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The Specialist

THE NEWSLETTER OF THE ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

Time to move on: post-MECA initiatives

After around 21 months it has become necessary to move on from the protracted and at times acrimonious negotiations over the national DHB multi-employer collective agreement (MECA).

The ASMS National Executive voted in March to ratify the provisional national DHB MECA settlement following the overwhelming mandate provided by the indicative membership ballot. In summary:

The response rate was 74% of ASMS members employed in DHBs.

- 88% of respondents voted 'yes' for acceptance and 12% voted 'no'.
- The response rates in each of the 21 DHBs ranged from 63% to 79%.
- The 'yes' votes in each of the 21 DHBs ranged from 71% to 100%.
- The 'no' votes in each of the 21 DHBs ranged from 0% to 29%.

Overall achievements

The new MECA has now been signed by the ASMS and the DHBs' Chief Executives. It's now time for closure and moving on consistent with our building block approach in which each negotiation seeks to build on previously negotiated improvements. Despite all the difficulties, frustrations and disappointments (eg, length of the new MECA, no enhancement for working on after-hours call duties) we have nevertheless achieved:

- Useful beneficial enhancements to current terms and conditions of employment.
- A launching pad in the form of the independent Commission for addressing the medical workforce crisis in DHBs, in particular the significant threat of superior terms and conditions of employment in Australia and also from the private sector in New Zealand. The Minister of Health David Cunliffe has publicly recognised the role of the commission in international relativity, particularly Australia, with his statement that the commission "will ensure that senior doctors working in New Zealand have pay and conditions commensurate with those working elsewhere" (his media statement is elsewhere in this issue of The Specialist). The only country specifically identified in the commission's terms of reference is Australia.
- Increased ASMS membership which strengthens our representational and advocacy capacity. Since the negotiations commenced back in May 2006 our membership has increased by well over 300 with the major periods of increase being around the national stopwork meetings mid-last year, the industrial action ballot late last year, and the recent membership ballot over the provisional agreement.
- Confidence that the ASMS can organise successful well attended national stopwork meetings with high media coverage and, depending on the circumstances at the time, achieve a strong vote for limited industrial action. As important as this capacity is the fact that the DHBs have witnessed and understand it.

'What it takes to stay'

Concurrently with ratifying the provisional national DHB MECA settlement the National Executive then adopted the following resolution:

That the Association focus its activities on the theme of 'what it takes to stay' in seeking to maintain and improve retention of senior medical and dental officers in District Health Boards during the period leading up to the renegotiation of the next national collective agreement. Further, the Association seeks as much as practical active engagement with district health boards over this objective.

There are at least five broad ways in which the ASMS can and intends to pursue the objective of achieving 'what it takes to stay'—the independent commission into competitive terms and conditions of employment; job sizing; the DHB-based joint consultation committees; the application of the 'Time for Quality' agreement; and the new national consultation committee.

1. Independent commission

The focus on 'what it takes to stay' involves a number of features. Top of the 'pops' is the priority the ASMS will be giving to the independent commission into competitive terms and conditions for senior doctors (terms of reference published elsewhere in this issue). The opportunity for an independent cabinet endorsed

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ASMS

Executive Director
Ian Powell

Assistant Executive Director
Angela Belich

Senior Industrial Officer
Henry Stubbs

Industrial Officer
Lyn Hughes

Industrial Officer
Sue Shone

Executive Officer
Yvonne Desmond

Admin Officer
Leigh Parish

Admin Assistant
Ebony Lamb

Membership Support Officer
Kathy Eaden

Level 11
The Bayleys Building
Cnr Brandon St &
Lambton Quay
PO Box 10763
Wellington
New Zealand

Ph 04 499-1271

www.asms.org.nz

investigation into what should the terms and conditions of employment be for a particular part of the workforce is rare and may not happen again for another 20 years, more likely longer. It is about an independent group with expertise recommending the 'rates for the job' in a broad sense of the term for a highly specialised workforce working in a small relatively geographically isolated country in the context of national and international shortages and.

