ISSN 1174-9261 ISSUE 71 | JUNE 2007

The Specialist

THE NEWSLETTER OF THE ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

Stopwork meetings, there really is no alternative

In the 1980s New Zealand was introduced to the term TINA—there is no alternative—popularised, with some effect, by politicians such as former British Prime Minister Margaret Thatcher. This was used to justify monetarist economic policies of that era, including those known as Rogernomics and Ruthanasia named after New Zealand finance ministers Roger Douglas and Ruth Richardson. There were, of course, alternatives at that time. TINA was a term used to try to close down debate.

Given its chequered history TINA is hardly the most appropriate term to use in the decision of the ASMS National Executive to implement the November 2006 Annual Conference resolution, overwhelmingly adopted by delegates, to proceed with national stopwork meetings because of the protracted impasse in our national DHB MECA negotiations which commenced over a year ago. But it does have a limited and simplistic applicability.

The National Executive has concluded that there is no practical alternative, taking all factors into account, but to proceed with national stopwork meetings commencing on 17 July in Waitemata and continuing throughout the country for up to four weeks. Around 27 stopwork meetings will be held in the 21 DHBs. However, the Executive has sought to minimise, hopefully prevent, patient inconvenience by giving DHBs around six weeks formal notification instead of just the legal two week requirement.

What is the problem and why?

Negotiations for the MECA commenced late May 2006 and the current MECA expired on 30 June 2006 (it still continues in force for members and new appointees until a replacement is negotiated and agreed). Since then we have had 22 days of negotiations, eight of which have been with an experienced and proactive industrial mediator (the last on 12 June). For much of this period, in fact it almost feels like since day one, we have been at an impasse.

Much of this is due to the approach of the parties to the negotiations. The DHBs approach is a financial costing one. They make an assessment of how much monies they wish to make available for the settlement and then try to restrict negotiations to 'slicing and dicing' this predetermined budgetary allocation. This quantum remained unchanged for a year until last month when it was increased but in a way that is most aptly described as too little, too late (delayed over a period of 46 months).

Compounding this approach is the fact that for foolish and inexplicable reasons the DHBs have attempted to use claw-back counter-claims to pursue an absurd de-professionalise and managerialism agenda in areas such as time for non-clinical duties, consultation rights, SMO accountabilities, and sabbatical.

On the other hand, the ASMS makes an assessment of what is necessary for New Zealand's ability to recruit and retain SMOs both in the immediate context and longer term (as well as fairly remunerating them). This takes into account factors such as our vulnerability due to small size (small critical mass to sustain a much larger medical workforce proportionally consistent with larger countries) and relative geographic isolation, New Zealand is always going to be in a potentially vulnerable position and needs to be proactive in order to address it.

Compounding and sharpening this vulnerability is increasingly assertive competition across-the-Tasman where terms and conditions of employment have recently been significantly increased in response to recognised shortages and the Bundaberg tradgedy. Already the signs are that the Tasman traffic is overwhelmingly westwards rather than eastwards.

Continued next page

ASMS

Executive Director
Ian Powell

Assistant Executive Director
Angela Belich

Senior Industrial Officer
Henry Stubbs

Industrial Officer
Jeff Sissons

Industrial Officer
Sue Shone

Executive Officer
Yvonne Desmond

Admin Officer
Barbara Narasy

Membership Support Officer
Kathy Eaden

Level 11,
The Bayleys Building
Cnr Brandon Street and Lambton Quay,
PO Box 10763,
Wellington,
New Zealand

Ph 04 499-1271

www.asms.org.nz

from previous page

The DHBs seem to be placing much store on the current doctor surplus in Britain. However, this falls down for two reasons—these doctors are more likely to be attracted to the superior terms and conditions of employment in competing Australia and the surplus is more likely to be a temporary phenomenon.

Why do we have this impasse?

The key difference between the ASMS and the DHBs that has led to this impasse is the fundamental difference in our respective approaches to these negotiations. Whereas the ASMS is thinking of tomorrow, in contrast the DHBs are only thinking of today.

The consensus assessment of the ASMS negotiating team can be summarised in the bullet points below:

- The DHBs have adopted a rigid dogmatic position and have failed to negotiate in a genuine way.
- They are attempting to impose more managerial barriers between senior doctors and patient care.
- They are attempting to impose more managerial control in place of professional standards.
- They have ignored New Zealand's vulnerability in the global health workforce which places services in jeopardy when unable to attract and retain enough good quality senior doctors.
- Thus, their negotiating strategy is risking standards of care and safety of patients.

