ANNUAL REPORT

2012

Table of Contents

National DHB MECA Settlement and Forthcoming Negotiations 3
Preparation Process 3
'Technical' Discussions 4
Constitutional Amendments 5
Activity in the Non-DHB Sector 5
General Practice 5
Rural Hospital Medicine 6
Hospices 6
Other Health Services 6
Industrial Team's Activities 6
Job Sizing /Back Pay 7
Service Reviews/Changes to Working Arrangements 7
Right to Make Public Comment 7
Advice to New Appointees 8
Complaints by or about Members 8
Long-term Illness & 'Return to Work' Plans 8
Suspensions and Clinical Competence Reviews 8
'Involuntary' Termination of Employment 9
Salary Overpayments 9
Mediation & Legal Costs 9
Parental Leave 9
Developments in Continuing Medical Education in DHBs 10
Health Sector Relationship Agreement 10
National Joint Consultation Committee 11
Joint Consultation Committees 11
Joint ASMS-DHB Engagement Workshops 14
National Bipartite Action Group 15
Surveying Full-Time DHB Senior Medical Staff Base Salaries 15
Extra Hospital Doctors Claim 15
North Shore Elective Surgical Centre 16
Application of New MECA Salary Scales by Auckland DHBs 17
Employment Relations Act Changes 19
State Sector Reform (Public Finance) Bill 20
Government Expectations for Pay and Employment Conditions in the State Sector 21

Health Benefits Ltd 21
Ministry of Health Budgetary Information 23
Proposed Restructuring of 'Responsible' (Regulatory) Authorities: Medical Council 24
Physician Assistants 25
Trans Pacific Partnership Agreement 26
Council of Trade Unions 26
National Affiliate Council 26
Meetings with Director-General of Health 26
International Travel 27
Association Publications 27
Membership 29
Medical Protection Society 30
Medical Assurance Society 30
Association Finances 31
Administration 31
Website 31
Job Vacancies Online (jobs.asms.org.nz) 31
Other Matters 32
World Medical Association: Ethical Implications of Doctors Strikes 32
Euthanasia 32
Medicines Amendment Bill 32
Recertification of General Registrants 33
Budget 2012-13 33
Northland DHB Laboratory Review 33
Clinical Ethics Network Survey 33
Draft Principles for Workforce Redesign 34
Surveying DHB Senior Medical Staff Superannuation Entitlements 34
Ko Awatea 34
Marlborough Branch 34
Associate Membership 34

Annual Report 2012

The major challenges since the 23rd Annual Conference in November 2011 have been concluding the national DHB multi-employer collective agreement (MECA) negotiations and preparing for the next negotiations commencing early 2013; the work of Health Benefits Ltd; the proposed operating of Waitemata DHB's planned Elective Surgical Centre at North Shore; the review of the Health Practitioners Competence Assurance Act currently underway and Constitutional amendments.

The National Executive comprises:

President	Jeff Brown (MidCentral)
Vice President	Julian Fuller (Waitemata)
Region 1	Judy Bent (Auckland)
	Carolyn Fowler (Counties Manukau)
Region 2	Andrew Darby (Waikato)
	Paul Wilson (Bay of Plenty)
Region 3	Hein Stander (Tairawhiti)
	Tim Frendin (Hawke's Bay)
Region 4	Brian Craig (Canterbury; also National Secretary)
	John MacDonald (Canterbury)

The biennial term expires on 31 March 2013. Nominations will be called for before the end of the year and the elections conducted early next year.

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. In addition it met by teleconference on 19 December where it voted to ratify the proposed settlement of the national DHB MECA following consideration of the result of the membership indicative ballot. On 8-9 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.
- Our approach to Joint Consultation Committees, including the promotion of the joint ASMS-DHBs *Quality & Patient Improvement Safety Plan*.
- Supporting and developing the new branch structures.
- Planned North Shore elective surgical centre.
- Re-elected government's health and industrial relations policy.
- Review Executive performance.

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

- Dr Anne Kolbe, Chair, National Health Committee (also David Graham, NHC Establishment Manager).
- Dr Kevin Woods, Director-General of Health (along with Dr Don Mackie, Ministry of Health Chief Medical Officer).
- Hon Maryan Street MP, Opposition health spokesperson.

A feature of the year was the holding of two national branch officers (presidents and Vice presidents) workshops in May and September, largely on the MECA negotiations. These were well attended, valuable for the National Executive (and national office staff), and appreciated by the branch officers. They are discussed briefly further below.

In an important development the National President discussed with the rest of the National Executive at its February meeting the value of investigating a possible Maori name for the Association. The Executive was supportive of this initiative subject to cultural appropriateness and authorised him to further investigate. Further progress will be reported at Annual Conference.

Other key activities were the Joint Consultation Committees in the 20 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; nine days a fortnight), Lloyd Woods (Industrial Officer), Kathy Eaden (Membership Support Officer; nine days a fortnight), Terry Creighton (Administration Officer) and Ebony Lamb (part-time Administration Assistant). We also engage additional accounting support on a weekly basis to assist with financial accounting and reporting.

The National Executive has made three important decisions in respect of staffing. At its July meeting, in response to increasing workload pressures and membership needs (in part through increasing membership) and the need to be more proactive in some areas, it determined to establish a third industrial officer to complement Lyn Hughes and Lloyd Woods. Due to increased membership and associated demands it was also agreed to establish a new position of senior administration officer in the team led by Yvonne Desmond. At the end this meeting the Executive also recorded its appreciation for the high quality work and calibre of the national office staff.

However, our existing accommodation can't provide for these two positions. Consequently it was also agreed that either expanded or new premises were required. The Executive Officer is in negotiations with the building owner to take over the full space of the 11th floor in the Bayleys Building where the national office is currently located. Agreement on terms is looking promising and, if successful, heads of agreement will be signed before year end with the new lease expected to take effect next May.

Advertising the two new positions was delayed until the Association could be confident of securing the necessary accommodation. The Industrial Officer position has recently been advertised while the senior administration officer position is expected to be advertised early next year.

The third decision was at the September meeting to establish a new position of Researcher in order to enhance the Association's influence on workforce and other health policy issues. The position is fixed term in order for the National Executive to assess its effectiveness and relevance. Lyndon Keene has been appointed to the position. His background includes as a journalist,

Ministerial senior advisor and painter (artist). The Association has engaged him previously on a freelance casual basis largely on workforce issues (eg, the submission to the SMO Commission in 2009 and the background papers to the joint working groups in the last national DHB MECA negotiations). He also researched and wrote the *Health Dialogue* on Lakes District Hospital in Queenstown in 2011). This new position is half-time and until March 2014.

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.

Arising out of its informal meeting on 8 February the National Executive the following day resolved to:

- Strengthen the emphasis on using the national DHB MECA to support members doing their jobs.
- Invite members, through *Executive Direct*, to forward any issues they wanted raised to their Branch President or Vice President (with contact details provided).
- DHB based Joint Consultation Committees would be a regular Executive agenda item.
- Branch officers would be used for advice on or about 'red flag' issues.
- Use part of the first national branch officers workshop in May to discuss experiences on distributive clinical leadership and senior medical staff engagement.

National DHB MECA Settlement and Forthcoming Negotiations

Annual Conference last year received a full report on the proposed settlement of the MECA negotiations and voted to endorse it. The proposed settlement was referred to all DHB employed members in an indicative postal ballot. The ballot adopted the Executive's recommendation with 93% in favour of acceptance. The response rate was 63%. On that basis the Executive felt confident to ratify the settlement. Subsequently the new MECA was signed by the parties and forwarded to all affected members accompanied by an explanatory guide. Following the settlement being reached ballots of members and non-members were held in each of the 20 DHBs on the bargaining fee. The outcomes in all ballots were conclusive and the bargaining fee continues as part of the new MECA.

Preparation Process

With an expiry date of 28 February 2013 no sooner than one negotiation was concluded than the National Executive commenced preparation for the next. Below is an outline of the preparation process:

- On 9 February the Executive agreed that a 'blueprint' publication consistent with the principles of the *Business Case* (2010) should be prepared with external assistance obtained to undertake this work; Lyndon Keene was subsequently engaged. It was also agreed that the next negotiating team should be smaller in number compared with previous teams; that branch officers should be used as a consultative mechanism; and that a meeting should be sought with the National Health Board over the misleading extra 800 hospital doctors claim (discussed separately).
- On 2 May a national branch officers' workshops was held in Wellington to discuss the approach to the MECA negotiations. It included the use of breakout groups after a presentation from the Executive Director.
- On 3 May the Executive assessed the workshop to be a success and that a second should be held in September.
- On 19 July the Executive had a lengthy unresolved debate on our approach to negotiations in the context of the state of the economic, the aftermath of the Christchurch earthquake

and public perception. It was also agreed to accept a proposal from the DHBs to participate in 'technical discussions' later this year in advance of the formal commencement of negotiations early next year.

- The second national branch officers' workshop was held on 26 September with presentations from Ian Powell, which included a focus on the development of salary scales during the lifetime of the Association, the outcome of the NZ Nurses Organisation and Resident Doctors' Association MECA negotiation, and the environment we will be negotiating in, and Lyndon Keene on the 'blueprint' publication (a draft had been circulated in advance).
- On 27 September the National Executive resolved that the focus of the negotiations should be on the competitiveness of the salary scales, including additional steps on the top. It was also agreed that National Executive members not continuing on the Executive in the next biennial term (ie, from 1 April 2013) would be invited to continue on the Association's MECA negotiating team.
- On 9 October the 'technical discussions' commenced (discussed further below).

Having an expiry date of 28 February creates some organisational challenges for the commencement of negotiations with the summer break. Under the Employment Relations Act formal notification of the commencement of negotiations can't commence before 60 days of the expiry date (ie, 28 December). Further, it is not practical to hold negotiations in January. In part this is the reason for the 'technical discussions'. We have also set seven days for formal negotiations from 7-8 February to 12-13 March. At the 26 September branch officers' workshop there was interest in holding a further workshop soon after this date in order for the negotiating team to report progress and to discuss further directions.

'Technical' Discussions

The Association endeavoured to pursue the following issues through this new process:

- Paid parental leave.
- Days-in-lieu for CME taken on a non-working day.
- CME transferability between DHBs.
- Recovery time after call or shifts.
- Coverage by the MECA of new employment entities.
- Entitlement of new appointees to be covered by the MECA after the expiry date.
- The Bargaining Process Agreement (a legal requirement of the Employment Relations Act).
- A number of minor typographical changes.

The Association's team for these discussions was led by Assistant Executive Director Angela Belich with National Executive members Carolyn Fowler and Tim Frendin and Industrial Officer Lloyd Woods comprising the rest of the team.

Two meetings were held in October with the two advocates from DHBs Shared Services Stephen Gray and Aaron Crawford and a DHB Chief Operating Officer (Kieran McCann from Wairarapa DHB for the first meeting and Warrick Frater from Hawke's Bay for the second).