A key part of 'what it takes to stay' means the ASMS and DHBs recognising the significance of the commission and the exciting opportunity that this provides. The ASMS is engaging additional support in order to prepare a substantial submission specifically focussed on all aspects of the terms of reference.

We are also working on persuading the DHBs to adopt a similarly positive attitude towards the commission by openly acknowledging the current and potential serious vulnerability of their senior medical workforce, including the implications for the accessibility of patients to quality care and services, instead of resorting to the short-sighted affordability argument that they adopted in our MECA negotiations. DHBs should be uninhibited by cost in their approach to the commission because its recommendations will go to their paymaster, the government, not just to them and the ASMS.

The commission provides DHBs with the opportunity to persuade government to increase its spending if that it what is required to achieve terms and conditions of employment that are sufficient for New Zealand to train, recruit and retain a high quality senior doctor workforce in DHBs.

2. Job sizing

Supporting members in job sizing noting that there have been several cases of remuneration increases arising out of job sizing reviews that have ranged from moderate to significant (eg, a recent across-the-board process at the Lakes DHB has produced average increases of around 12-14% remuneration increases while in neighbouring Waikato DHB, where the fiscal analysis at this point has been less precise, it has been at least 7% and may be up to 14%).

Job sizing is 'below the radar' activity and is not normally an across-the-board approach. Much job sizing is handled successfully on an individual service by service on an 'as needs' basis initiated by members who believe that that the nature of their job requirements mean that they are working well in excess of the average hours they are being paid for. Usually in these situations the outcome is increasing remuneration to bring it into line with average hours actually worked. On some occasions the outcome is an agreement to increase staffing levels, usually senior doctors but sometimes support such as administration and secretarial.

Job sizing works best when it is membership initiated, assessed and organised. To better assist members the ASMS has revised the ASMS Standpoint on job sizing and hours of work as a membership tool learning from our experiences since the first issue was prepared. This is now available on our website (www.asms.org.nz) and is also available from the national office on request. ASMS industrial staff are also available to advise and assist members.

> Job sizing works best when it is membership initiated, assessed and organised.

3. Local empowerment: Joint Consultation Committees

The MECA requires the ASMS and each of the 21 DHBs to set up joint consultation committees (JCCs) which are to meet at least three times a year. Their scope of coverage is not limited and can include matters to do with the application of the MECA. Their composition on the ASMS side involves the Executive Director (or Assistant Executive Director) and local ASMS representatives. On the DHB side they involve senior managers including the Chief Executive (usually) and the head of Human Resources/ Employment Relations.

JCCs have already provided us with useful vehicles. They have helped enable a process for enhancing the system of remuneration for after-hours' call duties in Tairawhiti DHB while a similar exercise is presently underway in Hawke's Bay DHB. They have been a vehicle for challenging contestable managerial decisions (for example, at Auckland DHB the ASMS successfully challenged the management decision to require senior doctors to complete a well intentioned but over-the-top conflict of interest form leading to its withdrawal). Reviews have also been challenged in the JCCs while useful work has been undertaken identifying resource and accommodation issues and even matters like business class while travelling on CME leave.

In Northland the JCC has initiated a novel approach to enhance greater senior doctor engagement and leadership in the DHB with the decision to hold a half-day workshop on the subject this month. During the half-day, other than acutes and emergencies, all clinical activities including clinics and lists will not be scheduled to enable participation. In Waikato DHB the new Chief Executive frustrated by an inability to affect change himself has challenged senior doctors who themselves are blocked by a managerial layer when pursing a concern not to give up

but to go to the next step up in order to resolve it (and again and again until it lands on his desk necessary).

In the coming period the ASMS will be exploring how we can further use the JCCs to address concerns and enhance work satisfaction in order to enhance DHBs' ability to retain our medical workforce. The more one enhances work satisfaction to the level that it strengthens retention the more this has the added benefit of assisting recruitment. A stable satisfied workforce is an invaluable recruitment incentive.

