Webber, Principal Advisor Legal and Governance, Division of Rural Hospital Medicine*
Tairawhiti District Health Board	*Unsigned*
University of Otago	*Dr John Adams, Dean, Dunedin School of Medicine*
Whakatane Hospital	*Senior Medical Officers*
Whanganui District Health Board	*Jeanette Black, General Manager, Public Hospital and Health Services and* *Dr Jan de Kock, Chair, Medical Staff Association*