



## Medico-Legal Update

MinterEllisonRuddWatts Partner, Wendy Brandon presented a wide-ranging Medico-Legal update to members at our May Branch seminar.

Health Bills currently in the parliamentary process are: the Health (Screening Programmes) Amendment – due for report back in August 2003; the Assisted Human Reproduction Bill and Human Assisted Reproductive Technology Bill – both due for report back in February 2004; and the Health Practitioners Competence Assurance Bill which was reported back to 'the House' on May 16<sup>th</sup>.

National, New Zealand First, Act, United Future and the Greens all expressed some 'minority views on aspects of the HPCA Bill. The Health Committee reported that they received 265 submissions, the majority from professionals or professional organisations. When considering the Bill they say they had to balance the demands of public safety against allowing practitioners sufficient involvement in the regulation of their professions so that they feel they have ownership of the new system. While most of the committee feel they achieved that balance, some considered that the professions should have more freedom to regulate themselves. Competence is not defined in the Bill as competence standards change from time to time.

In a new departure, the Health Committee recommended that the Health and Disability Commissioner be given statutory authority to deal with all complaints, including those that arose prior to 1 July 1996. This would see all complaints dealt with by the one agency. These early complaints must be dealt with using the laws of the time at which the alleged incident occurred.

The committee also recommends the constitution of the Health Practitioners Disciplinary Tribunal be three health practitioners, one layperson and a legal chair. They believe the majority of those on the Tribunal should be health practitioners as they have the clinical knowledge and expertise to make a judgement on whether a charge against a health practitioner is valid.

The committee rejected a request from the pharmacy retail sector to remove the requirement for pharmacists to own 51% of a pharmacy. The majority of the committee considered that ownership of a pharmacy by a pharmacy would enhance public safety. However, they did agree to the change allowing one pharmacist to hold a majority interest in five pharmacies as they believed one pharmacist could actively oversee five pharmacies but no more.

There is a lack of reference to the treaty of Waitangi in the Bill because the registration authorities set up under the Bill are not Crown entities and therefore can not be seen as Treaty partners. However, one of the functions of the registration authorities is to set standards for cultural competence of health practitioners and the committee expect cultural competence to include an adequate understanding of tikanga Māori.

Submissions closed March 28<sup>th</sup> with the Ministry of Health on a discussion paper for Public Health Legislation; Promoting Public Health, preventing ill health and managing communicable diseases.

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Wendy Brandon

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Wendy discussed employers' liability in SARS cases and pointed out that only employees who can establish "work related infection" will be covered. There is a three-fold eligibility test that requires that the work related infection was contracted in the circumstances set out in section 30(2) of the Act. Wendy notes that section 25(1)(b) expressly excludes "... the inhalation or ingestion of a virus". The significance of the absence of ACC cover is that persons who are not eligible for ACC compensation may bring an action for damages.

Referring to the Green Lane Heart Registry case in 2002, Wendy noted that few consents had been obtained at the time of retention. The Royal Liverpool Children Inquiry Report (Alder Hey) of 2001 and the Australian Health Ethics Committee 2001 report on 'Organs Retained At Autopsy', provided guidelines for the future on an appropriate process for obtaining consent and retaining organs. The Australian report recommended that Institutions should not initiate contact with Individuals about stored organs. Rather, they should rely on a wide spread dissemination of information (the responsibility for which should lie with the Minister of Health).

The Alder Hey inquiry recommended that "informed consent" means that a person must have all the information required to form a final decision. It is not enough for clinicians to tell the next of kin that they would like to examine the body after death and that might involve taking some tissue. The next of kin needs to know fully what happens in a post mortem examination. The general public should be educated to understand how human tissue is stored and archived as an ongoing resource for the general benefit of society.

Educating the general public to understand why and how human tissue is stored as an ongoing resource the general benefit of society may be the biggest challenge for health managers and policy makers

Wendy also provided an overview of highlights from the Commonwealth Fund Five Nations report (see story page 3)

## The Maine chance: Growing Support for a "Pharmac" model

A controversial scheme by US State Maine to cut the price of prescription drugs can go ahead after the US Supreme Court, lifted a lower-court injunction against it. In doing so, the court cheered the old and sick all around the country, heartened other States with the same idea, and infuriated "Big Pharmaceuticals", for whom Lehman Brothers predicted net income losses of between 1.5% and 3.5% if discounting becomes general.