4. 'Time for Quality' agreement

Along similar lines the ASMS will be looking to promote the enhanced clinical engagement and leadership envisaged by the 'Time for Quality' agreement whose engagement principles are also included in the MECA. This includes the requirement that the role of managers is to support (not lead) senior doctors in the leadership of changes to clinical service design, organisation and delivery.

The underlying principle of the 'Time for Quality' agreement is (a) quality is critical for the health system to succeed; (b) health professionals (in the MECA context senior doctors) are critical for ensuring quality; (c) if health professionals are to ensure quality then the most valuable resource they need for this is time. DHBs are therefore, responsible for providing this time.

Arguably, even more so than the JCCs discussed above, or rather parallel to it, 'Time for Quality' has the capacity to increase members' level of job satisfaction and reduce the 'push' factors that encourage leaving DHB employment. The potential opportunities here are immense.

5. National Consultation Committee

The MECA also sets up a new mechanism, the joint national consultation committee (NCC) which will meet at least quarterly. Unlike the other processes discussed above, the NCC is not workplace based. But it does envisage promoting increased engagement with the ASMS to address issues relevant to the increased engagement of senior doctors where this objective can be further facilitated through national opportunities. While it may undertake a number of projects that will assist this objective it will also be an opportunity for the ASMS to raise issues that can both (a) enhance engagement and (b) remove road blocks to engagement. To the extent that this happens it provides a further opportunity to improve work satisfaction and, as a result, retention.

Ian Powell
Executive Director

Commission on competitive and sustainable terms and conditions of employment for senior medical and dental officers employed by DHBS

The Director General of Health, with the endorsement of the Minister of Health, will establish a commission to recommend to the Minister of Health (through the Ministry of Health), District Health Boards and the Association of Salaried Medical Specialists, a national recruitment and retention strategy that will provide a sustainable pathway to competitive terms and conditions of employment for senior medical and dental officers (SMOs).

This joint commitment to establish the Commission recognises New Zealand's potential vulnerability as a small, relatively geographically isolated country in:

a) Retaining current senior medical and dental officer employees,

b) Recruiting and retaining medical and dental officers trained in New Zealand, and

c) Recruiting and retaining international medical graduates.

In reaching its recommendations, the Commission will have regard to, but not necessarily be bound by, other national conversations and work programmes, including tripartite initiatives and the work of the Medical Training Board. In its deliberations the Commission will take into account:

a) Drivers of demand for the SMO workforce, including population health need and models of service delivery.

b) National and international supply of SMOs, including opportunities for employment, and the terms and conditions of employment for SMOs in Australia and other countries.

c) Employment opportunities available for SMOs in both the private and public health sectors.

d) Margins between specialist salary scales and the relative remuneration of resident medical officers (in particular senior registrars) and SMOs.

e) Changes and trends in factors that affect the supply of SMOs to the New Zealand public health system.

f) The Government's priorities and health targets.

g) Any other factors it considers relevant.

The Commission's recommendations will be forwarded to the Minister of Health, District Health Boards and the Association of Salaried Medical Specialists by 31 March 2009.

Laurels – not for the resting on

Oh so tempting. To heave a massive sigh of relief. Relief that two years of acrimony are over. That agreement has been achieved. That negotiations can be put to bed for a while and we can all get back to the "real" work of hospital specialists. To rest on our collective laurels, thankful that industrial action has been avoided while tempering disquiet over some goals unachieved.

Should we rejoice in the huge increase in membership during the last throes of Ministerial intervention and provisional agreement? Celebrate the more than 3000 as an example of solidarity, and not as pecuniary pragmatists? Should we abrogate to a novel Commission the arbitration of the vexatious Aussie magnet? Look to independent analysis to kick our remuneration into CER touch, and not worry whence their data derives?

Or is the work just getting going? Is the important struggle about to start? Is the campaign to finds "what makes us stay" just beginning? How much can we, individually and collectively, lead the Commission, and the way our hospitals are run? Are we prepared to seize the opportunity to influence? At all possible levels?

