20073-24-063

Parliament Buildings
WELLINGTON

14 July 1982

Dear Sir/Madam

This letter is to make direct contact with you, as the Labour Shadow Minister for Health.

I am finding, after a few short months, that the responsibilities of this new portfolio are challenging.

I look forward to receiving from organisations and individuals involved in the health care area, any comments on health policy, either specific or general.

I shall also, from time to time, send you material or press statements, to ensure that you are kept informed from "my end".

Please feel free to contact me direct on any matter you so wish.

Yours sincerely

Ann Hercus

Ann Hercus
MP for Lyttelton

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PRESS STATEMENT

13 July 1982

Ann Hercus
Shadow Minister of Health

Pamphlets on the counters of all paint shops, giving warnings of the dangers of lead poisoning from older housing being repainted and how to minimise risks is the practical suggestion of Ann Hercus, Labour's Shadow Minister of Health.

"Mrs Hercus has been researching data on lead poisoning of children in particular, following old houses being repainted - and particularly where sandblasting or other methods which remove surface wood are involved."

"Clearly we need action - and pamphlets in paintshops makes common sense. The Department of Health should urgently print and distribute a helpful pamphlet to all paint outlets. I am sure we could count on the community spirit and concern of such outlets to make sure these were well displayed, and in particular given to all customers who, by their inquiries, are clearly contemplating repainting older houses, as a customer service.

Particular danger appears to come when a family move into an older house, decide to remove old or flaking lead based paint, and use sandblasting or sanding methods which remove some of the surface wood; and create dust with high levels of lead.

Old flaking paint itself is another problem. Undue lead absorption in young children in these circumstances must be minimised.

.../2

A pamphlet which

- warns of possible risks especially when young children are involved
- sets out the safest methods of old lead paint removal, and precautions to be taken
- outlines remedial action and checks which can be made if old paint has been removed in the past

is the sort of practical and inexpensive step which the Department of Health should now take, immediately. Old houses have to be repainted. The paint is bought from paint shops. It seems logical to place such pamphlets in those outlets, as a community service - rather than (as the Department of Health has done in the past) to get occasional newspaper publicity, and then merely try and pick up the pieces of families who unwittingly did the wrong thing - but found out too late.

Just half a dozen children a year saved from a week's chelation therapy in hospital would more than pay for the cost of the pamphlets.

The Department has already produced some years ago, Guidance notes on Control of Lead at Work, the community at home now needs urgently the same attention."

Ann Hercus

Shadow Minister of Health

With the Compliments of

ANN HERCUS
M.P. FOR LYTTELTON

New Zealand Medical Association
Otago Division
Symposium
Dunedin

Thursday
24 June 1982
8 pm

First, may I thank you for your invitation to me to join this symposium on "Medical Education - Medical Needs".

Like the Minister of Health, I am relatively new to the Health portfolio. I am, however, a member of the Public Expenditure Committee, and have been since I was first elected to Parliament, and that is proving a useful background. I also have two degrees which at the very least, makes me a supporter, not a denigrator of academic skills and training.

The name Hercus is a familiar one, at least to the older members of your profession. Sir Charles was a relative - but by marriage of course - so I cannot claim for a moment that the skills and talents of that fine man flow, even thinly, in my blood! But we

If I have learned anything in my five months as Shadow Minister of Health, it is that the jurisdiction is extraordinarily complex, the problems numerous, the lobbying vigorous, the possible solutions diverse and usually conflicting, the literature fascinating, the availability of hard data rare, the nuances subtle, and the characters often a glorious combination of charm and bloodymindedness!

The politics of medicine and health are indeed challenging.

I also quite openly admit - as all politicians should on occasions - that I do not pretend to understand all the problems, let alone all the answers.

My contribution to this seminar is therefore, realistically limited.

The invitation I received suggested I might address myself to "current concerns about possible oversupply of medical manpower", "the alignment of medical education with the medical needs of the community", and "women in medicine".

I assume I was given "women in medicine" because of the shape of my skin; and I hope someone is going to deal appropriately with the men.

May I first turn to the issue of "possible oversupply of doctors in New Zealand". I am delighted to note the cautious use of the

word "possible" - an improvement on the current rhetoric I read about the "coming crisis in medical manpower" etc etc., which proves that it is not only politicians who indulge in lovely extravagances at times!

My research into this vexed issue of supply of doctors leaves me with the overriding impression that, first, successive reports and official committees keep coming up with quite different conclusions, and on this topic, secondly, when predictive conclusions of "under" or "over" supply are judged by actual outcomes, they have by and large been considerably astray.

I am sure, therefore, with that sort of record, you would understand why I might be hesitant to accept (unthinkingly), claims that New Zealand faces a huge "surplus" of doctors in the late 80s.

I might add that I do understand how and why large margins of error can creep into this area of prediction - either on the demand or supply side.

Clearly it is complex. The potential fluctuations of the input variables can clearly be considerable.

I was interested in reading a recent article on this topic in the New Zealand Medical Journal of March 10, 1982. It suggested (quite convincingly, I thought) that adjustments in the medical school intake have a relatively small and short-term effect in affecting active doctor numbers, compared with the effects of adjustments in several of the other supply variables, particularly immigration.

