Pandemic

The Journal

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Contents

History of Pandemics

Covid-19 is certainly the first pandemic in decades that has hit New Zealand hard, yes SARS and Swine Flu were bad, but we were not locked down nor suffered as many deaths in New Zealand as we have with this Covid-19 pandemic. Yes, it's scary - but looking back it's important to remember that this is not the first pandemic we have faced and survived.

Infectious diseases follow people, and as humans have spread across the world, so have pandemics. Even with the technology, scientific knowledge and medical treatment the 21st century possesses, we are not immune from disease, and outbreaks are constant.

Since the inception of mankind, disease and infection have been an issue, however it was not until agrarian communities were formed and civilisation grew that the magnitude of diseases increased and formed what we now know as epidemics and pandemics. As populations increases and formed communities with trade routes between cities with different ecologies and cultures, so too did the rate of disease.

Some of the major pandemics that have occurred over time include:

Name	Date	Type of Disease	Death toll
Antonine Plague	165-180	Smallpox or Measles	5M
Justinian Plague	541-542	Yersina pestis bacteria from rats and fleas	1M
Black Death	1347-1351	Yersina pestis bacteria from rats and fleas	200M
New World Smallpox outbreak	1520-onwars	Variola major virus	56M
Spanish Flu	1918-1919	H1N1 Virus/Pigs	40-50M
HIV/AIDS	1981-Present	Virus/Chimpanzees	25-35M
COVID-19	2019-Present	Coronavirus - Bats	125,000 +

Whilst the actual number of pandemics to occur over history is unknown, what is clear is the knowledge humankind has gained from every occurrence:

- we know all pandemics have a gradual decline in the number of deaths over time.
- we know that disease is transported by animals and people
- we know to quarantine infected people.
- we know how to track the infectiousness of the disease and;
- we know that pandemics are not caused by the wrath of God

Punishment by God?

It's a tale as old as time - where there is widespread disease, there are sinners who are incurring the divine judgement of God. Many ancient societies plagued by illness rather unscientifically believed this perception, and it often led to disastrous outcomes and cost millions of lives. In the case of Justinian's Plague, the Byzantium scholar Procopius of Caesarea traced the origins of the bubonic plague to land and sea trade routes from India and China.

Despite this clear correlation of disease to travel, Procopius declared the cause of the disease to be the wrath of god on the Emperor Justinian for his evil doings.

Luckily humanity seems to have move on from such nonsense and now collates a response to pandemics as they arise, a lesson learnt at the cost of millions of lives.

Reducing the spread.

History shows that recent pandemics have focused on reducing the spread of disease, with its greatest tactic being the practice of quarantine. Quarantining infectious people or travellers before entering a city was first developed in the 14th century to protect Italian coastal cities from the “Black Death” that was spreading across Europe. Sailors traveling from infected cities were required to stay at anchor for 40 days before they were allowed to enter the city, as we all know this tactic is still used today and proves extremely successful, but only when quarantine laws are followed.

In this day and age, we now focus on reducing the spread of the disease and developing a cure. However as global populations rise, and our societies become more multi-cultural we are faced with new viruses that are spread at an unprecedented rate.

This is not our first pandemic and it will not be our last. However as social distancing continues, we can take solace in our other 21st century inventions such as the internet to stay socially connected, Netflix and delivered to your door wine.

You Want me to do What...?!!

Actual pandemic treatments through history.

TB hospitals

During the late 19th century, tuberculosis was the cause of 10% of all deaths in New Zealand. The Maori population was more vulnerable as it affected them 10 times more than non-Maori. The best treatment for tuberculosis and other lung diseases was then thought to be cold, clean mountain air, sunlight, exercise and good nutrition which then caused many sanatoriums to be built on higher grounds. Sanitoriums were also effective by keeping patients in isolation away from communities and provided progressive public heath workers a controlled medical environment where experimental cures could be administered, and patient recovery monitored.

A brochure on Central Otago sanatorium said: “The high percentage of sunshine and the cheerful surroundings appear to work wonders with the patients, and it is not easy to realise that they are [there] to have their health restored. With their sunburnt faces and well - nourished bodies, they look to be in perfect physical condition.

> **“One of the main lessons we learnt from the Spanish Flu was the importance of having an early and longer isolation period. When the flu cases began to decline, many went back to work and public gatherings resumed which then contributed to the second wave..”**

By the 1930s, interest and enthusiasm in this form of treatment diminished and was replaced by surgery and then by effective anti-tuberculosis drugs.

