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Post stopworks: moving forward with the MECA negotiations

Imagine the scene: The ASMS National President and Executive Director are sitting in front of the first of 26 unprecedented national stopwork meetings in response to the impasse in our protracted national DHB collective agreement (MECA) negotiations. The venue is one of the country's larger (and expanding) public hospitals. A mere five minutes before the commencement of the meeting sitting in front of them are eight members, two of whom then had to leave to answer their pagers.

This was what confronted Dr Jeff Brown and me at the first stopwork meeting on 17 July at North Shore Hospital. At this point we were both pondering whether there was a flaw in the ASMS's strategy. However, the floodgates quickly opened. Within around 10 minutes the eight dropping to six quickly became around 100.

This set the pattern for the rest of the meetings. Attendances were outstanding with around 1,740 members turning up. Nearly every meeting was the largest that members attending could recall. This ranged from six salaried GPs at Westport (100%) to around 260 at Auckland Hospital (arguably the largest meeting of New Zealand senior hospital doctors) in exceptionally cramped conditions, which in their own uncomfortable way added to the atmosphere of the meeting.

The mandate

The mandate provided by the meetings could not have been more explicit. A mere four members voted against rejecting the DHBs' proposal for settlement. 0.23% is a tad short of a mandate for accepting the DHBs' position! In advance of these meetings the ASMS forwarded the DHBs' proposal, in their own words, to all members. By a similar margin members also voted to condemn the DHBs' failure to negotiate genuinely a national agreement addressing recruitment and retention needs.

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In what was thought to be the most contentious issue, the ballot on industrial action, less than 50 attendees (around 3%) voted against the National Executive's recommendation. In some meetings the vote in favour of the ballot was unanimous.

Of course, there are qualifications to the overwhelming vote in favour of the industrial action ballot. It was linked to whether the impasse in negotiations was continuing. Further, any industrial action proposed would not include acute or emergency care. Our mandate is based on a high level of trust which the National Executive is humbled by and determined to respect.

DHBs' tactics

The DHBs, or at least their advocate, never thought that the stopworks would be so successful. They were surprised by the high turnouts and the high level of unanimity over the National Executive's three recommendations. They had hoped for low attendances and divisiveness (if not lack of support for the ASMS's position). But these aspirations were destroyed by the enormous media publicity over the first stopwork meeting at North Shore.

The immediate reaction was for their advocate to announce to the media that the DHBs wanted the ASMS to agree to 'final offer' arbitration. This was an attempted con job seeking to deflect members away from the meetings and away from further consideration of the industrial action ballot. It failed. Members were not conned. This form of arbitration is 'winner-takes-all', guaranteed to leave an aggrieved party, and favours positions closer to the status quo (ie, the DHBs' position).

Their next step was for their advocate to make an absurd claim that the DHBs were offering increases in specialist earnings in the vicinity of $45,000. Creative accounting leapt to new levels. The mythical $45,000 was created by applying an embellished percentage increase on top of a manufactured, completely erroneous claim of average

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specialist earnings. It created a few cheap media sound bytes but was quickly buried as the ASMS exposed this new attempted con.

Nevertheless members were offended by the dishonest accusation of greediness. At the Auckland DHB stopwork meeting members responded quickly with the following resolution:

That this meeting expresses its no confidence in the DHBs' choice of advocate.

Medical workforce crisis and government responsibility

One of the most interesting features of the stopwork meetings was the series of resolutions from the floor which described the current medical workforce situation (not just specialist) as a crisis; an important word whose meaning deserves to be fully understood. The compact Oxford Dictionary describes 'crisis' as 'a time of intense difficulty or danger'. The online *Free Dictionary* includes the following in its description:

the series of resolutions from the floor which described the current medical workforce situation (not just specialist) as a crisis;'a time of intense difficulty or danger'

- A crucial or decisive point or situation; a turning point.
- An unstable condition, as in political, social, or economic affairs involving an impending abrupt or decisive change.
- A problem that is coming to a head.