That article, and others, suggests to me that, assuming someone somewhere on high thinks there is a projected surplus of doctors and wants this reduced, the solution of a concentration on reduction of medical school numbers is likely to be a blunt, risky, disruptive and relatively unsuccessful instrument of surgery. Any doctor or politician who thinks that slashing the student intake "solves" the problem of "oversupply" is likely, it seems, to be sadly disappointed - at least on the basis of the evidence I have seen. The level of immigration may well have far more effective impact.

I must also say that it is my general impression in moving up and down New Zealand, and talking to health professionals, that there are shortages, not oversupply, in some specialties - for example GPs in some urban & rural areas, of geriatric physicians, of academic appointments

of psychiatrists and pathologists.

That general and subjective impression suggested to me the possibility of medical manpower mal-distribution is the major problem here and now in New Zealand to be considered in this complex question of supply.

I then discovered my personal impressions were at least in part confirmed by several reputable sources.

For example, the 1981 Report on General Practice Manpower in New Zealand stated in Chapter 3 "the data in this chapter shows how little we know about the pattern of GP provision in different parts of New Zealand. What is clear is the tremendous variatic

which exists between and within health districts".

Professor Beaven from the Christchurch Clinical School of Medicine calculates the need for a national crash programme for physicians within internal medicine.

I can however, find as yet, very little information on appropriate ways to evaluate patterns of location - or, for that matter, clear and explicit policy objectives or planning criteria on that topic. However, I will keep searching.

I also tried to discover how an "over" or "under" supply might be calculated or predicted - in other words, the criteria which such a conclusion might have been reached, and on which policy decisions are based.

I remain in confusion, I confess.

What Professor Cooper calls "ratio mesmerism" seems to play a large part. (I am used to that phenomena - it crops up in many areas other than health.) Concern with public expenditure (if you are in Parliament) or concern with protection of incomes (if you are a doctor) are both understandable, and explain perhaps some of the emphasis, but in the absence of clear health manpower objectives, I suggest I may well be doomed to remain confused!

I note however, that some health professionals and academics believe that more doctors have not yet resulted in improved health,

better distribution (both geographically and between specialties), a falling unit price for medical services, or a redistribution of what economists call the "factors of production".

On the other hand, I also note that the proportion of elderly people in our population is growing rapidly (a fact that both the Minister and I have both commented on in speeches made earlier this year) and in such circumstances I suggest past crude doctor/population ratios are not adequate supply determinants in those special circumstances.

I am also as aware as anyone in this room of the need to restrain Government expenditure - though certainly not (I add) in the manner of the current administration.

All that, I suggest, adds up to the need to be wary of the hazards of narrow and perhaps simplistic solutions to ill-defined and complex problems, within the blurry framework of vague health objectives.

I am rather attracted to the comment made in the New Zealand Medical Journal I referred to earlier, that we might use the current bulge in the system to improve the system, rather than devote large amounts of time and resources to the removal of the bulge. That would pose a real challenge - to formulate clearer health objectives and to specify the doctors' role in their attainment.

That brings me to the second topic - and I really only want to comment on two particular points on Medical Education.

Although I am aware that Behavioural Sciences are a component of medical education, I would suggest that largish groups and passive experience is an inferior way to teach the crucial communication skills which every doctor needs. The teaching of anatomy is clearly important. So too, is the anatomy of the community - the ways to best communicate with patients and their families - the ways to best listen and to give information - the ways to best communicate with patients from backgrounds which may be very different for that of most medical graduates. Communication is not only words - it's attitudes, expressions, gestures. Communication is feedback.

My family GP and I have much in common. We both know and can usually detect when a client comes to us waving the equivalent of a wart, but in reality seeking desperately to unload much deeper problems. My GP thinks that many of his colleagues are relatively untrained in this area - and so do many other health professionals I have talked to. I would be interested in your comments.

Continuing education is part of my life, partly because my husband is Director of the Christchurch Polytechnic. Continuing education is important for many reasons and for many groups - and few more so than your profession, which lives right on the cutting edge of rapid change.

I am aware of some of the post graduate programmes which operate. I want to

ask you a question.

Do you think it is time to contemplate some form of professional "carrot and stick" which makes attendance over a period of years at some minimum number of continuing education programmes compulsory I tried that one with an accountants seminar of 300, and they told me that they thought if their profession didn't initiate something along those lines, (and they thought they should) someone else would!

Lastly, can I turn to women in medicine. As with women in politics, demographic characteristics are changing rapidly - and in the same progressive direction! Overall, one doctor in six is now female, with one in five under the age of 30. I am informed the historical female doctor work profile is now not very different from the male.

I would regard it as an unacceptable act of discrimination if any manpower planning decisions inhibited the entry of women into medicine, or their career structure. As with women politicians, you usually get value for money!

Thank you once again for your invitation to join you here.

At birth, I entered the world with the assistance of the medical profession. I assume that I will die with medical assistance.

I hope, having participated in this seminar, I may depart tonight, with the same assistance - but not prematurely, I hope!