A U.S engineer, Flavius Earl Loudy, proposed a more creative solution which was to quarantine the sick in floating hospitals called “Aerial Sanatoria”. This solution, although far-fetched, would have provided the high-altitude air and plenty of sunshine needed for treatment. In Loudy’s piece titled An Aerial Sanitorium, he voiced his vision as: “Food supplies, as well as people, are conveyed to and from the airship by means of an electric hoist in the forward car or cabin. Patients who cannot stand the trip up to the airship can be carried up by an airplane ambulance… the airplane landing on or hopping off from the giant upper deck easily.”

Black death

There were many strange theories as to what caused the plague before the Yersinia pestis virus was discovered. Many believed that the Black Death was the result of pockets of “bad air” or miasma, which was released from earthquakes; while others believed that the alignment of Saturn, Mars and Jupiter were unfavourable which caused the bad air. Those who contracted the plague were discouraged from bathing as it was thought that bathing opened up pores and let more bad air in, making the disease worse.

This made perfumes and aromatherapy popular as people were told to carry fragrant flowers and herbs with them to prevent the disease. Plague doctors wore a beak-like mask filled with aromatics to protect them from the pungent air which became an iconic symbol of the Black Death.

With the many strange theories of the cause of disease came strange remedies and cures. To drive out the bad smells, some treatments involved using dung and urine which would have helped spread the disease rather than help patients recover.

Spanish Flu

Despite the name, the Spanish Flu didn't originate from Spain; however, it was the country that first reported the outbreak during World War I as it was one of the few countries that remained neutral. Other allied countries had censors to cover up news of the flu to keep morale high.

Infected soldiers may have contributed to the spread of the disease to other crowded camps across the country and overseas. When the pandemic peaked, New Zealand responded by practicing social distancing and cancelling public events. One of the main lessons we learnt from the Spanish Flu was the importance of having an early and longer isolation period. When the flu cases began to decline, many went back to work and public gatherings resumed which then contributed in the second wave. An American study found that the most successful approaches to containing the influenza included early and sustained implementation of social distancing. The flu also caused New Zealand to build a public health system for pandemics under the Health Act 1920.

Due to the war, there was a shortage of healthcare workers and relief efforts were mainly reliant on volunteers. This highlighted the need to flatten the curve for medical professionals to be able to cope with the influx. The scale of the pandemic overwhelmed hospitals, medical supplies ran low, hospitals became full and temporary wards were set up in church halls, schools, hotels and even under racecourse grandstands.

A treatment for the flu was the inhalation of zinc sulphate mist. Inhalers were mass produced by the Railways Department and many inhalation centres were installed in public buildings all around the country. We now know that the treatment was ineffective and may have heightened the risk of contagion by bringing people together. The strong mixture also inflamed the nasal tissue, making the person more susceptible to the flu.

Patients Before Profits

Unions respond

to Covid 19

What lies beneath the "we are all in this together" slogans?

What is unsaid when we ask people to "Unite against Covid19"?

Who profits and who is poisoned during a pandemic?

As the superrich fly on private jets into Queenstown airport before being chauffeured to subterranean bunkers to ensconce themselves in their doomsday shelters, the lengthening queues outside supermarkets sweltering in the sun, or at work, in understaffed wards, without the proper protective equipment. Meanwhile the Minister of Health goes for a long, long walk on a deserted beach.

A crisis throws everything into stark relief, as decades of history happen in the space of weeks. As the top European scientist noted in his resignation letter to the European Commission, "In time of emergencies people, and institutions, revert to their deepest nature and reveal their true character."

In France, underpaid hospital workers on strike at 203 emergency departments across the country in 2019 had protested on the streets in December under a banner that read, "The state will count its cash; we'll count the dead." No one then knew how quickly that would become true. Throughout the response, both nationally and internationally we have seen trade unions respond in the best interests of their members safety and the public health. Pushing to ensure non-essential businesses close and adequate personal protective equipment (PPE) be provided to essential workers.

A strike for everyone

One of the first ways unions have responded to Covid-19 is by implementing the necessary closures of non-essential business when governments or corporations have dragged their heels. In the hard hit Italian region of Lombardy, three steel and chemical workers' union took strike action on March 25 to close non-essential factories. Other Italian unions broadened strike action across the country, and raised the question over whether a needless death at work caused by Covid-19 should be regarded as a homicide.

Italy also was also the first place we saw Amazon workers take concerted action over their employer's failure to provide PPE, even after workers were testing positive to Covid-19.

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So quick was the response of Italian unions and the spread of wildcat strikes, it forced the Italian government to implement the lockdowns that are necessary to stop the spread of the virus. Prior to the strikes the Government had deemed nearly 60% of the country's workforce 'essential'.

As Covid spread across the world so too did the union response, with workers in Spain taking strike action to close non-essential business. In the United States grocery delivery workers for Amazon and Instacart have also taken strike action to demand better safety measures, improvements in working conditions and higher pay. And in Auckland, workers at plastics factory Sistema were originally told they were classed as 'essential' by the employer, but workers went out on strike and eventually Worksafe closed the factory.

