



Inside this Issue

Ethical issues concern the treatment and non-treatment of non-residents	1
China's healthcare system embodies the worst of socialist and capitalist models	4
British Foundation Hospitals play midwife to a reluctant electorate	7
2004 Conference	7

Ethical issues in the treatment and non-treatment of non-residents.

With considerable foresight our Seminar committee arranged in January for Jan Crosthwaite from the Department of Philosophy at The University of Auckland to speak to our August Seminar. Jan's subject was the ethical issues concerning the treatment and non-treatment of non-residents. A week before the Seminar, right on cue, the Holmes TV show picked up the case of a Tuvaluan non-resident seeking residency for dialysis treatment. What gave the case media piquancy was that he has convictions for assaulting his wife. A phone in poll was heavily in favour of deporting the gentleman. Jan picked up the issue and used it as a practical case study for his presentation.

Her presentation prompted wide discussion and debate amongst those fortunate to attend the seminar on the funding of services for both residents and non residents. It is clear that we can not get consistency in our policies on funding of treatment unless those policies are based on ethical principles.

The "Tuvaluan overstayer"

This gentleman came to public attention early in 2003 because when he was found to be in need of emergency renal dialysis, it was discovered that he had overstayed his visitor's permit and was in New Zealand illegitimately. This presented a problem for the health care services in Auckland. He had been given emergency treatment but was not eligible to continue receiving publicly funded health care. Moreover, he was an illegal immigrant scheduled for deportation to his home country. The care he would need to sustain his life was not (and is not) available in Tuvalu. If sent back to Tuvalu he would die from his illness. Compounding the issue was the fact that he was then also facing the courts on a charged of assaulting his wife.

In 2003, he was granted temporary residency (because his wife and child are New Zealand citizens) and this enabled him to be treated in the public health service. However in 2004, he was again in the news because he was once more charged and convicted of assaulting his wife, and his temporary residence status then became likely to be revoked. As an aside, as a prisoner he would be eligible for continued treatment, so this time the ethical problem about actions which will lead to someone's avoidable death lies with immigration and the courts, rather than the health services.

Jan noted that, although this Tuvaluan overstayer presents some unique characteristics, his was not a unique case. So rather than discuss all the details of his particular case, she did what philosophers standardly do, and raised issues for discussion in a more general and abstract way.

Many people who are not citizens or legal residents of New Zealand find themselves in New Zealand and in need of medical assistance. NZ has a number of Pacific Island "overstayers" and some will be at risk of needing dialysis, as well as other kinds of life-sustaining medical care. Some people from overseas come here deliberately to take

(Continued on page 2)



Jan Crosthwaite

(Continued from page 1)

advantage of the NZ health system, and some come for other purposes (for instance, to have their child born in NZ) which will involve use of some services.

Any person in New Zealand, citizen, legal resident, illegal resident, tourist or other visitor, may find themselves in need of health care. Emergency or acute care for a serious, life-threatening condition is provided without prior determination of eligibility or capacity to pay. Other care may be available on a fee-for service basis, for those who are able to pay, and free only for those who meet the Ministry Of Health criteria for eligibility. The criteria, last revised in 2003, do not include people in our country without a current legal permit; neither do they include all who are here legally.

Limiting the availability of elective and non-acute treatment for non-citizens to those who can pay seems perfectly reasonable. Whether one might want to set up the NZ health system as a private clinic for non-Kiwis is another question. Providing emergency life-saving treatment knowing that the country may carry the cost is ethically admirable.

What presents the ethical problems of interest is where someone needs on-going life-sustaining procedures which cannot be provided except through the charity of the NZ health system.

The introduction of that word "charity" is significant. Most of us think that charity is a virtue, and acts of charity are good. Some even think that we have a duty to be charitable to those in need. The question Jan raised was:

What are our moral obligations to provide assistance to others in need? In particular, where that need is for on-going care, without which there is a risk of loss of life or serious disability.

What are our moral obligations to provide assistance to others in need? In particular, where that need is for on-going care, without which there is a risk of loss of life or serious disability.