It is hard for anyone, other than a 'spin doctor' or those who do not wish to take responsibility for the situation, to dispute that there is a medical workforce crisis, whether one looks at the loss on average of one specialist a week to Australia, increasing numbers of specialists reducing their time in public hospitals in order to increase their earnings in the private sector (or withdraw completely to the private sector), 'trainee' specialists migrating to Australia for remuneration well in excess of what they can expect to earn in New Zealand and with little prospect of returning, or the current severe shortage of resident doctors forcing increasing numbers of senior doctors to once again work as 'juniors'.

Successive resolutions highlighted the government (and also DHBs) as having responsibility for resolving this crisis. The most explicit was at the Health Minister's home patch, Otago:

That this meeting has no confidence in the Minister of Health's ability to recognise and appropriately respond to the crisis affecting the recruitment and retention of senior doctors.

After the stopworks: disingenuous behaviour

With the last stopwork meeting on 9 August mediation between the ASMS and DHBs resumed on 16 August and then on the 24th. But the DHBs' approach was as if senior doctors had accepted their offer; as if, in a further leap in their creative accounting, 0.23% support for their position was somehow a mandate for the ASMS to accept their position. And yet in the same breath the Canterbury DHB chief executive who briefly joined the DHBs' negotiating team on his own volition declared that the situation of the medical workforce was a 'time bomb'.

There are two further disingenuous positions adopted by the DHBs since the stopwork meetings.

1. They are arguing that the government will not approve them spending more on our settlement than they are presently offering in the position rejected overwhelmingly by members at the stopwork meeting. But, on the other hand, the government is saying that it is not involved and the dispute is between the DHBs and ASMS to resolve.
2. The DHBs are obsessive about the costs of enhancing the MECA. But they are relatively unconcerned, at least in these negotiations, about the total costs of employing senior doctors (of which MECA costs are only part). Shortages are increasing the dependence on employing external locums at around three times the cost of a permanent appointment. Mediocre terms and conditions in the MECA, on top of the increasing job dissatisfaction, are contributing to increased shortages and therefore increased locum costs. The position of the DHBs in these negotiations, if accepted, would most likely increase the cost of employing senior doctors despite compressing the MECA's costs. In contrast, the ASMS approach is to increase the cost of the MECA in order to prevent further blow-out of the total costs of employing senior doctors.

Next steps

By the time this article is read circumstances may well have changed or further developed. The DHBs may seek formal 'facilitation' under the Employment Relations Act (the result of a 2004 amendment to the Act). This can best be summarised as non-binding arbitration and, should it accept the request, would be heard by the Employment Relations Authority. The Authority has the discretion to make recommendations and publish them.

The ASMS is not attracted by this due to factors such as doubts over the Authority's capacity to comprehend fully

the implications of the medical workforce crisis and the propensity of arbitration (binding or non-binding) to question employers' claims of affordability.

But if the Authority accepts jurisdiction the ASMS would have to participate. However, if the Authority was to recommend the DHBs' position the ASMS would reject it because of the compounding effect it would have on the workforce crisis and its rejection by members at the stopwork meetings.

the ASMS is taking nothing for granted and believes that the next most likely step is the organisation of the national ballot on industrial action should our political initiative not succeed and should DHBs continue with their present level of irresponsibility.

The ASMS has, through the Council of Trade Unions, gone to government. In part, this is in response to the strong messages from members at the stopwork meetings about government responsibility. In part, it is because of the failure of DHB leaders to face up to their responsibilities and provide leadership. In part, it is because of the high mana and credibility of the CTU with government (and DHBs). The outcome of this attempted circuit-breaker is unknown at the time of writing but should be known by the time this article is read.

Due to his departure overseas, the change of the DHBs' advocate may provide new opportunities, however the ASMS is taking nothing for granted and believes that the next most likely step is the organisation of the national ballot on industrial action should our political initiative not succeed and should DHBs continue with their present level of irresponsibility. Preparation is currently underway with a critical issue being timing.