Taking action on PPE

By far the most prominent role unions have played in the response, is by demanding, personal protective equipment be provided to essential workers, and by highlighting the disconnect between those co-ordinating the response of health services and those actually delivering it. As political editor for the New Zealand Herald Audrey Young wrote,

"The most important system from here on is the one that quickly conveys practical problems on the ground to the people with power to fix it.

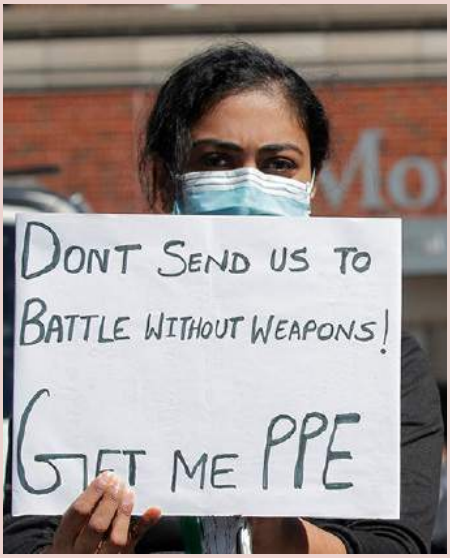
To that end, unions have been brilliant. Unions should be deemed to be an essential service in times like this.

Most union officials are working from home but they have direct connections to the front line workers such as nurses, hospital cleaners, aged care workers, and home support services.

In recent days they have done a service not just to their members but to the public in exposing supply problems especially of personal protective equipment (PPE)."

It's obviously not just New Zealand where unions have been raising concerns over PPE. At the end of March, 4000 nurses in Papua New Guinea went on strike for a day to raise their concerns about the lack of PPE and medical supplies and in India, workers at one hospital protested the fact that they had no PPE in their emergency departments.

In the United States nurses in New York have taken action to demand more PPE and prison officers are preparing a class action against the Federal Government for hazard pay after some of them contracted Covid-19 when transferring patients without being provided PPE.



A healthcare worker at the Montefiore Medical Center Moses Campus in New York City holds a sign during a protest demanding N95 masks and other critical PPE to handle patients during the outbreak of coronavirus disease [Brendan Mcdermid/Reuters], April 2020.

One New York emergency department nurse involved in the protests has observed of the disconnect between health authorities and those actually delivering the care, "The big struggle right now is about N95 masks, and how our country just can't supply this crucial item. [The CDC] used to say COVID-19 was an airborne disease that necessitated use of N95 masks. That was a science-based assessment. Then they lowered it because of the shortage, to let hospitals and local governments off the hook."

"Essentiality" and "Priority"

If, as many predict, New Zealanders escape the health effects of the pandemic relatively untouched, the economy is likely to be almost completely reshaped as international tourism recedes until a vaccine arrives in 12-18 months. The consequent rises in unemployment and pressure on government budgets is going to have a handbrake effect on wage growth.

The contradiction is that for health workers - never was so much owed by so many to so few. And although the recent settlement of ASMS for a one year agreement and 1.9% wage increase suggests the new normal may be constrained wage growth, whether or not nurses accept this if offered similar

French hospital workers on strike: ***"Exhausted carers equals patients in danger"***

when their bargaining comes up again in a couple of months' time will be interesting to see. Funnily enough no one yet seems to be suggesting the large supermarkets return their excess profits to the government to help pay for the urgent investment needed in health, to allow operational readiness to respond beyond the lockdown.

Eventually the contradiction between healthcare being "essential" but investment in our workforce development not being a "priority" will need to be resolved. The need for us to retain and recruit enough locally trained professionals into our medical laboratory, pharmacy, anaesthetic workforces will have to be dealt with, so too the lack of clinical leadership in our over-managed but under-led hospitals.

Indeed, the need has never been greater, not least because it is only a matter of time before the next health emergency is upon us. In weeks and months to come uniting against Covid19 requires more than just washing hands and walking alone, it will require uniting for and demanding workforce development.

Hazard Pay

Hazard pay is what it sounds like. Employers pay workers more on the expectation that the worker will then complete work that endangers their health and safety. The rationale behind it is to get people into undesirable and dangerous jobs that most people will avoid to protect themselves.

As the number of Covid-19 deaths in the United States rises and the low wages of frontline workers are put in the spotlight, there have been increasing calls for hazard pay for this group.

These calls have crossed the Atlantic and now a number of petitions are circulating in New Zealand demanding hazard pay for frontline healthcare workers. Like many US imports, hazard pay would be detrimental to New Zealand. That is not to say healthcare workers should not get paid more that they currently do. The Covid-19 crisis has highlighted how integral you are to the safety of the general population, but a pay increase on salary is entirely different to hazard pay.

