

Annual Report 2010

The major challenge since the 21st Annual Conference in December 2009 has been the national DHB MECA negotiations. Other challenges include promoting clinical leadership and engagement in DHBs consistent with the *Time for Quality* agreement and the *In Good Hands* policy statement, and the Government's proposed amendments to the Employment Relations Act.

The members of the National Executive are:

President	Jeff Brown (MidCentral)
Vice President	David Jones (Capital & Coast)
Region 1	Judy Bent (Auckland) Himadri Seth (Waitemata)
Region 2	John Bonning (Waikato) Paul Wilson (Bay of Plenty)
Region 3	Hein Stander (Tairāwhiti) - since June following the resignation of Torben Iversen in May Tim Frendin (Hawke's Bay)
Region 4	Brian Craig (Canterbury) John MacDonald (Canterbury)

In May Torben Iversen resigned to take up a specialist position in Victoria (although still working one week every four in Tairāwhiti). While technically eligible to continue on the National Executive practical considerations meant that he chose to resign. The Association is appreciative of the important contribution Dr Iversen made while on the Executive including bringing to the fore the position of members in smaller provincial DHBs, and for his role as Association representative in Tairāwhiti. In June Hein Stander was elected unopposed in a by-election.

The National Executive has met on four occasions in Wellington since the last Annual Conference, with a fifth meeting to be held immediately preceding this Conference. On 17-18 February the National Executive held its annual two day meeting to discuss strategic directions, the first day being informal. The informal day included:

- Preparing for the national DHB MECA negotiations, including strategic direction and the draft claim.
- The primary-secondary interface including the 'expression of interest' business case process and the Association's relationship with General Practice New Zealand.
- Role of the Association's branches.
- Reviewing the performance of the National Executive.
- Terms of reference for the National Consultation Committee.

The National Executive was pleased to have the following guests attend parts of the meetings during the year:

- Minister of Health, Hon Tony Ryall, attended the 18 February meeting.
- Helen Kelly, President of the Council of Trade Unions, attended the 1 July meeting.

Other key activities were the Joint Consultation Committees in the 21 DHBS, collective bargaining with non-DHB employers and individual employment-related cases and disputes.

The national office comprises eight full-time staff – Ian Powell (Executive Director), Angela Belich (Assistant Executive Director), Henry Stubbs (Senior Industrial Officer; four days/32 hours per week), Yvonne Desmond (Executive Officer), Lyn Hughes (Industrial Officer), Lloyd Woods (Industrial Officer), Kathy Eaden (Membership Support Officer), Terry Creighton (Administration Officer - commenced in March) and Ebony Lamb (part-time Administration Assistant). We also engage additional accounting support on a casual basis, usually to coincide with National Executive meetings, to assist with financial accounting and reports. In April Administration Officer Jo Jourdain left to get married and live in Christchurch. She proved to be an outstanding employee in her relatively short time with the Association.

Bruce Corkill QC, barrister, continued to provide valuable counsel and support. Due to his position as Chair of the Health Practitioners Disciplinary Tribunal we also use Bartlett Partners for back up employment law and medico-legal advice.

The National Executive was saddened to learn of the passing away on 19 April of our third National President and first life member, the much and widely respected John Hawke. He was elected to the first National Executive serving three terms before being elected National President for the 1995-97 term. National President Jeff Brown, former National President Peter Roberts and Executive Director Ian Powell attended the funeral. John Hawke was widely admired across dentistry and medicine for his professionalism, integrity, dedication and humour. Tributes to him were published in *The Specialist* (by close friend and fellow life member James Judson) and *ASMS Direct*.

National DHB MECA negotiations

The renegotiation of the third national DHB multi-employer collective agreement (MECA) has been the National Executive's major priority since the 2009 Annual Conference. The current (second) MECA expired on 30 April 2010 but still continues in force under statute for a further 12 months.

Negotiations for our MECA are now well underway. We have endeavoured to keep members informed during an unusual negotiating process which has affected the way in which we communicate through our electronic publication *ASMS Direct* and two issues of the *Bargaining Bulletin* which were mailed to DHB employed members.

The Association's overall strategic direction in these negotiations is based on the following resolution overwhelmingly adopted by our Annual Conference last December:

That the Association's strategic direction for the forthcoming national DHB MECA negotiations be based on the following statement:

That the Association promotes the right of equal access for all New Zealanders to high quality public health services. Both access and quality are threatened by the medical workforce crisis in our district health boards. Critical to resolving this crisis are:

- (a) *a clear pathway to competitive terms and conditions of employment for senior doctors and dentists;*
- (b) *recognition that district health boards are competing in an Australian medical labour market; and*
- (c) *recognition that the Government is responsible for resolving the crisis.*

The National Executive subsequently confirmed our negotiating team led by the Executive Director as advocate and Assistant Executive Director as assistant advocate. In addition to Executive members it comprised Drs Rod Harpin (Northland), Carolyn Fowler (Counties Manukau), Athol Steward (Whanganui), Stephen Purchas (Hutt Valley), Derek Snelling (Capital & Coast), Geoff Lingard (Nelson Marlborough), Matthew Hills (South Canterbury), and Peter Christmas (Southern).

The Association and DHBs first met for an informal discussion last December in Wellington in which we were able to discuss some of the problems which occurred in our previous MECA negotiations and also to discuss the implications and context of the above resolution. At a second informal meeting in Auckland in February the Association recommended that we hold a series of workshops on issues that would underpin the negotiations. The DHBs responded positively to our advice. Consequently between April and July four successful joint workshops were held on the following subjects:

- State of the senior medical workforce with respect to recruitment and retention.
- Australian medical labour market.
- Clinical leadership - what do we understand by it and want; capacity for it; and relevance to 'productivity'.
- SMO-RMO relationships and roles in light of the recommendations of the RMO Commission adopted by the government, which have major capacity implications for senior doctors in respect of service provision and training.

The DHBs established a two-tier structure - an overarching Employment Relations Strategy Group (ERSG) responsible for all their collective negotiations and a negotiation team. The ERSG is led by Karen Roach (Northland chief executive) and includes three other chief executives - Phil Cammish (Bay of Plenty), Julie Patterson (Whanganui) and David Meates (Canterbury); two chief operating officers - Ron Dunham (Counties Manukau) and Jeanette Black (Whanganui); and one human resources general manager - Sam Bartrum (Waitemata & Counties Manukau). Their negotiating team comprises Fiona McMorrان (advocate - DHBNZ), Bronwen Davies (DHBNZ co-advocate), Ron Dunham, Sam Bartrum, Jeanette Black, and Warrick Frater (Hawke's Bay chief operating officer).

To date we have had four formal days of negotiations (14 May, 18 June, 2 August and 8 September) with a fifth day scheduled for 24 November. The Association formally lodged a claim but deliberately reserved on the key financial issues of salaries, after-hours' shift and on-call hours, superannuation and CME expenses. Many of the issues in our claim were resolved during these four days although there are still a small number of important issues outstanding such as offering the MECA to new appointees after the 12 month statutory extension to the expiry date and making more pertinent the current locum clause by better ensuring it applies to work pressures arising out of all vacancies. The DHBs are also seeking to remove the bargaining fee provision. In general the formal negotiations have proceeded in a mature and constructive manner.

The four workshops proved to be very successful. The Association added to our team Drs Clinton Pinto (Counties Manukau), Peter Dean (Waikato) and Ruth Spearing (Canterbury). The DHBs also brought additional participants including some Association members. The Association contracted Lyndon Keene to produce high quality and influential background papers for each of the workshops. The cumulative effect of the workshops was to demonstrate a shared appreciation of many of the problems confronting DHBs and the senior medical/dental workforce and the extent of the recruitment and retention vulnerability. Arising from the discussion was also a shared appreciation of the value in exploring a shared approach to government over a settlement focussed on helping addressing this workforce crisis.

As a consequence at an informal meeting on 28 July after the completion of the workshops the DHBs asked us whether we would be interested in exploring a joint approach to the government to which we responded positively. After further discussions and confirmation by both the 20 DHB's chief executives and the Association's National Executive, in September we reached an agreement under a provision in the Employment Relations Act called a 'variation'. This involved varying the current (expired) second MECA but not concluding a settlement of it while negotiations continue and the preparation of a joint 'business case'. Both parties have described this agreement as a 'holding pattern' and released a joint media statement to this effect.

'Holding Pattern'

The main features of this 'holding pattern' are:

1. The ASMS and DHBs will prepare a 'business case' timed to fit in with the government's budget cycle for the 2011-12 financial year.
2. The current MECA is not settled but will be 'varied' to include a 2% salary increase effective from 31 January 2011 and some other minor improvements that have already been agreed. This is through a mechanism called a 'variation'.
3. Negotiations over the current MECA will resume on the financial elements, including remuneration once the outcome of the business case is known.
4. In the event that full agreement has not been reached by 30 April 2011 (12 months after the expiry of the current MECA) when the protection under the Employment Relations Act ends, the DHBs will continue to offer the MECA to new appointees (those currently employed on the MECA continue to be covered by it until a replacement is negotiated).

The 'Variation'

The most important part of the 'variation' is the insertion of a new Clause 7.3 to the MECA which states:

The parties agree that no further changes will be made to this Agreement before 1 May 2011 but this will not preclude further negotiations for a replacement to this Agreement after that date. The parties also agree to jointly develop a business case that will address the senior medical & dental officer workforce challenges facing District Health Boards. Acting in good faith and by using their best endeavours the parties shall develop the business case by no later than 31 October 2010. It is intended that the business case should inform consideration by the parties and the government of any likely changes in remuneration to this Agreement in the 2011/12 and subsequent years.

It also increases the current specialist and medical officer salaries by 2% effective on 31 January 2011. In addition, there are several other relatively minor improvements and tidy-ups to the current MECA which include the following:

- Making more explicit and prominent the principles of clinical leadership and engagement under the *Time for Quality* agreement between the ASMS and the DHBs.
- Providing automatic full MECA coverage in the event of any further DHB mergers.
- Clarifying that the MECA can cover doctors or dentists who are completing their vocational training while working in SMO positions.
- Removing the limit on the reimbursement of vocational registration fees to once only; ie, entitling more than one to be reimbursed.
- Full reimbursement of the professional fees associated with a vocational scope of practice for a part-timer whose work within that scope is only for that DHB.

- Those who hold part-time positions in more than one DHB and whose combined job size is full-time will be entitled to full reimbursement of work-related expenses providing that they don't do private practice. This extension also applies to CME expenses.
- Agreement that the ASMS and each DHB will review the DHB's relocation costs for new appointees through the Joint Consultation Committees.
- Making explicit that annual leave may be taken in advance.
- Establishing that an SMO who falls ill while on annual leave may be entitled to paid sick leave and have those days credited back to their annual leave entitlement (the DHB may require a medical certificate where the period of illness exceeds three days). This principle also applies in the event of bereavement during annual leave.
- Tidying up the current entitlement for paid leave to attend various professional meetings.
- Making it explicit that CME expenses can be used for sabbaticals and secondments as well as continuing medical leave (this is a common practice but was not currently specified).
- Permitting the use of CME expenses to purchase laptops and electronic aids but with protections against managerial misuse (eg, where the DHB should be providing them as a work-related 'tool of the trade'). This will require agreement with the DHB although the large majority of DHBs already allow this to happen.
- Flexing the eligibility for sabbatical programmes to include universities and research institutes.