This question hides some further questions:

Who is 'us'? Are the obligations that concern us those of individuals, or persons in a professional role, or 'us' as a society?

Who is the 'other'? Do any obligations to assist some other person in need apply to specific kinds of other persons or to any one at all who is in need?

Moral obligation to help others

Most moral systems endorse a duty to assist another person in serious need, particularly if that person is in danger of death or serious disability. These are not necessarily legal obligations. While they may be required of the morally good person, the penalties for failure are more likely to be loss of respect (or self-respect) than legal penalties.

Consequentialist theories (which identify the right or good act in terms of what brings about the best overall results) would hold that in general the overall good is furthered if people assist others who are in need. Kantian views also support a duty to assist others in need.

Christianity famously offers the parable of the Good Samaritan (Luke, 10:30-35). Few would argue that charity and beneficence are not virtues.

Any obligation to assist need not be overriding. It need not require that one risk one's own life in rendering assistance, and it might be outweighed also by significantly weighty responsibilities, for example, if one cannot provide assistance to this individual without at the same time failing to provide significant assistance to someone for whom one has special responsibilities. (This needs to be born in mind for later consideration.)

Some ethicists make a distinction here between what is obligatory, or morally required of us, and what is 'over and above' the call of duty. So the hero who saves someone at considerable personal risk has acted in a way that is morally praiseworthy, but such heroism is not required of us all. We might be a better person if we did it, but not a bad person if we do not. The technical term for acts of this kind is 'supererogatory'. Is assisting others a duty, or is it supererogatory?

As individuals, Jan said that she thinks we do have a (limited) moral duty to assist others who are in serious need, within our capabilities.

Some occupations and professions have special obligations to assist, which are stronger than those that apply to people not in these roles or professions. In these cases the obligation to assist is often expressed in professional codes and guidelines, and may even be enforced legally. Life-savers have stronger obligations to assist swimmers in difficulty than do other swimmers. Physicians, and other health-care workers, may have obligations by virtue of their skills, training, and professional codes, to provide assistance in situations, and of a kind, which others do not.

Again, these obligations to assist may not be unlimited. There has been debate since the 17th century as to whether physicians who did not stay in plague-ridden London to assist the sick were guilty of a failure of ethical, or professional, duty, or were merely prudent and reasonable men. Even where one has a duty to aid, Jan thinks that to do so at risk of one's own life is supererogatory.

Doctor's obligations to help others

There is wide acceptance, including in New Zealand, that in an emergency situation doctors have a duty to render aid, within their expertise. For example, The World Medical Association's "International Code of Medical Ethics" states that, 'A physician shall give emergency care as a humanitarian duty unless he is assured that others are willing and able to give such care'. It is not so clear that doctors have a duty to go on providing care, without recompense. However, one might argue that in at least some cases, the need to protect life - which grounds the requirement for emergency aid - would support a duty to continue care. But it seems reasonable that this would be limited if it should interfere with the doctor's own well-being or other equally serious responsibilities.

A self-employed physician is entirely free to offer her services as a charitable act. But where these services are paid for by others, or use resources provided by others, then the physician has a duty of care in the disbursement

(Continued on page 3)

(Continued from page 2)

of these resources. Physicians within a public-health system need to temper their provision of care by awareness of considerations of equity and best overall use of publicly-provided resources.

Those in charge of public health care systems have responsibilities for determining the fair and proper use of the resources provided from the public purse, for the benefit of citizens and others accepted by citizens - through decisions of appropriate bodies - as eligible to receive these benefits

There is well-known potential for conflict between the professional responsibilities of physicians for the care of their patients and as custodians of scarce public resources. Those in charge of public health care systems have responsibilities for determining the fair and proper use of the resources provided from the public purse, for the benefit of citizens and others accepted by citizens - through decisions of appropriate bodies - as eligible to receive these benefits.

Doctors these days are used to working within the demands of limited resources, and have spent considerable time working out medically-based selection criteria to govern, or at least order, access. Where they, and all of us, feel uncomfortable is with non-medical criteria playing a role in this. Should we allow someone's social role, or non-medical factors, to determine access or ranking in a list?