Employers do not offer hazard pay as a thank you to workers putting themselves in dangerous positions. While this lack of selfless generosity on the part of employers will come as a shock

to many, what hazard pay actually does is act as a way for employers to buy their way out of health and safety obligations and put workers in increasingly dangerous positions while doing nothing to make conditions safer. There is the expectation that if a worker is being paid more, they are accepting the risks associated with the work and nothing needs to be done to mitigate these risks.

> **“Hazard pay undermines the conditions workers have struggled for and nothing should allow employers to buy their way out of these protections.”**

You need to have the right to say no to doing work that you believe is dangerous. While taking hazard pay doesn’t deprive you of this outright, it makes it much harder to take a principled stance on the issue. Whether consciously or not, employers will be less amenable to health and safety complaints if they believe they are paying you to accept these conditions. Any money that would potentially be used for hazard pay would be better spent increasing the safety of workers in the health sector. Hazard pay undermines the conditions workers have struggled for and nothing should allow employers to buy their way out of these protections.

The Health and Safety at Work Act stipulates employers are responsible for maintaining the health and safety of employees in the workplace. To allow them to pay more to put you at ever - increasing risk enables them to ignore this responsibility.

Unions have been advocating for PPE, safer rosters, and better conditions for workers facing the brunt of the Covid threat. The focus needs to be on solidifying these protections and pushing for stronger health and safety provisions for those most at risk.

Workers in hazardous conditions should be paid more as those at the forefront of the pandemic are underappreciated and underpaid. This should be part of a wider conversation about increased wages. It shouldn’t be left to a temporary top up payment. While more money in your pocket for a few weeks might be nice, it is no substitute for adequate PPE and health and safety protections in the workplace.

Reaping the Whirlwind

understaffed rosters come home to roost

As the likes of Air New Zealand and Sky City announce inexplicable amounts of lay-offs due to insufficient workloads, the Health Sector puts out a call to arms for the retired or retrained workforce to fill the many, MANY vacancies.

"Thanks for volunteering to do the weekend shift Jane", "thanks for working late last night John".

These are just some of the phrases becoming all too familiar in the health sector as our health providers are praised for "stepping up" and "going that extra mile" in this Covid-19 world.

Yes, our health practitioners are the heroes of this pandemic, putting their health and the health of their "bubble" at risk to care for New Zealand's most vulnerable, but what really lies at the root of this praise? Why are our health providers being posed with 12 hour shifts and 50 hour working weeks when all rostering and fatigue experts say otherwise?

The answer is quite simple, years and years of understaffed rosters are finally coming home to roost.

What's that old saying? If you put a frog in gradually heated water, it won't realise its being boiled to death? From SMOs to Orderlies, years of poor working facilities, poor wages and an underappreciation of the workforces has led to distinct and historical shortages that has gradually become the norm. Well Covid-19 has turned up the heat and the health sector is only now realising its boiling.

Whilst public health services may be the best example of chronic under investment being demonstrated by the current crisis, laboratory workers are no less an easy example of systematic underfunding and understaffing in the health sector. During this pandemic, the New Zealand Laboratory workforce has processed an unprecedented 2000+ samples a day across 8 laboratories and has been praised by the Prime Minister for "working 24/7 tirelessly to ensure we know the true scale of the outbreak, and to ensure those with Covid-19 know, and get the appropriate care".

This workforce is also plagued with enormous vacancies stemming, insufficient laboratory equipment and a historical undervaluation by the public sector. Laboratory workers in the public sector will see over 32% of its workforce reach retirement age within the next 10 years of which new graduates will only replace 10%. It's easy to see why...

What would a new graduate do when faced with the choice of the understaffed public sector or the mildly better private labs? Most choose private, but even more choose to not become a medical laboratory worker altogether. This is not just a problem in the laboratory workforce, this stems to all health workforces and speaks to our governments reliance on overseas workers to fill our vacancies rather than investing in a sufficient homegrown workforce.

Well now the boarders are closed and our tap into the international workforce will run dry for 12-18 months, whilst so many of our current international workers understandably seek to return home. As hospitals are at essential services only and the Covid-19 curve is flattening, we are not in a staffing crisis..... yet, however it has all the ingredients if the situation escalates.

However, any kind of crisis can be good - it wakes us up to our problems. The question is whether the government will arise from its sleepy slumber and realise what our health providers are worth and make the retaining and recruitment of locally trained professionals a priority when we move to normalcy and a post-covid world.

Mitigation and Covid –19

COVID-19 has well and truly taken over the globe. With the rapid transmission and infection rates, the Coronavirus has the potential to infect an estimated 60% of the world's population within the next 2 years. The world has asked collectively how can we mitigate transmission?