What are stopwork meetings?

As has been emphasised on several occasions stopwork meetings are not strikes. They are an entitlement under the MECA. The entitlement is to hold at least two 2-hour meetings per annum without loss of pay in order to discuss matters of importance to members. Stopwork meetings could be held, for example, to discuss staffing or safety issues—even car parking for that matter! Other unions use stopwork meetings much more than the ASMS including, for example, for seeking approval of proposed collective agreement claims prior to negotiations and for considering ratification of proposed settlements.

Although in the past there have been occasional SMO stopwork meetings in some hospitals these have been rare and over local matters. This is the first time senior doctors have had national stopwork meetings.

Why hold stopwork meetings?

The decision of the ASMS Annual Conference last November to authorise the holding of stopwork meetings and the subsequent resolve of the National Executive to implement that decision is in response to the practical reality that the impasse that existed well before last November still remains. This is also despite being in mediation and the mediator making two different proposals to bridge the gap between the parties (whereas the ASMS responded positively to both, the DHBs did not). Further, members of the ASMS negotiating team are well aware of the growing frustration and anger of many members about the lack of progress and their belief that the ASMS needs to adopt a firmer position.

The purpose of the stopwork meetings is two-fold:

1. To report back to members and discuss the impasse between ourselves and the DHBs.
2. To discuss ways in which we might find a way through this protracted impasse.

They provide an opportunity for the ASMS negotiating team to assess membership sentiments and views, including on possible strike action which is being actively discussed already by many members.

Ostriches should not be role models

Unfortunately, over health workforce recruitment and retention, especially in the context of a collective agreement negotiation, the approach of the DHBs is 'if in doubt, put your head in the sand.' Ostriches are impressive creatures but, at least in sand, they should not be seen as role models by DHBs for their industrial relations strategy. While their heads remain in ostrich-like pose they will continue to be ignorant of, oblivious to and in a state of denial over the reality of the health workforce they employ and its potential and actual vulnerability.

The stopworks have become a necessary means by which we seek to pull their heads out of the sand and work with them in satisfactorily settling the MECA within the framework of a vision and strategy for the maintenance and development of a viable and sustainable senior medical workforce in New Zealand.

Of course, strictly speaking TINA is not the only alternative. There is another; it is called capitulation!

Ian Powell
Executive Director

President's Column

The impact of the highly improbable

Doctors are the best judge of doctors. Expert testimony is unbiased and accurate. Doctors bury their mistakes and protect their own. Doctors will never go on strike.

Show me the evidence. That when we are confronted with the unexpected and the unusual, we act scientifically and dispassionately. For if you do, you are peculiar amongst the species, the only professional to do so.

The rest of us are too much influenced by instinct, history, Plato and Gauss.[1]

Our evolutionary past did not favour complex probabilistic thinking, the only thinking that can start to untangle complex chaotic systems - like humans, hospitals and health care. We have survived by assuming, instantly, that every snapped twig signals a wild animal, that all wild animals eat humans, no matter the true probabilities. That some twigs just snap, that some animals do not want us for supper. We confuse improbability with impossibility. Lured by centuries of hunter-gathering we are disposed to make snap decisions on the basis of minimal evidence and facile theories. That is how our brains are derived and naturally nurtured.

Our spoken and written history is the explanation of low probability events after the fact. We are driven to explain the non-mundane. The crisis, the exciting, the calamity. Story telling helps us make sense of what happened but retrospective distortion is rife in any such story. Any causal chains we may construct were quite invisible to contemporaries. And any expert testimony needs constant cognisance that if these causal chains had been visible, it is likely the unforeseen consequences would not have occurred.

Plato and his ilk have often encouraged us to prefer simple theory to messy reality. Easy and linear logic over dirty dangerous explanations for the way we act. Obligingly we are inclined to select only the data that fit our theories. Mold models to our mood. To filter what we see, what others tell us, through the lens of likeability. Or liability? To choose costing and accounting models to reinforce our prejudices. To try and control, not engage, those integral to running complex chaotic systems.