The Bargaining Process Agreement has been agreed (subject to initiation) with George Downward having once again agreed to be the 'clinical expert' required by Schedule 1B of the Employment Relations Act. Apart from that the process was probably worthwhile in that a number of minor duplications and mistakes have been cleared up and some areas of ambiguity identified. However, we made no progress on the other issues listed above possibly with the exception of the 'Days-in-lieu for CME taken on a non-working day' issue where the DHBs are looking to come up

with an appropriate wording (though they are clear that that will not make the issue a DHB claim).

The DHBs also came up with a list of issues to resolve including further minor typographical issues and some duplications. The substantive issue that they raised was a desire that the MECA stated that non-clinical time be done on DHB premises. We said that the ASMS position on this last issue was clearly set out in our *ASMS Standpoint on Professional Development & Education* which specifies that about two-thirds of non-clinical time should be done on site.

The parties are still working on some wordings but do not expect to meet again as part of this process. All the 'agreements' reached (such as they are) are subject to agreement in the formal negotiations.

Constitutional Amendments

At its July meeting the National Executive agreed to recommend to Annual Conference amendments to the Association's Constitution in two areas – secret strike ballots and Executive initiated Constitutional amendments. Background information on the proposed amendments, including the wording, has been provided to branches and members.

The Employment Relations (Secret Ballot for Strikes) Amendment Act 2012 became law in May. Under this Act unions are required by 15 May 2014 to include in their constitutions a provision that requires a secret ballot of affected members before they may take strike action. Unions that do not currently have such a provision in their rules are required to amend their rules as soon as is reasonably practicable after the commencement to Section 5 of the Act, which was 15 May 2012.

The Association does not have a strike ballot provision in its Constitution. Although the matter could be left until next year, the Executive considered it to be sensible to consider it at this year's annual conference.

The Executive approved a recommended clause that meets the statutory requirements. The first four procedures, including the wording that must appear on the ballot paper, are expressly required by the legislation while the fifth point (about the National Executive determining such other procedures as may be practical and necessary to conduct the ballot) will allow a degree of flexibility to meet the particular circumstances at the time.

The second area is National Executive initiated Constitutional amendments. Under the current Constitution, there is provision for branches and members to initiate and submit constitutional amendments, but no express provision for the National Executive to do so. This has not caused any difficulty in the past and is unlikely to do so in the future; nevertheless the Executive believes it would be sensible to clarify the position by giving the National Executive express authority to initiate constitutional amendments.

Activity in the Non-DHB Sector

Advocates over the past year for collective bargaining were Angela Belich, Lyn Hughes and Lloyd Woods. These collective agreements are highly dependent on a group of very active ASMS members who sometimes face considerable employer opposition to their attempts to negotiate collectively. The National Executive appreciates these members who joined or assisted negotiating teams. Their input and assistance is the key to continued successful bargaining.

General Practice

It is possible that general practice will become an area of growth for the Association. At present the Resident Doctors' Association, after some difficulties, is negotiating a collective agreement for general practitioner trainees with the Royal New Zealand College of General Practitioners. Some very high percentages are quoted for the proportion of general practitioners who are employees

but it is difficult to distinguish between those who are employed by a company that they themselves own and those on a more standard employment arrangement.

The industrial team works with some GPs employed under individual agreements. Typically GPs as employees undervalue conditions and allow salary rates to atrophy over time so that a competitive salary in year one starts to look uncompetitive in, for example, year five. The industrial team negotiate collective agreements for very small numbers (as small as two) to try and give some sort of protection to these members.

The biggest GP-group that the Association represents comprises 22 GPs in the Wellington region union health centres. Presently we are trying to negotiate a separate MECA for them having withdrawn from a multi-union collective agreement with other unions covering nurses and other employees. This new collective agreement will be the first exclusively general practice MECA.

Ngati Toa Hauora, which it is hoped will eventually be included in this Wellington GP MECA, has an established collective agreement which was renegotiated this year. Other collective agreements are very small and employers are struggling to recruit - Te Oranganui (Whanganui); Christchurch union health centre; Waitakere/Otara union health centre; and Hokianga Health have long standing collectives. All have been renegotiated or are in the process of renegotiation. Settlements have been around 2% to date.

Rural Hospital Medicine

The Faculty of Rural Hospital Medicine is part of the College of General Practitioners and nearly all of these graduates will be covered by our DHB MECA at small hospitals such as Taupo, Thames, and Queenstown or by our separate non-DHB collective agreements at Hokianga, Oamaru and Dunstan. All rural hospital specialists are likely to spend most of their working lives with conditions determined under a collective mostly the DHB MECA. This year the Oamaru and Dunstan Hospitals collective agreements were both renegotiated to match the DHB MECA.

Hospices

The Hospices MECA, which covers 10 hospices, was rolled over and expires in April 2013. The Association also negotiates the collective agreement for members employed by the Otago Hospice which we hope to eventually incorporate in the MECA years. The Association continues to recruit members at hospices not covered by the MECA and bring them under the Hospice MECA. The Employment Relations Act currently allows us to include employers were we have only one member under a MECA where as we could not negotiate a stand-alone collective agreement with fewer than two members.

Other Health Services

The New Zealand Blood Service collective agreement is closely tied to the DHB MECA. This was successfully renegotiated and expires in June 2013. The Family Planning Association collective agreement was renegotiated this year with an increase of 3% for 2011 and 2% for 2012. It expires in October next year. The Queen Elizabeth Hospital collective agreement covering rheumatologists has been renegotiated with an increase of 2%. It expires in May next year.

Industrial Team's Activities

The Association has an experienced industrial team to advise members about their various employment entitlements, to assist them in the application and interpretation of their employment agreements and to advise, represent and otherwise support them as they respond to complaints arising from their employment. Each year as the membership has increased and the range and complexity of issues have widened the industrial team has become busier contributing to the National Executive's decision to establish an additional industrial officer position.

The industrial team is led by Assistant Executive Director Angela Belich and has been fully staffed throughout the year by Senior Industrial Officer Henry Stubbs and Industrial Officers Lyn Hughes and Lloyd Woods. The industrial team operates from the Association's national office in Wellington but travel frequently throughout the country, meeting members in their workplaces and holding discussions with management.

Members of the industrial team meet as regularly as possible, to look at complex cases and to ensure consistent advice on routine matters and develop considered advice on the more challenging cases.

Despite a significant increase in serious and time-consuming cases, no case was referred to the Employment Relations Authority and there was a reduction in (a) the number of "involuntary" terminations of employment and (b) legal fees incurred.

Job Sizing /Back Pay

Many of the major DHB-wide job sizing reviews and adjustments have now been completed and those that remain to be completed or undertaken tend to be in smaller services or services where clinical workloads have relentlessly increased in recent years or where recruitment and retention issues have surfaced to force the issue. The gradual acceptance by DHB management of the need for non-clinical time has also been a factor. Thirty percent non-clinical time is now common. In some cases it has been difficult to achieve. In other cases it is generally accepted that there may be a transition period to achieve this aim.

Back pay associated with the job sizing has become more of an issue. In some cases the DHBs simply claim 'there is no money'. In others the difficulty lies in gaining agreement to an effective date or in the calculation itself. Arguments around back pay for extra work proven through job sizing can be destructive of good will and can create a lot of work for the industrial team.

Services where industrial officers have been actively engaged in assisting job size reviews in the past year have included: radiology, anaesthesia, ICU, emergency departments, paediatrics, radiation oncology, medical oncology, general medicine, renal, plastics, palliative care, neurosurgery, mental health and general surgery.

Service Reviews/Changes to Working Arrangements

Due to the Association insistence on good consultation and clinical engagement there is a constant stream of review documents arriving for industrial team review. Even the most innocuous looking of these may well (and generally do) have some effect on members work. In some cases these reviews are very important and full consultation is demanded with the subsequent workload for both the Association industrial team member and our activists within the DHB. We are very reliant on membership input and comment relating to these major reviews and grateful where this occurs.

Right to Make Public Comment

The attempt by Southern DHB to threaten Dunedin hospital emergency medicine specialist Dr John Chambers with disciplinary action over public comment within his professional expertise and experience has attracted prominence, including in the *Otago Daily Times* and Parliament. In part, this is due to the sensitivity of encroaching upon the right of DHB employed specialists to make public comment, particularly where it is critical of the DHB's position. In part, this is due to the allegation in Parliament that the Minister of Health was encouraging Southern DHB to take disciplinary action.

Dr Chambers was approached by the *Otago Daily Times* to respond to comments from Southern DHB on the six hour target and responded in a way that was consistent with Clause 40 (Public Debate and Dialogue) of the MECA. Specifically it states that:

40.1 *In recognition of the rights and interests of the public in the health service, the employer respects and recognises the right of its employees to comment publicly and engage in public debate on matters relevant to their professional expertise and experience.*

40.2 *In exercising this provision employees shall, prior to entering into such public debate and dialogue, where this is relevant to the employer, have advised and/or discussed the issues to be raised with the employer.*

Further, he was also approached as Otago Vice President of the Association. Dr Chambers is also in the leadership of the College of Emergency Medicine in New Zealand. The Association has challenged the threatened issuing of a formal notice of warning. To date Southern DHB has not issued a formal warning and has had direct discussions with the Association which are continuing. This case is now being handled by the Executive Director.

Advice to New Appointees

The industrial officers continue to provide useful and welcome advice to senior medical and dental practitioners contemplating appointments in New Zealand and to many applicants as they go through the appointments process. We encourage members to remind known applicants of this service both to ensure the applicant joins the workforce equitably with 'eyes wide open' and for us to better monitor any trends or issues arising. New appointees are very grateful for this service and almost without exception go on to join the Association once they take up their appointment. We also direct applicants to the Association website as a very useful source of information and advice for prospective and current employees. Notable over the past twelve months is the increase in interest from United Kingdom applicants and for new SMOs, appreciation of the increases to the first step for appointment brought about in the January MECA changes to salary scales.

Complaints by or about Members

The increase in serious cases involving complaints of one sort or another, by or against members appears to have flattened out but remains a major area of work for the industrial team. The industrial team endeavour to have these matters dealt with as informally as possible to leave both parties satisfied with the outcome. There has been a decrease in issues relating to bullying and the development of an *ASMS Standpoint* on bullying by the industrial team is expected to bring a further decrease in time.

In the year under review the industrial officers have had to advise and otherwise support fewer members than in 2011 in major cases involving what might be described as "inappropriate" behaviour but this is still a major area of work

Long-term Illness & 'Return to Work' Plans

We have supported around 14 members who had difficulties of these kinds and are pleased to report a decrease from the high of 17 in 2011. Problems have included: members facing terminal illnesses, coping with chronic illness stress and serious illness. Several DHBs have been much faster than in the past to institute a review of health (as per Clause 27.5 of the MECA) and with the increasing constraints on funding we believe the relatively generous leave allowed in the past may be similarly constrained.

Suspensions and Clinical Competence Reviews

We have supported eight members facing restrictions on their clinical practice. There has been an apparent increase in the use of Clause 42 of the MECA (Investigations of Clinical Practice) when even quite minor concerns have been notified and in each case the employer's initial reaction was to impose clinical restrictions. Clause 42 has protections around the use of such restrictions and these are very important in ensuring the process is as fair as possible.