Initially New Zealanders moved to flatten the curve through restricting social interaction and instigating better hygiene policies. However, with the rapidly changing global situation, New Zealand went further than mitigation and moved towards elimination. This has created drastic changes to all New Zealanders day to day lives and the way the healthcare system functions. With all these changes driven by mitigation, it has revealed important platforms for discussions about employment relations in the health sector.

Flattening the curve

New Zealand initially based its pandemic planning on the mitigation model which focuses on implementing measures to flatten the curve. These strategies aim to control a pandemic by creating herd immunity so that health care systems are not overwhelmed. However, these strategies culminate a high-risk factor as they are uncertain to adequately control transmission, and potentially take years to work. We saw these measures with the likes of social distancing and more stringent hygiene practices being enforced. This was also seen in the health care sector with increased use of PPE and restructuring of the way service was carried out. However, countries have continued to take inconsistent approaches to mitigate Covid-19.

The world at a glance

China was the first to roll out stringent mitigation measures by reducing travel, limiting social

interaction and eventually moving into quarantine to stamp out the virus. However, other countries such as the United States have taken a less stringent approach and are suffering the consequences.Currently the US is the undisputed epicentre of the coronavirus pandemic with 336,830 confirmed cases which is more than Spain, Italy and the United Kingdom combined. Their limited response is partially to blame, with no official lockdown and no added provision of supplies to slow the spread, they are heading for a tipping point that will result in immense loss of life, damage to the health sector, and damage to its workers. New Zealand observed the spread running rampant globally and enlisted the mitigation policies alike China by turning to an elimination policy.

Stamping it out

The Elimination policy saw NZ move into a lockdown, what this meant in the health sector was that all non-essential work stopped, work was reorganised, new rosters were devised, and tighter personal protective equipment policies were rolled out. Mitigation policies such as social distancing and increased hygiene methods were failing to properly deal with the virus and its transmission. Workers from the Health sector were reporting business as usual and feeling unsafe in their work environment. On top of this, essential workers had to fit into the new regulations while facing added stress at work. During the 2014–2016 Ebola virus outbreak in West Africa, a saturated health-care system led to increased rates of infection of other diseases and deaths of health-care workers. Events like these highlight the importance of enhanced support and mitigation policies to support the health sector in crisis, and protect staff from infection.

Examples of what needs to happen in the New Zealand include:

- **Moving to shift rosters and working in pods, to reduce transmission and fatigue.**
- **Only doing essential work, and working from home where possible.**
- **Being provided with adequate PPE.**

However, with the introduction of the elimination policy a light was shone on what needs to happen in the New Zealand health sector to control the spread of Covid-19.

All of these were forms of mitigation and also ensured that workers were not fatigued or becoming sick.

> **“The mitigation and elimination methods being used to stop the spread of the virus, have highlighted important issues in relationships between employees and employers in the health sector.”**

This situation also highlighted some concerns within employment relations and how employers respond to pandemics. Personal protective equipment was identified by employees as inadequate, many were receiving insufficient training for the use of PPE, and in some instances workers felt vulnerable and that normal precautionary measures were not in fact mitigating the spread of the virus.

Further, the move to shift rosters, and working in pods as a form of mitigation helps to control spread of the virus and ensure that the health system is not overloaded. This highlighted a need for safe and effective rostering and has made employers work together with employees to write rosters collectively, to minimise the risk of fatigue. Additionally, by moving to have some employees working from home, there has been reduced interaction and possibility for transmission. On top of this, employees have also been able to consider how their work and personal life interact, in the issue of childcare and other vulnerable people in their lives. With these issues being recognised, employees have been able to voice their concerns and make employers stop and think about how they are maintaining a safe environment for their employees.

Therefore, the mitigation and elimination methods being used to stop the spread of the virus, have highlighted important issues in relationships between employees and employers in the health sector. With this added focus on preventing spread, more information has surfaced about what employers should be doing to protect their employees and has provided a platform for this to be considered. Furthermore, the policies that have been enlisted have helped mitigate and eliminate this threat efficiently. With these mitigation policies continuing to be used we can only hope we flatten the curve and improve conditions for workers moving forward.

Rising Unemployment

All economists are agreed that the Covid-19 crisis will see unemployment rise. There is considerable debate about how much it will rise, but there is general agreement that the years of very low unemployment will be over for some time to come. The gloomiest predictions suggest that unemployment could rise as high 28%. Such a dramatic change in arguably the most important of the common economic metrics will inevitably impact collective bargaining.

Already, quite aside from collective bargaining, we are hearing employers respond to reasonable discussion about changing rosters by throwing out the comment that 'You're lucky to have a job, just do it!'