One way of trying to address these kinds of questions is to argue that where it is the public which funds the services, the public needs to establish priorities and agree on at least non-medical criteria for their allocation. This has been found extremely difficult to achieve, and the results might not be what we would hope. We would need to live with any public prejudices that emerge.

Many doctors were horrified at the idea that the dialysis services which had been provided as an emergency measure to the Tuvaluan overstayer should be withdrawn. This might reflect just a view that it is morally wrong to withdraw life-sustaining treatment.

Jan said that life-sustaining services may be withheld, or withdrawn, by doctors acting ethically. Intensive care staff face this dilemma quite frequently. But this is in situations where the on-going treatment is judged in some sense futile. Medical services can be withheld also where there are medical counter-indications.

The problem with the case of the Tuvaluan overstayer is that there were no medical grounds for withholding or withdrawing treatment. Rather, treatment was being denied on the grounds of the personal/social situation of the patient. We should be very cautious about allocating services on non-medical grounds, particularly on the basis that someone is in the wrong social category. The question then is whether being a non-resident is an acceptable basis for denying access to medical care, at least in the case where this has life and death consequences. Such a decision isn't up to the individual doctor, or group; it is a decision to be made at the societal level.

Duties of the society/state to meet the need of others

In NZ, we by and large have a national or publicly-funded, health service. Does it have any obligation to provide assistance for non-citizens? The services a society provides are paid for by its citizens, and it is reasonable for access to these to be limited to members of the society or nation. The AA does not send its vans to help non-members whose car has broken down. There is even a question as to whether a state may allow some access for others, as an act of benevolence or charity. If the state's responsibilities are to its citizens, then one can argue that it is wrong to use its money for any purpose which does not aid its citizens.

If providing charitable services was at the expense of the access of citizens to these services, then this would seem unjust, and so unethical. At the very least, such use would have to be something which was approved by the normal approval mechanisms for public actions. We, as citizens, would have to want our society to be kindly and compassionate in this way to needy non-citizens and be prepared to sacrifice some things to enable this.

Unfortunately, where the public purse from which health services draw is limited, and the possibilities of health care far exceed what can be funded, then any use of those services by non-citizens is a limit on the availability of some services to citizens.

NZ does provide access to its health care services to people who are not NZ citizens and taxpayers. Some of this is through reciprocal arrangements with other states; some of it is in compliance with international codes and agreements such as those on the treatment of refugees. Little would meet the idea of charitable health services that being discussed here. Charity is more likely located under overseas aid.

One might assume that if everyone belongs to some nation and each nation has obligations to care for its citizens, then there should be no need for any state to provide charitable health care. But not all citizens stay within their own country. It would be fair enough then to have reciprocal arrangements, such as NZ has with Australia and the UK. But we do not have these arrangements with all countries, and with some it would make no sense because they either do not have public health systems, or the level of service they could provide is entirely out of kilter with that provided in NZ.

It is this disparity of service which presents the sting in the ethical issues here - to refuse NZ health services to a non-resident can mean abandoning them to die, as in the case of the Tuvaluan overstayer. Hence his call on our charity.

But, if NZ were to make a practice of providing health services free of charge to non-residents who are in the country, this would arguably lead to more people from countries with fewer resources coming here when they foresee a need. No country can be expected to provide health care for all in its region. It would be in dereliction of its duty to its own citizens. So, a policy of charity, unless tightly circumscribed, might be both costly and unethical. Maybe having health insurance should be a requirement for visitors?

Jan believes that emergency life-saving treatment should

(Continued on page 4)

(Continued from page 3)

be provided to all in NZ who happen to need it - citizen or not. This is a cost to the country, but it is also part of being the kind of country that she and many New Zealanders want NZ to be. She thinks it is also reasonable and morally acceptable to request payment for these services from those who are not within the properly determined categories of eligibility for free services, and would argue for a policy of treating in cases of serious need, but with the intention of requesting payment from those not qualified for free service. Realistically however, one must assume that at least some of the recipients of emergency care will be unable to pay, and their home country may not be prepared or able to foot the bill. Therefore, such a policy would have an underlying expectation of a number of 'bad debts'.