Generally we encourage the ASMS member to access Medical Protection Society or other medico-legal support for the medical aspects of the concern and we take responsibility for correct application of Clause 42. This requires a partnership approach and has worked well. These cases usually require an immediate response. Overall this work is taxing for all involved. It is very important to individual doctors and can break an individual's career.

'Involuntary' Termination of Employment

Involuntary terminations include: dismissals, resignations or retirements in anticipation of dismissal (usually to avoid a disciplinary process or investigation of some kind) and redundancy.

These are unusual but may increase given the changes within the DHB sector due to regionalisation and changes to models of care. Most members are protected from changes to their job descriptions by such changes having to be "mutually agreed" (Clause 13.1 of MECA). This year the team has dealt with three involuntary terminations, which included one resignation and two retirements following investigations into clinical practice.

This year's total of three compares with four cases in 2011, twelve cases in 2010 and two in 2009.

Salary Overpayments

In the last 12 months we have advised three members who have been called upon to repay significant sums received as salary overpayments. All of the cases this year arose from human error in human resources or payroll.

In one case the overpayment continued long after the member drew it to the attention of management. In all cases the amount of overpayment notified was reduced after investigation by the industrial team, one by $22,000

Mediation & Legal Costs

No matters were referred to the Employment Relations Authority although three matters were referred to mediation:

- An agreement for the accrual and payment of lieu days was not honoured when a member resigned from the DHB. This was resolved through negotiation in the member's favour.
- A member was not translated fairly between the medical officer and specialist salary scale and had been appointed on the wrong step initially. This was resolved in the member's favour.
- A member was denied an equitable retention allowance on appointment. This was resolved in member's favour.

It is pleasing to note that the industrial team was able to complete their work in the past year and resolve most issues themselves with very little need to seek outside legal advice. Legal fees for the year were $4,377.

Parental Leave

In 2011 the industrial team became aware that some DHBs had been incorrectly paying members for annual leave in the first year after a period of parental leave. For most employees the Parental Leave Act 'contracts out' of the Holidays Act in that for the first twelve months following parental leave payment for the annual leave will be at the average of the last twelve months. This means that when a person has twelve months unpaid on parental leave their pay for annual leave is minimal especially if annual leave is taken shortly after the return to work. For members, however, the Association argued the MECA applies in clearly stating that annual leave is on 'full pay'. Eventually the DHBs agreed to make up the arrears for the members concerned.

Developments in Continuing Medical Education in DHBs

The 2010 'variation' to the national DHB MECA explicitly allowed agreement with individual DHBs for members to apply their accrued CME funds to purchase laptops and other electronic aids where the "main purpose" is to support the member's continuing medical education. This was followed by stand-alone agreements with the Auckland, MidCentral and Canterbury DHBs for the use of CME expenses to purchase information technology to be used for CME purposes and the class of travel available to members when travelling overseas for CME purposes. One or other of these policies have now been used as the basis for new policies at most DHBs with some regional specific minor changes.

These new policies allow members to choose the class of air travel subject to journey time being in excess of four hours, there being sufficient funds available and the additional expenditure not compromising the member's College and Medical Council MOPS and recertification requirements.

The *ASMS Standpoint on Professional Development and Education* is the authoritative document on this and is available on the ASMS website.

Three DHBs (Whanganui, Wairarapa and West Coast) have provisions in the MECA that set no cap on CME funding. Following an investigation as to the use of the provision West Coast DHB members agreed that they would benefit from agreeing to the Canterbury DHB policy including the introduction of the $16,000 cap. Provided a 12-month trial shows the new policy is effective, the cap will become permanent.

Health Sector Relationship Agreement

Five meetings of the tripartite Health Sector Relationship Agreement (HSRA) Steering Group have been held this year (although due to a clash of commitments the Association was unable to attend the first meeting) with a sixth to be held prior to Annual Conference. The participants are the Ministry of Health (through the National Health Board), all 20 DHBs, and each of the CTU affiliated four main health unions (NZ Nurses Organisation, Public Service Association, Service & Food Workers Union, and the Association). All are signatories to the HSRA. The significance of this body is the primary means by which the government through the Ministry of Health, DHBs and health unions engage on a national level. In last year's Annual Report the National Executive reported its decision to suspend our participation in the Steering Group in response to the conduct of the DHBs national leadership in the DHB MECA negotiations. At its February meeting the Executive lifted the suspension because of the settlement of the MECA, the objection to bad conduct had been made, and because of the value of participation.

Participation in the Steering Group is proving to be a valuable opportunity for the Association to engage with key players and organisations at a high national level. The main issues and agenda items in the first five meetings have been:

- Regular reports from the National Director of the National Health Board on NHB issues.
- Health Workforce New Zealand activities, including the review of the Health Practitioners Competence Assurance Act and the review of the regulatory authorities.
- Management-union engagement in the context of achieving 'high performance cultures.'
- Productivity in the health sector including a presentation from Statistics New Zealand.
- Public-Private Partnership process in respect of Canterbury DHB.
- Treasury financial update presentation
- ASMS concerns over the lack of commitment in some DHBs to clinical leadership.
- Reviewing life preserving services arrangements (discussed separately).

- A session with the Director-General of Health.

Arising from the long-running disputes (including a series of very disruptive strikes) in 2010 between the DHBs and APEX (representing medical radiation therapists) and MLWU (Medical Laboratory Workers' Union), the HSRA Steering Group requested the parties to develop guidelines or a tool kit to assist with the implementation of the Life Preserving Services provisions of the Health Sector Code of Good Faith (a schedule to the Employment Relations Act). A working group based on the three tripartite parties to the HSRA was formed to undertake this task. The Association's Senior Industrial Officer was a member of the working group.

After a number of meetings and a certain amount of wrangling with the Ministry of Health, the task of preparing a draft set of guidelines for senior medical officers employed by DHBs was left to Henry Stubbs. He drew on the Association's experiences and the advice we had previously given to members during health sector strikes along with an excellent document produced by Dr Andrew Connolly (Clinical Director of Surgery, Counties-Manukau DHB) during the 2010 disputes. He also had some helpful discussions with Dr Geoff Robinson (Chief Medical Officer, Capital & Coast DHB) representing the national CMOs' group.

Despite some terse and tense email exchanges between the Association and the Ministry of Health and at least one stand-off, this has now been satisfactorily resolved with the guidelines approved by the HSRA Steering Group.

National Joint Consultation Committee

This year the National Joint Consultation Committee set up under the national DHB MECA has met three times with a further meeting planned for early December. The terms of reference for the NJCC were amended in the last MECA to focus clearly on what the NJCC actually did rather than projects that never eventuated.

We have increasing doubts around the value that DHBs place on the NJCC. This year there has never been a meeting at which more than one Chief Executive has attended and, at the final meeting last year, DHBs resiled from their agreement to the regional services guidelines that had been agreed at the previous meeting. This had been the only substantive achievement of the NJCC. What had appeared to be a useful idea of using preloaded credit cards for CME expenses had also failed to gain DHB support.

The most useful part of the meetings this year has been the opportunity for consultation with Health Benefits Ltd. Other matters addressed in the meeting have been the a discussion on recertification with Medical Council staff, preparations for MECA bargaining, the Joint Quality and Safety Improvement plan, alternative ways of making CME expenses procedures more efficient and issues arising from local Joint Consultation Committees.

A further indication of DHB perception of the value of the NJCC is the recent and short notice cancellation of the planned December meeting.

Joint Consultation Committees

JCCs have now been in full operation for seven years. All JCCs, have had, or are scheduled to have, at least three meetings by the end of this year. A new development has been the establishment of a single JCC for the Southern DHB with members from Southland and Otago meeting jointly with management on two occasions this year. Two JCCs each this year were also held separately for members in Otago and at Southland. Next year the Southern DHB JCCs will all be district-wide—in Dunedin, Invercargill and Queenstown. Bay of Plenty DHB JCC has for some years had one meeting a year held in Whakatane with two at Tauranga. Next year will also see one of the three Nelson Marlborough held in Blenheim.

The Executive Director generally attends two out of the three JCCs at each DHB with the Assistant Executive Director attending the third. Industrial Officers attend at least one JCC in each DHB in

their region each year but sometimes attend more frequently. This year Association branch officials have taken an increasing role in JCCs by ensuring a decent attendance, following up on issues and taking an active role in setting agendas and in the meetings themselves

The DHB Chief Executives almost always attend the JCCs and we take considerable pains in setting meeting dates well in advance so that they can attend. Some of them take advantage of the opportunity to update on issues they are concerned about.

Building issues have become something of a theme. The most obvious case is Canterbury DHB as it rebuilds hospitals, and begins on a new hospital (the proposal for a public-private partnership did not go ahead in part because of doubtful profitability for the private sector) However, other DHBs particularly in the South and lower North Island have had considerable disruption as seismic risks are identified. Other DHBs are planning new building though Government requirements are forcing the consideration of some form of public-private partnerships at Counties Manukau. These plans need continued oversight by the JCCs to ensure engagement by members. Constrictions in available capital funding may have meant many of the building plans are put on hold causing difficulties where existing accommodation has had to be vacated because of earthquake risks.

Regional and sub-regional planning and activity has become a regular item on the JCC agenda as DHBs establish shared 'back office' and some regional clinical services. This is likely to become more important as sometimes quixotic collaborations develop such as Auckland and Waitemata and Hutt Valley and Wairarapa or as merged services progress (West Coast with Canterbury).

National issues with potentially considerable impact on all DHBs discussed at JCCs in all DHBs include:

- Health Benefits Ltd. This has been discussed at nearly every JCC and we have found that the Association and DHBs have been largely in agreement about the potential benefits and costs.
- Implications of the government's elective targets
- Implications of the Medical Council's requirements for the recertification of general registrants
- The Auckland DHBs plan to have all SMOs with up to four years' relevant experience appointed on step one indefinitely. Discussing this approach at nearly all DHBs around the country has revealed that the plan appears to be limited to the Auckland metro DHBs.
- We have attempted to generate discussions on SMO staffing at each DHB by gaining DHB agreement to regular reports on SMO staffing levels and the uptake of sabbatical. These have been of varying accuracy and usefulness but can be used to generate a discussion on vacancies and raise the profile of the MECA sabbatical clause.
- Health Workforce New Zealand has been a regular item but largely to monitor developments.
- The Joint Quality & Safety Improvement Plan has been on discussed at each DHB. Action on it has mostly consisted of SMO engagement workshops where quality initiatives were discussed.
- Policies on CME expenses were the subject of discussion at smaller DHBs as the breakthroughs achieved on this front spread to them. Members and some DHB managements have begun to discuss ways of making the reimbursement of CME expenses more efficient.
- DHBs unanimously agreed with our position that the one-off Medical Council supplementary disciplinary levy for 2013 was reimbursable under the MECA.