We can expect more of that as this crisis continues. Of course, you are not 'lucky' to have a job, you have a 'right' to have a job, and then to be remunerated fairly and treated safely and well whilst at work.

In the 1980's speaking in Auckland visiting British Trade Unionist Ken Capstick remarked that 'Unemployment is not a scourge that blows in and out randomly on the wind, it is a tool of the employers to discipline workers and supress wages.'

That was during days of high unemployment and he was right of course. The Damocles sword of unemployment hung over most bargaining tables in those days, and to great effect. In manufacturing workers cowered at the prospect of their employer moving offshore. Scared by the prospect of joining the ranks of the unemployed, 'soft' wage settlements abounded. And to no avail, many of those employers moved offshore anyway with scant regard for the jobs they were destroying. Not one single job was saved by accepting soft pay settlements.

Of course, you are not ‘lucky’ to have a job, you have a ‘right’ to have a job, and then to be remunerated fairly and treated safely and well whilst at work…

There is no evidence that wage increases cause or exacerbate unemployment, and in fact the opposite is the case. As early as the beginning of the automobile age Henry Ford already knew this. He was famous for understanding that unless he paid his workers well, they would not have the money in their pockets to buy his product. It is also the case that having higher average wages ensures a higher tax take and more money circulating in the economy.

So, as we prepare to face any assertions at the bargaining table that we should be 'grateful to have jobs' and therefore accept low, or even zero, pay increases, lets stock up on the refutations:

- The right to a job is fundamental in our society. Jobs are not reserved for the lucky.
- Jobs have worth irrespective of the wider economic conditions. The skills, effort, knowledge, responsibilities and qualifications that make up jobs remain the key ingredients that must be rewarded.
- If wages fall behind the escalating costs and pressures on workers, it can lead to a spiral of reduced economic activity, lower spending, and smaller tax take.
- Failure to award fair pay increases leads to a lower standard of living for affected workers.
- The Health Sector needs to remain attractive and competitive as an employer during the current public health crisis, and in general for its contribution to society.
- It does not help the unemployed to downgrade the value of jobs, and in fact diminishes the incentive for the unemployed to enter the paid workforce.

We will be in turbulent times for some time to come and at this stage it is anyone's guess how future bargaining will pan out. But we must resist being made to feel as though we should simper with gratitude to the generosity of our employers for maintaining our jobs and resist their attempts to scare us with the prospect of unemployment.

APEX Operations Under Lockdown

During the lockdown, Unions are considered to perform essential work, as long as non-essential activity is conducted from home or remotely. In health, our role in supporting health workers has indeed demanded considerable work especially around health and safety but also changing rosters and ensuring terms and conditions of employment were not undermined as a result of the covid response.

So what does our virtual office look like? On the eve of the lockdown, we all picked up our laptops and headed home. We did arrange for one person to maintain a presence in the office to answer phones and email out to colleagues any resources they might need. Our IT security is reasonably "tight" as you can probably imagine given the significant amount of personal information we hold. Remote access to our system is therefore restricted so ongoing access to resources and membership processing took a bit of ingenuity: but we got there.

Our Daily Timetable

It seems like our virtual office the new norm, but it did take a few days to get into the swing of things. We meet by zoom every morning at 0900, catchup on yesterday's

events, talk through national and local information and developments, and review the day ahead. We might zoom again at 2.00pm if the issues arising demand it.

There is a national Unions' and DHBs meeting at 1100 which Deborah attends. This "group" has been responsible for inputting into such resources as the vulnerable workers and 70+ occupational health assessment, childcare arrangements, accommodation options, leave provisions and more recently attempted at the employers request to land a workforce flexibility document providing guidance on how the workforce might be more rapidly and flexibly deployed. This document hit a snag as the DHBs "overlooked" the fact that unions cannot diminish their member's terms and conditions of employment under our respective collective agreements. That is not to say the employers can't do more than the CAs, they are after all minimum rate documents, but we can't reduce your entitlements!

And at 3.00pm Deborah also attends a Ministry of Health subgroup on behalf of all unions (alongside an NZNO and MERAS advocate) to discuss PPE. The Ministry of Health was responsible for masks; the DHBs for scrubs (not that they are PPE), gowns, goggles and visors. Dealing with the anxiety many healthcare workers felt, and often patients as well, not just in hospitals but importantly the community, aged care and disability sectors was a key part of this work. And not just who should wear what but access and supply became issues as maldistribution problems were identified pretty early on and (in Deborah's view) took far to long to get resolved.

The Ministry process is not a quick one with multiple layers of signoff required after each change to any document, so things tend to go round and round a bit, but overall we are getting there albeit the lag time is somewhat frustrating. This subgroup is also assisting the Ministry's media strategy around promoting health workers at this time.