There are other improvements (separate from salaries and other major cost items) the Association is still seeking and they will continue to be debated as negotiations continue. The details of the 'variation' were summarised in *ASMS Direct* and also outlined more fully in our *Bargaining Bulletin* publication mailed to all DHB employed members.

The 'Business Case'

The 'business case' is timed to fit in with the government's budget cycle for the 2011-12 financial year. Its purpose is to better inform the parties (ie, DHBs and Association) and government on the actual recruitment and retention of senior medical staff in DHBs, particularly in the context of the government's health policy objectives, with a particular emphasis on remuneration. It also considers economic benefits, including potential savings. It advocates why the government should invest as one of its main health priorities in senior doctors and dentists in order to achieve its objectives.

The writing of the business case was overseen by a joint Association-DHBs steering group which has had two half-day and four full day meetings between 14 September and 12 November. The Association's representatives are Executive Director Ian Powell, Assistant Executive Director Angela Belich, National President Dr Jeff Brown, Vice President David Jones, National Secretary Brian Craig, and Wellington based member of the negotiating team Derek Snelling.

It is hoped that the outcome of the business case will be known to the Association immediately prior to Christmas although this is unlikely to be able to be made public at that time. Negotiations continue in the meantime but not on the issues affected by the business case; particularly salaries, superannuation, after-hours remuneration, and CME expenses. Once the outcome of the business case is known then negotiations will focus on these matters.

Why 2%? Why 31 January 2011?

The 'variation' includes a 2% salary increase effective nine months after the expiry date of the current MECA (31 January 2011). Part of it involves respecting the position taken by unions representing over 75% of the DHBs workforce (NZ Nurses Organisation, Public Service

Association, and Service & Food Workers Union). In response to the government's financial squeeze on DHBs they agreed in what is called a 'national terms of settlement' (NTOS) for a 2% salary increase taking effect nine months after the expiry date of the various collective agreements negotiated by these three unions. That agreement also explicitly recognises that it does not cover senior medical and dental officers and accepts that something different would have to be negotiated between the Association and DHBs.

A further factor is that the government has instructed state sector employers (including DHBs) not to agree to any back-dating of any salary increases. Given that it was virtually certain that negotiations would continue beyond the end of January, the National Executive's response was pragmatic.

The National Executive has decided on a balance between respecting the position of other DHB employees and both keeping alive and increasing the traction of our negotiations in which we are seeking to address the specialist recruitment and retention crisis in DHBs.

Protecting New Appointees: Post 30 April 2011

The current MECA expired on 30 April 2010. Under the Employment Relations Act, DHBs are required to offer the expired MECA to new appointees for a further 12 months (ie, to 30 April 2011) while negotiations are still underway. In other words, there is a 'statutory extension' to the MECA in its application to new appointees for up to 12 months after the formal expiry.

There is a provision in the MECA which is ambiguous in terms of whether this obligation to offer the MECA to new employees continues beyond this 'statutory extension' (ie, continues from 1 May 2011 onwards) should negotiations still be going on. However, the DHBs and Association have agreed upon a 'letter of undertaking' from the DHBs to us confirming that the DHBs will continue to offer the MECA to new appointees after 30 April 2011 in the event that negotiations are still continuing. The DHBs' letter has now been received.

Employment Relations Amendment Bill (No.2)

On 16 August the Government introduced an amendment to the Employment Relations Act 2000, the Employment Relations Amendment Bill (No.2), containing 32 amendments to the Act. While the main principles of the current Act remain intact, such as rights to collective bargaining and rights of union recognition, and it is not a return to the Employment Contracts Act 1991, it nevertheless seeks to erode some important features of the Act.

The amendment that has attracted the most attention is the provision that extends the current 90-day provision for trial periods to all employers (currently it only applies to those who employ fewer than 20 employees). The concern is not so much trial periods but the loss of protection against unfair dismissal during trial periods. If a trial period has been agreed between the employer and employee, then under the Bill the employer could dismiss the new employee during the 90-day trial period and the employee will have no right to bring a personal grievance or other legal proceedings in respect of the dismissal. If DHBs were to insist on an agreement to a trial period with a new senior medical or dental appointee (particularly when recruiting from overseas), it would be likely to discourage that appointee from taking up employment in New Zealand thereby exacerbating the existing medical workforce shortage.

Other amendments that caused the Association particular concern were:

1. Amending the test of "justification" for any action of an employer (eg, dismissal) from the current objective test (ie, was the action one that a fair employer, acting reasonably, would have taken?) to a subjective one (ie, was the action within the range of actions open to a fair employer?). While the Association does not have many dismissals or personal grievances, this change would reduce our ability to defend a dismissal or an action that might

unjustifiably disadvantage a member. It would increase the employer's discretion in these areas.

2. Removing "reinstatement" as the primary remedy (where it is sought) in dismissal cases. While we handle few dismissal cases and have taken even fewer personal grievances relating to dismissals, if "reinstatement" loses its primacy as a remedy, it becomes even less likely that reinstatement would ever be achieved in a successful dismissal case.
3. Requiring a union representative to seek the employer's consent before entering the workplace (consent should not be unreasonably withheld). While the main disadvantage of this amendment would be for unions representing more vulnerable parts of the health workforce, it might also impose unnecessary bureaucratic hurdles for the Association.

The National Executive approved a submission on the Bill which was forwarded to the Industrial Relations and Transport Select Committee. On 22 September the Executive Director, Assistant Executive Director and Senior Industrial Officer made a supplementary oral submission to the committee. Background material on the Bill has been provided in *The Specialist* while the submission was made available to members on our homepage.

The Association has also advised the DHBs MECA negotiating team that subject to the outcome of the Bill, we will be seeking to address some of our concerns in subsequent claims for the next MECA.

In recognition of the work being undertaken by the Council of Trade Unions (which is in the interest of Association members as well as the wider workforce) over the wider implications of the Bill, the National Executive resolved to donate \$3,500 to its 'fairness at work' campaign. This was advised to members in *Executive Direct*.

Holidays Amendment Bill

The Government also introduced, at the same time as the Employment Relations Amendment Bill, the Holidays Amendment Bill proposing a relatively small number of amendments to the Holidays Act. Aside from the question of the fourth week of annual leave, the bill represented a reasonable degree of consensus between Government, Council of Trade Unions and Business New Zealand.

The most controversial feature of the bill was that it enabled employees to request to be paid out (ie, cash up) one week of the statutory entitlement (four weeks) each year. While this may pose a threat to employees who receive only the statutory minimum entitlement, this is not likely to be so for employees with a greater entitlement where that capacity already exists (at the employer's discretion).

The Bill also allows an employer to require a medical certificate within the first three days of an illness providing they give the employee notice of the requirement as early as possible and agree to meet the cost. This is may be a problem for a very small number of members (2-3) who use a lot of sick leave.

Other minor changes which are either not disadvantageous or possibly beneficial involve the relevant daily rate, transferring the observance of a public holiday, day-in-lieu for working a public holiday, and an annual close down.

Given the above and the fact that the Council of Trade Unions was making a comprehensive submission, the National Executive determined not to make a submission.

Industrial Climate in DHBs

The industrial climate has been two-fold and contradictory. On the one hand, the 'national terms of settlement' (NTOS) process involving the DHBs and three of the four major health unions affiliated to the Council of Trade Unions - NZNO, PSA and SFWU - meant a smooth negotiating

process with ratified settlements achieved without industrial action or acrimony between the parties for about 75% of the DHBs' workforce. The Association is the fourth union.

On the other hand, there have been difficult and acrimonious collective bargaining disputes involving three non-CTU affiliated unions – Resident Doctors' Association, APEX (representing a number of smaller occupational groups including MRTs and physicists) and Medical Laboratory Workers Union (affecting up to 14 DHBs). At one point it appeared that the resident doctors' negotiations were veering towards strike action from mid-October. In anticipation the Association initiated discussions with the DHBs and quickly negotiated an agreement on arrangements, including remunerative compensation, for senior medical and dental officers in the event of RMO strike action. In summary, the agreement was based on the 2008 agreement (with changes tightening up on the wording). In 2008 the remuneration compensation was \$300 per hour for each hour worked between 8am and 6pm (\$500 per hour for each additional hour worked in excess of the normal job size for the day); \$500 per hour for every hour worked between 6pm and 8am; and \$250 per hour for each hour on-call (excluding hours paid for work done). This continued with the revision that the \$300 per hour was for when the impact was more than minimal and \$150 per hour would become the rate for minimal impact. However, due to changed circumstances in these negotiations, strikes have not been called and appear unlikely to be called this year.

However, in the other two negotiations strike action has been significant. Over 700 notices of partial strike action have been given (mainly by APEX). The cumulative affect of this volume of partial strikes affecting diagnostic services has raised serious concerns of patient safety among Association members. It has put much pressure on the application of life preserving services (including risk of permanent injury and disability) under the 'Health Sector Code of Good Faith' which is a schedule to the Employment Relations Act. This led to the chief medical advisers/officers of the 20 DHBs releasing a public statement on 20 October warning of the risks to patient safety although their message was muted by a second call for compulsory arbitration and the removal of the right to strike.

In response to concerns about patient safety during these particular types of strikes (partial, high volume and diagnostic) which are even making deferring cases risky because of consequential difficulties with scheduling, the Association has been raising the issue in the Joint Consultation Committees. The position we have advocated is that it must be left to our members to determine on a case-by-case basis whether the test or image they have sought is necessary for the delivery of life preserving services. If there is to be debate about that between the parties to the industrial dispute, that debate must be conducted later when the risk to the patient has gone or been reduced. In the meantime the tests or request for imaging should proceed without delay. The decision of the relevant senior medical or dental officer in the matter of what is or is not a life preserving service is decisive, is not to be questioned, overrules what might or might not be in a life preserving services agreement, and must be carried out promptly. The Association has also written to the Chair of the DHBs Employment Relations Strategy Group outlining this position and expressed an expectation of full DHB support (many DHBs have offered this in the JCCs where it has been raised) for our members in this position. Members have also been advised of this in *ASMS Direct*.

Tripartite: Health Sector Relationship Agreement

Five meetings of the Tripartite Steering Group under the auspice of the Health Sector Relationship Agreement (HSRA) have been held to date (a sixth meeting is to be held on 14 December) along with a special meeting on the future direction of the 'national terms of settlement' process' on 4 November. The participants are the Ministry of Health (now largely through the National Health Board), all 20 DHBs, and each of the CTU affiliated health unions including the Association; all are signatories to the Health Sector Relationship Agreement. The Executive Director has represented the Association at all meetings. The significance of this body continues

to grow and it is the primary means by which the government, DHBs and health unions engage on a national level.