There is no moral requirement that elective health-care procedures which are available either as a free or part-payment service to citizens should be provided to people falling outside the criteria of eligibility. If such services are available on a fee for service basis, then they should be provided in a manner which is non-discriminatory. Inability to pay would usually be held to be not a discriminatory basis for refusing such services.

Non emergency services, which are necessary for sustaining life, or preventing serious disability, present a problem. These can involve a significant and on-going cost-burden, both financially and in terms of use of resources which may be needed for others.

Non emergency services, which are necessary for sustaining life, or preventing serious disability, present a problem. These can involve a significant and on-going cost-burden, both financially and in terms of use of resources which may be needed for others. The provision of dialysis falls into this category.

If it is ethically required, or desirable, to provide emergency life-saving services, then the arguments supporting this would seem to extend to the provision of on-going services which are necessary to sustain life.

Where resources are limited, it is morally acceptable to establish clear criteria for access, provided these are fair, reasonable and do not discriminate on improper grounds. Being illegally in the country doesn't seem to be improper as a ground for denying or reducing access. The point about charitable service is that one has no entitlement, and one might rightly lose one's place in a queue to someone who does have entitlement.

One test for access to scarce resources should be whether the person has other means of meeting their needs. So there is arguably a moral difference between cases where the services are available and where they are not available in the home country. If services which would meet the individual's basic need are available in their home country, then the fact that these may not be the services the person would prefer does not suffice to justify a claim on them in NZ. For example, if peritoneal dialysis is available and clinically appropriate, then there is no justification for accessing haemodialysis in NZ because this is preferred but not available in someone's country of origin.

Jan summed up, saying she had been suggesting that there is a duty to assist others in serious need, but not at the cost of equally weighty responsibilities - such as to fellow citizens with serious health care needs.

She then noted a few final points.

First, there is arguably a difference between someone who enters the country deliberately to obtain services, and someone who finds themselves in need of services having come here for other reasons. No country is obliged to make its health care services available to the world. But preventing access to those who would seek free health service to which they are not entitled is a matter of immigration policy and procedures. It should not be up to clinical staff to make such a determination.

Second, where care is provided to someone who does not have entitlement, there is no obligation to provide the full range of choices, or of levels of care, which would be the entitlement of those who meet eligibility criteria for publicly-funded health and disability services.

Third, many have been concerned as to whether it is a responsibility of, or an appropriate task for, clinicians and health-care professionals to refuse or withdraw treatment from persons who are clinically but not socially eligible.

Many feel that clinical staff shouldn't have to bear the burden of enforcing administrative decisions which conflict with what they accept as ethical imperatives. Arguably it is contrary to professional ethics and responsibilities to refuse on the basis of social status treatment that would otherwise be available and clinically recommended.

A contrary argument is that, where appropriate criteria of access to publicly-provided services have been established, clinicians and health-professionals working within these services have an obligation to implement and abide by those criteria.

Contributions Welcome

1. The Auckland Branch welcomes contributions to **Inform** on subjects of interest to managers in the health and disability sector. Articles may be longer researched contributions, comments on current practice, or shorter notes and/or reviews. The range of possible subjects is very wide.
2. The maximum length is generally 3000 words. Shorter contributions are very welcome. Please include an e-mail address so authors can be contacted and a brief list of key points or an abstract.
3. Copy should be provided by e-mail or on a computer disk.
4. Contributions may be passed to the Editorial Committee for consideration.
5. Make submissions or contact the Editor for more information at admin@nzihm.org.nz

China's Healthcare System embodies the worst of Socialist and Capitalist models

Many may assume that after nearly 50 years of Communist rule, healthcare in China while sometimes basic, is available to all. Not so says *The Economist* in its August 20th edition.

When the World Health Organisation (WHO) ranked the public-health systems of 191 countries four years ago, China was placed at 144, behind some of Africa's poorest. India, which has half China's GDP per head, came in at 112. The criteria included fairness of access to health care and fairness of contributions to the cost.