Allegiance to Gauss distorts what we see and what we expect to see. We assume everything conforms to the bell curve of normal distribution. We formulate treatments, complaints processes, health systems, on the basis of "normal" bulges and "thin tails" or outliers. But earthquakes, crises, and calamities (and most physiological and psychological systems) obey fractal distribution or power laws. They are not "normally" distributed. They have non-linear dynamics. They have many more outliers, or "fat tails". So many more things go wrong, have unexpected consequences, besmirch unusual mirrors on life, than we naturally assume or like to admit.

Trouble is, it is harder to live with this insight than without it. We humans prefer predictions and forecasts, and retrospectively distorted stories, even when they are nearly always wrong. Can we as doctors claim otherwise? When we are confronted with the unusual, the unexpected, the unfathomable, the irreconcilable, the unconscionable? When we are asked to judge ourselves, or judge our peers by expert evaluation or professional opinion?

When we have to examine our own realities and the imperative of the urgent, weighed against the workforce of the future? The responsibility of reacting balanced with the problems of planning. Do we knuckle down and do what we train tirelessly for, for the patient in front of us, or step back from the chaos and consider collective action?

Because who do we trust to determine the future shape of us? Those who wish to control, cajole, constrain us, in the belief that instinct, retrospective distortion, simple theory, and overzealous pursuit of outliers will interrogate the data and resile the reality. Or ourselves, who labour and love and care and caress with colleagues, for those we will heal today and those we will care for all our tomorrows.

Join together, avoid lonely crusading, and drive each other to move beyond instinct, outside of the myths of history, further than simplistic philosophy, into the realms of chaotic reality. Of incidents and accidents despite intent, of improbable outcomes, of confrontation to avoid conflagration, of very good persons doing very good acts. To support each and every one of us in our passionate pursuit of professionalism, in all its peregrinations, in all its performances. In all its possible perfections, and imperfections.

Jeff Brown
National President

1 Nassim Nicholas Taleb – The Black Swan

Time to tell a story

A former ASMS National President, Dr Peter Roberts, was fond of introducing important issues and points he wished to raise and promote in the context of telling a relevant story. Taking his thoughtful lead it is appropriate to tell a story from South Australia which is affected by workforce shortages and inadequate terms and conditions of employment to address recruitment and retention pressures.

Intensivists are a case in point. For some time their college had been warning the Royal Adelaide Hospital that their intensivist staffing shortages risked the withdrawal of college accreditation for intensive care. However, hospital and state authorities ignored these warnings. Instead they called what they denigrated as the college's 'bluff'.

This tactic failed with the college withdrawing accreditation for 2008. Of course, the loss of accreditation leads to loss of trainees which in turn makes it almost impossible to recruit to specialist positions. Further, the ramifications are wider than simply intensive care.

The South Australian state government and hospital authorities were suddenly faced with an avoidable crisis which caught them by surprise and was unexpected (although for those with understanding it was no surprise at all). Consequently they were thrown into panic leading to negotiations with the ASMS's counterpart union. This led to an agreement in March for an 80% loading on top of the current salaries for intensivists. It does not take rocket science to consider the implications of this drastic response to the other specialist groups in South Australia.

This is a prime example of persistent neglect of the importance of ensuring that entitlements contained in collective agreements are regularly enhanced in order to recruit and retain. The longer the period of neglect, the greater the risk of a crisis and the need for a drastic and more costly response driven by panic.

Reinforcing the lessons of this Australian story is the strong message from the Ministerial Medical Workforce Taskforce in its report, *Reshaping Medical Education and Training to Meet the Needs of the 21st Century,* to the Ministers of Health and Education (March 2007). It gave the following unambiguous warning that the government and DHBs ignore at their peril:

Of all OECD countries, New Zealand relies upon the highest proportion of overseas-trained doctors to meet its medical workforce. Currently some 41 percent of all doctors registered in New Zealand received their primary medical qualification overseas…There is a significant gap between the overall numbers we train and the requirements of the New Zealand health system. Although for a small country the "brain exchange" that results from a significant influx and efflux of doctors has benefits for the system, the size of this long-term net deficit is unsustainable.

Unfortunately those pulling the strings in our national DHB MECA negotiations, as well as in the other DHB workforce collective agreement negotiations, are in the mindset of only being prepared to act when a crisis occurs rather than preventing the crisis from happening. They think of today only and not of tomorrow. It says a lot about the quality of DHB leadership when their approach can be summarised as neglect—crisis—drastic response—fiscal blow-out.

It would be nice and wise if they were to extend their emphasis on preventative health care to a preventative industrial relations strategy.