Its main achievement has been the NTOS process (which the Association was not party to but was kept informed about). The Association's active participation in the HSRA helped allow our different approach to be handled in a professionally respectful and collaborative manner. The discussion at the Steering Group included its development, application and debriefings on the process.

Time was also spent discussing the implications arising out of the application of life preserving services agreements particularly during medical radiation technologist and laboratory worker partial strikes. Concern was expressed over risks to patient safety with strikes that were high volume partial strikes affecting diagnostic services. Deferred access had become dangerous in these circumstances because of the consequential difficulties for timely re-scheduling. This may lead to a consideration of the application of the 'Health Sector Code of Good Faith' (schedule to the Employment Relations Act) with respect to life preserving services.

Examples of the other issues discussed to date are:

- Health sector restructuring and policy imperatives including externally driven speed and the need for ensuring union consultation.
- Employment Relations Amendment Bill (No.2).
- 2010-11 Budget.
- Application of *In Good Hands*.
- Briefings from Treasury on the state of the economy.
- Session with the National Shared Services Agency establishment board (now Health Benefits).
- The Government's primary care initiatives.

New Zealand Public Health and Disability Amendment Bill

The New Zealand Public Health and Disability Act when it was first passed restored a degree of local influence over the public health system largely because the public and health professionals no longer trusted government appointed bodies to protect the taonga of the public health system. Subsequent developments exposed flaws in the relative autonomy of DHBs with unnecessary duplication of resources and some difficulties obtaining collaboration between DHBs.

This Bill was an attempt to redress the balance by giving the Minister of Health power to compel collaboration and force economies of scale. As well the Bill established the Health Quality and Safety Commission (HQSC), recommended by the Ministerial Review Group report in 2009.

The Association made a written submission (along with 13 other groups and individuals) on the Bill which was largely supportive of the amendments. We did, however, express concern that the amendments did not mandate consultation with clinicians particularly where the power to make those decisions shifted from the DHB (which were required to consult with senior medical and dental officers under the national DHB MECA) to the Minister of Health. We suggested that the legislation (rather than simply the regulations that the Minister might promulgate) require consultation with clinical networks or the appropriate health professionals and that the Bill should be revised to capture the tenor of the *Time for Quality* agreement between the Association and the DHBs and the Government's *In Good Hands* policy statement on clinical governance and leadership.

The Association supported the establishment of the HQSC but expressed concern at the suggestion that the Commission be 'self funding'.

Vice President Dr David Jones and Assistant Executive Director Angela Belich appeared before the

the Health Select Committee on 4 August. The Health Committee reported back to Parliament on 17 September. The Committee recommended a change which clarified the Ministers power to direct with respect to the Crown Entities Act but otherwise changes were very minor.

Two issues both of which were raised by the Association (among others) remained of concern to the opposition parties. These were that requirements for consultation were to be set out in regulations rather than required by legislation and that the HQSC may at some point be required to be self funding. The Labour Party was to have introduced a Supplementary Order Paper (SOP) on the first issue and the Greens were to have introduced an SOP to deal with the funding of the HQSC.

Because the government chose not to speak on the Bill, it went through this stage very quickly, so quickly that the Labour Party did not table its SOP and that the Green SOP on funding of the HQSC was passed, probably inadvertently, on a voice vote and thus became part of the substantive Bill. A press statement was issued by the Association supporting the change and congratulating Greens health spokesperson Kevin Hague MP. It was designed to discourage possible government moves to reverse the Greens' successful amendment

It was within the power of the government to refer the Bill back to the Committee stage rather than proceed with the 3rd reading (which is normally just a formality) but in the event the government chose to live with the amendment. The Bill was adopted unanimously by all political parties. This multi-party consensus is encouraging.

Promotion of Clinical Leadership in DHBs: In Good Hands

In 2009 the Association was delighted with the decision of the Minister of Health to establish a task group headed by National President Jeff Brown to provide further advice on clinical leadership in DHBs. Their report was titled *In Good Hands* which the Minister then forwarded to the DHBs with his endorsement. *In Good Hands* included both core principles and transformation requirements which are reinforced by requirements to report on their implementation and performance. Last year the Minister was clear to the National Executive that *In Good Hands* forms part of government policy on clinical leadership. Following an important meeting with the Association in 2009 the Minister also set up a working group to advise on reporting guidelines on the implementation of policy statement. This group, which included the National President, completed its task in around a month but thereafter no effective progress was made.

In late December the Ministry of Health forwarded DHBs a 'performance measure' which was a considerably 'watered down' version of the recommendation of the Minister's advisory group. In March the Association formally wrote to Mr Ryall outlining our concerns. This was followed by a period of confusion over the application of the 'performance measure' as the Association endeavoured to pursue the issue through our Joint Consultation Committees. The outcome was three different interpretations from DHBs - it applied to the 2009-10 year, to the 2010-11 year, and did not apply at all. The Association is concerned that a combination of poor Ministry leadership coupled with insufficient commitment by the DHBs has led to inertia over the implementation of one of the Government's flagship health policies which the Association also strongly supports.

Partly due to this frustration the National Executive at its April meeting approved proceeding with a survey proposal from Dr Robin Gauld, Associate Professor of Health Policy at the University of Otago, on the implementation of *In Good Hands* in DHBs. This survey of all DHB employed Association members has been promoted in *ASMS Direct* and Dr Gauld will report its results to Annual Conference.

Primary-Secondary Relationship

Last year we reported on the difficulties associated with the Government's policy on the primary-secondary relationship. Part of it was the initial focus on devolution and part was the lack of opportunity for effective clinician engagement. The vehicle was the Government's 'expressions of interest' process which led to nine bids being accepted by the Ministry of Health to move to the next stage of developing proposed business cases. These selected organisations were required to develop a detailed business case, including costings, and a development pathway by 15 February 2010 with evaluation of them to be completed by 28 February. In response to concerns raised at last year's Conference after his address to delegates the Minister promptly extended the deadline by two weeks. In another change the term devolution was quietly dropped and replaced with terms such as collaboration and integration.

However, it still proved difficult to ensure effective clinical engagement largely due to lack of time and the time of the year. This was despite the Ministry of Health providing sound advice on the importance of clinical engagement with secondary care. In some areas it was better – MidCentral and Wairarapa – but in others it was disappointing. The major failures were the Greater Auckland Integrated Health Networks, Pinnacle with four of the five Midland DHBs, and West Coast (the first two in part at least made more difficult because the business cases involved multiple DHBs). There were also concerns involving Canterbury but at least that business case was based on stronger foundations in the form of the 'Canterbury Initiative'.

The National Executive was very concerned about the risk of poor decision-making arising as a result and consequently resolved to take this up with the Minister. On 19 March the Association wrote to the Minister specifying our concerns (this followed an earlier letter on 23 December). Our concern was that the business cases, some of which also lacked financial rigour, went no further than the level of clinical leadership and engagement justified. This led to a positive reaction including the holding of some 'stakeholder' meetings convened by the Ministry of Health and attended by the Assistant Executive Director.

The 'expression of interest' business case process has been disappointing and, in some instances at least, detrimental to the promotion of clinical leadership and disproportionately time consuming. It has also led to some specific concerns about the possible de-stabilisation of secondary care services; in particular, radiology in the Auckland region and community mental health in the Midland region. However, engagement is improving and the positive challenge of primary-secondary care is much wider than the specific business cases themselves. For this reason the National Executive has resolved to make this an important session in our Annual Conference programme particularly from the standpoint of achieving clinical leadership.

Joint Association-General Practice NZ Statement

One of the most significant events of the year was the signing in February of the joint statement between the Association and the Independent Practitioners Associations Council (now General Practice New Zealand). The significance is the Association's role as the organisation representing salaried senior doctors (and dentists) in secondary care (as well as salaried doctors in primary care) and GPNZ representing primary care networks. The joint statement was achieved in a timely manner following contact between the two organisations developing quickly late last year and recognition that we had more in common than was previously appreciated. The joint statement stated:

IPAC and ASMS jointly affirm:

1. *The necessity for all professionals across the spectrum of patient care to work together in the interests of individual patients.*
2. *The necessity for all professionals across the spectrum of care to work together for groups of patients, to design systems and pathways that bridge home to health centre to hospital care.*

3. *The necessity for all organisations representing professionals working together to transform the system, to provide equitable access to health care, in the best place at the best time by the best individuals and teams.*
4. *In jointly affirming these necessities, IPAC and ASMS will work together to promote clinical leadership and governance throughout the New Zealand health system such as shared access and shared initiatives between primary and secondary care.*

The joint statement became the framework and foundation for further collaboration with its emphasis on clinical leadership, clinical governance, and collaboration such as through shared access and initiatives. GPNZ and the Association have continued their contact since the signing of the statement, including over the Government's 'expression of interest' business case process. Both are expected to discuss soon with the Ministry of Health the issue of management of acute cases. National President Jeff Brown and GPNZ Executive Chair have spoken together in public forums. GPNZ will participate in a session on achieving clinical leadership in the primary-secondary relationship at Annual Conference. The National Executive is looking to further our constructive relationship with GPNZ in the following year.

Activity in the Non-DHB Sector

The cycle of settlements for the 15 collective agreements covering the 164 members who have their terms and conditions of employment set by collective agreements other than the national DHB MECA is deeply affected by progress of the DHBMECA. None of the agreements is completely uninfluenced by the national DHB MECA. Indeed it is very likely that the MECA has some influence on the remuneration of many senior doctors in New Zealand including those in private practice, both in general practice or as specialists. However, some agreements are very tightly tied to the MECA.

We are in the process of passing on the 2% increase negotiated as part of the 9 September 'variation' to the Hospice MECA (11 employers, 35 members) where a settlement including the 2% for a term until June 2011 is presently out for ratification; the New Zealand Blood Service (8 members); Dunstan Hospital (seven members) and Oamaru Hospital (three members) where bargaining has been initiated but a claim has yet to be lodged. Both the rural hospitals (Dunstan and Oamaru) have faced or are facing financial difficulties because of financial pressure from the Southern DHB.

The Queen Elizabeth Hospital (where we have three members) has also had an historic relationship to DHB conditions but has a somewhat different salary scale because of the early incorporation of superannuation. This collective settled at 2.5% for 2009 and 2.5% for 2010 until 31 August 2011. The Compass Health Sexual Health Service collective agreement (five members) has settled at 2% until 30 June 2011.

General practice collective agreements are not so tightly tied to the national DHB MECA. This year we have settled one of these where the employer is an Iwi authority: Te Oranganui, (three members) settled at 4.25% for 2010 and the future funding track for 2011, until 30 June 2012. Ngati Porou Hauora (10 members) is still being negotiated. One other Iwi authority where we have a collective, Te Runanaga O Toa Rangatira (nine members) does not expire until June next year. The Wellington Primary Health Care multi-union collective agreement (21 members employed by four separate employers) is being negotiated with a 1% 'final offer' presently being considered by members of the four unions involved. The Christchurch Union and Community Health Centre (five members) settled earlier this year, with an increase delivered through changes to advancement through the scale until 30 June 2011. Bargaining at the Hokianga Health Trust has been initiated for a collective agreement which is in a period of statutory extension (term extended for up to 12 months while negotiations continue) from 30 June 2010. Members (six) have yet to approve a claim.