- The JCCs have also been used to check on pending reviews. Examples of failure to consult appropriately and failures to engage with members are still occurring, sometimes despite specific commitments.
- Job sizing continues as an issue though many DHB-wide have been completed (or are close to completion).
- In one guise or other the tight financial situation was a topic of discussion at most DHBs.
- Aid programmes as part of CME where college approved.
- Primary/secondary collaboration has been an item on all agendas but has had different implications locally.
- Information technology was an issue in a number of DHBs (Lakes, Taranaki, Whanganui, MidCentral, South Canterbury and Counties Manukau). Many of the issues were with systems which needed to be updated but were awaiting regional or national initiatives.

Issues specific to a particular DHB that have been discussed include:

- Laboratory tendering process and jury service leave (Northland) where SMOs are no longer being excused from jury service.
- GST on laptops bought as a CME expense and car parking (Auckland).
- The Clinical Academy project, a new corporate logo and an environmental sustainability project (Counties Manukau).
- Proactive recruitment of registrars and SMO (including clinical directors) job description templates (Waikato).
- Performance appraisal (Bay of Plenty).
- SMO staffing of Taupo Hospital (Lakes).
- CT scanner breakdowns (Hawke's Bay).
- Midland DHBs drug and alcohol policy and problems with outsourced radiology (Taranaki).
- Provision of electronic technology (laptops and tablets) as 'tools of the trade' rather than using CME expenses and family members who are also DHB employees (Whanganui).
- Regional women's health service (MidCentral).
- Payments for 1 in 2 call and CME Expenses for electronic technology (Wairarapa).
- Realignments of directorates and the coffee quality (Hutt Valley).
- SMO leave form, bullying and the shortfall in RMO funding as a result of HWNZ reallocations (Capital & Coast).
- Non-clinical time and the ACTOR rostering system (Nelson Marlborough).
- Buller Integrated Family Health Centre and the 'transalpine plan' for joint services with Canterbury (West Coast).
- Rural focused urban specialists (RUFUS – Canterbury).
- Theatre staff turnover and bullying competitive recruitment between Dunedin and Kew, and an offensive advertisement for a clinical director position (Southland).
- The need to achieve distributive clinical leadership and emergency department issues (Otago).

- Management disorganisation and lack of commitment to the JCC, clinical leadership and the Dunedin Hospital emergency department (Southern).
- Two Chief Executives with which ASMS had had particularly constructive relationships (Cathy Cooney of Lakes and Garry Smith of Auckland) left their positions during the year.

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. Since the last Annual Conference there have been 14 workshops (including two in three DHBs). They have been:

1. Lakes (December) on In Good Hands (including presentation from National President Jeff Brown), locally developed key performance indicators, enhancing quality, patient safety & satisfaction, and enhancing engagement.
2. Hutt Valley (December) on the 'big picture' in the DHB (eg, governance and operational relationship), the experience of establishing a stroke unit, the clinical governance structure, and advice on Coroner enquiries.
3. Waikato (February) with an emphasis on developments on primary care along with the DHB's Project Catalyst (internal savings) and Waikato Hospital mortality data. Unfortunately the workshop was disappointing with some of the programme lacked practical relevance, it was too much 'stand and deliver; sit and listen', and the attendance low. However, there has been a review of this experience by the DHB and Association in the context of planning the next workshop.
4. South Canterbury (May) on clinical information technology, patient safety initiatives, enhancing productivity and effectiveness, and primary-secondary integration.
5. Tairawhiti (June) including the themes of 'difficult conversations in health,' specific projects, and how can success be extended across the DHB.
6. West Coast (June) on 'transalpine' clinical collaboration and engagement.
7. Waitemata (July) on the quality safety agenda and specific projects.
8. Whanganui and MidCentral (July) jointly on clinical collaboration between the two DHBs. This was the first combined DHB workshop and was held in Whanganui.
9. Northland (September) with the themes of the Quality Improvement & Patient Safety Plan, increasing clinician engagement and the quality safety agenda.
10. Capital & Coast (September) on quality improvement including involvement from Ko Awatea (Counties Manukau).
11. Canterbury (September) on technology and facilities management (attended by around 230).
12. Hutt Valley (October) on sub-regional collaboration.
13. Lakes (November) focussing on a future framework for clinical governance & engagement, project updates, information sharing, and information services.
14. Waitemata (November) on mastering adverse outcomes & professional interactions and advance care planning.

The only DHBs where no workshops have been held at all since their inception remain as Auckland, Counties Manukau and Nelson Marlborough (although one scheduled for this month was cancelled by management but is expected to be held next year).

National Bipartite Action Group

The Association is an observer on the National Bipartite Action Group (NBAG) which was established in 2010 between the 20 DHBs and the three other main health unions affiliated to the Council of Trade Unions (Public Service Association, Nurses Organisation and Service & Food Workers Union). Although not affiliated to the CTU, the Resident Doctors' Association and other unions serviced by Contract Negotiation Services are also observers.

NBAG meets two monthly on a face-to-face basis and also has a one hour teleconference in the intervening month. Our participation late last year and early this year was affected by our suspension of participation in the HSRA Steering Group.

The Executive Director attended three full meetings this year. Features of the meetings include sessions with Health Benefits Ltd and Health Workforce New Zealand, progress in the development of national services, regional bipartite engagement over annual planning processes, and smokefree policy in the context of the government's 2025 smokefree objective and with specific reference to employment.

Surveying Full-Time DHB Senior Medical Staff Base Salaries

Each year since 1993 year the Association has surveyed the base salary of SMOs. Initially these surveys were used in local bargaining of collectives in each DHB and their predecessors. We have continued to collect over the three national MECAs; changes to the scales and progression through the scales are now the main changes. The survey is of mean full-time equivalent base salaries and does 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.

The data is now also being used to monitor senior medical officer staffing levels, the catalyst for which was the extra hospital doctors' dispute.

We are now up to our 19th salary survey. As at 1 July 2012:

- The annual increase in base salary was 4.3% for specialists and 5.1% for medical officers between 1 July 2011 and 1 July 2012 reflecting changes to the salary scale that came into force in January.
- The average base rate for specialists is $184,271 ($176,918 per year for women and $187,661 per annum for men).
- The average base rate for medical officers is $144,488 ($143,729 for women and $145,137 for men).
- Specialists in the Wairarapa DHB on average have the highest base pay and those in Counties Manukau the lowest (just above Waitemata). Medical officers have the highest average base pay in Whanganui while those in Auckland have the lowest average base pay.
- The top step of both scales has the greatest number of senior medical officers on it of any step with 1,311 specialists on the top step (out of 3,826) and 221 (out of 540) medical officers on the top step.

Extra Hospital Doctors Claim

At the last Annual Conference Minister of Health Tony Ryall was criticised by delegates for his claim of 800 extra hospital doctors employed by DHBs since he became Minister three years earlier. This was quickly followed by discussion and debate at the National Joint Consultation Committee later that month. It was attended by Michael Hundleby, Deputy National Director of the National Health Board, and responsible for the provision of the data to the Minister. While

defending the data as robust, he was unable to answer a number of questions such as the breakdown of senior and resident medical officers.

It was agreed at that meeting that the NHB and Association would meet as soon as possible to discuss the data in more detail. However, largely because of inaction at the NHB, the meeting took seven months to arrange and took place on 26 June. During the intervening period occasional public reiterations of the erroneous extra hospital doctor numbers by the Minister of Health had to be countered by the Association drawing upon the data provided to us by DHBs.

At the June meeting the Association was represented by the National President, Executive Director, Assistant Executive Director and Lyndon Keene. The NHB was represented by Michael Hundleby and Peter McIver. We had asked for the data prior to the meeting to give us a chance to make informed comment. The day before the meeting we received an email saying "We have been instructed by the Minister's office to not release any data information. This can be discussed at the meeting tomorrow."

At the meeting Michael Hundleby stated that their data was derived from the DHBs consolidated accounts through payroll information. He asserted that the information was of total doctors and was not broken down into senior and resident medical officers. Any contractors or doctors paid through agencies would not appear in the NHB data.

The Association explained how using figures which did not reflect reality unnecessarily aggravated senior doctors and soured relationships when managers and senior doctors should be developing closer working relationships. We were struck by the fact that while the NHB claimed that the data was not broken down senior and resident medical officers, the data they provided the Minister of Health in April was, in fact, broken down this way.

The meeting was unsatisfactory. Although the NHB said they would provide the Association the data in a few days this did not happen despite the document containing it being available. Some weeks later they simply advised the Association that the data was on the government's website.

An analysis of this data confirmed the veracity and accuracy of the Association's position. In summary, the NHBs data on senior medical officer increases was consistent with the Association's. The differences were slight and due to differences in timing of recording (April versus July) and being full-time equivalents (NHB) and headcounts (Association). The only explanation for the claimed 800 extra hospital doctors (by now 1,000) was either a major explosion of resident medical officers or dodgy RMO data. The latter is the most likely explanation as that period coincided with the three Auckland DHBs engineering a 'cap, in the locum rate for RMOs, which meant that possibly over 200 RMOs had switched from 'casuals' to employees. The former were not counted but the latter were.

Subsequently the September issue of *The Specialist* featured an article analysing the true situation. It also revealed that while DHB SMO numbers have increased since 2008, the rate of increase has slowed down. While this has been an avoidable and distracting dispute, it is interesting that the Minister has not made his claim of extra hospital doctors in public for several months and the Association's countering of earlier public claims has had the effect of health journalists not reporting the claims.

North Shore Elective Surgical Centre

At its February meeting the National Executive agreed that the planned elective surgical centre (ESC) next to North Shore Hospital was an important issue for the Association. The ESC is scheduled to commence in July next year and originates in a 'pilot' conducted at Waitakere Hospital that itself attracted some controversy over differential pay rates for specialists.

The Executive's assessment was largely due to the consequences of the form of employment (including differential specialty rates) and use of financial incentives to drive the 'model of care' proposed for the ESC. There were also concerns about it being partially privatised through the

formation of a joint venture or subsidiary company although these specific concerns have not materialised. To this end it was a major subject matter in the subsequent *Executive Direct*, in two issues of the *ASMS News* and one *Direct* for Waitemata members. It was also the subject of media coverage including the *NZ Herald*, *Sunday Star Times* and Radio New Zealand's *Nine to Noon* programme.

In response to the Association's concerns DHB management approached us to hold discussions in order to see whether agreement could be reached on the employment relationship for SMOs working in the ESC. This initiative was accepted and five meetings were held during July-September. The Association's team comprised the Executive Director, Assistant Director, Vice President and the Branch President and Vice President. Unfortunately these meetings failed to reach agreement due to the determination of key players in the DHB's team to run the ESC as if it was a publicly owned private hospital on public premises, including the use of specialists as private contractors and the unduly strong focus on speed and volumes. Much of this was due to the unwise overly ambitious business case to government from the DHB which extrapolated too much, too literarily from the Waitakere 'pilot' without factoring in some of the its limitations such as the lack of resident medical officer training.