U.S. drug prices have been rising by about 10% a year, three or four times the rate of inflation. This not only hurts the uninsured, but pummels States directly by increasing the cost of Medicaid, the Federal-State programme that provides health care for the poor (and also pays for prescription drugs for the elderly, not covered under Medicare). Many States, struggling with falling revenues, have tried to restrict benefits and eligibility under Medicaid. New York and Connecticut are both suing drug firms over their prices and profits. Maine took a different tack

Under its scheme, the State requires drug manufacturers who wish to sell their products in Maine to negotiate price rebates with the State authorities or, if they refuse, to jump through multiple hoops of State approval for every prescription in which their pills or potions are dispensed. Though this sounds somewhat socialist, and smacks of interference in interstate commerce, the justices overlooked that for the moment.

Other States have been watching eagerly. About half of them have been contemplating price-cutting, and 29 of them filed briefs with the court on Maine's behalf. Hawaii has a law ready to take effect; 18 legislatures have similar bills pending. Maine may still need to get approval from the federal Department of Health and Human Services, and may have to refine its scheme in various ways. But now the discount gate is at least part-open, it cannot be long before the rest of the country tries its best to gallop through it.

## 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 [nzihm@extra.co.nz](mailto:nzihm@extra.co.nz)

## New Zealand measures up in Five Nation Comparison of Health Care Experiences

For the past five years the Commonwealth Fund has conducted an International Health Policy Survey of health care experiences of adults in Australia, Canada, New Zealand, the United Kingdom and the United States. The 2002 survey reports on a comparative survey of sicker adults. The study finds that despite differences among health care systems, large proportions of citizens across the five countries report dissatisfaction with their health care system and serious problems including medical and medication errors, faulty patient-physician communication, and poor care co-ordination. The most crucial policy implication of these findings is that a focus on a small population of intensive health system users could have the potential to both control costs and improve care.

This survey's focus on sicker adults highlights the challenges these five nations and other advanced industrialised countries share as they seek to redesign medical care delivery systems to make care more effective, efficient, safe and responsive to patients. Survey findings point to common concerns with varying performance, indicating opportunities to learn from cross-national initiatives.

The survey started with screening interviews with 2500 adults in each country reduced to a final sample of 750 or more non institutionalised "sicker adults" in each country. This screening method yielded a study group of sicker adults with either ongoing health care needs or recent, more intensive use of the medical care system. A full report can be located in the Health Affairs Journal or at [www.cmfw.org](http://www.cmfw.org)

The principle focus of the survey was quality of care. To assess views on the direction of recent changes in the performance of the health care system, the survey asked respondents whether they thought the quality of the care they had received had become better or worse over the past two years, or had remained the same. Two thirds or more in all five countries saw little recent change.

A sizeable majority of the respondents had been cared for by three or more physicians during the past two years. Overall, their experiences indicate frequent problems with the co-ordination of care. As these patients moved through the care system, half reported that they found themselves repeating their health story to multiple health professionals. Although the percentage reporting co-ordination failures varied among countries, the frequency of such problems in all five countries indicates common experiences with duplication of effort or delays. One-fifth to one-quarter of respondents also encountered conflicting information about their care from different physicians and health professionals.

Twenty percent of New Zealand respondents seeing three or more doctors reported medical records or tests did not reach the office in time for their appointments and the same percentage report duplicate tests being called by different health professionals.

Prescription Drug Use Among Sicker Adults in Five Countries 2002					
	AUS	CAN	NZ	UK	US
Use prescription on a regular basis	66	64	65	67	71
Number of prescriptions used regularly					
None	34	36	35	33	29
One	17	13	14	16	11
Two or three	26	26	25	29	24
Four or more	23	23	25	22	36
Review of medication by physician relied on the most in the past 2 years, doctor has not reviewed and discussed all of the medications taken	41	37	34	46	30
Problems taking prescription medicines					
Stopped taking without doctor's advice because of side effects	15	17	16	16	19
Taking medicine but serious side effects doctor did not tell about	11	9	9	11	9
Skip doses to make medication last longer	9	8	7	6	16
Taking but difficulty understanding medication instructions	3	2	2	3	3

The survey revealed heavy reliance on medications among sicker adults. Two thirds or more of respondents in each country said they rely on prescription medications on a regular basis. Although prescription drugs can have serious side effects and interact with other medications,

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34% of New Zealand respondents said their doctor had not reviewed or discussed their medication with them in the past two years. Sixteen percent said they had stopped taking a prescription medication without a doctor's advice because of side effects. Few reported difficulty in understanding the instructions for the medicine.