Happily the Waitakere and Otara collective agreement (three members; expired in June 2009) which has been under negotiation for over 12 months accompanied by much ill-feeling, looks likely to settle shortly.

The New Zealand Family Planning Collective Agreement (26 members) does not expire until November 2011.

The most challenging negotiation has been the attempt to establish a collective agreement for the 19 members we have who are branch medical advisers for ACC. The employer was clearly utterly unaccustomed to the negotiating process and Industrial Officer Lloyd Woods and his negotiating team of Drs Burgess, Naidu and Austen have at least established the principle that a collective agreement should be established and have received a 2% salary offer, though the process has been difficult.

This year advocates were Industrial Officers Lyn Hughes and Lloyd Woods, and Assistant Executive Director Angela Belich

Industrial Team's Activities

Throughout the year under review, the Association's industrial team has been fully staffed with: Angela Belich (Assistant Executive Director who leads the team), Henry Stubbs (Senior Industrial Officer), Lyn Hughes and Lloyd Woods (Industrial Officers). While much of their core work is based in the national office in Wellington, each of the industrial officers is frequently required to travel to meet members in their workplaces and to hold discussions with management. Although this travel is time consuming and, at times, disruptive of routine work, members do seem to appreciate and value site visits and often, issues will be resolved more quickly and effectively following face-to-face meetings with members and managers.

The core work of the industrial team is to respond, as quickly as priorities and other workload pressures allow, to enquiries from prospective members, new members and existing members alike and to offer advice and representation to those members who seek it in respect of the application and interpretation of their employment agreements or workplace disputes and difficulties of one kind or another.

Advice to New Appointees

This continues to be an important part of the work we offer members and potential members. Often a job applicant's first contact with the Association is via our website and we continue to receive good comments from job applicants and new members about the design of the website and its useful and interesting information.

Successive national DHB MECAs have consolidated and extended national terms of employment for senior medical and dental officers in New Zealand and for some time it has been apparent to us that there is now less room for individual negotiation at the time of appointment than in the past. With some exceptions, the starting salary (i.e. step on the salary scale) is largely determined by years of experience as a specialist and relativity within the DHB and department.

Job Sizing

As anticipated some time ago, comprehensive job sizing reviews are becoming less common in DHBs as long-running reviews that were initiated some time ago are completed and implemented. A small number of long-running reviews are getting closer to completion and have identified significant understaffing at a time when there is little real prospect of recruiting to fill the 'new' vacancies in the near future. An equally pressing issue is the difficulty in recruiting to fill new vacancies that arise in those services where job sizing has been completed and is more or less settled.

Clinical Concerns and Investigations

In the course of the year, usually in conjunction with the Medical Protection Society, we have supported and advised five members dealing with investigations (or threats of investigation) into aspects of their clinical practice. Such investigations are usually conducted under Clause 42 of the MECA. Three of these investigations have been at what we have judged to be the 'serious' end of the spectrum and have threatened (or are now threatening) the member's ongoing employment and right to practice. In one case, with the support of the MPS, we have resisted a full scale inquiry on the grounds that such an investigation was an over-reaction to a matter that was unusual and might be better dealt with in some other manner.

The Association's involvement in these cases is at the 'threshold' stage when the DHB is considering whether to proceed with an investigation or not and if so, with what terms of reference and the identity of the investigators. Once the decision to proceed has been made, we leave the MPS to provide the on-going support and representation during the investigation.

Allegations of Bullying

A difficult and (for our members) a distressing problem arises with allegations of 'so-called' bullying. Sometimes our members are the complainants but unfortunately more often they are the persons whose behaviour is being called into question. The problem for members who face allegations of bullying is that the term 'bullying' is seldom fairly defined and they are left to respond to emotionally charged allegations from a complainant who is distressed or who has been challenged or criticised about aspects of their own behaviour or performance. Having said that, it is also apparent that some of those complained about, have gone a bit too far and have behaved inappropriately.

In the course of the year we have advised five members facing allegations of bullying: one is on-going; two have been resolved more or less satisfactorily; and in two others, the members remain aggrieved because of the employers' clumsy handling of the original complaints. These cases generally take up a lot of time.

We have also supported and advised several members who felt they were being bullied by one or more of their colleagues.

Sick Leave, Stress and Return to Work Plans

A feature of cases that involve allegations of bullying or harassment is that the complainant or victim (sometimes both) end up taking 'stress leave'. Strictly speaking there is no such thing as stress leave and the leave is in reality 'sick leave'. If these cases are not dealt with very carefully, such leave may drag out for weeks and sometimes months, eventually creating other difficulties for the SMOs involved.

We generally advise members to use 'stress leave' sparingly and only for quite short periods of time. 'Stress leave' is often best regarded as 'time out' to give those concerned time to calm down, for the parties to assess the gravity of the situation and to consider how best to proceed.

However, in those cases where a member takes long periods of sick leave, whether in the face of allegations of bullying or other illness, the Association has worked with them and the DHB's Occupational Health Unit (and sometime the Health Committee of the Medical Council) to develop return-to-work plans for their gradual reintegration to workplace. During the year, the Association has assisted several members return to work in this way. Unfortunately we have also dealt with several cases where the members chose not to return to work and we assisted them negotiate an 'exit package'.

Involuntary and Negotiated Departures

In the course of the year we are not aware of any member who was dismissed but we did assist 12 members negotiate their 'involuntary' departure. In a few cases that was to avoid a possible dismissal and the serious consequences for the member that might ensure, but in most cases it was simply a recognition that relationships with their employer, manager or colleagues had broken down to the point where it was better for all concerned that there be a parting of the ways.

Referrals to Mediation and Employment Relations Authority

One dispute was taken to mediation, which led to its successful resolution. This case was a longstanding job sizing/workload issue that involved only one member.

During the year, no case went to the Employment Relations Authority or to the Employment Court. Although the Association deals with many difficult cases, often involving complex issues, professional reputations and (potentially) large sums of money, the industrial team is very experienced and continues to be able to resolve complex cases by patient and careful negotiation, without recourse to litigation. Our industrial officers are very conscious of the need to rebuild and strengthen our members' relationships with their employers, managers and their colleagues.

There are currently no outstanding cases that are expected to end up before the Employment Relations Authority or the Court.

Other Matters of Note

From time to time the industrial team refer to the National Executive issues of a particularly sensitive nature, some that require broad policy consideration and others that do not readily lend themselves to an industrial or legal response. Sometimes these referrals are simply for information but more often they are made because the industrial team is seeking guidance or approval for a particular course of action.

During the year such referrals have included:

- The application and interpretation of Clause 26 of the MECA relating to onerous duties. This is a problematic clause that had its origins at a time when the provisions for annual leave and study leave were less generous and job sizing was largely non-existent or in its infancy. The application of the onerous duties leave clause is quite problematic and no guidance has emerged to assist employers or members alike. At some stage this will need to be addressed.
- The ongoing (sometimes it seems constant) reviewing and restructuring of services to respond to budget deficits and Government or Ministry requirements deal. This is often quite unsettling for members and will sometime conflict with the employers' obligation to consult both the Association and our members.
- The apparent increase in complaints of 'bullying and harassment' by and of our members. Every employer, it seems, now has a policy on bullying but not enough effort is put into defining 'bullying' or training employees and managers alike on 'what it really is' and how it might be avoided in the workplace.
- The erosion of non-clinical time by 'clinical creep' in the face of increasing clinical workloads and shortages of members and other resources.
- Disputes between members and the policy implications for the Association of members on both sides of (usually) a relationship dispute seeking ASMS advice. The industrial team is a small one and not well-resourced to assign an industrial officer or, in an extreme case, employ a barrister for each member of a department that is falling apart.

- The interpretation of the annual leave provisions of the MECA as it relates to pro rating for part-timers. Neither the law nor the MECA is clear on this issue and as job sizing has resulted in more hours being allocated for after-hours work, non-rostered or non-scheduled non-clinical time and other management type work, it has become clear that a small but significant number of our 'part-time' members are receiving annual leave as if they were full-timers. This has given rise to some uncertainty about how many hours of annual leave should be given to 'part-timers' (ie, those members whose clinical work is effectively completed often in only two or three days). There is no simple answer to this issue and expert legal opinion from two sources would indicate that the arrangements that each DHB currently has in place meet the requirements of the Holidays Act and the MECA.

Bargaining Fee

An annual bargaining fee, set at the same level as the Association membership fee, was agreed as part of the national DHB MECA. In the last financial year this payment totalled \$81,148. Based on s53 of the Employment Relations Act, the Association believed that this provision, along with the rest of the MECA, continued to apply for 12 months after the formal expiry date while the DHBs and the Association continued to negotiate.

In June Membership Support Officer Kathy Eaden noticed problems in the collection of the bargaining fee at some DHBs. Subsequently we discovered that some DHBs (at least four) believed that the bargaining fee should not continue to be levied during the statutory extension of the MECA. The Association raised the issue at the National Consultative Committee meeting in July. We also obtained a legal opinion from Bruce Corkill QC which strongly supported our understanding which we passed on to the DHBs' Employment Strategy Group.

We received a reply which agreed with our view but reminded us that DHBNZ 'can only recommend' and that some DHBs may still refuse to deduct the fee. Further, the letter stated that no fees will be deducted post 30 April 2011 unless a new MECA is in place and has a bargaining fee clause and that issues may arise with this clause if there is backdating. We have yet to receive bargaining fees for 2010 from six DHBs. The Association is following this matter up with these DHBs.

National Consultation Committee

The National Consultation Committee (NCC) is a creation of the second (current) national DHB MECA. It is a joint DHBs-Association national committee comprising six representatives from each party (one of whom must be a DHB chief executive and one who must be the Association Executive Director). It is to meet at least quarterly and the DHBs are to meet the travel costs of the members who attend as Association representatives. In 2010 three meetings have been held to date - 7 April, 30 June and 8 September with a further meeting scheduled for 24 November. A meeting scheduled for 9 March was cancelled owing to the unavailability of key DHB personnel.

The DHBs' team comprises Garry Smith (Chair of the national chief executives' group and Auckland chief executive), David Meates (Canterbury chief executive), Warrick Frater (Hawke's Bay chief operating officer), Joy Farley (Taranaki chief operating officer), Pat Hartung (Taranaki human resources), and Jim Wicks who recently has been replaced by Cath Jackson (Capital & Coast human resources). The Association's representatives are the National President, available Executive members, and the Executive Director (the Assistant Executive Director also attends).