Ian Powell
Executive Director

"They're complaining about a lack of resources again – get the PR people to knock up a few thousand Get Well cards"

Disruptive doctors – mountain or molehill?

In March this year the Medical Council sent out a draft for consultation of guidelines for organisations on dealing with disruptive doctors.

Given both the variety of options already available to employing authorities for dealing with unruly employees and the potential detriment and indignity to the profession, the document is puzzling. The mere words "disruptive doctors" carry a derogatory flavour. Add the questionable assertion in the preamble - "Historically, disruptive behaviour by doctors has been tolerated…" to the emotive and accusatory language used in cataloguing alleged behaviour and an ugly image emerges. Behaviour is said to range from "racial, ethnic or sexist slurs" to "demands for special treatment".

But is there substance to assumptions that there is a problem? The Council's statement that "the modern focus on the importance of teamwork to ensure patient safety, and quality in medicine means disruptive behaviour can no longer be tolerated" is condemnatory of the profession. Such condemnation cannot be limited to those alleged to have behaved badly but to those who implicitly have allegedly allowed or tolerated unhealthy work practices. And yet the draft document speaks to a group - employers - who have been named as neglectful, before pointing to a new method of reining in the miscreants.

Employers may also seek to view a doctor advocating strenuously for a patient, publicly opposing a new management fashion for reforming all or part of a health service or drawing public attention to staff shortages as disruptive.

The term "disruptive doctors" apparently has its genesis in the United States of America, where one published study[1] spoke of doctors who "had spooked their colleagues with behaviours such as wearing a gun in the operating room". An internet search will reveal many other reported instances of extreme and bizarre behaviour, which may well be of questionable veracity. There is no suggestion that such conduct is replicated in New Zealand, yet the panic has crossed the Atlantic and, taking the form of a draft guideline, threatens to gain a foothold in what ASMS Senior Industrial Officer Henry Stubbs describes as the "minefield of employment law."

Among statements in the draft document are those which are either inconsistent with, or which overlook employer responsibility, good industrial practice, minimum standards of procedural fairness and existing processes. For instance, Clause 43 of the New Zealand District Health Boards Senior Medical and Dental Officers' Collective Agreement (MECA) already defines the procedure for addressing performance concerns relating to clinical practice and its impact on patient safety. Why create another process? Why set up "behavioural review meetings"?

Employers are obliged both by statute and by common law to adopt fair and proper procedures for dealing with disciplinary and competency issues. Furthermore, under the Health and Safety in Employment Act 1993, and the "good employer" provisions in the New Zealand Public Health and Disability Act 2000, there are statutory obligations to have in place policies to provide good and safe working conditions for their staff.

In its response to the Medical Council, the ASMS warns that the proposed process is likely to become protracted and highly litigious, and that involvement of the Council would only serve to delay and impede the low key resolution of problems. Moreover, under employment law, the relevant professional body has no recognised role in the employment relationship.

The Medical Council has the function of defining standards of competence for doctors, but it is questionable whether it has any role (whether expressed or implied) in providing guidelines to employers. If disruptive behaviour occurs in the workplace, common law and statutory obligations apply. Active steps must be taken to improve the situation. Employers should not need to be reminded of their obligations via a guideline from the Council.

The ASMS has urged the Medical Council not to set up another basis for complaints or referrals about medical practitioners, and has requested that it takes the matter of revising or finalising a guideline no further.

Sue Shone
Industrial Officer

1 Ronald Schouten, M.D at Massachusetts General Hospital, Boston. Reported in OB/GYN News March 1, 2005.

Letter from ASMS negotiating team to members on MECA negotiations

Below is a copy of the letter sent to DHB-employed ASMS members from the ASMS negotiating team following the issuing of formal notification of stopwork meetings to each of the 21 DHBs

Dear Colleague,

A stopwork meeting has been called for ASMS members, SMOs (senior medical and dental officers), employed by your DHB. Your attendance is strongly encouraged. The purpose of this letter is to explain what the meeting is, what it is not, and why it is necessary.

The national DHB collective agreement (MECA) negotiations have dragged on for more than a year. Despite our many efforts to bargain, negotiate and concede your team is frustrated. The DHB team have only recently moved their position, but too little and too late. There is still a large gap between us on fiscal and non-fiscal issues. An impasse is the most neutral way of describing the situation.