After making strong gains in the first three decades of Communist rule, health indicators have changed little in the past quarter-century, despite the extraordinary economic achievements of China, with annual average GDP growth of 9.7% in the past 20 years. Some health experts believe that in parts of the country—particularly in the west where incomes are half the level of the booming eastern seaboard—life expectancy might even be falling.

Mao Zedong, for all his egregious faults, would have done better at providing it claims *The Economist*. In Mao's day, nine out of ten country people had access to subsidised health clinics run by the much celebrated "barefoot doctors". But in the course of China's relentless march towards capitalism in the past two decades, this arrangement has collapsed. In the countryside, 90% of the population now has no health insurance. In the cities, nearly 60% are uncovered. Out-of-pocket spending on health care is soaring.

Better to live on the coast

Judged by life expectancy, infant mortality and child-birth deaths, China's record looks impressive. Twice as many children in India die in the first few months of life, and twice as many mothers die in childbirth. At birth, Chinese girls can be expected to live to 73 and boys to 70—a level comparable to medium-level developed countries. But there are huge disparities between regions. In richer areas, such as around Shanghai on the coast, health indicators are as good as they are in many western countries. In western China, they are those of a basket-case country.

According to the World Bank, China has lifted 400m people out of severe poverty in the past two decades. But millions have slipped back into it as a result of health-care costs. Millions of others are dying because they cannot afford health care. A government survey three years ago found that some 60% of rural residents avoid hospitals altogether because of the expense. Diseases once declared tamed, such as tuberculosis, measles and snail fever, have been making a comeback. And amid the disarray of the system HIV is now rapidly taking hold.

This makes health-care reform a crucial part of China's development strategy. To ease growing pressures on its fragile financial system, China wants to become less dependent on government investment as an engine of growth. But unless consumers feel confident that they can cope with the risk of a serious health problem (as well



as with all the other increasingly costly contingencies), it will be difficult to encourage them to spend.

For President Hu Jintao and Mr Wen improving health care has also become part of a political strategy aimed at salvaging the Communist Party's badly tarnished image. Mr Wen and Mr Hu now stress the need to address the concerns of the marginalised. In 2002, the party set a goal of turning China into a middle-income country with a "well off" population by 2020. But in recent months the emphasis has shifted from simply increasing GDP per head to achieving broader measures of wealth, such as enjoying good health.

But getting there will be far more difficult than fulfilling GDP growth targets. For the past 20 years, the government's financial commitment to health care has been declining. Urban hospitals, though mostly still state-owned, now receive only about 10% of their operational funds from the state. For the rest they have to generate their own revenues, mostly from selling medicine and medical tests (the cost and wilful over-prescription of which is the biggest grievance of patients).

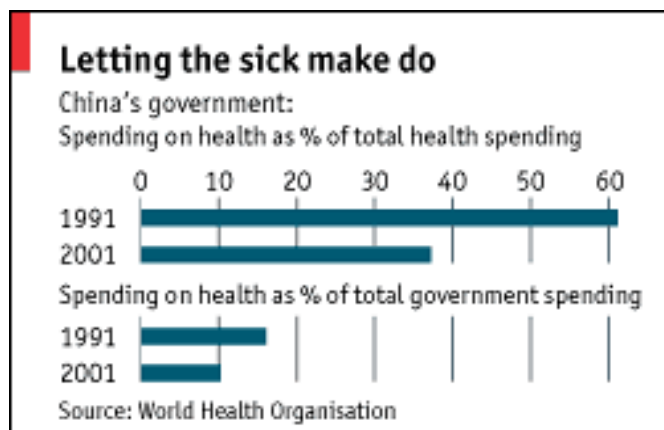
Even immunisation isn't free

Rural hospitals are in even worse financial shape. The most basic ones are run by governments at the township level, the lowest tier of government hierarchy. For most of these administrations, the only source of funding is the trickle of income they receive from higher-level government, plus taxes and fees that they raise from farmers and businessmen. Even preventive medicine now has to rely on fees. The WHO says that China is the only country in the western Pacific region which relies on patients to finance childhood immunisations. Not surprisingly, many peasants now avoid such treatment.