The issues discussed to date include:

1. Terms of reference. The current terms of reference, which are an appendix to the national DHB MECA, are outdated including reference to activities which are not relevant to its work. The NCC is reviewing them following consideration of a draft prepared by the Association.
2. Bargaining fee payments. The Association raised initially concerns over slow and inaccurate payments of the bargaining fee by DHBs and subsequently concerns that some DHBs had taken the view that the fee was no longer payable (discussed separately).
3. DHS advice to new appointees on Association membership and medical indemnity insurance requirements. Investigations showed that while advice was provided it was not always as full and detailed as it could have been. A particular concern was the lack of familiarity with the provision of medical indemnity in New Zealand by international medical graduates from countries where medical indemnity was simply provided by the state or employer.
4. Employment obligations and arrangements for regional service developments. A small group was established (Pat Hartung, Cath Jackson and Angela Belich) to develop some principles for where members might expect to travel some distance to work in another workplace or DHB. This exercise is largely completed with a high degree of consensus reached.
5. Quarterly reporting on clinician engagement and leadership in the context of the *In Good Hands* principles and transformation requirements.
6. Variable experiences of clinical leadership in DHBs.
7. Hospital after-hours trials.
8. 'Expressions of Interest' and subsequent business case process for primary care providers.
9. Excessive obligations when claiming CME expenses. This had been a recurring issue in several Joint Consultation Committees. The DHBs have now agreed to take back these concerns to human resource managers and chief finance officers.
10. Arrangements during anticipated resident medical officer strikes.
11. Variations to the national DHB MECA. The Association raised concerns about inconsistent approaches to DHB specific variation to the MECA.
12. Specialist vacancy and turnover data.
13. Questionable use of external and other (non-medical) consultants by DHBs.
14. How to demonstrate health sector productivity and effectiveness.

While the discussions have generally been good and positive, neither the Association nor the DHBs are maximising the NCC's potential. There is consensus that the NCC needs to be more outcome focussed. To assist this the terms of reference will be revisited with a view to greater relevance.

Joint Consultation Committees (JCCs)

This is the fifth year that the DHB-Association Joint Consultation Committees (set up under the national DHB MECA) have been in full operation. All JCCs, with the exceptions of the West Coast, have had, or are scheduled to have, at least three meetings by the end of this year. The third JCC for the West Coast had to be cancelled because of the Canterbury earthquake and we have had difficulty rescheduling.

The Executive Director attends most JCCs but the Assistant Executive Director and Industrial Officers have attended some (and the Senior Industrial Officer one). It is usual for chief executives to attend and give a verbal report on the current issues facing the DHB. These reports have tended to focus on DHBs financial situation and the planning process, mainly the District Annual

Plan but also the four draft regional service plans currently before the Ministry of Health (the four regional DHB groupings will be expected to forward the Ministry revised drafts by March 2011).

Overall there has been good attendance at JCCs by members who have become JCC 'delegates'. The meetings and the JCC delegates' emerging role as the 'eyes and ears' of the Association would be further strengthened by widening the departments and services represented on the JCC.

One issue that the Association has raised repeatedly at JCCs (and also at the National Consultative Committee) has been the process of reporting on the government's *In Good Hands* policy statement which the National President had an important role in developing. Despite several times appearing as if we had ascertained what the DHBs were required to report and when they were required to report it, different DHBs clearly had different ideas. It has become clear that no report generated by the DHBs will be nationally available this year.

Nearly all JCCs had cause to discuss two government initiatives; the 'expression of interest/business case process now called 'Better Sooner More Convenient' (or BSMC) in primary care (although only nine of these had been approved, many covered multiple DHBs). Particular concern has been expressed at the three Auckland DHBs with regard to possible devolution of hospital radiology funding to primary care, the five Midland DHBs over the Pinnacle 'expression of interest' recommending the devolution of around \$64 million to Pinnacle (not included in the subsequent business case), and a proposal to transfer West Coast DHB employed GPs to the PHO.

Some of the main themes have been:

1. Funding including district annual plans.
2. Effectiveness of clinical leadership and engagement.
3. Government health targets, especially the six hour target for emergency departments (eg, need for and effectiveness of assessment and planning units).
4. Restructurings including of clinical leadership have been discussed at Auckland, Whanganui, Hawke's Bay, Nelson Marlborough and Southern (the Whanganui and Southern proposals did not proceed because of strong opposition including from the Association).
5. The industrial climate, particularly the impact of forms of strike action on life preserving services agreements and patient safety.
6. Canterbury has spent some time dealing with consultation on the new hospital and on cellphone black spots. Car parking provides an ongoing theme of discussion at Counties Manukau.
7. Discussion of the physician assistant pilot or demonstration project has been a regular feature of the JCCs at the Northern DHBs (Northland, Waitemata, Auckland and Counties Manukau). It has also been discussed at other JCCs.
8. The Association has started to raise as a regular agenda item at each DHB any further Health Workforce New Zealand initiatives including the obligation for specialists to develop career plans for resident doctors from 2012 and the deployment of GP registrars in hospital settings.
9. The Association ensures that a regular agenda item is any pending formal review that would come within the consultation obligations of the MECA.
10. There have also been a number of DHB-wide projects discussed mainly focused on achieving efficiencies of cost cutting such as Concord (Auckland) and Rutherford (Nelson Marlborough).

Other issues discussed in the JCCs have included:

- Organisation and follow-up on engagement workshops (discussed below).
- Job sizing.
- The 'hospital after hours' project.
- Policies for sabbaticals, the use of CME expenses (eg, laptops, electronic aids and travel), and recording of CME leave.
- After-hours payments.
- Non-clinical time and 'clinical creep'
- RMO issues.
- Rights of private practice and conflict of interest.
- Appointment processes for senior medical/dental staff including clinical leadership positions.

Joint ASMS-DHB Engagement Workshops

Since 2008 the ASMS and individual DHBs have been holding joint workshops on enhancing senior medical/dental staff engagement in their DHB. They are generally half-day (afternoon) with non-acute/non-emergency services not scheduled at the time, and have been well attended and successful. This year there have been nine workshops

Since the last Annual Conference workshops have been held in Northland (2), Waitemata, Waikato, Lakes, Tairāwhiti, Taranaki, Hutt Valley, and Capital & Coast, with a second workshop scheduled after Annual Conference in Lakes. The only DHBs where no workshops have been held at all since their inception are Auckland, Counties Manukau and Nelson Marlborough.

The subject matter has been wide ranging depending on the challenges facing each particular DHB. They have included general discussions on how best to get engagement (such as what needs to be changed and what is going well), formation of a clinical council, sub-regional service collaboration, primary-secondary relationship, utility of clinical indicators, DHB budgets, clinical governance and clinical leadership, and clinical involvement in planning cycles.

Surveying Full-Time DHB Senior Medical Staff Base Salaries

The survey provides a helpful comparison of the salary gains that have been made since the commencement of local bargaining in 1993 through to the last two national negotiations with DHBs and their predecessors. The comparison incorporates advancement through the salary scales plus changes to the scales.

Both the 16th (as at 1 July 2009) and 17th (as at 1 July 2010) annual survey of full-time equivalent (fte) base salaries for DHB employed senior medical staff were completed this year. The overall movement over the last six years reflects the pattern of MECA settlements with the much more significant movement in the average pay last year (2009) and minimal movement this year (2010):

- The annual increase between 2007 and 2008 was 10.2% for specialists and 9.3% for medical officers. Between 2008 and 2009 this increased by 6.6% to \$170,578 for specialists and by 6.0% to \$132,383 for medical and dental officers.
- The average base rate has increased for specialists by 0.8% to \$171,977 (\$164,520 for women and \$175,191 for men) between 1 July 2009 and 1 July 2010. The average base rate for medical officers has increased by 0.4% to \$132,881 (\$134,297 for men and \$131,243 for women).
 - Specialists in the Wairarapa on average have the best base pay and those in Waitemata the lowest. Medical officers have the highest average base pay in Lakes DHB while those in Auckland have the lowest average base pay.

- The top step of both scales has the greatest number of doctors on it of any step with 885 specialists on the top step (out of 3533) and 174 (out of 548) medical officers.

These are mean full-time equivalent base salaries and do not take into account hours worked in excess of 40 hours per week (which are recognised through job sizing), the availability allowance or other special enhancements.

Surveying DHB Senior Medical Staff Superannuation Entitlements

Superannuation has been surveyed now for 10 years with the 9th and 10th survey being reported this year. The pattern over the 10 years has been a gradual decrease in members who are in the closed GSF and NPF schemes and an increase in those who receive the 6% subsidy under the MECA clause. As at July 2009 474 were in GSF and NPF decreasing to 457 by 1 July 2010 with 2,909 receiving the 6% contribution on 1 July 2009 and 3,029 as at 1 July 2010.

Constitutional Amendments: Association Branches

The National Executive has been considering for some time a proposal to amend the Association's Constitution as it relates to the conduct of branch business and the election of branch officers. It arose from a National Executive discussion in September 2008 about the role of Association delegates on the Joint Consultation Committees, which, in turn, led to a discussion about the role and functioning of the Association's branches.

At its meeting on 14 May 2009 the National Executive authorised the preparation of a discussion paper and consideration of possible constitutional amendments relating to branch officers and management. This paper *Aligning Branch Structures with Effective Functioning* was subsequently approved by the National Executive and went to the 2009 Annual Conference for wider discussion (but not deliberation).

On 29 April 2010 the National Executive approved constitutional amendments for consideration by the 2010 Annual Conference. These have been previously forwarded to branches as a remit in accordance with the Constitution and are also attached to this Report.

In summary the recommended amendments:

1. Retains the current Clause 15 without change. This clause simply sets up the branches.
2. Deletes the current Clause 16 that deals with Branch Meetings & Business.
3. Inserts a new Clause 16 dealing with Branch Officers & Committees.
4. Inserts a new Clause 17 dealing with Branch Meetings & Business.
5. Would require all subsequent clauses in the Constitution to be re-numbered.

Key Features

Key features of the proposed amendments are:

1. To create two branch positions, a Branch President and a Branch Vice President who collectively would be known as the 'Branch Officers'.
2. The Branch Officers will be elected for two-year terms, in ballots organised and conducted by the national office.
3. The Branch Officers would be responsible for the management of branch business. They may (but are not required to) appoint a branch committee to assist them.
4. Members of a Branch Committee, where it is decided there should be one, may be appointed or co-opted by the branch Officers or elected at a Branch Meeting. Members of a Branch Committee may also include members from the region who are employed by non-DHB employers.

5. The Branch Officers may work closely with the local senior medical and dental staff group by taking branch business to meetings of the senior staff group for discussion and a formal decision, if that is appropriate.
6. It is important to note, however, that the branches, through the Branch Officers, would keep control of branch business by determining to what extent Association business would be referred to the senior medical and dental staff group and whether it is simply for wider debate or a formal decision.
7. There is still a mechanism for local members to call for meetings of the branch, as there is for members who are dissatisfied with a decision of the branch or of its Branch Officers, to refer the matter to the Executive Director and the National Executive for resolution.
8. Similarly, the current provision for secret ballots on branch matters is retained.