And at a local level, each DHB established a local engagement group who had an APEX advocate assigned to it to ensure communication with members in each DHB flowed, that national advice is being followed and implemented and of course trouble shoot problems for members. These meetings occur 1-2 times a week depending on the DHB.

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>
> **Too many employees in too many workplaces enjoy a level of complacency about the security of an individual employment agreement as opposed to a collective….”**

In the private sector, keeping in contact with members through delegates and employers alike where issues arise, remains the responsibility of the relevant advocate. Luke specifically took on the wage subsidy portfolio for our members affected by this. Luke is also our representative on the Holidays Act work, which is continuing through this time.

And the advocates have been kept busy with rosters changing in the response to COVID with some managers thinking that also means “no MECA”…. Only to have to be reacquainted given, as we seem to have to keep saying, collective agreements continue to apply.

Spare a thought if you will however for those without a collective agreement. Too many employees in too many workplaces enjoy a level of complacency about the security of an individual employment agreement as opposed to a collective. A collective must of course be negotiated by a Union, and in doing so will have the benefit of professional advice as well as the industrial strength to ensure such provisions as redundancy, change management and change to roster provisions, penal rates and hours of work. At times like this, especially when threatened with redundancy, the value of a collective agreement is obvious, albeit harder to secure.

What else have we been up to?

For starters bargaining has continued albeit with HR staff attempting to defer wherever possible. The DHB Laboratory and NZBS MECA was settled through facilitation which occurred by zoom, ending any protestations from DHB employers that bargaining couldn’t occur unless face to face!

Preparation for legal cases also continues as well as representation of individual members. Again zoom has come to be an essential tool in performance and grievance meetings.

We have also continued to work on resources for you, this journal being just one example. Preparation for bargaining coming up in the latter part of the year including the creation of MECAs for our Anaesthetic Technician members (amongst others) is also progressing, although with the economic impact of COVID who knows what we might face in the coming months in the bargaining environment.

And our membership team continues to keep up to date with members joining, going on parental leave, retiring and the like.

What we can't do, and probably won't be able to do for some time, is get out into your workplace to meet with you. The inaugural APEX MCDHB collaberation meeting set to discuss fatigue and the MCDHB building project has been postponed as just one example of the "freeze" on face to face encounters. And our September delegates meeting may also be unable to proceed; so whilst on line and other support mechanisms for delegates are being developed, the crucial engagement only made possible by meeting together will have to wait.

What's next?

We have also prepared for what's next: level 3 will allow more of us into the office but still not a full team if we are to maintain social distancing and other anti COVID measures. So our virtual office in one form or another is likely to remain with us for some time.

Thanks to everyone who has emailed rather than phoning in. Despite email traffic increasing by 30% over the last 4 weeks, given our isolated locations it has helped us to ensure we continue to respond to you in a timely fashion. Just one quick tip:if you email ask@apex.org.nz it will be referred onto the appropriate advocate to respond to. If you want to avoid that intermediary step, email your divisional email directly e.g. lab@apex.org.nz or mit@apex.org.nz (all divisional emails are printed on the back page of this journal).

Social Scientists

Scramble to

Study Pandemic, in Real Time…

Author Warren Cornwall explains how social scientists are examining the ways in which the coronavirus pandemic is affecting everything from people's behavior to the economy. ***The following article was originally published in the journal Science on 8 April 2020.***

If pandemic lockdowns have people feeling a bit like lab rats stuck in cages, in some ways that's exactly what they are. As the coronavirus touches on virtually every part of life around the globe, social scientists are rushing to suck up real-time data on how people are responding to the unfolding pandemic.

"Unlike physicists or biologists, social scientists are frequently constrained from using controlled experiments to test hypotheses. But interventions such as natural disasters—or a pandemic—can help create such experiments, if a researcher is ready to take advantage."

Economists are gathering data about supply chains. Political scientists are scrutinizing how government responses track with ideology. Psychologists are monitoring children in after school programs. Behavioral scientists are surveying thousands of people to see how they respond to information in a crisis.

James Heckman, a Nobel Prize–winning economist at the University of Chicago, suggests researchers need to take to heart former Chicago Mayor Rahm Emanuel's adage: Never let a crisis go to waste. "Here, scientifically, I think we need to operate on that credo," Heckman says. "We're getting new information. It's very valuable information."

For some researchers, the pandemic has created an unexpected opportunity to run "natural experiments." Unlike physicists or biologists, social scientists are frequently constrained from using controlled experiments to test hypotheses. No university, for instance, would approve an experiment that involved firing one group of workers and seeinghow they fare compared with their still employed colleagues. But interventions such as natural disasters—or a pandemic—can help create such experiments, if a researcher is

ready to take advantage.