The ASMS Annual Conference (November 2006) overwhelmingly resolved that your negotiating team should call stopwork meetings if the impasse at that time continued. We then initiated mediation to explore whether the impasse might be overcome. But, after seven subsequent days of mediation with a pro active mediator, the impasse still remains.

The stopwork meeting is designed to achieve the following two aims:

1. The ASMS negotiating team needs to inform its member SMOs where the parties are at.
2. The ASMS negotiating team needs to seek direction from its member SMOs.

Stopwork meetings are **not** strike action. Instead they are a legal entitlement for all ASMS members under the MECA and the Employment Relations Act to discuss matters of importance. Your negotiating team has organised the meetings in conjunction with local ASMS representatives to enable as many SMOs as possible to attend in their work hours. Unlike strike action, they are on full pay.

Formal notice of the stopwork meeting has been given to your DHB a good six weeks (two weeks is the legal requirement) in advance so that bookings for clinics, operations, procedures and meetings are able to be cleared with minimal disruption to patients.

Emergency and acute patient care will, of course, continue but all elective and booked patient services, administrative meetings and other duties should be cancelled by your DHB for the duration of the stopwork meeting. Your DHB is not entitled to raise any impediment to your attendance at a stopwork meeting. We reiterate that it is not strike action.

We have deliberately planned and given notice to encourage maximum SMO attendance with minimum disruption to individual patients.

Please use this chance to discern, to debate, to decide and to direct.

Your negotiating team depends on you.

Stopwork Meetings

DATE	DHB	TIME	VENUE
Tue, 17 July 2007	Waitemata	9am	Conference Room 1, North Shore Hospital
Tue, 17 July 2007	Waitemata	2pm	KawaKawa Room, Waitakere Hospital
Wed, 18 July 2007	Tairawhiti	9am	Morris Adaire Boardroom, Gisborne Hospital
Thurs, 19 July 2007	Northland	9:30am	2nd Floor Conference Room, Whangarei Base Hospital
Fri, 20 July 2007	Bay of Plenty	10am	Nikau Room, Tauranga Hospital
Mon, 23 July 2007	Hutt Valley	1.30pm	Meeting Room 2, Learning Centre, Hutt Hospital
Tue, 24 July 2007	Counties Manukau	1.30pm	Academic Lecture Theatre, Middlemore Hospital
Wed, 25 July 2007	Capital & Coast	10am	Nordmeyer Lecture Theatre, Level D, Wellington School of Medicine
Thurs, 26 July 2007	Canterbury	10am	Hakatere Room, Old Nurses Home, Ashburton Hospital
Thurs, 26 July 2007	Southland	1.30pm	Hospital Lecture Theatre, Ward 18, Kew Hospital
Fri, 27 July 2007	West Coast	1pm	Doctors' Lounge, Grey Hospital
Fri, 27 July 2007	Hawkes Bay	2pm	Harding Hall, Hawkes Bay Hospital
Mon, 30 July 2007	Waikato	9am	Auditorium, Bryant Education Centre, Waikato Hospital
Tue, 31 July 2007	West Coast	10am	Community Room, Buller Medical Centre, Westport
Tue, 31 July 2007	Taranaki	1.30pm	Corporate Meeting Room 1, Taranaki Base Hospital
Wed, 1 August 2007	Nelson Marlborough	9am	Dalton House, Nelson Hospital
Thurs, 2 August 2007	Nelson Marlborough	10am	Senior Medical Staff Common Room, Wairau Hospital
Thurs, 2 August 2007	Canterbury	1pm	Rolleston Theatre, Christchurch Medical School
Fri, 3 August 2007	MidCentral	10am	Lecture Theatre, Level One, Palmerston North Hospital
Mon, 6 August 2007	Auckland	1.30pm	Clinical Education Centre, 5th Floor, Auckland City Hospital
Tue, 7 August 2007	Wairarapa	12.30pm	Room A, Personel Deparment, Masterton Hospital
Tue, 7 August 2007	South Canterbury	1.30pm	3rd Floor Meeting Room, Garden Block, Timaru Hospital
Wed, 8 August 2007	Otago	10am	Fraser Conference Room A, Fraser Building, Dunedin Hospital
Wed, 8 August 2007	Whanganui	9am	Lecture Theatre, Wanganui Hospital
Thurs, 9 August 2007	Bay of Plenty	9am	Doctors Common Room, Whakatane Hospital
Thurs, 9 August 2007	Lakes	2pm	Conference Room, 3rd Floor CSB, Rotorua Hospital

KiwiSaver and ASMS members in the public sector

The recent changes to the KiwiSaver superannuation initiative have significantly enhanced the attractiveness of this scheme for ASMS members. This article briefly summarises the key benefits and features of KiwiSaver schemes and the interaction between KiwiSaver schemes and the national DHB collective agreement (MECA).[1] This article is therefore focussed on the entitlements of ASMS members employed by district health boards. Members with other employers are welcome to contact the ASMS for advice.