Medical Council Matters

During the past 12 months the National Executive has considered a number of Medical Council matters.

Memorandum of Understanding with DHBs

On 18 August the DHBs and Medical Council signed a Memorandum of Understanding which is much more detailed and comprehensive than the statement of collaboration that they have had in the past. It includes an oversight group which will report to the quarterly meeting of DHB chief medical advisers/officers. Its scope covers detailed undertakings from both parties on registration, practising certificates, orientation, induction and supervision of international medical graduates, re-certification, intern learning, competence and conduct, sharing of information on doctors who are not employees, and doctors' health. The Memorandum will be reviewed two yearly or earlier.

Strengthening Recertification Requirements for Doctors Registered in a General Scope of Practice

In April the Medical Council initiated consultation on strengthening recertification requirements for general registrants. The Association has over 400 members classified as medical officers, most of who are employed by DHBs. The existing arrangement for medical officers to obtain recertification was by either participating in a College programme plus credentialling and performance appraisal by their employer or by having a collegial relationship with a doctor in their vocational scope of practice who is meant to assist them to meet Council's requirements.

The Council proposed that general registrants (who are not in a formal training programme or are in non-clinical practice) participate in an accredited programme that includes a three yearly practice visit or regular practice review run largely by colleges (reincarnated as council branch advisory bodies). It also proposed to remove or improve the collegial relationship model. The Council is looking to the new regime for general registrants being in place by 1 July 2012 but general registrants are encouraged to participate in such a programme prior to that.

In response the Association wrote to the Medical Council advising that:

- Requiring general registrants currently participating in continuing professional development with a college to shift to the system proposed by the Medical Council is unnecessary particularly as the evidence for the efficacy of practice visits have yet to be presented. Inclusion of a regular practice review in this programme should be voluntary for a college without (in effect) requiring them to disclaim all responsibility for a general registrant if the college does not want to engage in a programme of compulsory practice visits.

- The issue of costs and resources had not been addressed in the consultation paper. It should not be expected that CME expenses will cover these costs. College fees may also be a problematic method of funding for doctors not associated with a college.
- Abolishing the collegial/oversight system requires more discussion than an aside buried in a consultation paper that appears to be about something else. The new system for supervising IMGs would mean that, post-general registration, the primary relationship will be with the employer rather than a professional type apprenticeship relationship.
- The Association did not believe that with this proposed change for over 400 of our members it was sufficient to send a general letter with a limited consultation period.

Supervision of International Medical Graduates

The Medical Council has now moved to the new system for supervising international medical graduates (IMG) which was the subject of consultation in 2009. It means that rather than supervision of an IMG being an individual to individual relationship IMGs will be supervised in an approved practice setting (APS). A working group (which includes chief medical officers) has been meeting to set criteria for the accrediting of APSs. The process will be through a paper audit using self-assessment. The Council has consulted further on how accreditation should take place and is considering whether accreditation with another body should be sufficient for achieving APS status. There is, for instance, a requirement for an APS to have at least two vocationally registered doctors in the same scope as an IMG, including evidence of how supervision would work across sites.

The National Executive decided that a brief submission should be sent to the Council because of some causes for concern as well as the overriding issue of time for supervision (which the Council believes will be no greater than in the previous system). If a DHB does not adequately observe the appointment clause in the national MECA our members will no longer have the option of indicating that they are uncomfortable about supervising a particular IMG. Further, alternative accreditation systems may not specify some of the important issues set out in the Medical Council form especially the requirement for at least two vocationally registered doctors (others include clinical governance, annual appraisal and peer review).

‘What to do when you have concerns about a colleague’

After going through a consultation process a draft statement called ‘what to do when you have concerns about a colleague’ has now been adopted by the Medical Council. On the whole the statement is a sensible outline of appropriate actions in the circumstances. However, the Association has advised the Council of some concerns. In particular:

- The statement did not make clear that the responsibilities in the Health Practitioners Competence Assurance Act apply to all health practitioners and seems less enthusiastic about doctors reporting on other health professionals than reporting on doctors perhaps because the Council is taking care not to encroach into the territory of the other regulatory authorities.
- There was an inappropriate use of the term ‘personal grievance’ (as per the Employment Relations Act).
- The statement did not make sufficiently clear that the HPCA Act provides protection from any civil or disciplinary proceedings for any health professional who reports on another in good faith on either competence or health.

Policy on Interns

Following consideration by the National Executive at its February meeting the Association raised concerns over clarification with the Medical Council over its proposed changes to their policy on interns. Interns would no longer be rostered on nights in their first six months unless a 'more senior medical staff member is available on site' rather than the previous situation where 'senior medical staff' are able to attend the ward within ten minutes. Six months post-registration they would be able to be rostered on nights if a 'senior medical staff member' is available to attend the ward within 10 minutes.

The draft policy then went on to change terminology in a confusing way by referring to the need (where a hospital doesn't maintain on site supervision) to ensure a 'senior doctor' is available within 10 minutes of a request to attend (changed from a senior doctor being 10 minutes drive away). It was probably clear from the context that what is meant by 'senior doctor' and 'senior medical staff' in this context is the same as 'more senior medical staff' (ie, a registrar or equivalent but not a house officer but was nevertheless confusing).

Revision of the Medical Council's Statement on Non-Treating Doctors

The National Executive resolved not to make a submission on the Medical Council's revision of its statement on non-treating doctors. It was considered that the changes were sensible. The main implications were for Association members employed by ACC.

Legislative Barriers to Workforce Innovation

In late April the Association received a letter from the Minister of Health with the title 'legislative barriers to workforce innovation'. It included a list of sections of legislation which restricted various statutory powers and functions to doctors and required feedback within a month. Our initial decision was to leave any comment to the colleges. However on closer examination it was clear that the power of duty rested more with a registered medical practitioner rather than a doctor of any particular speciality.

The more disturbing connotation of the letter was that legislation restricting various statutory functions to registered medical practitioners is regarded as a 'barrier to workforce innovation' rather than an important protection of the health and safety of the public. It is possible of course that some of this legislation is outdated or no longer necessary and assessing it to discover whether this is so may be timely. However, the questions in the letter do not address the issue of safety but are focused on which legislation is the most significant barrier. Each of these 66 items needed to be assessed separately to see whether the restriction was any longer necessary or whether another health professional could perform the function either instead of or along with a doctor. In the limited time available the NZMA attempted to do so.

The way the approach was couched is to set up any opposition as 'patch protection' which was slightly offensive in itself. Rather than the Association taking a lead role in dealing with what appeared to be a systematic approach to disentangling medical practitioners from any special role embedded in legislation, the National Executive resolved to be supportive of the NZMA and any college which lobbies the Minister to take a more safety conscious rather than ill-considered approach.

Physician Assistant Pilot

The Association has been following with interest the Health Workforce New Zealand supported physician assistant pilot in Counties Manukau DHB which, after some delays, is now underway with two physician assistants recruited from the United States working in its general surgery department. There were major difficulties in the setting up of the pilot due to its top-down decision-making and the insistence that they work in electives whereas the advice of the general surgeons was that it would be better to have them assisting house surgeons with acute cases. The

Association did not take a position on the pilot and, along with the NZ Nurses Organisation, did not accept a request from the Resident Doctors' Association to support a legal challenge to the pilot. Nevertheless in the first instance we believe it makes more sense to pilot better use of existing occupational groups such as nurses rather than create a new group not covered by the Health Practitioners Competence Assurance Act.

However, the Executive Director has kept in contact with the general surgeons and our approach has been consistent with their advice. At one point out of exasperation the general surgeons pulled out of the pilot but within 24 hours agreement had been reached on terms acceptable to them including the reallocation to acute cases. The difficulty will come in the evaluation of the pilot because the department selected is strongly functional and effective already and because of the uncertainty of whether the success will be due to the nature of the position or the personalities of the individuals. The Assistant Executive Director also attended a conference on the South Australian and Queensland physician assistant pilots in Adelaide in October.

Roundtable Meeting on Provision of 24/7 Acute Care in Provincial Hospitals

On 26 March the Executive Director attended a roundtable meeting on the provision of 24/7 acute care in provincial hospitals convened by the Ministry of Health. It was chaired by retired physician Dr John Henley assisted by Dr David Galler (in his then capacity of Principal Medical Adviser) with a range of people from various organisations, several who were specialists (list of attendees attached).

The purpose of this project is to develop a greater understanding of the existing and potential vulnerability of 24/7 acute service provision in provincial hospitals, so that action can be taken at appropriate levels of the system (district, regional, national) to reduce the risk of service failure. Ten hospitals across New Zealand were identified as provincial for the purposes of this project. This project is part of a wider body of work commissioned by the Minister of Health to strengthen health services. The issues raised at the meeting are being used by the Ministry to inform further sector engagement, leading to development of an agreed action plan, including future structures and processes required to advance the project through implementation.

The process was not about assessing the hospitals' individual capability or capacity, but rather assisting them to maintain the appropriate level of care. The focus was primarily but not exclusively on the senior medical officer workforce, given that their presence or absence was pivotal to the viability of an acute service. Similarly, the focus was not on issues specific to particular specialties, but rather generic issues. The context for the acute care in provincial hospitals project involved the challenges facing the health system, including workforce availability, and development and implementation of government health policy, including the recommendations of the Ministerial Review Group.

Possible solutions to problems were identified in the following areas - workforce availability, quality and volume relationships, role of the colleges in training, accreditation and registration, service configuration and models of care, and systems issues.

Paul Henry

On 9 August the Executive Director was interviewed by TVNZ's *Breakfast* programme following an article the previous day in the *Sunday Star Times* on the Association's issues paper on the status of the specialist workforce crisis in DHBs. The interview was conducted by the programme's co-host Pippa Wetzell. The interview itself was not controversial but immediately after there was further dialogue between her and fellow co-host Paul Henry during which the latter made some derogatory references about overseas trained doctors working in New Zealand.

That same day, in response to these references (and to some membership complaints), the Executive Director formally complained to TVNZ about Mr Henry's comments. On 20 August he received a verbal apology from the programme's editor which was quickly followed by a formal

apology. Given this the National Executive decided to take no further action. These developments were reported to members in *ASMS Direct*. Mr Henry has subsequently left the employment of TVNZ following a later more controversial incident.

Pan Professional Medical Forum

The Pan Professional Medical Forum, formed in 2005 and comprising the Council of Medical Colleges, the Association, Resident Doctors' Association and NZMA, has held four meetings to date since the last Annual Conference. The meetings are now facilitated by new CMC chair, Dr Lindy Matthews. It continues to be less active than previously and its utility is still open to debate. It appears to still serve a useful purpose but it is not realising its potential. Subjects discussed include:

- Updates from the Association and the RDA on their respective MECA negotiations.
- Implications of the high profile resignation of the Capital & Coast DHB chief executive.
- Primary care led 'expression of interest' and business case process, including implications of clinician engagement and leadership.
- NZMA organised conference on the 'role of the doctor' (1-2 November).
- Physician assistant pilot at Counties Manukau DHB.
- Health Workforce New Zealand including the utility of its communications.
- Reliability and accuracy of Medical Council workforce data.