In our daily dealings with the ill and injured and infirm – are we prepared to show that we are the leaders of reason and rationing? In our weekly wranglings with the planners and funders – are we prepared to show that we are the leaders of reason and rationing? In our monthly meetings with the politicians and policy makers – are we prepared to show that we are the leaders of reason and rationing?

Because if we do not seize the opportunity our MECA offers we have no more than a few dollars more in our pockets. And we could have got those by crossing the ditch, or by moonlighting as a locum here and there.

No.

Our MECA offers so much more. It offers a real opportunity to seize leadership. To lead Time for Quality. To embed in daily, weekly, monthly and annual plans the clinical nous and intuition so sadly lacking from some of the decisions of DHBs in recent times. To demand time in our regular schedules to lead teams, departments, hospitals, DHBs and health systems to divvy up the dollar for the greatest good. Whilst according the individuals with idiosyncratic illnesses the respect and resources we know they deserve.

Our MECA offers the chance to inform the Commission with data we - each and every one - can validate regarding the pull factors of overseas and private practice, and the attractive factors that keep us in this often fantastic environment.

Our MECA negotiations have brought out the diversity of opinion amongst intelligent highly motivated specialists. It has challenged many of us in dimensions we had never considered. It has threatened some at the core of their ethics. Yet it has united us in resolve to improve our lot for the good of those who we want to work with us, and those who we want to become us, and those who we know depend on us.

The challenge now is to not rest, on laurels or otherwise, but to seize all the opportunities we have won. To influence more than we have ever be able to, in the clinics, in the corridors, in the meeting rooms, in the boardrooms, in the planning portfolios, in the ministries. If we want to.

Because the doyens in the DHBs are really, truly, honestly, earnestly, looking to us to help lead them to the reality of rationing. To how they can deliver on the inexhaustible appetite for more than that is Health.

It is up to you. And up to us.

Jeff Brown
National President

Executive Director's Column

Constant battle: Improvement management engagement with senior doctors

Clause 1 of the MECA outlines the collective agreement's key underlying principles. It has three sub-clauses, one of which (1.1) states that:

The parties acknowledge the importance of collegiality within the workplace and will actively encourage collective negotiations and responses to workplace challenges and issues.

The intent of this sub-clause is to encourage and require senior management in DHBs to engage with SMOs. This engagement, which is more extensive and penetrating than simple 'we hear what you are saying, narrower consultation, involves being collective and collegial at the earliest practical opportunity in order to jointly resolve challenges and issues, including over any processes developed to resolve them. Invariably in DHBs this does not happen with SMO engagement left too late and often marginalised as a result.

> "Failure to engage early with SMOs in resolving challenges and issues is one of the greatest sources of wastage, if not the greatest, in the health system."

Failure to engage early with SMOs in resolving challenges and issues is one of the greatest sources of wastage, if not the greatest, in the health system. The amount of health dollars wasted on large amounts of time, effort and resources spent on inadequately, sometimes appallingly, is enough justification by itself for early and thorough engagement with SMOs, let alone the far greater opportunity it would provide for fiscally robust and sustainable decision-making. The corrosive impact of these poor processes is even more damaging in the longer term in that it undermines the confidence of senior medical staff in the integrity and usefulness of future consultation exercises.

Unfortunately, DHBs do not practice and promote the importance of proactive engagement with and leadership by SMOs well enough. Where it occurs, much of their advocacy of SMO engagement is at the level of rhetoric or sometimes noble aspiration but ineffective execution. The ASMS has experienced many cases in several DHBs of SMOs being consulted, not even engaged, far too late in the process. As a result SMOs become casted in a limited reactive and marginalised position which invariably encourages negativity and distrust. This is 'lose-lose' all round.

Affected SMOs should be actively engaged when a challenge or issue first arises in order to discuss how it might best be addressed rather than having to react to an approach initiated by management. By this approach a DHB is more likely to better understand what the challenge or issue is and, as a result, what sort of process, if any, should be used to resolve it. The capacity to go down 'rat-hole' and embark up yet another wastage process become considerably minimised, if not eradicated.