While there is general support for the establishment of the ESC in principle, as the date of commencement draws closer and more discussions are held with services affected by but not in the ESC, there is increasing opposition and unhappiness with what is proposed in respect of the use of financial incentives for the model of care and the remuneration model. It has become increasingly polarising which is affecting the whole organisation.

Following an informal meeting between the Executive Director and the DHB's Chief Executive in October, it was agreed to have further informal discussions between the parties on the remuneration model. These have commenced and are continuing.

Application of New MECA Salary Scales by Auckland DHBs

A major dispute involving the three Auckland 'metro' DHBs (Waitemata, Auckland and Counties Manukau) over their endeavours to treat the translations from the previous 15-step MECA scale to the new 12-step scale (by dropping of the three bottom steps of the former so that the old Step 4 became the new Step 1) as if they also applied to subsequent post-translation placements of new appointees (those with up to four years' experience) on the new scale. They are seeking to use a one-off translation from the former to the current scale in 2012 as if it was also the basis of placement to the new scale for new appointments.

In doing so they are creating new inequities that will serve to undermine the intent of the MECA settlement which was to improve the competitiveness of the lower end of the specialist scale for less experienced specialists including registrars seeking their first specialist appointment. The only specialists not disadvantaged would be, from 2013 onwards, will be those who have just obtained vocational registration and are seeking their first specialist appointment in an Auckland DHB.

All new appointees in their 1st, 2nd, 3rd and 4th years as a specialist (ie, post-vocational registration or overseas equivalent) would start on Step 1 of the specialist scale. Consequently those with five years' service as a vocational registrant will be placed on Step 2 and so on down the rest of the scale.

This applies in 2012 but then would also be extended to all subsequent years. There is no problem in 2012 but from 2013 and beyond it would create serious anomalies between this and subsequent years' cohorts of appointees, with similar years of experience as specialists. It will also undermine the intent of the new salary scale to try to improve specialist recruitment. The practical effect would be to describe it as the 'theft' of one salary step per annum from new appointees in this position.

The following is an example of the sort of problem this would` create. Under this system all new appointments with between 1-4 years of relevant experience will start on Step 1. Thereafter, they will advance one step every year until at the beginning of year 4 they will be on Step 4. However if a former 'classmate' (also entering their 4th year) joins the same service or DHB on that date, after having spent three years overseas, they will be offered employment on Step 1, or three steps below their 'classmate' who will have exactly the same years of relevant experience.

The same point also applies, in this example, to an overseas recruit with four years' experience. Given New Zealand's dependence on international recruitment this would do the opposite of the intent of the MECA settlement which was to improve recruitment. It also applies to recruitment from other DHBs not going down this Auckland path as it would involve a loss of one or more salary steps.

The table below outlines the unfairness of this position:

YEARS OF RELEVANT EXPERIENCE ON APPOINTMENT IN 2012	INITIAL SALARY STEP IN 2012	MOVE TO STEP IN 2013	MOVE TO STEP IN 2014	YEARS OF RELEVANT EXPERIENCE ON APPOINTMENT IN 2013	INITIAL SALARY STEP IN 2013	INITIAL SALARY STEP IN 2014
1	1	2	3	1	1	1
2	1	2	3	2	1	1
3	1	2	3	3	1	1
4	1	2	3	4	1	1
5	2	3	4	5	2	2
6	3	4	5	6	3	3

This table shows that with a strict application of this metro Auckland approach from 2013 (ie, 2013, SMOs with two years of relevant experience would be one step behind their colleague with similar relevant experience who started in the DHB or New Zealand in 2012).

In 2014, they would be two steps behind their colleagues with similar relevant experience. The table also shows that any SMO appointed in 2014 would be two steps behind their colleagues with comparable relevant experience who stayed in New Zealand and took up their appointment in 2012.

To give a practical example, under the Auckland metro approach, in 2012 a specialist with no relevant experience as a specialist would be placed on the new Step 1. In 2014 that person would then be on Step 3. However, their 'classmate' with no relevant experience as a specialist in 2012 who instead goes overseas, or to another DHB outside metro Auckland, to work as a specialist and applies (and is offered) a position in Auckland in 2015 would be placed on Step 1.

Initially it appeared that this was the position of the four northern DHBs. However, following further discussions with management, including some effective advocacy by our Branch President and Vice President, Northland have made it clear that they are not part of this approach. Concerns that other DHBs might follow the lead of the three Auckland DHBs have not materialised. The Association is unaware of any of the other 17 DHBs following them. Further, in most DHBs the Association has raised where they have explicitly stated that they agree with the Association's position. In three cases within the same sub-region there was some uncertainty which the Association is seeking to clarify – Wairarapa, Hutt Valley and Capital & Coast.

The Association has being pursuing the dispute two-fold in the Auckland region. First, following a letter to the Chair of the Northern DHBs chief executives' group, there have been meetings with the human resource general managers. To date, this has not advanced far with a sub-contractor

engaged by them producing a paper which essentially seeks to rewrite premise for the MECA settlement, specifically the rationale for the step reductions. It sought to replace a perceived 'relativity disadvantage' with a material financial disadvantage.

Second, it has been raised in two rounds of JCCs in the three DHBs. This has had the effect of creating uncertainty with senior management and revealing some divisions. It has become clear that this approach has been driven from within the human resource general managers group with their advice accepted by chief executives without appreciation of the context and implications. It has been about trying to correct a perceived inequity in the last MECA settlement despite the fact that the 'inequity' was expressly and knowingly agreed between the parties in negotiations and that it was ratified by both parties (it was expressly pointed out in the information sent to members in the Association's indicative postal ballot where the vote to accept was 93%). The DHBs' position has the effect of materially disadvantaging all new recruits except for those who have just obtained vocational registration and are seeking their first specialist appointment in an Auckland DHB.

The dispute continues but the position of the three Auckland DHBs is becoming increasingly divisive and untenable.

Employment Relations Act Changes

In July the National Executive considered advice on expected changes to the Employment Relations Act that the Government was expected to pass through Parliament before Christmas. These were:

<u>Concluding a Collective Agreement</u>

The Government would seek to return to the pre-2004 provision where the duty of good faith does not require a concluded collective agreement. At the moment the parties must conclude unless there is "a genuine reason, based on reasonable grounds, not to." The removal of a duty to conclude a collective agreement will weaken the framework for collective bargaining, including the position of the Association in bargaining as employers can adopt a position where they refuse to negotiate meaningfully because they don't want a collective agreement. This would have made it more difficult for us to have achieved a collective agreement for our members employed by ACC.

<u>The 30-day Rule for New Employees</u>

Currently if the work of a new employee is covered by a collective agreement and a new employee is not a member of the relevant union, the employee must be employed on the terms and conditions in the collective agreement for their first 30 days of employment. The Government is seeking to change this to allow employers to offer new employees less (or more). This would give the employer power to have alternative sets of conditions in the workplace to those set through collective bargaining and use this power to undermine the collective bargaining process. Many of our collective agreements (including DHB MECA Clause 7) have provisions which compel the employer to offer the collective to prospective employees and these may continue to operate if the legislation is passed. This will depend on how the legislation is phrased.

<u>Allowing Employers to opt out of MECA Bargaining</u>

At present it is difficult for an employer to refuse to bargain collectively in whatever configuration bargaining is initiated (MECA or single employer collective agreement). Coupled with the changes to the timing of initiation (see below) the effect of this change will be to make it more difficult for unions to achieve a combined agreement across a sector or to rationalise bargaining.

<u>Allowing Proportionate Pay Reductions as a Response to Partial Strikes</u>

At the moment employers, in response to partial strikes such as work to rules or go slows, can either suspend the workers, lock them out or accept the partial performance of work. The

Government is seeking to allow employers to deduct a portion of pay even if this brings the pay down below the minimum wage. It is unclear how deductions will be related to the portion of the work not being done as a result of the partial strike. This provision will not apply to lock-outs which are employer initiated.

Making the Timeframes for Initiation of Collective Bargaining the same for both Unions and Employers

Currently the union can initiate bargaining 60 days before the expiry of a collective agreement and the employer can initiate 40 days before. As well as amending this provision the Government also seeks to amend the Act to say that if either the employer or the union initiate prior to the expiry date of the existing collective agreement then it will stay in force for a further 12 months (at the moment only applies to union initiation). At the moment being able to initiate first allows unions to shape the coverage and nature of the bargaining. Good faith obligations in bargaining will then flow from the coverage and other aspects of the employer initiation. Again though technical, this serves to weaken the position of the union in bargaining.

Subsequently the Cabinet has approved the changes to the Employment Relations Act along with an unexpected new provision seeking to reduce the protection of vulnerable employees when they are transferred from one employer to another. Another unexpected change is to allow a party to collective bargaining (employer or union although in reality the former) to apply to have an unresolved negotiation to be deemed to be concluded. To date, however, the amending bill has not been introduced into Parliament which casts some doubt over the ability to adopt the Bill this calendar year.

State Sector Reform (Public Finance) Bill

The National Executive considered at its July meeting Government plans to introduce the State Sector Reform (Public Finance) Bill into Parliament. In part, at least, this intention arose out of discussion in the public service stemming from the work of the Better Public Services Advisory panel largely centred on the need for a more centralised system and a longer view in the public service. Discussion of crown agents, such as DHBs has been marginal though it is clear that they have been in the ambit of some of the thinking.

The new Bill has to have an emphasis on strengthening the role of the State Services Commissioner over the whole of the State Services including government workforce policy. The Commissioner would produce 'draft government workforce policy including without limitation items such as workforce strategy guidance and pay or conditions.' This draft could or would then be issued as a 'Government Workforce Policy Order' as an Order-in-Council that would impose obligations on those statutory bodies affected including DHBs. .

The Crown Entities Act 2004 includes a section (116) which provides for an Order-in-Council to be issued requiring consultation with the State Services Commissioner on collective bargaining and requiring them to have regard to the Commissioner's recommendations but DHBs have been specifically exempted from the operation of that provision under Section 44 (Schedule 3) of the New Zealand Public Health and Disability Act.

The proposed change suggests a much more central and more political control of bargaining which will have the force of a regulation. Orders-in-Council are formally speaking made by the Executive Council which includes the Governor-General but, in practice, will be the result of a Cabinet decision. This will mean (if it applies to DHBs) that collective bargaining would become much more centralised, DHBs would have less autonomy to negotiate, bargaining will be politically focused, and Ministers will not be able to distance themselves from the process. There may be other implications as well which are not yet clear.

Government Expectations for Pay and Employment Conditions in the State Sector

The Association received a letter from the Director-General of Health, along with a paper setting out the government's expectations for state sector pay and employment conditions, which was considered by National Executive at its July meeting. Similar letters were sent to other unions in the state sector.

DHBs are crown agents under the Crown Entities Act 2004 and are therefore required to 'give effect to a government policy that relates to their functions and objectives if directed to by the responsible minister (s103). The Minister must consult with them prior to giving such a direction and publish such a direction in the Gazette. These requirements do not apply to 'whole of government directions' which are presently a quite limited set of directions under the Crown Entities Act (s107) though they are likely to soon be extended.