Council of Trade Unions

The Association continues to benefit from our affiliation with the Council of Trade Unions (CTU) at both a national office level and with the affiliates. The Executive Director (or in his absence the Assistant Executive Director) usually attends the CTU's quarterly National Affiliate Council while he (or the Assistant Executive Director) participates in the Health Committee along with the Nurses Organisation, Public Service Association and Service and Food Workers' Union. The work of the CTU on analysing health spending and Vote Health in the Budget has been very valuable.

Our affiliation also allowed the Executive Director to attend an important meeting in February chaired by Minister of State Services Tony Ryall and including Deputy Prime Minister Bill English, the Ministers of Education and Tertiary Education, senior public servants, CTU, and other representatives of state sector unions on the broad state sector policy and industrial environment.

There have been three Council meetings to date but the Association has only been able to attend two of them (a fourth is scheduled after Annual Conference). There was also a special Council amendment to consider the CTU's response to the Government's announced proposals to amend the Employment Relations Act.

Issues considered by the National Affiliate Council, included:

- The CTU's 'fairness at work' campaign which includes the amendments to the Employment Relations Act.
- Formation of 'Together', a union being set up by the CTU to allow employees in workplaces without collective agreements and union coverage to join at low cost.
- The CTU's submission on the Public Health and Disability Amendment Bill which was consistent with the Association's position.
- Review of the Holidays Act.

Meetings with Director-General of Health

The Executive Director continued his regular informal meetings, usually monthly, with the Director-General of Health (Stephen McKernan until his departure and then Andrew Bridgman acting in the role) with seven held to date (another meeting is scheduled for later this year). These meetings are very useful to the Association and the Director-General also identifies significant benefits. There is also important informal contact between the Executive Director and the Director-General.

The Association had a very close and professional relationship with Stephen McKernan and greatly appreciate the importance he attached to his relationship with us. His understanding of how health systems work and the values that underpin them was very impressive. We wish him well for the future. After a period of delay and some controversy over the advertising process a promising appointment was made with the Chief Executive of the National Health Service in Scotland, Dr Kevin Woods. The Association issued a media statement welcoming his appointment and noting his commitment to and experience of clinical networks and workforce development and planning.

These informal meetings are an opportunity to raise issues, perspectives and differences that might not otherwise be brought to the Director-General's attention. Topics for discussion included:

- Updating on our national DHB MECA negotiations.
- Industrial action in DHBs.
- Primary-secondary integration including the weakness of the 'expression of interest' business case process.
- Monitoring and reporting requirements for *In Good Hands*.
- Director-General appointment process.
- Merger of Otago and Southland DHBs.
- Possible privatisation of Lakes District Hospital (Queenstown).
- Otago-Southland consultation process for unfunded treatments.
- Specific internal DHB problems.

Following the establishment of the National Health Board as a unit (the largest) within the Ministry of Health and his appointment as its National Director, the Executive Director has also had three informal meetings with Chai Chuah as well as additional informal contact. Subjects have included:

- Application of *In Good Hands* including monitoring and reporting.
- Capital Investment Committee's advice to DHBs to discuss with the private sector what they are both considering in terms of capital investment.
- Association involvement in regional service planning.
- Association involvement in policy development over the management of acutes.
- The Association's national DHB MECA negotiations including the 'business case' process.
- Problems in specific DHBs, including dysfunction.

International Travel

The following international travel was undertaken by national office staff since the previous Annual Conference:

- The Executive Director attended both of the twice yearly Industrial Coordination Meetings organised by the Australian Medical Association, in conjunction with the Australian Salaried Medical Officers Federation. The first was in Canberra in April. Issues discussed of particular interest included the proposed new federal health policy, ASMOF developments in Queensland and New South Wales, physician assistants, ramifications for New Zealand of increases in Australian medical graduate numbers, the recently established Health Workforce Australia, recognition of non-clinical duties in Victoria, and salary sacrifice fraud in Western Australia.
- The Executive Director visited Sydney in September to attend the second Industrial Coordination Meeting. Some of the issues he reported back on were the federal National Health and Hospitals Network Agreement, independent hospital pricing authority, activity based funding, and Local Hospital Networks, representation of resident doctors in New South Wales, doctor union representation in Queensland, medical workforce developments, physician assistants, and the application of the current 'heads of agreement' in Victoria. There was also a guest speaker; Dr John Buchanan (University of Sydney) on health union involvement in future health reform. While in Sydney he also met ASMOF and AMA (NSW).
- The Executive Director visited the United States and Europe during 18 May-5 June with the main purpose being to attend the Convention of the Committee of Interns and Residents in Boston and the British Medical Association's consultants' conference in London. He also visited the Union of American Physicians and Dentists in Los Angeles (a counterpart union); the local branch of the Doctors Council (another counterpart union in the United States) and Physicians for a National Health Programme in Chicago; Marburger Bund in Berlin (our counterpart union in Germany); Landelijke Vereniging Van in Amsterdam (our counterpart union in Holland); and the Irish Medical Organisation and Irish Hospital Consultants Association in Dublin. In London he also met officials of the British Medical Association (including the Chief Executive) and Medical Protection Society while in Boston he also met the Doctor Council (a counterpart union). Subjects discussed in these meetings included doctor unionism in the United States, updating on developments in the American health system, an industrial dispute (including strikes) in Germany, developments in the Dutch health system, the effect of the recession on the national consultants contract in Ireland, developments in the National Health Service in the United Kingdom (including practice based commissioning, polyclinics in England and revalidation), and issues affecting consultants, junior doctors, general practitioners, and staff and associate specialists in the United Kingdom.
- The Assistant Executive Director visited Canberra on 29 September to attend a summit hosted by the Australian Medical Association to consider the difficulty in placing trainee interns for the 2011 year and beyond. Then, on 1 October, she attended the 'Physician Assistant in Australian Healthcare' conference in Adelaide organised to consider the outcomes of the physician assistant pilots in Queensland and South Australia.

Association Publications

The Specialist, the Association quarterly newsletter (generously sponsored by the Medical Assurance Society) is a cornerstone of our advocacy work. Since the last Annual Conference the medical workforce crisis in DHBs and our national MECA negotiations have been the basis of key front page articles some of which have also attracted coverage in the mainstream media. These articles have been on:

- Strategic directions for our MECA negotiations.
- New Zealand's poor international (OECD) specialist workforce ranking.
- Loss of registrars to Australia.
- New Zealand's specialist workforce crisis threatens key government objectives.
- Quantifying the minimum specialist pay gap with Australia.

Other important articles have included:

- How the New Zealand health system compares with other countries.
- Health funding 2010 and beyond.
- Getting the primary-secondary interface right.
- Successful Association lobbying on the National Health Board.
- Fully funding ACC.
- Heroes and vigilantes.
- Health Budget for 2010-11.
- General Practice New Zealand.
- Devolution or integration: secondary services and primary care.
- Cognitive fluency.
- The case for ethical networks in New Zealand.
- Minister of Health's letter of expectations to DHBs.
- Amending the Public Health & Disability Act.
- Proposed changes to the Employment Relations Act.
- Fair and loathing.

In addition there have been regular columns by the National President, Executive Director and the Medical Protection Society.

The *ASMS DHB News* supplements *The Specialist* and plays an important role in local matters and supplying other relevant information. The main theme in all *DHB News* has been the joint consultation committees. This communication vehicle is also adapted for our members employed outside DHBs, largely in relation to collective bargaining.

We have also continued our email publication, *ASMS Direct*, which is produced on an as-needed basis. The membership circulation list is over 3,069. To date 17 issues have been produced this year. Much of this has focussed on the national MECA negotiations, specialist workforce crisis in DHBs including recognition by Minister of Health, the Director-General position, health spending including Budget analysis, *In Good Hands* including application and survey, Medical Council statements, Paul Henry controversy, changes to industrial law, and DHBs supporting members in the application of life preserving services agreements during strikes.

Other subjects covered included:

- The ASMS-IPAC (now GPNZ) joint statement.
- Proposal to expand current role of Pharmac to hospital medicines and some medical devices.
- Medical Council on Dr Ranchhod controversy.
- 'National Terms of Settlement'.
- Analysis of Ministerial Review Group (Horn) Report.
- John Hawke.
- Quality and Safety Commission.
- Resignation of Capital & Coast chief executive.
- Health Minister's announcements on medicine recall guidelines review, operating theatres productivity, DHBs quarterly reports, self-funded drugs in Dunedin public hospital
- RMO MECA negotiations.
- World Medical Association statements on doctors including engaging in public debate and prescribing.
- The Budget, specifically Vote Health.
- Credentialling framework.
- Funding public hospitals.
- DHBNZ medical workforce 'road show' (Professor Gorman).
- Health Minister's requirement for DHBs to share board members for greater collaboration.
- Launching of new health domain: .health.nz
- World Health Professionals Alliance on H1N1.
- Samoa.
- World Medical Association statements on climate change, patient safety & quality of care, and stress in the medical pressure.

The national *ASMS Direct* is also supplemented by local *ASMS Directs* on Association activities and local issues, mainly around the Joint Consultation Committees.

Four issues of our electronic publication, *Executive Direct*, have been sent reporting on the February, April, July and September Executive meetings.

The Executive Director has for several years had a regular column in the fortnightly *NZ Doctor*.

Membership

Once again the Association has had a record membership year (the eleventh in succession). Membership, as of 31 March 2010 was 3,496, compared with 3,481 at 31 March 2009, representing an overall increase of 15 (0.4%). It represents a 143% increase over the 1,440 members in our first year of existence (1989-90). The bargaining fee, introduced in 2008, attracted payments from 161 senior medical and dental staff; to date 46 bargaining fee payers have converted to full financial members.

It is interesting to note the annual membership pattern increase since 1998-99 (the last year where we had a membership decrease) – 1999-2000 (105 – 6%), 2000-01 (118 – 6.4%), 2001-02 (98 – 5%), 2002-03 (146 – 7%), 2003-04 (117 – 5%), 2004-05 (239 – 10%), 2005-06 (164 – 6.4%), 2006-07 (95 –

3.5%), 2007-08 (162 – 5.7%), 2008-09 (486 - 16%) and 2009-10 (15 - 0.4%) an overall increase of 99.5% over this period. Since our formation in 1989 there have been three years of membership losses – 26 (1.8%) in 1991-92, 47 (3%) in 1993-94, and 15 (0.8%) in 1998-99.

The annual average increase since our formation is 103 (4.6%). Under the period of the Employment Contracts Act (1991-92 – 2000-01) the average annual increase was 52 (3.3%). Under the period of the Employment Relations Act, since 2000-01, to date the annual average increase has been 169 (6.6%).