The best example of effective engagement that I have seen is in New South Wales with their sophisticated and impressive clinical networks based on active medical practitioner leadership. In New Zealand recent positive examples include the cancer control strategy (although this needs to get more into the issue of resourcing including allocation) along with engagement of SMOs in shaping driving the regional service developments for cancer and blood in Otago and Southland DHBs and women's health in MidCentral and Whanganui DHBs.

But these are exceptions and the regional service reviews have been driven by crises. When they become the proactive modus operandi of DHBs we will know from the sustainable benefits that arise that the system has hit the jack pot.

Ian Powell
Executive Director

Dr Kenneth Clark, Mid Central Health

The Medical Training Board

If I were to ask 'who or what in New Zealand looks at medicine in its entirety, considers where it is going and where it wants to go?' what might your answer be? Equally, 'who or what has oversight of medical training and coordinates all the relevant parties ('stakeholders' in bureaucratic language) with the aim of ensuring highly trained doctors who are fit for task and in the numbers required by our health system and our population?' what would your answer be? Perhaps the Ministries of Health and Education; perhaps the universities and the colleges; the Medical Council or even perhaps the ASMS, the RDA, the NZMA or the DHBs? None of the above, or all of the above?!

I would suggest that until now New Zealand has had a critical lack of such overview with the inevitable result being ad hoc decision-making often shaped by political imperative and sectorial self interest.

Late in 2007 the Medical Training Board (MTB) came into being with the unenviable task of fulfilling the roles I have outlined above. It is an independent body with accountability to the Minister of Health and the Minister of Tertiary Education – note not the Ministries of Health and Education. The Board has also been given a strategic oversight role of the Clinical Training Agency (CTA) which currently funds medical training; a role that has been embraced by the leadership of the CTA and a role that can but help the Board to achieve its aims. I will attempt to give you a flavor of the work the Board is doing, who is on the Board, what its strengths are and what it may be able to offer salaried medical specialists, and, where it may fall down.

The initial work-streams of the MTB – with a planned-for first report to the Ministers in June of this year – are as follows:

- Configuration of the 'transition years' (from graduation to entry into vocational training) and how these years dovetail with those before and after. What do we want to achieve in these years and how best can it be achieved?
- 2021 and beyond. In other words medical workforce planning and projections.
- Implementation of the above two projects. Core to this goal will undoubtedly be the embedding of training within service delivery wherever the setting – hospitals, primary care and within private medicine.

Who is on the MTB? Predictably, a number of senior medics, not representing specific sectors of the Health system but rather with key experience in the colleges, universities and in the clinical workplace. In addition there is a vocational trainee, a medical expert in Maori Health and a DHB Chief Executive. The Board is supported by senior staff from the Ministries of Health and Education and from the CTA. The Chair of the Board is Mr Len Cook, a statistician with extremely broad experience including participation in the Medical Workforce Taskforce. I, and no doubt others, initially pondered the wisdom and motives of appointing a non-medic to the chair role but any reservations have rapidly been dispelled. Len Cook is very effectively drawing on the strengths of the members of the Board plus he has the background and experience to know his way around the draughty back alleys of Wellington – a very necessary skill set if the MTB is to gain real traction with its recommendations and prescriptions for change.

What is in all this for salaried medical specialists? As already alluded to but I make no apologies for repeating, the Board has the potential to provide a medical forum at high level for meaningful interaction and cooperation between the universities, colleges, Medical Council, Ministries and the DHBs. Hopefully we will see true overview of the training continuum with proper reference to needs and realities.

Secondly, the Board is keen to significantly raise the profile of the training and supervision responsibilities carried by SMOs. Put simply – time to train, funding for training and training for trainers. Following on from recognition of the SMO 'trainer' role will need to come clarity and integration around the roles undertaken by SMOs in training and supervising medical students, prevocational doctors and those in vocational training.