The Minister of Health may also give directions under the New Zealand Public Health and Disability Act but these are also quite constrained. This Act also requires consultation with the Director- General of Health before terms and conditions of employment are finalised. Therefore on of the expectations, which refers to the submission of bargaining strategies and settlement proposals to the State Services Commission, strictly applies only to settlement proposals with respect to DHBs. It is unlikely however that any DHB management or Board will rest on their legislative rights and bargain or settle in opposition to these guidelines.

Perhaps the most relevant for the Association is the requirement that CPI or relativity do not 'suffice' as the sole basis for pay adjustment 'specific business imperatives (such as improved performance and demonstrable recruitment and retention difficulties) are required.' Progression through scales must be taken into account and backdating is not generally favoured.

There are also requirements to provide (in the case of DHBs) the Ministry of Health, with up-to-date information on progress and risks of bargaining and aggregated information on remuneration levels and personnel cost movement over the year as at 30 June.

Health Benefits Ltd

Health Benefits Ltd is the crown entity charged with making $700million cumulative savings (initially over five years but now extended to 2016). This has been a major issue for the Association this year at Executive meetings, National Joint Consultation Committee, National Bipartite Action Group and Joint Consultation Committees. The Association has been supportive of and helped fine tune for consistency with the engagement obligations under the DHB MECA, a 'change management framework' agreed between the DHBs, health unions and HBL. The process, issues and concerns have been fully reported to members in *The Specialist* along with *ASMS DHB News*.

One of the most critical parts of HBL's work has been the Finance, Procurement and Supply Chain business case. In February the National Executive provided feedback to HBL on the need to ensure that senior medical staff and other clinicians are made fully cognisant of the impact of their proposals in detail at each DHB and, in particular, on patient safety, and deliberation on whether the proposals proceed or not is consistent with advice arising out of extensive clinical engagement and leadership. The Association is presently considering representation on a FPSC business case design working group.

Following discussion at the National Joint Consultative Committee where we raised the confusing feedback that we had received on HBL's process for clinical engagement, the Assistant Executive Director and National Secretary liaised with HBL over this matter. This led to constructive discussion and progress on HBL's two main areas of clinical engagement - Health Benefits Clinical Council and Clinical Advisory Groups which are part of the collective procurement programme.

The key issue will be selecting the right people for various clinical advisory groups and ensuring they can co-opt and network well.

Health Practitioners Competence Assurance Act Review

Health Workforce New Zealand issued a public discussion paper as part of what they describe as a strategic review of the Health Practitioners Competence Assurance Act. The review findings and recommendations will be released for discussion between March and April 2013 and the final report will be released at the end of July 2013. The process after that may include legislative changes which may be sent to a select committee. The review is also the subject of a Conference session.

Two previous rounds of consultation (the 2007-2009 operational review of the HPCAA and consultation on a paper in 2010 "How do we determine if statutory regulation is the most appropriate way to regulate health professions?") have not delivered the results that are required by HWNZ. The relatively minor changes that resulted from the operational review have been awaiting introduction into parliament for some time and are now planned to be sent to the Health Select Committee this year.

The Association made a submission to the review emphasising our concern that the primary purpose of the legislation, which is to protect public safety through regulating health professionals, would be diluted by the addition of ensuring the provision of a workforce to the Act. This could require the authorities to lower standards if appropriately qualified professionals were not readily available.

Other points covered were our belief that employer credentialing would not ensure patient safety in the absence of registration; though the Medical Council was not perfect; proposals for a shared secretariat with other professions were likely to make problems worse while not saving much money; and reimbursement of annual practising certificates had been freely negotiated by DHBs and ASMS as part of the MECA. We also said that multi-disciplinary teams were effective only if based on secure professional roles.

Health Workforce New Zealand Proposal for the Prioritisation of Training Funding for Medical Specialties

Last year HWNZ made several attempts to draft prioritisation criteria for determining its investment in medical postgraduate training (funding previously allocated through the Clinical Training Agency which has now devolved into HWNZ). The Association commented on both proposals attempting to draw attention to concerns over the linking of funding prioritisation for training, which requires a long-term approach, to shorter term government target objectives which are largely shaped by the circumstances of the time, the policy of the government of the day, and the inclinations of the health minister at the time and pointing out that even if the process gets the training in medical specialties to exactly match the future needs of the New Zealand health system it will still be pointless unless the trainees stay in the country when qualified.

To its credit HWNZ recognised that its proposals were not getting support from unions, professional associations, Medical Council and DHBs and tried another approach. A meeting was called in March this year involving many of the key individuals in the system. The Association was represented by Vice President Julian Fuller and Assistant Executive Director Angela Belich. National President Jeff Brown also attended but as a member of the National Health Board. Unfortunately no DHB Chief Executives were present which meant there wasn't someone present who had a clear idea of the cost implications of these changes to DHBs.

HWNZ Executive Chair Professor Gorman had some interesting points to make;

- The money allocated to post graduate medical training amounts to $100 million per year.
- The former Clinical Training Agency had 'over contracted' to DHBs for this training and subsequently the allocation was normally under spent placing some of the money at risk in the current environment.
- Some specialties had their training positions fully funded, some had them partially funded and some had no funding from HWNZ at all. The existing system is not logical. He claimed the money simply went to DHBs bottom lines.
- Though there had been an expectation that most general registrants who were not in vocational training programmes would be in general practice or as medical officers in psychiatry, in fact they were widely distributed in many hospital specialties.

The communication that Professor Gorman sent out subsequent to the meeting overstated the level of consensus reached. The group acknowledged that determining the balance of a particular trainee's workload that was 'service' as opposed to training was difficult but not that it was impossible. However, there was consensus that DHBs should be incentivised for success in getting PGY2s and beyond into training programmes and for the successful pursuit of training programmes.

There was also consensus that funding should be allocated for national action on specialties at particular risk. This action would be different depending on the scale and nature of the problem. Paediatric oncology and paediatric pathology were mentioned in the context of very small numbers where direct national intervention to ensure sufficient trainees may be necessary. Other groups, such as psychiatry and obstetrics & gynaecology may need to be funded to embark on a medium term national strategy to address their particular issues.

Professor Gorman proposed that DHBs submit post-graduate medical training plans before the end of May 2012. These plans would say how many PGY1s, 2s and vocational trainees the DHBs plan on having and how they proposed to address critical workforces and quality assessment proposals. By the end of June numbers were to have been agreed with DHBs and would be funded on an FTE pro-rata basis. Further funding was to be allocated on an FTE pro-rata basis when various quality measures had been satisfied. A final slice of funding was to be contestable and open to DHBs, other employers and colleges to apply for money to address the critical shortage problems.

The plan had a number of shortcomings. The ranking of specialties as to their criticality is still central. Factors, such as numbers, distribution, and age breakdown, that led HWNZ to these rankings, need to be made clear to the profession. Even if the list is taken as a working model for the next financial year then it needs to be contested, critiqued and improved as part of an evidence-based tradition. In practice the plan seems to have been experienced by DHBs as a cut in funding as existing funding was top sliced to provide the contestable pool.

Ministry of Health Budgetary Information

At its July meeting the National Executive considered the papers provided to the Government by the Ministry of Health. There were a number of interesting features including:

- The Ministry pointed out that projected increases in the last few years have not matched actual cost increases and that this compounds over time. The shortfall or, as they call it, 'required efficiency and reprioritisation' is calculated as $376.157 million this financial year, $718.963 million in 2013-14, $1,087.388 million in 2014-15 and $1513.703 million in 2015-16.

- The funding track for DHBs for the past three years has included an increasing 'efficiency adjuster' of 0.6% in 2009-10, 1.8% in 2010-11, and 1.6% in 2011-12. The average efficiency gain required in the future will be 2.3% per annum. DHBs will save 0.3% of this by the 'forecast gains from effective management of wage pressure' thus bringing what is needed to save elsewhere to 2%.
- Clinical workforce sustainability was regarded as important but must be financially affordable and sustainable, comparable across the state sector labour market and supportive of attracting and retaining a workforce able to meet the needs of the public health sector.
- Guidelines for negotiations are set by the Government Expectations for Pay and Employment Conditions (discussed separately) and DHBs have a 'national employment relations strategy.'
- In the 2010-11 year the costs of settlement averaged 1.77% and in 2011-12 1.5% for 85% of the workforce. Expected ranges of settlement for this year are deleted on the grounds of allowing the Crown to negotiate without disadvantage or prejudice.
- It appeared that DHBs that do not agree with Health Benefit Ltd plans will have to find equivalent savings through other mechanisms. Failing to realise HBL savings is mentioned as a risk.
- Capital investment of $6.8 billion over the next ten years is envisaged.
- Funding for new initiatives will come from savings including $60 million from HBL in the 2012-13 year.

Proposed Restructuring of 'Responsible' (Regulatory) Authorities: Medical Council

The Health Practitioners Competence Assurance Act 2003 established authorities to protect the health and safety of the public by ensuring that health practitioners are competent and fit to practice their professions. The Medical, Dental and Nursing Councils were among these. These are referred to in the Act as 'responsible' authorities but are also often referred to as 'regulatory' authorities.

In April 2011 Health Workforce New Zealand circulated options for decreasing the size of regulatory authorities (including the Medical and Dental Councils) and amalgamating their secretariats. The Association and other professional bodies reacted negatively to the proposals and the regulatory authorities also did not agree to the proposals. Apparently the government concluded that it was unable to force amalgamation given the current legislation and brought forward the planned review of the Health Practitioners Competence Assurance Act partly so the legislation could be amended to force such amalgamations.

In February the National Executive considered subsequent developments. The Minister of Health had summoned the regulatory authorities to a meeting on 26 January where they were reportedly advised that unless they proceeded to amalgamate secretariats voluntarily the Minister would force them to do so. It was not clear whether this referred to a planned change in the HPCA Act or whether he will use his power to appoint to the authorities to appoint individuals pledged to this course of action.

Since then progress has been slow made more difficult because of the secretive process including the exclusion of professional associations and colleges. The driver appears to be cost although HWNZ's initial costing of potential savings was significantly over-estimated. Some regulatory authorities are particularly concerned about risks to their professional autonomy. The current stage is a series of meetings of the authorities facilitated by former Health & Disability Commissioner Professor Ron Paterson.

Physician Assistants

In 2010 Health Workforce New Zealand set up a variously titled 'pilot' or 'demonstration' in Counties Manukau DHB involving two physician assistants (PAs) recruited from the United States working in its general surgery department on acute admissions. Two evaluations were done; a formative evaluation which was reported on last year's Annual Report and a summative evaluation done by an Australian consultancy Siggins Miller and released in March this year which was considered by the National Executive at its May meeting.

Essentially the evaluation found that the physician assistant 'pilot/demonstration' at Middlemore showed that physician assistants would be a useful addition to the New Zealand health system. Unsurprisingly teams that had the addition of a physician assistant had better results than those that did not. These positive results were attributed by the evaluators to the physician assistants training in the medical model and 'would not have been seen with the addition of another house-officer, nurse or nurse practitioner.' Evidence was not provided to justify this conclusion.