Ian Powell
Executive Director

'Good Medical Practice' reviewed

The Medical Council is reviewing its resource Good Medical Practice. The ASMS had some concerns about what precisely the draft that the Council sent out for consultation meant by "supervision" and also the requirement the Council had for doctors who had been "cautioned" to inform the Council. Submissions on the review closed in July.

It is not clear to the ASMS precisely what the Council means in its review document. The Council's covering letter to the draft states that there will be an expectation that doctors will assist colleagues who require supervision. It was not clear if this refers to the relationship now more commonly referred to as a 'collegial relationship' where a vocationally registered specialist 'supervises' a non-vocationally registered doctor or to the supervision by senior doctors of junior doctors.

The ASMS would have issues with a policy that gave our members no option other than to 'supervise' in the collegial sense. It is not necessarily that our members may have issues with the practice or qualifications of a colleague and are not happy to act in a collegial relationship for that reason, though that scenario has occurred. Sometimes the decision of the employer to employ a non-vocationally registered doctor places another burden, without consultation, on an already overburdened doctor. Vocationally registered doctors working at DHBs may be willing to take on that burden if the employer makes appropriate time and resources available but if they have no option by fiat of the Council then these are unlikely to be forthcoming. At least one College will not accept an off-site collegial relationship.

The word "caution" is also used ambiguously in the review document. A number of ASMS members have at various times been warned or even threatened with dismissal by their employers for advocating on behalf of their patients. It is probably not the Council's intent to be informed of these incidents. Other doctors have had warnings for trivial matters that have no impact on their practice. It is probable that the word "caution" is used in another sense which the Council needs to make clear.

Angela Belich
Assistant Executive Director

Blame Us (Inc.)

The fragility of contentment is challenged by efforts to avoid blame, name and shame. Time and again we rail against individuals and institutions that trumpet a doctor as the cause of all evil. We claim that such blaming, naming and shaming does nothing for the aggrieved, creates a second victim, and risks losing a highly trained, highly expensive individual who could potentially help many more patients in the future.

But what has been the outcome? What has been the cost? To individuals and the system. Is there a better way?

Before suggesting an innovative, cost saving, beneficial solution, let us explore why patients and relatives may not be happy with the current climate of complaints and their management.

For most of the time that modern humans have existed it has made good adaptive sense to be fearful, cautious, timid. Jonathan Haidt shows that "bad is stronger than good" is an important evolutionary selective pressure. Our brains are wired for most sensory input to pass through the amygdala before being processed by the cerebral cortex. We react long before we know what we are reacting to. We make hard work of being happy because we are hardwired to emphasise the negative. As an important survival mechanism, for hundreds of thousands of years.

So when things go wrong in medicine, as they inevitably do, our instinct is to look for the negative, for the blame, the name, and the shame. We may suppress or overlay this instinct with our "higher" cortical thinking. We may suppress or overlay this instinct with our cultural systems. But does this thinking or culture satisfy the instinct?

We have tried to remove the bogeyman. We have tried to remove direct, immediate, blame. We have sentinel event reviews, we have customer relations departments, we have incident reporting triplicates, we have root cause analyses, we have ACC, we have HDC, we have advocates, agency and self-appointed, we have expert advisors, we have Council reviews and DHB reviews. And sometimes all for the same event. How many hours of health professional and managerial time is laboured, how many dollars spent? Could this labour and money be freed up for more productivity in health care?

We and those we look after are familiar, in our everyday journeys through the bumps and scrapes of life, with attributing instant blame. We hurt because we fall, or cut ourselves, or collide. We blame the object, the person, or occasionally ourselves. Then get on with our journey.