For example, some social scientists are retooling existing studies, hoping to capitalize on the data they already collected to see how the virus is changing things. Dillon Browne, a child psychologist at the University of Waterloo, was studying the emotional well-being of kids in after-school programs in Toronto. Then, disaster struck. Twice. First, teachers started to go on strike, periodically shuttering the programs. Then, the pandemic closed them for good. The upheaval seemed like a disaster for the research, Browne says. But now his team has turned it into a study of how these dramatic changes impacted 235 kids. "It's been rolling with the punches and the punches keep flying," he says.

Charissa Cheah, a psychologist at the University of Maryland, Baltimore County, is recalibrating her research on how Chinese and Korean American children in the state cope with discrimination. With money from the National Science Foundation, which is working to quickly fund coronavirus-related research, she's surveying several hundred families she has studied over the past 5 years. She's also expanding to families elsewhere in the country. She's hoping to learn how parents and children are responding to anti-Asian discrimination that has surged with the virus, and what broader lessons it might hold about these dynamics. "I did see [the pandemic] creating, I wouldn't say opportunity, but a unique context in order to understand how some of these processes work," she says.

Economists are digging in as well. Matthew Kahn at Johns Hopkins University, Baltimore, has studied how industries cope with disasters. He and a collaborator are already gathering data to compare how companies are adjusting, depending on their supply chains and the different restrictions imposed by countries around the world.

He's also rewriting the closing chapter to a new book about the economics of climate adaptation. Now, it's going to talk about the coronavirus. "With any natural experiment, you're studying the cause and effect. In real time, these companies are reoptimizing in the face of these shocks," he says. University of Chicago economist Lars Peter Hansen, another Nobel laureate, isn't embarking on any immediate research. But he has long been interested in how decision-makers and markets deal with uncertainty. In a situation wracked with unknowns, he wants to examine how everyone from investors to government

policymakers to health care managers respond. “How to integrate uncertainty into these kinds of decisions seems, to me, a first-order challenge and it’s definitely something I want to work on,” he says.

But Hansen and several others caution that much of the emerging research might not fit the classic definition of a natural experiment, because the pandemic’s impacts are so widespread and messy. The best natural experiments usually look at similar groups of people where one group experiences a very specific change, says David Figlio, an economist at Northwestern University who has worked extensively in education policy. In contrast, virtually no one has avoided the reach of the pandemic, and it touches so many parts of life. “There have been dozens of very smart people now saying, ‘Wow, this is going to be such an incredible opportunity to study things. And I’m not so sanguine about that,” Figlio says. Figlio notes that some researchers have suggested the mass shift to teaching classes online caused by the crisis could provide a natural experiment, testing how students perform with online education versus face-to-face classes. But he questions what the results will really show, when many teachers are being forced into online teaching with little preparation. “My hunch is people are going to stink it up this year,” he says.

Experts who study communication during disasters are also getting funding to launch studies. With help from a National Science Foundation grant, Ellen Peters at the University of Oregon, Eugene, has already surveyed 1300 people to see how their emotional state connects to what actions they take to protect themselves and who they considered reliable sources of information. Her team found that doctors and the Centers for Disease Control and Prevention, ranked the highest among both conservatives and liberals, at 75% or higher.

In most disasters, such work would rely on people’s recollections after the worst has passed, Peters says. This time, “We’re actually trying to catch people as it’s happening.” The results could be of immediate use to policymakers, who have already asked Peters for advice. It could also shed light on long-term questions about how people interpret risk and decide what to do in a disaster. Peters plans five rounds of surveys, giving her a real-time window into how people’s emotions and actions are evolving in this globe-spanning experiment.

US coronavirus crisis shows the benefit of a universal health system

The following is an exerpt from an article by Ian Powell (a Wellington based health commentator and former executive director of the Association of Salaried Medical Specialists) on the value of public health systems, ***published on the Stuff NZ website on April 12 2020***

"Americans have a system that has no sense of health being a public or common good. It is provided through private health insurance, which is largely employer based, and has been described as 'an umbrella that melts in the rain'. Already more than 30 million Americans have no health insurance. It is estimated that by July around a further 7 million Americans will have become uninsured due to the loss of jobs. On top of this almost 30% of American workers have no paid sick leave entitlement with their employers.

President Obama's Affordable Care Act made some improvements. But he selected players from the health insurers to drive its design which ensured that the US system remained overwhelmingly private and for-profit.

He goes on to say…. without public capacity to deal with Covid-19, even if tests, antivirals or vaccines had been developed and approved in time, there were no institutions in place to administer it to millions of Americans at no charge.

And sumarises that…..Universal public health systems are best placed to deal with pandemics because they are integrated and whole-of-system."

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