The Board sees the long established apprenticeship model as still being the basis of medical training but will promote realism as to the shortcomings of this model in the modern clinical environment of 'safe hours' and reduced patient length of stay. There is a clear need for the apprenticeship model to be meaningfully supported by other models and training tools including on-line resources and clinical skill laboratories.

If the MTB's recommendations relating to the prevocational transition years are adopted we should see some reversal in the drift of such doctors into locum work and overseas. It is very clear that hourly rates are but one part of the reasons for discontent in resident doctor ranks; system changes are required if we are to turn around the current circumstance.

Has the Medical Training Board a future? Well, I sincerely hope so. Our health service desperately requires coordinated medical leadership. However, much will depend on whether the Board receives a positive reception to its initial outputs – sadly not so much the reception it receives from the profession but in terms of the impressions made on politicians and on the relevant Ministries. If the specter of a looming general election is added in I readily profess to genuine nervousness as to the Board's future. Here though I make a plea for conditional but real support for the MTB from all doctors and all organizations representing doctors in New Zealand. With such support we might, just might, finally be on the road to greater medical say in this country's health system.

Dr Kenneth Clark
Member Medical Training Board, Specialist Obstetrician and Gynaecologist, Medical Director/Chief Medical Officer MidCentral Health

Appointment of New Industrial Officer

Lyn Hughes has been appointed as our new Industrial Officer at national office. She started with the Association on 8 May replacing Jeff Sissons who has left the Association to travel overseas.

Her immediate prior appointment was as a Legal Officer for the New Zealand Police Association. She was a solicitor in the Employment Rights Unit at Thompsons Solicitors in the UK from 2005 until 2007. This is a firm that specialises in union cases and employment law.

From 2002 to 2005 she was a solicitor advocate in the employment law department of Croner Consulting also in the UK. She has also worked as a trainee solicitor at the Derby Law Centre doing some employment law and as a legal adviser at a local Magistrates' Court.

Lyn will be responsible for Northland, Waitemata, Auckland, Counties Manukau, Waikato and Lakes District Health Boards.

ASMS 20th Annual Conference at Te Papa

Thursday 20 – Friday 21 November 2008

Delegates required

The ASMS meets the costs and makes all travel and accommodation arrangements for ASMS members to attend its 20th Annual Conference as delegates.

Leave

Clause 29.1 of the MECA includes provision for members to attend Association meetings and conferences on full pay. Members are advised to start planning now and encouraged to make leave arrangements and register and register by 30 September 2008.

Dinner and Pre-Conference Function

A Conference dinner will be held on Thursday 20 November. Delegates are also invited to attend an informal cocktail function on the evening of Wednesday 19 November.

Registration of Interest

Please help us plan for another great Conference and to assist with travel and accommodation reservations by emailing our Membership Support Officer, Kathy Eaden, at ***ke@asms.org.nz.***

Your interest in registration will be noted and confirmed closer to the date 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.

Register your interest today

ke@asms.org.nz.

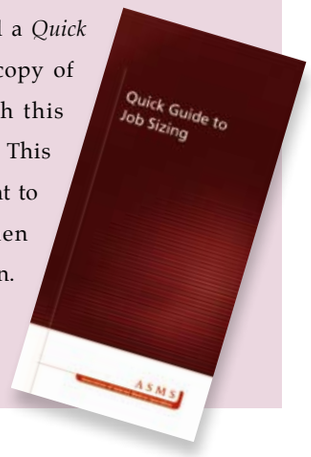
Job sizing – an update

ONCE UPON A TIME the main purpose of job sizing was to ensure SMOs were paid for the work (i.e. hours) that they did. This undoubtedly remains an important purpose and product of job sizing, but today perhaps an even more important purpose is to provide an objective measure of the number of SMO hours required to deliver a particular service.

By sensibly and methodically identifying the clinical demand and clinical duties of each service, adding a proper measure of time for non-clinical duties and factoring in the number of SMOs required for holiday and CME relief, each service is now able to objectively establish the SMO staffing numbers required to meet its clinical workload.