If only a doctor could be the instant blame for anything that goes wrong in a patient's journey, the instinct could be assuaged, and the healing continue. Why not appoint an SMO in each DHB to take the blame? This senior specialist would accept that he or she was responsible for the error or mistake. They would rapidly apologise, take full individual blame, and free the rest of the team to continue an unblemished therapeutic relationship. The costs of this FTE appointment would be far outweighed by the savings in report writing, answering aggrieved advocates, facilitating family fall-outs, providing expert testimony, reviewing performances.

In fact, the SMO may not even have to exist in the DHB. As most complaints are in writing, the written response accepting personal blame could be prepared from a distance, with early personal conversations by telephone from anywhere in the country on an on-call basis. ASMS could contract to provide this service for every DHB. For the price of an FTE in each of 21 DHBs your union would generate income, the DHBs would free up resources, and most importantly, SMOs and their colleagues would be freed from the exhausting elongated processes of blaming, naming and shaming.

The few times a doctor was required to actually front up to a patient and take the blame may be a challenge for such an innovative system. But staying with the fundamental principle of getting speedy satisfied patients provides a solution. The service (let's call it "Blame Us" – just think of the business cards and cachet of such a name) could hire an actor, preferably from a medical soap, to front up to the patient. We know what happens in ER or Shortland Street is more believable than the vagaries of real medicine. We know the sincere and heartfelt apologies of doctors in medical dramas, who are portrayed as flawed and fallible in their screen lives, carry power and persuasion. Hiring such an actor would provide a familiar face giving a believable personal apology taking all responsibility. Instant satisfaction of instinct. As a bonus, in the unlikely event of any patient wanting to take their case further, there would be no risk of loss of medical registration, or indeed of the loss of any health professional from the workforce.

And real doctors could achieve happiness – total immersion in a task that is challenging yet closely matched to their abilities. Being doctors, not taking blame.

The efficiency and productivity gains from Blame Us (Inc) will be reinvested in doctors to staff our hospitals to look after patients without blame, name or shame.

Jeff Brown
National President

Public and private patients

A recent opinion by the Health and Disability Commissioner and the attending publicity has illustrated some of the issues with the "mixed" practice that many of us have. The issue arose from fees that a patient was asked to pay for her preoperative biometry and postoperative follow-up in the private rooms and, more importantly, whether she was informed of these fees or that she had a choice of follow-up in the public outpatients or the private rooms.

The practice of using public hospital facilities to treat patients who have been initially seen in the private rooms is widespread and accepted. There are numerous reasons why this occurs including the ability of the patient to pay for his/her treatment, the facilities available in the private hospital, the need for particular equipment which is only available in the public hospital and the possible need for intensive monitoring after an operation.

However, the question then is, "Has the patient been adequately informed of their options in the private and public sector?" In the HDC case the patient claimed that she thought she had become a public hospital patient, following her referral to Southland Hospital and that all of her treatment should be free. the HDC found that the ophthalmologist had failed to ensure that she understood the options available to her and that her treatment should have been free.

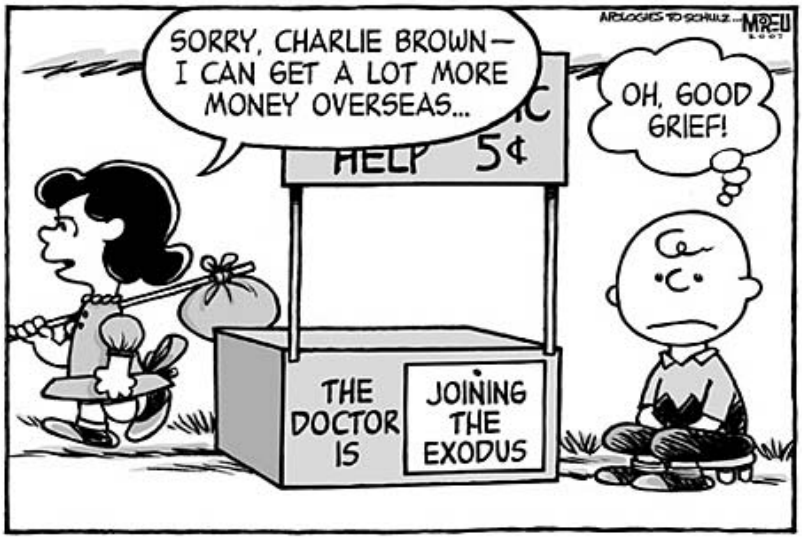
There is the ethical dilemma of patients "queue-jumping" by having their initial assessment as a private consultation and then gaining a place on the public hospital waiting list at the expense of someone else who has suffered from the delays inherent in the public hospital outpatient system for a first specialist assessment. This can be addressed by insisting that once patients are seen privately, then all of their management should be in the private sector. That may sort out those people who can afford to pay, but, as noted above, there are other considerations which may determine the best sector to use.