Medical errors have become a highly visible quality of care issue. The survey asked about medication errors and medical mistakes or errors. The results show that the rate of reported medical errors increased among those who saw more physicians. Medication errors increased with the increase in the number of medications taken regularly.

#### Medication and Medical Errors Among Sicker Adults in Five Countries 2002

	AUS	CAN	NZ	UK	US
Mistake made in past two years					
Believed a medical mistake was made in treatment or care	19	20	18	13	23
Given the wrong medication or wrong doses by a doctor, hospital or pharmacist	11	11	13	10	12
Either type of error was made	23	25	23	18	28
Mistake caused serious health problems					
As percent of those who experienced a medical error	55	60	60	51	63
As percent of all respondents	13	15	18	9	18
Percent experiencing a medication or medical error by number of doctors					
1–2 doctors	16	16	15	13	19
3 or more doctors	28	32	29	21	34
Percent of sicker adults taking 4 or more medications regularly who were given wrong dose or wrong medication in the past 2 years	15	14	16	17	16

At least half the respondents reported that their regular physician does not ask for their ideas or opinions about treatment or care. At least 20% in each country reported a time when they left their doctor's office without getting important questions answered. An even higher number failed to follow the advice their doctor did give them. When asked why, a sizeable proportion said that they did not agree with the advice given or the recommended care was too difficult to follow. Costs were another leading reason for failing to follow advice.

Despite evident communication failures, the majority rated their physician highly. Ratings of excellent or very good tended to be highest in New Zealand. Paradoxically, New Zealand respondents express high levels of dissatisfaction with the health care system. Adding further complexity to the results, New Zealand rates comparatively better for access to care and waiting times. The access and waiting time results are not dissimilar to those recorded in surveys in earlier years using differently drawn sample groups. Cost barriers did influence access and this was the only area of the survey where care experiences varied significantly by income.

In all five countries sicker adults experiences indicate that a failure to co-ordinate care can result in duplicate tests, delays in care, wasted patient and medical staff time and conflicting information. Deficiencies in patient-doctor communication can compound such concerns through a failure to involve patients in decision making. The survey indicate frequent failures of physicians during patient visits to exchange information and answer questions, to discuss care goals and options, and to review medication regimes.

New Zealand respondents expressed some of the highest levels of dissatisfaction with their system overall. The public response to the series of major health reforms may account for some of this discontent. Concerns might also reflect capacity restraints as New Zealand's health spending as a percentage of GDP remains below the Organisation for Economic Co-operation and Development (OECD) median.

## The effects of Direct to Consumer Drug Advertising

DTC drug advertising, available only in New Zealand and the United States, has had a bad press lately and is blamed as being a major contributor to ever-rising pharmaceutical bills. Helene Lipton, presenting to our April seminar commented critically on the effect of DTC advertising. Does DTC provide consumers with information that empowers them to care for their health, or are they misleading in a way that presents a public health hazard? Two new studies and five perspectives reported in the March/April 2003 Health Affairs Journal examine these issues. The full text of these papers is available on line at [www.healthaffairs.org/WebExclusives/Pharma\\_Web\\_Excl\\_022603.htm](http://www.healthaffairs.org/WebExclusives/Pharma_Web_Excl_022603.htm)

Joel Weissman, David Blumenthal, Alvin Silk, Kinga Zapert, Michael Newman and Robert Leitman surveyed 3,000 adults in 2001 and 2002 to test what effects DTC ads had on their healthcare experiences and outcomes. They contend the results show that DTC advertising has been successful in prompting patients to discuss their health conditions with physicians and to improve their diet and drug taking regimes. They did not address economic and ethical issues so were unable to comment on whether patients were receiving drugs that were more expensive than necessary, or whether they were misled by DTC ads. They also accept that surveys of consumers can not address whether DTC advertising adds costs to the health care system and if it does, whether its benefits are worthwhile.

Robert Dubois also argues in favour of DTC advertising because, through education of physicians, it helps to contribute to less geographic variability in prescribing patterns when compared with medical or surgical procedures. "No restrictions on drug promotion would reduce inappropriate uses of drugs", he writes, "without also hurting the positive aspects of promotion." He does concede however, that for many ailments less costly alternatives are available for the broader population of people with those conditions and consensus is not clear regarding their use. Promotion might provide patients with added clinical benefit but perhaps at a higher than desired cost.