The ASMS has recently issued *Standpoint No. 3* on **Hours of Work and Job Size.** It is a revised and enhanced version of our first Standpoint. This revised version also contains practical steps that may be taken by SMOs if their management are unwilling or unable to implement the results of any job size. The revised *Standpoint No. 3* is available on the ASMS website and we encourage members who are yet to undertake job sizing or who have met resistance from management in implementation to visit the website and download *Standpoint No. 3*.

We have also produced a *Quick Guide to Job Sizing*, a copy of which is enclosed with this copy of The Specialist. This quick guide will be sent to all new members when they join the Association.



SMOs benefit more from KiwiSaver

As an SMO who qualifies for employer-subsidised super of 6%, you may be in a great position to maximise the financial benefits of KiwiSaver to help your savings grow even faster.

With KiwiSaver, employer contributions of up to 4% of your before-tax salary are totally tax free as long as you're making at least matching contributions to your KiwiSaver account. So, if your DHB or current super scheme allows, you may be able to put some of your employer-subsidised super into KiwiSaver to take advantage of this tax-free benefit.

Here's how it works

If you match your employer's 6% contribution with your own 6% contribution, you could structure your 12% contribution like this:

8% invested in KiwiSaver
= 4% from DHB (tax free) + 4% from you

4% invested in standard super scheme
= 2% from DHB (taxed at 33%*) + 2% from you.

On a $100,000 salary you get:

An extra $5,340 in contributions each year – if you don't already have a super fund going, or

An extra $1,320 in contributions each year – if you already have a super fund going.

These figures don't include the other financial benefits KiwiSaver offers, like the $1,000 kick-start payment, the government's matching payments of up to $1040 a year, and the $40 annual fee subsidy. These all add up to make splitting payments an extremely attractive option.

To find out more contact Medical Assurance Society on **0800 800 MAS (627)** or email **society@medicals.co.nz**

* Employer superannuation contribution tax rate

Media statement from Health Minister David Cunliffe on ASMS ratification of MECA settlement, 8 May 2008

MEDIA RELEASE

Minister welcomes decision by Senior Doctors.

Minister of Health David Cunliffe has welcomed news that Senior Doctors have ratified a settlement on pay and conditions.

"Today's decision is good news for both patients and senior doctors," Mr Cunliffe said.

"The commission which will be established as part of today's agreement will ensure that senior doctors working in New Zealand have pay and conditions commensurate with those working elsewhere." [emphasis added]

Mr Cunliffe acknowledged Senior Doctors and DHBs for taking a constructive approach to achieving a positive outcome, which supports the long-term objective of promoting quality in the health sector, patient safety and strategic workforce planning.

"Today's announcement shows that health workforce negotiations can have positive outcomes for all parties without disrupting patients."

Have you got a filler for this space?

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 around 3000 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.

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 Cnr Brandon St & Lambton Quay Wellington

American doctors support national health insurance

Reflecting a shift in thinking over the past five years among United States doctors, a new study shows a clear majority of doctors (59%) now supports national health insurance. The study by the Indiana University researchers is the largest survey ever conducted among doctors on the issue of health care financing reform. It is based on a random sampling of names obtained from the American Medical Association's master list of physicians throughout the country.

Such plans typically involve a single, federally administered social insurance fund that that guarantees health care coverage for everyone, much like Medicare currently does for seniors. The plans typically eliminate or substantially reduce the role of private insurance companies in the health care financing system, but still allow patients to go the doctors of their choice.

A study published in the *Annals of Internal Medicine*, a leading medical journal, reports that a survey conducted last year of 2,193 physicians across the United States showed 59% of them "support government legislation to establish national health insurance," while 32% oppose it and 9% are neutral.

The findings reflect a leap of 10 percentage points in physician support for national health insurance (NHI) since 2002, when a similar survey was conducted. At that time, 49% of all respondents said they supported NHI and 40% opposed it.