Currently membership is 3,532 (an increase of 36 since 31 March 2010) and, although membership growth in the latter part of the year is generally offset by subsequent resignation factors such as retirement that always occur at the end of our financial year, we expect the 31 March 2011 membership to exceed current numbers. The combination of recruiting new members and strong membership loyalty continues to be the key to our effective representation in both collective and individual matters.

Currently about 88% of our members pay their subscription by automatic salary deduction (about 77% of new members employed during the past year opted for fortnightly payments).

Again, despite incomplete information, it remains the case that few Association members are also members of the NZMA. Those who were NZMA members at the time of joining the Association represent an estimated 12% of our current members. Just 3% of members who joined the Association in 2010 were also members of the NZMA compared with 22% in 1996.

Medical Protection Society

The Association has continued our close working relationship with the Medical Protection Society, including working together on several cases where our respective roles overlap or intersect. Much of this involves the Senior Industrial Officer and other industrial staff working with the MPS representatives and lawyers on specific cases. The Executive Director visited the MPS in their London office in June. The Association also met MPS Chief Executive Tony Mason and Dr Rob Hendry from the United Kingdom last month while they were visiting New Zealand. The MPS provides a regular column for *The Specialist*. We are grateful for the generous decision of MPS to again sponsor the Conference dinner.

Medical Assurance Society

The Association's collaborative 'preferred provider' relationship with the Medical Assurance Society continues to strengthen. This includes the Society's generous sponsorship of *The Specialist* while the Association contributes to the Society's quarterly publication, *Hi Society*. The Society has also generously agreed to continue to sponsor the pre-Conference function this year.

The quarterly advisory consultancy meetings between the Executive Director (and Executive Officer) and Society Chief Executive Martin Stokes (and Sales and Marketing Manager Glenys Powell) continue. Discussions at these quarterly meetings have also included our concerns with our national DHB MECA negotiations, other health sector collective agreement negotiations, the impact of the economic recession on the Society, the Canterbury earthquake, recent developments in the National Health Service in the United Kingdom, the application of *In Good Hands* in DHBs, the application of FBT and PAYE to the use of CME expenses for purchases (for personal ownership), and the Association's relationship with General Practice New Zealand. A fourth meeting is scheduled in December.

Association Finances

The Association's net surplus was \$478,761 for the financial year ending 31 March 2010 due mainly to the total expenses being under budget by \$195,000, interest earnings exceeding expectations and bargaining fees contributing \$81,148 to the annual income.

As advised in the last year's Annual Report the National Executive established an investment committee. It comprises the Vice President, Executive Officer and the Chief Executive of the Medical Assurance Society (Martin Stokes). Following recommendations by the investment committee in April, the National Executive adopted a revised & strengthened investment policy. In particular, it defines the objective more clearly and defines limits and types of investments.

Advertising Policy for ASMS Publications

Following discussion over the appropriateness of advertising specialist vacancies in the publications of New Zealand medical organisations the National Executive at its September meeting adopted the following as the Association's advertising policy for its publications, including the website:

The ASMS is the professional association and union representing senior doctors and dentists; working for better health care in New Zealand.

jobs.asms.org.nz solely advertises job vacancies for salaried senior doctors and dentists (specialists and medical/dental officers) within New Zealand; appointments that are outside New Zealand will not be published.

Recruitment agencies are permitted to place positions on the website on behalf of New Zealand employers. However all contact information contained within an advertisement must lead to the employer (not the agency); this includes logos and web-links.

Other categories of advertisement may be accepted at the discretion of the National Executive provided they meet the basic principles of Advertising Standards Authority New Zealand's Advertising Code of Ethics. Advertising on behalf of the alcohol, gaming and gambling, pharmaceutical or tobacco industries is expressly forbidden.

Administration

Following the resignation of Joanne Jourdain who relocated to Christchurch the administration team welcomed Administration Officer Terry Creighton on board in March.

In addition to the homepage revamp some effort has gone into optimising the website to attract the target traffic. This year has seen two additional surveys including the *In Good Hands* survey which was conducted in conjunction with researchers at the University of Otago to our full DHB membership. We have also developed an exit survey which retiring members and those changing employers are encouraged to complete.

Strong focus continues on communicating with members in a timely and efficient manner, enhancing the membership database, striving for efficiencies in all areas along with maintaining the professional standard of the Association's publications (including issues papers and reports for the MECA negotiations), and ensuring that National Office equipment and information technology are regularly updated.

Website

For some years the Association's website has been a regular 'one stop shop' for SMOs seeking advice and current industry information however any changes to the site were both infrequent and not immediately apparent. Consequently much thought was put in to utilising the website more widely in order to update both members and the general public on issues and make it a more natural place to go to for information about senior doctors and dentists, both industrially and on other issues. The new look homepage, completed in August, contains a lot more news items and visual interest, and makes better use of the space by dividing the page into three columns. The content is updated most days and is evident by the change of accompanying graphics; the homepage also contains an RSS news feed.

Job Vacancies Online (jobs.asms.org.nz)

For most senior doctors and dentists seeking employment in New Zealand the ASMS website is their first point of contact; it has New Zealand's most comprehensive listing of specialist and medical/dental officer job vacancies (50 on average) despite only half of the DHBs regularly utilising the service. Because jobs.asms.org.nz, is a service rather than a business venture, the rates are very affordable; proceeds are put into growing the market and enhancing our services to both jobseekers and their prospective employers. Recently we have committed to another year-long advertising campaign with *BMJ Careers*, the United Kingdom's principal publication for medical recruitment and careers advice with a print edition delivered to 110,000 doctors.

In conjunction with the *BMJ Careers* venture we refined our rates further and launched a marketing campaign to encourage all DHBs to list all of their vacancies on the site as they arise; there is no additional charge for the exposure received through the *BMJ Careers* promotional campaign. Incentives offered include one month's free advertising with any three-month listing, an annual fee cap which gives unlimited on-line advertising for a whole year for just \$3,000 and adaptations of this for employers with fewer vacancies. The response has been reasonably encouraging with a further three DHBs expressing interest in the annual advertising option. The greater the take-up of this opportunity the greater the advertising frequency we can achieve with *BMJ Careers* and the longer we will keep the campaign running.

Other Matters

NZMA Symposium on the 'Role of the Doctor'

On 1-2 November the NZMA organised a well attended and successful symposium on the role of the doctor. The large majority of the around 80 attendees were doctors from various professional bodies, colleges and doctor unions. The main guest speaker was Professor Sir John Tooke, Vice Provost (Health) and Head of the Medical School, University College, London. The Association was represented by the National President and Executive Director. A feature of the conference was the development of a statement on the role of the doctor.

Trends in Service Design

The Association was requested by the Minister of Health to comment on a draft Ministry of Health paper, *Trends in Service Design and Models of Care*. As well as taking up the failure to clearly identify that specialist services are provided at secondary hospitals, issues to do with regulating standards, travel demands for specialists and the risk of causing GPs in small practices to leave the workforce, the Association's advice to the Minister emphasises that changes in service design should be regarded as experimental and therefore should be "monitored, measured and reported on."

Requests for Financial Support

The National Executive is considering a request for financial support from the organisers of the 'Health of the Health Professional' conference in Auckland, 3-5 November 2011. This is a biennial Australasian conference which has previously been attended by the Senior Industrial Officer (also by Industrial Officer Lyn Hughes last year).

On the other hand, the National Executive declined a request to financially support a seminar attached to a conference organised by the Mayo Clinic in Wellington on 15 February 2011 because it has not been the Association's role to financially support conferences of this nature.

Revised Vocational Training Programme for General Practitioners

Health Workforce New Zealand has established a reference group for the project to design and implement a new vocational programme for general practice. The Association was invited to forward a nominee and Dr Peter Freeman has been selected. He chairs the New Zealand Faculty of the College of Emergency Medicine and is Vice President of the College's Council.

Inaugural World Healthcare Networks Conference

The inaugural World Healthcare Networks Conference co-hosted by General Practice New Zealand and the Australian General Practice Network was held in Auckland on 22-24 July. It was a well attended and interesting event. The Executive Director attended on the second and third days including participating as a panel member on the subject of 'Fusing Organisational Cultures: Overcoming the Structural and Attitudinal Impediments to Collaboration and Integration.'

NZMA Specialist Council

The Association has received a request to send a representative to attend meetings of the NZMA's Specialist Council. It is currently being considered by the National Executive.

RDA 25th Anniversary

The Resident Doctors' Association requested that the Association publicise its 25th anniversary. The National Executive agreed to a brief notice in *The Specialist* at no charge.

Brian Craig
ASSOCIATION NATIONAL SECRETARY

9 November 2010

Attachment: National Executive's Recommended Constitutional Amendment

15 BRANCHES

- 15.1 For the purposes of promoting and organising local activities the membership of the Association shall be divided into local branches with at least one branch in each district health board region.
- 15.2 Each branch is entitled to appoint and send one or more representatives to annual and special conferences of the Association, in accordance with clause 10.3(d) of this constitution.
- 15.3 The National Executive may from time to time establish additional branches, based around one or more employer or on some other basis, to encourage or facilitate greater membership involvement in the activities of the Association.

16 BRANCH OFFICERS & COMMITTEES

- 16.1 Each branch shall elect a President and a Vice President who shall be the Branch Officers. The Branch Officers shall be responsible for managing the business of the branch and shall be elected for two-year terms that will begin on 1 July in alternate years.
- 16.2 The Association's national office shall conduct biennial elections for Branch Officers in the three months immediately proceeding 1 July in an election year. The national office shall also conduct elections to fill any casual vacancies that may arise. A Branch Officer who is elected to fill a casual vacancy in a mid-term election shall hold that position for the remainder of the two-year term.
- 16.3 To assist them to conduct the business of the branch, the Branch Officers may establish a Branch Committee. Members of a Branch Committee may be appointed by the Branch Officers or elected at a meeting of the branch.

17 BRANCH MEETINGS & BUSINESS

- 17.1 In managing the business of the branch, Branch Officers may work closely with any local senior medical and dental staff group that exists and, whenever it is appropriate to do so, to refer Association or branch business to meetings of the senior medical and dental staff group to encourage wider discussion and participation in branch decisions.
- 17.2 If it is practical to do so, branches shall hold at least one formal meeting a year for the purposes of facilitating formal discussion within the branch and consideration of remits for the Annual Conference. Otherwise, branch meetings shall be held as frequently as the Branch Officers or local membership interest may require and at such other times as the National Executive may request.
- 17.3 The Branch Officers shall convene a branch meeting if four members or 10% of the branch membership (whichever is the higher number of members) requests it.
- 17.4 If five or more members of a branch are dissatisfied with any decision of their Branch Officers or of a branch meeting they may send a formal written statement of their concerns to the Association's Executive Director. The Executive Director shall promptly refer the matter to the National Executive for its consideration and a decision as to how the matter should be resolved.
- 17.5 Decisions at branch level will normally be made by a majority of branch members present and voting at a branch meeting. However, if 20% of the branch members attending the meeting request a secret ballot a secret ballot shall be conducted of all branch members.