A Perspective by John Calfee supports the Weissman and Dubois papers but four other Perspectives challenge the two papers arguments. Jerry Avorn asks, "what about the capacity of DTCA to achieve its main purpose: increasing sales of the advertised product? Weissman's study found high-DTCA-influenced patients were only slightly more likely than other patients were to end their visit with a prescription for the advertised drug (47 percent versus 41 percent). Despite the enormous size of the study, the level of significance of this modest difference was just  $p = .06$ . If this had been a clinical trial of the DTCA intervention, it would not have passed the FDA's standard for efficacy. Is this the best bang for the buck we can get for a nearly \$3 billion annual investment in health communication to Americans?" He argues that the \$3billion a year spent on drug advertising could improve overall population health if it paid for public service advertisements spotlighting undiagnosed diseases or encouraged behavioural changes to promote health.

Thomas Bodenheimer challenges the Weissman survey's claims about the reasons patients discuss health concerns with doctors. He says, "symptoms, not advertising, should get the credit." Elaine Batchelor and Marianne Laouri argue that the trend toward increased drug cost sharing may spur demand for more balanced information about drugs. Finally, Martin Gahart and colleagues of the US General Accounting Office write that the U.S. Food and Drug Administration has not prevented misleading claims in drug advertisements despite its efforts to do so. Consumer surveys conducted by the FDA and others have consistently found that DTC advertisements influence consumers to ask their physician for a specific brand-name prescription drug. They found that the percentage of patients doing so was consistent across studies—about 30–35 percent of those who remembered seeing a DTC ad. In the consumer surveys they examined, about 5 percent of consumers requested and received a prescription from their physician for a drug they were not currently taking, in response to a DTC advertisement (the percentage ranged from 2 percent to 10 percent).

Drugs that are promoted directly to consumers often are among the best-selling drugs, and sales for such drugs have increased faster than sales for drugs that are not heavily advertised to consumers. Most of the spending increase for heavily advertised drugs is the result of increased utilization, not price increases. For example, between 1999 and 2000 the number of prescriptions dispensed for the fifty most heavily advertised drugs rose 25 percent, but the number dispensed for drugs that were not heavily advertised increased only 4 percent.

The survey did not address economic and ethical issues

There was no comment on whether DTC adds to healthcare costs and if so, were those costs worthwhile

The number of prescriptions dispensed for the fifty most heavily advertised drugs rose 25 percent, but the number dispensed for drugs that were not heavily advertised increased only 4 percent.

## A career long e-mail address for Health Workers

One of the largest corporate email and directory services in the world NHSmail, the new secure email and directory service for all NHS staff, is now online and reported to be delivering benefits that have a direct impact on patient care.

The new service, procured on a ten year contract with EDS, gives all staff working for the NHS in England the opportunity to claim an **@nhs.net** email address for the duration of their career within the NHS. The service will also provide a directory with up to 1.2 million entries, making it one of the largest corporate email and directory services in the world.

“Reliable and speedy communications are fundamental to an efficient, patient-centred health service,” said Sir John Pattison, Director of Research, Analysis and Information in the Department of Health. “By offering staff an email address they can keep throughout their NHS career, easy access from wherever they happen to be working and an extensive, up to date directory, NHSmail will pave the way for improved communication and collaboration between colleagues across the NHS.”

Once they have registered for the new service, NHS employees from health visitors to clinic clerks, and from GPs to physiotherapists, will be able to send and pick up emails wherever there is a web browser, will benefit from shared working for joint projects and initiatives, and will enjoy the highest level of security.

The new email service also has the approval of the BMA for clinical messaging, provided it satisfies their guidelines. These guidelines are available in a joint publication from the BMA and the NHS IA ‘Using NHSmail for Clinical Communications’. A copy of this document can be obtained by contacting Melanie James at the NHS IA on: [melanie.james@nhs.net](mailto:melanie.james@nhs.net)

The high level of security on NHSmail means that for the first time clinical emails can be safely used to replace paper-based communications where ‘structured messaging’ is not practical, such as: patient referrals, discharge letters and clinical enquiries.

For these applications, clinical information produced today on word processors can be sent as attachments to emails on NHSmail, securely encrypted, with the option of automatic confirmation of when the message is delivered or read. Brendan Docherty, Clinical Manager Cardiology and Critical Care at Queen Elizabeth Hospital, Woolwich, London, is an early user of the service. “The NHSnet system is straight-forward and simple to use - and can be accessed with minimal training. If I move departments or trusts and I can carry my own email address with me, improving continuity and contact with key staff in the NHS. Its benefits - easier, faster, consistent communication with my staff, and with the wider NHS.”