Despite the views of the majority of interviewees that the findings of this trial could not be generalised to dissimilar settings the evaluators conclude that similarly positive results would be expected to occur in other sites as the results were a consequence of the PAs training. One house surgeon's view, that the current system is unsafe and that she and house surgeon colleagues were leaving for Australia (where the decision has been not to adopt the PA profession) but would stay if physician assistants were introduced immediately into the New Zealand system leads on to the evaluators identifying an immediate need to import American physician assistants.

The evaluation repeats some of the criticisms that have been made, dismisses them, but does not answer them. One of the critical points was that the salary level in the trial was substantially better than that which would be offered should the profession be introduced on a permanent basis suggesting that recruitment and retention might be a problem, particularly of US trained PAs.

Further, the evaluation omits reference to the failure of the Australian pilot projects to lead to the introduction of the profession in Australia and the closure of the PA training schemes in Queensland and South Australia.

NZ Nurses Organisation has been highly critical of the evaluation – it would be extraordinary if an extra experienced clinician did not make a difference to the results of a team which had them added as an extra member; inserting a 'programme logic' approach eight months into a one year programme; and the Australian evaluators do not understand the New Zealand regulatory system as they appeared to believe that prescribing rights are provided under the HPCA Act rather than set out in the Medicines Act.

The evaluators said that the next step would be to demonstrate to sector groups the value of the role by robust engagement, and by setting up a series of demonstrations in areas such as primary care. They saw a role for physician assistants in emergency departments, general medicine, acute and elective surgery, orthopaedics, and preoperative assessment clinics. If the stake holders remain obdurate then they suggest a number of short demonstrations using American trained and registered PAs over a range of settings.

The National Executive resolved that the Association wrote to HWNZ critical of the Siggins Miller evaluation. HWNZ's response was more conciliatory than their previous correspondence on this topic. It admitted factual errors in the evaluation but nevertheless accepted the recommendation to pilot physician assistants in primary care, especially in rural settings. HWNZ invited our participation in a group to refine the evaluation framework but we have heard nothing further of this proposal since. Demonstration is being set up in primary care, particular in rural Waikato and Gore. The New Zealand Medical Association is co-operating with Health Workforce New Zealand on the project.

Trans Pacific Partnership Agreement

The Trans Pacific Partnership Agreement is an agreement under secret negotiation between New Zealand, Australia, United States and six other countries. Their objective was to have completed negotiations by the end of last year but nearly 12 months later there still appears to be some distance to go, particularly as Japan has now entered the process. The Association has continued the focus established last year by the National Executive of using normal channels, including communications, to raise concerns. The three main areas of special interest to the Association remain:

- Pharmaceuticals and the lobbying of large United States pharmaceutical companies to limit the use of generic drugs and competitive purchasing by Pharmac.
- The possibility that insurance companies that took over ACC could use disputes procedures to get compensation if future governments sought to reverse privatisation.
- Actions that could be taken by companies like tobacco or alcohol companies to limit public health initiatives such as plain labelling, restrictions on advertising, or restricting access because they damage that company's business.

The difficulty of being able to understand the specific issues has been the highly secretive process. We are grateful for the regular analysis of developments by CTU economist Dr Bill Rosenberg. Background material has been placed on the news section of the Association's homepage.

Council of Trade Unions

The Association first affiliated to the Council of Trade Unions (CTU) in 1990. As in previous years the Association continues to benefit from our affiliation 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 although clashing commitments have made this difficult. The work of the CTU on analysing health spending and Vote Health in the Budget continues to be very valuable.

National Affiliate Council

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).

Issues considered by the National Affiliate Council, included:

- Ports of Auckland dispute (along with AFFCO).
- The pending proposed amendments to the Employment Relations Act (subsequently approved by cabinet for referral to Parliament).
- Trans Pacific Partnership Agreement including with reference to Pharmac.
- Union leadership development.
- Fulton Hogan – death of Charanpreet Dhaliwal (young student employed as security guard and murdered on first night at work).
- Health and Safety Employment Review (in response to the Pike River Mine disaster).
- Lobbying Disclosure Bill.

Meetings with Director-General of Health

The Executive Director continued his regular informal meetings, usually monthly, with the Director-General of Health, Dr Kevin Woods with six held to date. These meetings are very useful to the Association. 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:

- The settlement of our last national DHB MECA negotiations and preparation for the next.
- The Association's relationship with DHBs nationally.
- Health Workforce New Zealand.
- North Shore elective surgical centre.
- Health Benefits Ltd activities.
- Public Private Partnerships.
- Aftermath of Christchurch earthquake.
- National Health Board and the 800 extra hospital doctors claim.
- Association media statements.
- SMO engagement workshops.
- Specific internal DHB problems.

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 industrial coverage of resident medical officers in New South Wales, industrial coverage of GP registrars, Australian Nursing Federation's application for 'low paid bargaining authorisation' for practice nurses, AMA policy on supervision and assessment of hospital based trainees, cost cutting and cost shifting in Victoria, and changes to anti-bullying legislation in Victoria. He also met the Federal Secretary of the AMA.
- In May-June the Executive Director visited the United States, Germany and England for three weeks. The prime purpose was to accept an invitation to attend the Assembly of Marburger Bund, the German doctors union, in Nuremburg. The Association and Marburger Bund have developed good relations in recent years with the latter attending our Annual Conference last year. He also had the opportunity to attend the General Assembly of Bundesärztekammer (German Medical Association), also in Nuremburg. In the United States he met the Doctors Council (physicians union), Committee of Interns and Residents and Physicians for a National Health Programme in Chicago and New York. In England he had meetings at the British Medical Association, University of Greenwich Business School, Rand Europe, King's Fund, Trade Union Congress, Hospital Consultants & Specialists Association and other unions, and Medical Protection Society.
- In September the Executive Director attended the second Industrial Coordination Meeting which was held in Auckland and hosted by the Resident Doctors' Association. Some of the issues he reported back on were intern selection of medical graduates, the AMA's safe hours' audit (2011), the latest Health Workforce Australia report, and physician assistants.

Association Publications

The *Specialist*, the Association quarterly newsletter (generously sponsored by the Medical Assurance Society) is a cornerstone of our advocacy and communications work. Since the last

Annual Conference the state of leadership in the public health system ('Is our health system in a state of kef'), preparation for the next national DHB MECA negotiations ('A most flexuous process'), the Health Benefits Ltd process ('The costly distraction of avoiding a train wreck'), and vindication of the Association in the extra hospital doctors controversy have been the feature of all four issues from December to September under the headings.

Other feature articles were on the following subjects:

- The joint ASMS-DHBs *Quality & Patient Safety Improvement Plan*.
- Prioritisation of funding by Health Workforce New Zealand.
- Medical Council online survey: what do specialists who leave New Zealand really want?
- The risks of Private-Public Partnerships to the health system.
- Executive Director's address to Marburger Bund Assembly.
- Are we ready for old age?
- Medical Council workforce survey 2011: what does it tell us?

In addition, other issues covered included:

- 2011 DHB salary survey.
- Physician assistants.
- Minister of Health's Letter of Expectations to DHBs.
- Memorandum of Understanding with Medical Protection Society.
- Growth in SMO numbers.
- Frequently asked questions on CME.

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. It is increasingly being used by journalists as a resource and source of information and comment. *ASMS Direct* also links in with news items on the website homepage. The membership circulation list is over 3,400. Four issues were produced between the last Annual Conference and the end of last year with a further 15 issues to date this year. Much of this has focussed on the national MECA negotiations (the last settlement, bargaining fee ballots and preparation for the next negotiation), the extra hospital doctors' controversy, Medical Council reviews and initiatives, and the right of doctors to make public comment (Dr John Chambers).

Other subjects covered included:

- Nominations for positions on the Health Practitioners Disciplinary Tribunal.
- Financial support for locked out meat workers in Rangitikei.
- Membership exit survey.
- *Quality & Patient Safety Improvement Plan*.
- DHB workforce survey on clinical governance and engagement.
- Hospital productivity.

- Honouring of Dr James Judson.
- Application of one-off supplementary medical disciplinary levy.
- Clinical ethics network survey.
- Nurses criticisms of evaluation of physician assistant demonstration pilot at Middlemore Hospital.
- HBL collective procurement projects.
- Public-Private Partnerships.
- Health Quality & Safety Commission seminars.
- Constitutional amendments.
- Australian medical graduates coming to New Zealand?
- Effects of cost cutting.
- Nurses criticise review of HPCA Act.

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, May, June 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 2012 was 3,878, compared with 3,572 at 31 March 2011, representing an overall increase of 306 (8.6%). It represents a 169% increase over the 1,440 members in our first year of existence (1989-90). The bargaining fee, introduced in 2008, attracted payments from 241 senior medical and dental staff this year; to date 98 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%), 004-05 (239 – 10%), 2005-06 (164 – 6.4%), 2006-07 (95 – 3.5%), 2007-08 (162 – 5.7%), 2008-09 (486 - 16%), 2009-10 (15 - 0.4%), 2010-11 (76 – 2.2%) and 2011-12 (306-8.6%) an overall increase of 121% 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 102 (7.1%). Under the period of the Employment Contracts Act (1991-92 – 2000-01) the average annual increase was 61 (4.3%). Under the period of the Employment Relations Act, since 2000-01, to date the annual average increase has been 160 (8.1%).

Currently membership is 3,894, an increase of 16 since 31 March 2012 however this figure does not include the 19 members who have yet to renew their annual membership. 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 2013 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 90% of our members pay their subscription by automatic salary deduction (about 88% 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 11% of our current members. Just 2.5% of members who joined the Association in 2012 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 which was an opportunity to meet new Chief Executive Simon Kayll. The MPS provides a regular column for *The Specialist*. We are grateful for the generous decision of MPS to again sponsor the Conference dinner. Dr Rob Hendry from the United Kingdom, who has specific responsibility for New Zealand, will be speaking at Annual Conference.

Virtually all Association members are also members of MPS and from time to time a member will call both organisations for advice on a particular matter. The industrial staff are well aware of the complications that may arise when a member seeks advice from more than one source on the same issue and they seek to identify and avoid such situations at an early stage.

When an industrial officer receives a call from a member and they consider it appropriate to do so, they will advise the member to contact MPS and discuss the situation with one of their medico-legal advisers, all of whom are qualified doctors in medical practice and some of whom also have law degrees. Similarly the MPS medico-legal advisers refer matters to ASMS when they consider the matter is primarily an employment one or best dealt with under the employer's internal processes.

This raises what can sometimes be a difficult question of what are the 'jurisdictional' boundaries between the work of MPS and ASMS. Fortunately the development over the years of close personal and professional relationships between MPS and ASMS staff has meant that 'jurisdictional' issues have not become a problem. More often, however, we have worked closely together on 'overlapping cases to ensure the member received the best possible advice on each aspect of their case from the organisation better placed to deal with that particular aspect of the matter.