Many of the KiwiSaver rights and obligations come into effect on 1 July 2007. From then existing employees have the option to 'opt in' to a KiwiSaver scheme by either giving notice to your employer or by directly joining a KiwiSaver scheme.

Features of KiwiSaver

A key benefit for employees without existing rights to employer superannuation contributions (eg, subsidised superannuation under the MECA) is the compulsory employer contributions to KiwiSaver schemes. These contributions will be phased in over the next four years starting at 1% from 1 July 2008 and increasing by 1% each year to 4% in 2011.

Aside from compulsory employer contributions, there are six important benefits that a KiwiSaver scheme provides over earlier superannuation schemes:

- Each KiwiSaver account starts with a 'kick-start' contribution of $1,000.
- The Government will provide a dollar-for-dollar tax credit on employee contributions of up to $20 per week paid directly into the scheme.
- The Government will provide a subsidy of $40 per year towards administration fees.
- Specified Superannuation Contribution Withholding Tax (SSCWT) is waived on the employer's contribution up to a maximum of 4% of gross wages.
- A proportion of KiwiSaver funds may be diverted towards either a deposit on a first home or mortgage repayments.
- The Government will contribute $1,000 per year of membership up to a maximum of $5,000 per employee as a one-off payment towards a deposit on a first home. Treasury have announced strict guidelines regarding eligibility for this subsidy (such as an upper limit on the value of the home).

There is a major disadvantage to KiwiSaver in relation to many existing schemes. KiwiSaver contributions are locked-in until the latter date of contributors turning 65 or five years passing since their first contribution. This is significantly more restrictive than many existing schemes.

New appointees (employees)

Employees commencing a new job (of 28 days or longer) on or after 1 July 2007 will be automatically enrolled in a KiwiSaver scheme. They may 'opt out' of contributing at any time from the beginning of their third week of employment until the end of their eighth week of employment.

A new employee may nominate a KiwiSaver scheme they wish to contribute to or require the DHB to contribute to their existing KiwiSaver scheme if they have joined previously.

Where a new employee does not nominate a KiwiSaver scheme then they will be enrolled in the employer's preferred KiwiSaver scheme. If the employer has not nominated a preferred scheme then the employee will be allocated to a random KiwiSaver scheme by Inland Revenue. After three months, contributions will be paid by IRD into the employee's KiwiSaver account.

Existing Superannuation Schemes

Under the existing MECA entitlements DHBs are required to pay either:

- The required employer contribution to any of the superannuation schemes operated by the National Provident Fund or Government Superannuation Fund (including both defined-contribution and defined-benefit schemes). These schemes have been closed to new members since 1992; or
- For others, a dollar-for-dollar matching contribution up to 6% of gross taxable salary towards a scheme that meets the requirements of the State Sector Act 1988 and is subject to a participation agreement between the scheme provider and the employing DHB.

Which of these an SMO is currently using may have a significant bearing on the decision to join KiwiSaver. The Government has been clear that State Sector employees will not be eligible for employer subsidies to KiwiSaver schemes on top of their existing entitlements.

Complying superannuation fund status

Existing schemes may apply to the Government Actuary for complying superannuation fund status. It has been announced in the latest Budget that compliant schemes receive all the employee benefits of KiwiSaver except for the $1,000 kick-start and $40 per annum administration fee subsidy.

The three main prerequisites for complying fund status are that they be open to all employees, they have a minimum contribution rate of 4% and lock in of savings until age 65. The ASMS understands that many schemes (including the National Provident Fund and Government Superannuation Fund) are unlikely to be eligible for approved status particularly because of either restricted eligibility or easy access to funds.

Government Superannuation Fund and National Provident Fund schemes

It is probable that contributors to the Government Superannuation Fund or the National Provident Fund will be unable to require their employer to contribute to KiwiSaver. The ASMS will continue discussions with DHBs to clarify this point.