State-owned enterprises once shouldered much of the responsibility for basic health care, including the running of their own hospitals. But with the collapse of many such businesses, workers have been left to fend for themselves. Private businesses are supposed to pay for medical insurance, but most do not bother.

(Continued on page 6)

(Continued from page 5)



The chronic under funding of public health has created a culture of cynicism and corruption in China's hospitals. As well as having to pay up front before they are treated, patients frequently complain that in order to get good treatment they need to pay "red packets" (bribes) to doctors and nurses.

In the past year—goaded by the SARS outbreak—the authorities have stepped up their efforts to ensure that country people and the poor get access to basic health care. In the countryside, they have designated more than 300 counties (about 10% of the total) where a new "co-operative medical system" is being tried, with a plan to make it countrywide by 2010. Funding is shared between voluntary participants, the local authorities and the central government. In addition, a new insurance scheme, paid for by central and local governments, has been introduced for the poorest of urban and rural families to cover the cost of serious illnesses. The scheme is due to be implemented nationwide next year.

But both projects have serious drawbacks. Local governments are often unwilling to make the necessary contributions, especially in poorer areas. And individuals are often unwilling to pay for a service they feel they may not immediately need. For the past two decades, local governments have gouged farmers for contributions to an almost non-existent health-care system, with the money being used mostly to pay staff (many surplus to requirements or simply non-existent, with the money being used to line officials' pockets) rather than to pay for services. Consequently, there is reluctance to join any new scheme.

Can market forces provide the answer?

What other options does China have? Some officials, seeing the market as the panacea, suggest that the government should withdraw entirely and let prices be controlled by competition. In recent years, many township governments have sold off or leased their hospitals to private investors. But while in some cases the investment may have helped improve conditions, there is little evidence that the price of health care has fallen.

In the cities, a few hospitals have been built with private money, and businesses have taken over some of the hospitals that used to be run by state-owned enterprises. By 2005, state enterprises are supposed to cease their support for all hospital facilities. Some hospitals will be

closed; others merged with bigger ones or sold off.

But there are signs that the central government is at last trying to adopt a more coherent policy for health-care reform. In early April, at its annual national conference on health-care issues, the Health Ministry circulated a secret draft of a policy paper outlining the respective roles of the government and the private sector in urban health care. Experts familiar with the document say it suggests that the government retain control of the main hospitals, but let second-tier hospitals be owned and operated privately. One expert estimated that this could involve the privatisation of 60% of urban hospitals. This would allow the government to increase its spending on the hospitals it keeps, thus reducing their financial dependence on charges for medicine and tests.

On the face of it this sounds a good idea. China's problem is not a shortage of medical facilities. It has a relative abundance of them: 1.6 doctors per 1,000 people compared with 0.4 in India, and 2.4 hospital beds per 1,000 people compared with India's 0.8. But this means that official resources are stretched too thin. Concentrating on key hospitals would enable the government to pay doctors a decent wage (though Chinese sources say that the document does not promise this will happen). At present a hospital director earns about the same as a company sales representative with a couple of years of experience. No wonder doctors are demoralised.

But if large numbers of people are still unable to afford treatment, such reforms will create a better system only for the affluent. In the long run, what China needs most is a health-insurance system that works. This should include insurance for private treatment (now non-existent), giving patients a bigger choice of facilities and stimulating private investment in hospitals. It would also need to ensure that those who contribute little or nothing to the system still get some coverage. In other words, the government needs to spend a lot more, particularly in the countryside and among rural migrants to the cities.

One reason why China's health-care system is in such a mess is that the central government's share of tax revenue has dropped in the past 20 years. But relying on local governments to do more will not work. At the township level, the majority are bankrupt. The central government needs to allocate more of its own money—and to force provincial governments (which like to go their own way fiscally) to make sure the allocations reach their intended targets.