Both MPS and the Association agreed that it would be advantageous to draw up a Memorandum of Understanding to record both organisations mutual understanding of the 'jurisdictional' boundaries of our work and to include a strong commitment to collaborate on matters of overlap. The Memorandum has been approved by both organisations – the Association at the February National Executive meeting.

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 (this sponsorship has been provided for several years).

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 included our approach to the forthcoming national DHB MECA negotiations, the Association's difficulties with the DHBs at a national level, employment of general practitioner registrars, Public Private Partnerships, demise of the Pan Professional Forum, and retrospective pension changes for international medical

graduates from the United Kingdom in New Zealand. The President of the Medical Students Association Michael Chen-Xu also attended one of these meetings.

The previous year MAS commissioned research from the Association on international medical graduates in New Zealand with particular reference to those that leave New Zealand within three years. This was undertaken by Lyndon Keene and completed early this year. The Society has advised of its appreciation of the quality of this work

Association Finances

The Association's net surplus was $541,637 for the financial year ending 31 March 2012 due largely to a combination of membership subscription (FTEs), interest earnings and bargaining fees exceeding expectations and total expenditure coming in well under budget; the main area of under spending was collective bargaining which contained a precautionary buffer.

The ASMS Investment Committee comprising Executive member Paul Wilson, Executive Officer and MAS' Investment Products Manager (Daniel Callaghan) reviewed the investment strategy and agreed to continue the conservative approach, placing reserves on reasonably short term deposits with staggered maturity dates; at 31 March these totalled $3,020,064 over varying terms of between 6 to 15 months.

Administration

The administration team, led by Executive Officer Yvonne Desmond, is an experienced and dedicated team ensuring that the office runs smoothly and the industrial team is well supported.

With a steadily rising membership we are fortunate that the members database lends itself to regular adaption to ease the demands of maintaining accurate records. A recent advance in this area involves automated processing of fortnightly membership subscription payments which is a real time-saver. Also under development is an online membership application form which will interface with the database and enable members to join or update their records via the website. It is envisaged that this project will be complete by the January.

Strong focus continues on communicating with members in a timely and efficient manner, striving for efficiencies in all areas along with maintaining the professional standard of the Association's publications (including the *StandPoint, Health Dialogue* and *Specialist Workforce Alerts*). The salary and exit surveys are also conducted on a regular basis.

Website

Maintaining an effective website remains a key focus with the homepage continually evolving to accommodate the latest relevant news and information. As well as providing the latest health sector news, the site continues to serve as a 'one stop shop' for SMOs seeking advice and current industry information. The site attracts 2,500-3,500 unique visitors each month. In addition to adding staff videos to the 'About Us' section, for the first time we posted video coverage of the 2011 Conference presentations which were well received.

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

The ASMS website is often the first point of contact for senior doctors and dentists seeking employment in New Zealand, accordingly the vacancies section, *jobs.asms.org.nz, a*ttracts 1,500 visitors each month; around half of the total site visits. Despite the few DHBs who refrain from utilising the service, it remains one of the most comprehensive listings of specialist and medical/dental officer job vacancies in New Zealand; the number of job listings averages 90, representing 75% of all DHBs.

Because *jobs.asms.org.nz* is a service rather than a business, the rates are very affordable with proceeds put into growing the market and enhancing our services to both jobseekers and their

prospective employers. In line with that commitment we have commissioned a totally new and more user friendly jobs portal that will allow job seekers to access job descriptions, apply directly to employers and register for job alerts. This new job service is expected to go live by year end.

Other Matters

World Medical Association: Ethical Implications of Doctors Strikes

In October 2011 the World Medical Association adopted a paper on the ethical implications of doctors' strikes which was considered by the National Executive at its February meeting. The paper promotes restrictions on the right to strike but New Zealand would appear to comply with the resolution. In particular, the minimum 14 days' notice as an essential service but more so the Health Sector Code of Good Faith (schedule to the Employment Relations Act) with particular reference to life preserving services. The paper refers to arbitration in some countries. New Zealand is not one of them but there is a facility for facilitation by the Employment Relations Authority (although this is under threat with the Government's proposed amendments to the Employment Relations Act). The paper is broadly supportive of the right to strike under certain circumstances and notes that it is legitimate for strikes not only to be over the healthcare system and patients but also terms of employment, including remuneration. In fact, the paper states that the latter can be beneficial for the former. The WMA's recommendations are left to national medical associations to follow through.

Euthanasia

In August the Prime Minister stated on talkback radio that euthanasia was practised by doctors quite a lot. The Executive Director was asked to comment by the *Dominion Post*. Although reluctant to comment, he described Mr Key's comment as simplistic. This then became front page coverage the next day, including photographs. That same day and the next there were a number of print and electronic media comments from specialists and also the Society of Palliative Medicine criticising Mr Key. This included an interview with Dr Sinead Donnelly (Chair of the New Zealand Committee of the Australian & New Zealand Society of Palliative Medicine) on Radio New Zealand's *Nine to Noon* programme. The Association did not participate in this subsequent debate despite invitations to do so. However, the Society's media statement and position statement on euthanasia was put on the Association's homepage. Later in the month the Executive Director had an informal meeting with Dr Donnelly on her initiative over this debate and also Labour MP Maryan Street's bill which still sits in the 'lottery' selection process. He advised that the Association did not have a position on euthanasia. But the National Executive in September agreed to invite the Society to provide an article for publication in *The Specialist* on the state of palliative care. This has been accepted. The Prime Minister meanwhile subsequently acknowledged that his comments were 'sloppy' and has also agreed to meet the Society.

Medicines Amendment Bill

The Medicines Amendment Bill was considered by the National Executive at its May meeting when it had had its first reading and been referred to Parliament's Health Committee. The Executive was concerned that in the preparation of the bill the Government only consulted with the regulatory authorities rather than with colleges and other professional organisations. The Bill extends prescribing rights to nurse practitioners and optometrists (nurse practitioners did have this by regulation), introduces a category of delegated prescriber who can have prescribing rights by virtue of an authorisation provided by an authorised prescriber, and introduces a new definition of medicine. The Executive agreed not to make a submission on the Bill leaving this instead to the colleges and other professional associations but did agree to advise the Ministry of Health of our concern about excluding the colleges and professional associations in the development of the Bill before its introduction to Parliament. The Bill has now gone through the select committee stage and is awaiting its second reading.

Recertification of General Registrants

Last year we reported that the Medical Council called for proposals from organisations to run a recertification programme for general registrants. The National Executive decided not to make a proposal, it being outside the Association's role. This year the Medical Council decided medical practitioners with general registration who are permanently employed by DHBs and who on 14 March 2012 were already enrolled in a College recertification programme would be exempt the bpac^{nz} programme but only for the next two years i.e. until 14 March 2014 at which time they would be required to join the bpac^{nz} programme unless the College had amended its recertification programme in the meantime to include essentially the same requirements as those under the bpac^{nz} programme. This decision took account of some but not all of the Association's concerns involving medical officers who were involved in College programmes.

Budget 2012-13

The Government's Budget for the fiscal year 2012-13 was announced on 24 May and considered by the National Executive at its July meeting. The Budget was the second 'zero budget' in a row with increases in expenditure in some areas having to be found from cuts in other areas of government spending. The analysis of CTU economist Dr Bill Rosenberg has been very helpful in understanding what it meant for Vote Health. This year he has estimated that there is a $254 million shortfall in addition to the shortfall of around $230 million over the last two years. The savings projected are down to $47 million (half of this will be from prescription charges and changes in the asset value threshold for aged care) from the $109 million projected last year. There is a considerable decrease in money allocated for capital expenditure in Vote Health as well - from $454 million last year to $289 million this year. This is worrying as many DHBs have extensive earthquake remedial work to do as well as the costs of rebuilding Canterbury hospitals.

Northland DHB Laboratory Review

Particularly during 2005-08 the Association was involved in a number of cases when DHBs put up their hospital laboratories to tender from private interests. This was in response to the government's decision to devolve the then demand driven funding of community testing to DHBs. In response the majority of DHBs went down the path of going for 'Requests for Proposals' (RFP) processes for community testing in which the outcome was capped funding arrangements with a single (usually) private provider in which considerable savings were achieved. In other cases the hospital laboratory was also made part of the RFP (it was also able to make a bid to do community testing). The Association was embroiled in this in an endeavour to ensure that the hospital laboratory continued to be publicly provided. Overwhelmingly, and despite a successful interim injunction application, we were unsuccessful. Since then no further partial privatisations have occurred. In 2011 Northland DHB had to address these matters as the community testing contract term was coming to an end. At one stage the DHB appeared to be only putting community testing in the RFP. But, in response to some pressure, there was a change with the hospital laboratory also to be added. The Association injected itself into the process and after some frank but constructive discussions it was agreed that only community testing was put up. The hospital laboratory was not threatened. This was a 'below the radar' success that was assisted by high ASMS membership levels in Northland and a constructive working relationship between NDHB and ASMS.

Clinical Ethics Network Survey

In February the National Executive approved a request from Dr Al MacDonald (Capital & Coast and former National Executive member) to undertake an electronic survey of Association members on a clinical ethics network. The survey was subsequently conducted and Dr Macdonald has now completed his analysis of the returns. He has provided this to the Association and will also give a presentation to Annual Conference.

Draft Principles for Workforce Redesign

The New Zealand Medical Association sent the Association, along with several other organisations including the colleges, draft principles for workforce redesign they developed. This followed on from their Role of the Doctor Statement and Health Equity Review Position Statement. There was support for the broad principles when considered by the National Executive at its September meeting.

Surveying DHB Senior Medical Staff Superannuation Entitlements

Superannuation entitlements have now been surveyed for 12 years. The pattern over the period has been a gradual decrease in members who are in the GSF and NPF schemes (which closed to new members in the early 1990s) and an increase in those who receive the 6% subsidy under the MECA clause. As at July 2012 419(compared with 430 in 2011) were in GSF and NPF with 3,374 SMOs receiving the 6% contribution as at 1 July 2012 (up from 3,171 in 2011).

Ko Awatea

The Association was encouraged by Ko Awatea (Counties Manukau) to send a team to its three day Executive Quality Academy in March. Despite it being a valuable activity, for a number of reasons (including cost and other commitments) the National Executive decided not to take up this request. However, it was promoted in *ASMS Direct* along with subsequent Ko Awatea events.

Marlborough Branch

The Marlborough Branch Vice President position has become vacant due to the holder's (Jacqui Irvine) move to Australia. A by-election is currently underway with a call for nominations issued (an earlier nomination call failed to produce nominees).

Associate Membership

Clause 7 of the Constitution provides for former members no longer eligible for membership to apply to the National Executive to become associate members ($100 per annum subscription). The main benefit is receipt of Association publications and the right to attend Annual Conference as an observer. At its February meeting the Executive approved the second associate member, Dr Peter Dzendrowskyj. He is working overseas and has been an Association delegate from Counties Manukau to Annual Conference and the Joint Consultation Committee.

Brian Craig
ASSOCIATION NATIONAL SECRETARY 20 November 2012