Defined benefit schemes (such as the Government Superannuation Fund) have traditionally been regarded as superior to defined contribution schemes (such as KiwiSaver). Arrangements such as suspending Government Superannuation Fund contributions in favour of KiwiSaver contributions may be advantageous although they are only available to certain members of the scheme. As such, the decision as to whether to continue with a Government Superannuation Fund or National Provident Fund superannuation scheme or to switch to a KiwiSaver scheme is a complex one. We recommend seeking independent advice as to the benefits and disadvantages.

Other approved schemes

Except where existing schemes are eligible for complying fund status the decision to change from an existing scheme to a KiwiSaver scheme will often involve balancing the convenience of existing schemes (which may have advantages such as accessibility of funds and variable contribution rates) against the tax breaks and subsidies of KiwiSaver schemes.

A useful option for many employees may be to split their contribution between a KiwiSaver scheme and their pre-existing scheme. Perhaps the most useful benefit of KiwiSaver, the tax break on employer contributions. is capped at an employer contribution

Mechanics of KiwiSaver

An employee can choose to contribute either 4% or 8% of their gross wages towards the KiwiSaver scheme. The employer contribution may be greater than this depending on the trust deed of the scheme but only up to 4% of gross wages will be tax free.

For example: John is an ASMS member commencing work in the public health sector. He earns $200,000 per annum gross salary. He decides to join KiwiSaver and to set aside 8% of his gross salary as his contribution to his superannuation scheme. The DHB makes a matching contribution of 6% as required by Clause 17 of the MECA.

In his first year of saving, deposits into John's KiwiSaver account are:

- $40 Annual fee subsidy
- $1,000 kick-start
- $1,042.86 tax credit from the government
- $16,000 employee contribution (note that this is paid from net wages)
- $10,680 employer contribution ($8,000 tax-free and $4,000 taxed at 33% SSCWT)
- $28,762.86

Each year thereafter John will save an additional $27,762.86 (the initial kick-start payment is a one-off). If John receives any salary increases, the employee and employer amounts will be based on the new gross salary.

John would save an equivalent amount if he contributed 4% to KiwiSaver and 2% to another scheme (with his employer matching both contributions). This may give him easier access to some of his contribution although he will have to pay two sets of administration fees.

KiwiSaver contributions are locked in until the latter of five years of contributing or reaching age 65. Part or all of the KiwiSaver contributions may be accessible in cases of extreme financial hardship, serious illness or permanent emigration.

of 4% of gross salary. To receive this, an employee would have to contribute an equivalent amount into KiwiSaver. Putting the additional 2% employee contribution and 2% employer contribution into a pre-existing scheme would allow employees to take advantage of the accessibility of these funds. It is not clear at the time of writing whether this will be a viable option but we are discussing this issue with the DHBs.

Conclusion

The ASMS is in discussion with several DHBs around the interface between the KiwiSaver changes and the MECA. We are hoping to shift this to a national basis. There are a number of issues that we are working through. We will try to ensure that members receive the maximum benefit from KiwiSaver.

KiwiSaver is an innovative and positive government initiative. It has the potential to provide significant benefits for New Zealanders including many ASMS members. For members not taking advantage of superannuation benefits through the MECA, KiwiSaver makes the case even stronger to do so.

Jeff Sissons
Industrial Officer

1 This article is for information only. The ASMS does not purport to give investment advice. Any decision to significantly change your investment should be taken in conjunction with an investment advisor. Also, due to the speed with which KiwiSaver is being implemented, several important issues are still being worked through.

For further information, phone 0800 549 472 (0800 kiwisaver) or go to www.kiwisaver.govt.nz or www.sorted.org.nz

ASMS services to members

As a professional association we promote:

- right of equal access for all New Zealanders to high quality health services
- professional interests of salaried doctors and dentists
- policies sought in legislation and government by salaried doctors and dentists

As a union of professionals we:

- provide advice to salaried doctors and dentists who receive a job offer from a New Zealand employer
- negotiate effective and enforceable collective employment agreements with employers. This includes the collective agreement (MECA) covering employment of senior medical and dental staff in district health boards which ensures minimum terms and conditions for more than 2,700 doctors and dentists, over 90% of this workforce.
- advise and represent members when necessary
- support workplace empowerment and clinical leadership

Other services

www.asms.org.nz

Have you visited our regularly updated website? It's an excellent source of collective agreement information and it also publishes the ASMS media statements.