Achieving this will involve changing priorities. Prestige projects may have to be abandoned. And there will have to be a fairer allocation of resources to address the current imbalance by which cities currently enjoy 80% of health resources despite having only 35% of the population. And to make sure it all works, there will need to be an effective system of oversight which China now sorely lacks. The idea of good corporate governance is novel enough in China, but in health care it is non-existent. A sea change is needed in everything from hospital management to the way central and local governments spend their money. Even so, slowly and reluctantly as it may be, China is beginning to discover that market forces alone cannot produce good health care



New Zealand Institute
of Health Management
A Branch of the Australian
College of Health Service
Executives

For all inquiries re Branch
activities or membership contact
admin@nzihm.org.nz or
(09) 577 5477 Phone/Fax



Inform Editor Bruce Parkes

Seminar Programme

September 13th

@ Gillies Hospital
5:30p.m. for 6p.m.

**Child Health: Current
Issues and Future
Directions**

Dr Pat Tuohy: Chief Advisor
Child and Youth Health,
Ministry of Health

Non Members Welcome
Cost

Members \$20
Non Members \$25



Eurest supports our seminar
programme

British Foundation hospitals play midwife to a reluctant electorate

As we enter our triennial Health Board election cycle it is topical to recall Hugh Ross' June seminar presentation. Hugh alerted us to the unedifying spectacle of some British hospitals seeking "Foundation status", frantically scurrying to attract an electorate. Foundation Trusts are an attempt by their government to let some providers float free. They will enjoy a greater freedom and have a wider board of governors, with direct elections from members of the foundation trust hospital.

The problems start with the electorate, or rather with the odd way it is selected. Laws setting up foundation hospitals stated that they should have some public representation in addition to patient representatives on their governing boards, partly to sell the policy to wary Labour backbenchers. Because hospitals normally serve areas that cross local-government boundaries they can't just borrow existing local-government electorates. Instead they have had to draw up ad hoc constituencies and register their own voters.

Some of these constituencies are vast. Birmingham Heartlands and Solihull trust, which is registering voters at the moment, serves over 1m people. Contacting all of them would be expensive, so instead the hospital includes some extra forms when writing to patients and advertises on the radio a bit. So far fewer than 4% have registered. The active membership will be smaller, since many are not volunteers but rather former patients who did not get round to opting out. At Guy's and St Thomas's Hospital, where an election was held in April, only 901 people voted from a local population of over half a million.

With the limited the powers available to members, it is perhaps surprising that even this many bothered to vote. Members cannot vote directly for the chairman or directors of the hospital; they elect up to a third of the governing board, which typically has 35 members. Though the governors do have the power to appoint auditors and sack hospital managers, it is not yet clear what else they might do. Richard Lewis, a visiting fellow at the King's Fund, which scrutinises the NHS, says that the existing foundation hospitals have spent the last four or five months "trying to establish a role for their governors". This makes it hard for voters to know what they are voting for.

More voters might come forward if the benefits to patients of more public involvement in running hospitals were clear. But they are doubtful too. An article in the *British Medical Journal* earlier this year said that "although involving patients has contributed to changes in the way services are provided, little convincing evidence exists that these changes have improved quality of care, satisfaction, or health outcomes." We all have our own views on how our DHBs measure up against those criteria.

INNOVATIONS FROM ISOLATION

Wednesday September 29th – Friday October 1st
Rotorua Convention Centre

Our Joint NZIHM and RACMA Conference is only a month away. Managers and clinicians work in partnership as leaders in health care organisations through the world. This conference will provide a further opportunity to cement this relationship through shared professional development and networking.

The focus of the conference is on new developments and innovations in a variety of health management contexts. Keynote speakers from Hong Kong will share their SARS experiences, management and medical staff relations will feature highly, along with workforce planning, service reconfiguration and lessons from both those who have led large hospital redevelopments and those who are successfully providing community based services. With both keynote and concurrent sessions, this programme is sure to appeal to health managers in both line management and clinical leadership roles.

On line registration is available at www.meetingsfirst.com.au/fsite/site/registration.asp or download a form from www.meetingsfirst.com.au/RegistrationForm.pdf