So, assuming that the status quo remains, we need to ensure that there is no ambiguity in the minds of our patients who have been seen privately initially about whether, subsequently, they are seeing us privately and will be charged, or whether they are in the public system.

The principles of informed consent are important here. The patient should be informed of the available options and their decision confirmed in the notes. This could include a reference in the letter to the referring doctor, with a copy to the patient, as well. It would be prudent, following their procedure, for their choice to be re-affirmed in case they have changed their mind, and a note made together with the appropriate follow-up arrangements.

In this way it should be possible to avoid claims of exploitation or at least give a platform for a robust defense if such claims are made.

Michael A Sexton
Medico-Legal Adviser, Medical Protection Society



Additional stopwork meeting resolutions

"Below are additional resolutions moved from the floor at the stopwork meetings over the impasse in our national collective agreement negotiations with DHBs and adopted either unanimously or overwhelmingly. The resolutions affecting the medical workforce, government responsibility, and condemnation and no confidence have been forwarded to the Prime Minister and Minister of Health."

Medical workforce and government responsibility

Waitemata (also Northland)
That this meeting gives a clear message to the public, DHBs and government that the entire New Zealand medical workforce is in a crisis and urgent remedial action needs to be taken at government level.

Tairawhiti (also Greymouth)
That this meeting gives a clear message to the public, DHBs and government that the entire New Zealand Health workforce is in a crisis and urgent remedial action needs to be taken at government level.

Counties Manukau
That this meeting expresses the view that if significant intervention at DHB and government level does not occur, patient safety will be severely compromised as a consequence of the current and escalating workforce crisis in New Zealand hospitals. Further, responsibility for this deterioration in patient safety will lie fairly and squarely with the Minister of Health, Ministry and DHBs.

Capital & Coast (also Southland, Ashburton and Wanganui)
That this meeting expresses the view that if significant intervention at DHB and government level does not occur, patient safety will be further compromised as a consequence of the current and escalating workforce crisis in New Zealand hospitals. Further, responsibility for this continued deterioration in patient safety will lie with the Minister of Health, Ministry and DHBs.

Taranaki
That this meeting expresses the view that if significant intervention at DHB and government level does not occur, patient safety will be further compromised as a consequence of the current and escalating workforce crisis in NZ hospitals. Further, responsibility for this continued deterioration in patient safety will lie with the government and DHBs.

Otago
That the medical workforce crisis is impairing junior and senior doctor training in Otago.

Hutt Valley
That this meeting condemns the failure of the government to recognise and intervene in the health workforce crisis in district health boards. Further, we hold the government accountable for this failure.

Hawke's Bay
That this meeting condemns the failure of the Minister of Health to recognise and intervene in the health workforce crisis in district health boards. Further, we hold the Prime Minister and her government accountable for this failure.

Hawke's Bay
That this meeting express its concern about the serious crisis affecting the ability to recruit and retain senior doctors and dentists in New Zealand and its impact on the right of New Zealanders to receive the care and treatment they need.

Waikato
That this meeting express its concern about the severe crisis affecting the ability to train, recruit and retain senior doctors and dentists in New Zealand and its impact on the right of New Zealanders to receive the care and treatment they need. Urgent action is required if this crisis is to be resolved.