Support among doctors for NHI has increased across almost all medical specialties suggesting growing sentiment that the United States' fragmented and for-profit insurance system is obstructing good patient care, and a majority now support national insurance as the remedy.

American doctors have often expressed concern about lack of patient access to care due to rising costs and patients' insufficient levels of insurance. An estimated 47 million Americans currently lack health insurance coverage and another 50 million are believed to be underinsured. At the same time, health care costs in the United States are rising at the rate of about 7% a year, twice the rate of inflation.

Dr Aaron Carroll, Director of Indiana University's Centre for Health Policy and Professionalism Research and lead author of the study, commented: "Many claim to speak for physicians and reflect their views. We asked doctors directly and found that, contrary to conventional wisdom, most doctors support the government creating national health insurance."

Other signs indicate that attitudes among doctors are changing. The nation's largest medical specialty group, the 124,000-member American College of Physicians, endorsed a single-payer national health insurance program for the first time in December.

Ian Powell
Executive Director

In America we are currently living in a Kindergarchy

In America we are currently living in a Kindergarchy, under rule by children. People who are raising, or have recently raised, or have even been around children a fair amount in recent years will, I think, immediately sense what I have in mind. Children have gone from background to foreground figures in domestic life, with more and more attention centered on them, their upbringing, their small accomplishments, their right relationship with parents and grandparents. For the past 30 years at least, we have been lavishing vast expense and anxiety on our children in ways that are unprecedented in American and in perhaps any other national life. Such has been the weight of all this concern about children that it has exercised a subtle but pervasive tyranny of its own. This is what I call Kindergarchy: dreary, boring, sadly misguided Kindergarchy.

On visits to the homes of friends with small children, one finds their toys strewn everywhere, their drawings on the refrigerator, television sets turned to their shows. Parents in this context seem less than secondary, little more than indentured servants. Under the Kindergarchy, all arrangements are centered on children: their schooling, their lessons, their predilections, their care and feeding and general high maintenance--children are the name of the game.

No other generations of kids have been so curried and cultivated, so pampered and primed, though primed for what exactly is a bit unclear.

The Kindergarchy
Every child a dauphin.
by Joseph Epstein

The Weekly Standard
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ASMS
Association of Salaried Medical Specialists

L11 The Bayleys Building
Cnr Brandon St & Lambton Quay
PO Box 10 763
Wellington
New Zealand

T +64 4 499 1271
F +64 4 499 4500
E asms@asms.org.nz

Ian Powell
Executive Director

11 June 2008

Special Circular 2008/1

TO: All Financial Members of the ASMS

SUBJECT: 2008 ANNUAL CONFERENCE remits

Dear Member

I am writing to advise that the Association's 19th Annual Conference will be held in Wellington at Te Papa on 20th and 21st November 2008 (Thursday-Friday). Please schedule this in your diary. Delegates are also invited to attend a cocktail function on the evening of Wednesday 19th November. The function will be held at The Boatshed on Wellington's Taranaki Wharf and will be generously sponsored by Medical Assurance Society.

Any financial member and any branch (as well as the National Executive) may forward written remits for consideration by the Conference. Remits may include amendments to the Constitution, policy matters and other matters. Pursuant to Clause 10.4 of the Constitution the respective deadlines for receipt of remits by the National Office are:

Constitution Amendments	Wednesday	20 August 2008
Policy Remits	Saturday	20 September 2008
Other Remits	Monday	20 October 2008

The Conference attendees comprise both National Executive members and branch delegates although only the latter may vote. Each branch is entitled to one delegate per 25 members (with a minimum of one delegate per branch).

Should you be interested in attending the Conference please contact your local branch representative or Membership Support Officer, Kathy Eaden at the national office. Financial members are also able to attend as observers. In addition to policy making, a relevant educational programme is also planned covering industrial, health policy and medico-legal matters.

I will write directly to branches at a later date advising of Conference information and remits for discussion.

Yours sincerely

Ian Powell

EXECUTIVE DIRECTOR

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