We welcome your feedback as it is vital in maintaining the site's professional standard.

New Support Service for Doctors

The Medical Assurance Society and Medical Protection Society have joined forces to bring their members a new support service. The support service provides access to a free professional counselling service. Doctors seeking help can call 0800 225 5677 (0800 Call MPS). The call will be answered by the Medico-Legal Adviser on duty who will then arrange counselling directly through EAP Services. The service is completely confidential.

ASMS Job Vacancies Online

www.asms.org.nz/system/jobs/job_list.asp

We encourage you to recommend that your head of department and those responsible for advertising vacancies, seriously consider using the facility.

Substantial discounts are offered for bulk and continued advertising.

ASMS email Broadcast

In addition to *The Specialist* the ASMS also has an email news service, *ASMS Direct*. This is proving to be a very convenient and efficient method of communication with members.

If you wish to receive it please advise our Membership Support Officer, Kathy Eaden in the national office at *ke@asms.org.nz*

How to contact the ASMS

Telephone	04 499-1271
Facsimile	04 499-4500
Email	asms@asms.org.nz
Website	www.asms.org.nz
Postal Address	PO Box 10763, Wellington
Street Address	Level 11, The Bayleys Building, Corner Brandon Street and Lambton Quay Wellington

DHB Chief Executive salaries

In considering the ASMS's fiscal claims in the national DHB MECA negotiations a sense of perspective is required. The table below is an updated comparison of the average national salaries of DHB chief executives over a three year period from 2002-03 to 2005-06. Please note that this is a conservative calculation. Chief Executive salaries are reported in $10,000 bands and we have used the lower end of the band.

As can be seen from the table, while recognising that it covers a different period of time, the increases have no relationship with the 'future funding track' (estimated inflation minus 0.5%).

The table summarises the annual increases. Over the same three year period as the previous MECA salaries increased by $48,666 (18.5%).

Please note that the figures published for the 2004-2005 year differ slightly from those previously published. The salary of one Chief Executive was unavailable previously- it has now been added.

	2002-03	2003-04	2004-05	2005-06
Salary ($)	263,333	274,285	293,810	312,000
Increase ($)	–	10,952	19,524	18,190 *
Increase (%)	–	4.12	7.12	6.19

* One of the largest movements in salary between 2004-05 and 2005-06 was the replacement of Southland DHB's Chief Executive (salary between $230,000-$240,000) with an interim Chief Executive (package between $320,0 00-$330,000).

When this increase is factored out, the increase in Chief Executive remuneration falls to $14,579 or 4.91%.

ASMS 19th Annual Conference at Te Papa

Thursday 1 – Friday 2 November 2007

Delegates required

The ASMS meets the costs and makes all travel and accommodation arrangements for ASMS members to attend its 19th Annual Conference as delegates.

Dinner and Pre-Conference Function

A Conference dinner will be held on Thursday 1 November. Delegates are also invited to attend an informal cocktail function on the evening of Wednesday 31 October.

Leave

Clause 30.1 of the MECA includes provision for members to attend Association meetings and conference on full pay. Members are advised to start planning now and encouraged to make leave arrangements and register without delay.

Registration of Interest

Please help us plan for another great Conference and to assist with travel and accommodation reservations by completing this form. Either post, fax or email the details to our Membership Support Officer, Kathy Eaden, at ***ke@asms.org.nz.***

Name: _____

Employer: _____

Address: _____

_____

Special Dietary Requirements: _____

_____

Phone: _____

Email: _____

Your interest in registration will be confirmed with your local branch secretary as each branch is allocated a set number of delegates. Extra members are welcome to attend the Conference as observers.

WE'VE PLACED KIWISAVER UNDER THE MICROSCOPE TO MAKE IT EASIER FOR YOU

The Society will be offering a KiwiSaver scheme for health professionals.*

Whether it's getting into your first home, making the most of tax free employer contributions or knowing what you need to do to see your staff right, we can help you discover the many benefits of KiwiSaver.

* No money is currently being sought and no application for KiwiSaver will be accepted or money received unless the subscriber has received an investment statement.

MEDICAL ASSURANCE SOCIETY

We make it easy

For advice on KiwiSaver call or email us on **0800 800 MAS** (627) **kiwisaver@medicals.co.nz**