Professional contact details for all NHS employees, and information about their role and clinical interests, will be collected into the directory, which will be available online, making it easy to find the right person to contact even if he or she is located at the other end of the country. The information will be provided by each NHS organisation via a special ‘connector’ and daily updates will ensure the information stored is kept up to date and accurate. Currently the NHSmail Directory contains more than 700,000 entries and these will be added to and expanded over the next 12 months. By March 2004 the directory will contain a fully populated entry for every member of staff employed by the NHS.

Other key features of the new service include an electronic calendar to allow staff to record appointments, set reminders and plan meetings. Teams working on projects will be able share access to emails and diaries, streamlining communications and improving services delivered to the patient. EDS will provide round the clock telephone and online support.

The national roll-out of NHSmail follows a series of successful pilots at NHS sites throughout England. By reducing the need for individual organisations to run their own email systems, the new centrally managed service will bring cost and efficiency savings, particularly for smaller organisations that currently find the provision of such services onerous.

In announcing the service the NHS Information Authority glosses over the down side of e-mails. How do you stop the risk of receiving 1 million unwanted e-mails with riveting inanities, such as, kittens offered free to a good home? How do you pick out that person at the other end of the country from the 700,000 entries in the directory?

Will this be another of those innovations our Ministry of Health copies from the NHS? Perhaps someone will tell us at our August conference!

- **This system is available to all Trusts and Practices linked to NHS**
- **There will be an entry for every member of staff employed by the NHS**



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 nzihm@xtra.co.nz or  
(09) 577 5477 Phone/Fax



## Up coming Seminars

June 23<sup>rd</sup>

@ Gillies Hospital  
160 Gillies Ave, Epsom  
5.30m. for 6 p.m.

**Why nurses should be  
over-represented in the  
higher echelons of health  
care management in New  
Zealand, Australia and the  
United Kingdom"**

Rod Perkins: Senior Lecturer in  
Health Management, School of  
Medicine University of Auckland

**Non Members Welcome  
Cost**

Members \$20  
Non Members \$30

Light refreshments supplied

July 23<sup>rd</sup>

@ MinterEllisonRuddWatts

**Privacy and Confidentiality  
of Health Records**

## Profile

We have a new NZIHM Executive  
Officer. Linda McKay has taken over  
from Michelle Duane who has left to  
care for her busy young family. Linda  
combines her part time role with  
NZIHM with a similar position as  
administrator for HINZ (Health  
Informatics New Zealand).

Linda is a Professional Event  
Manager with over 16 years  
experience, both within New Zealand  
and overseas. She spent 7 years  
based in London working as a  
Conference Producer specialising in  
Computer, Export, Travel and Maritime  
Law events for IBC - an international  
conference company. While on route  
back home to NZ Linda helped set up  
and train new staff at the Sao Paulo,  
Brazilian Branch of IBC. Linda then  
spent 3 years with an Auckland based Professional Conference Organising  
Company.

With the birth of her first child in 2000 Linda moved to the "working from home"  
sector and set up her own Event Management company. Based in Devonport, she  
secured the role of administrator for HINZ at its formation in 2000 and was  
instrumental in the success of their first national conference and exhibition held  
last August. This year sees the second HINZ national conference. They are joining  
forces with NZIHM for a combined 2003 event, taking place 6-8 August at the  
Auckland Hyatt Regency Hotel. The appointment of Linda to the NZIHM position  
maximises the synergies between our two organisations.

Linda looks forward to her new role at NZIHM and to meeting many members over  
the next few months. Despite having had her second child just 12 weeks ago  
Linda is proving adept at balancing the demands of two children and two  
organisations.



## Health New Zealand



**Conference & Exhibition 2003  
Advancing Knowledge for Quality Healthcare  
6 - 8 August Hyatt Regency Auckland**

Enjoy the synergies and cross stream options of a combined conference for the New  
Zealand Institute of Health Management, Health Informatics New Zealand, NZ  
Health IT Cluster and NZ Health Level 7 User Group (NZHUG). Conference  
organizers are collaborating again with Australia's Health Informatics Conference  
2003 (HIC 2003) and Health Level 7 (HL7) Australia to deliver to you a number of  
high quality and exciting international speakers who are experts in health  
management, standards (HL7), clinical, consumer and nursing informatics domains.  
Submitted papers are currently being reviewed and the final programme will be out  
soon. Early-bird discount until 21 June.

On Line Registration and forms @ [www.hinz.org.nz](http://www.hinz.org.nz)