MidCentral
That this meeting express its concern about the severe crisis affecting the ability to train, recruit and retain senior doctors and dentists in New Zealand and its impact on the right of New Zealanders to receive the quality of care and treatment they deserve. Urgent action is required if this crisis is to be resolved.

Whakatane
That this meeting urges government to actively intervene in resolving the medical workforce crisis in New Zealand. The government must accept responsibility for resolving this crisis.

Wairarapa
This meeting urges the DHBs to develop now a sustainable strategy that will ensure adequate retention and future recruitment of SMOs in the medical workforce. The current strategies of the DHBs undermine this goal and will adversely affect the healthcare all New Zealanders will receive in the future.

Northland
That this meeting express its concern about the serious crisis affecting the ability to recruit and retain senior doctors and dentists in Northland and its impact on the right of Northland patients to receive the care and treatment they deserve.
[Consequentially adapted for Southland, Tauranga and Whakatane]

Westport
That this meeting draws the West Coast DHB's attention to the extreme vulnerability of the rural general practice workforce in this area. This meeting further recognises the importance of meeting the ASMS claim for retention and recruitment of GPs on the Coast. The meeting has grave concerns about patient safety if the impasse continues.

Condemnation and no confidence

Nelson
That this meeting encourage the government to intervene in the DHBs' failed industrial relations strategy for the medical workforce.

Taranaki (also Christchurch)
That this meeting urges the DHBs to do everything in their power to avert industrial action.

Marlborough
That this meeting condemns the misrepresentation by the DHBs of their offer to the public.

Tauranga (also Hutt Valley)
That this meeting condemns and has no confidence in the district health boards industrial relations strategy for the health workforce.

Lakes
That this meeting expresses no confidence in the DHBs' industrial relations strategy which places the health of New Zealanders at risk.

Whakatane
That this meeting expresses its concern in the DHBs' advocate's serious misrepresentation of senior doctor recruitment and retention and remuneration.

Auckland
That this meeting expresses its no confidence in the DHBs' choice of advocate.

Otago
That this meeting has no confidence in the Minister of Health's ability to recognise and appropriately respond to the crisis affecting the recruitment and retention of senior doctors.

Suggestions to ASMS

Auckland
That the ASMS make every effort to produce robust data with regard to recruitment and retention of senior medical officers in order to support and strengthen our position.

Auckland (also Taranaki)
That this meeting urges the DHBs to accept the independent mediator's proposal for settlement based on a two year term.

Southland
That ASMS amend its claim by changing the base salary increase to 20% in order to help address recruitment and retention and reduce excessive expenditure on locums.

South Canterbury
That there be one salary step on each scale [specialist and medical officer] set at the current top step in order to encourage and retain New Zealanders to take up medicine.

Words on paper and reality

Although not unique to it, a feature of the health sector is the multitude of nice words on paper. There is a place for worthy literary documents; they can set the tone, provide a guiding underlying philosophy or principle, and outline a policy context within which decision-making and behaviours might be framed and shaped. But they cannot exist in isolation and must be linked to tangible and substantive processes and outcomes. In the absence of these linkages they risk becoming gratuitous and misleading; in fact, disingenuous.

Recent examples: MECA negotiations, health professional leadership and privatisation

Three recent examples make this point. A few years ago the Council of Trade Unions (to which the ASMS is affiliated), DHBs and government reached an agreement known as the framework for constructive engagement. For anyone who believes in positive collaboration between health professionals (and other staff) and management, the words were excellent; music to one's ears. However, it is not possible to say that this framework agreement has, overall, made an iota of difference to extending collaborative relationships within DHBs. Those DHB leaders who were inclined towards engagement with staff did so anyway and those that did not honoured it in its breach.

Second, beginning with former Health Minister Annette King, successive annual Ministerial letters of expectations to DHB chairs have called for partnership relationships with clinicians (not just doctors but also nurses and other health professionals). But the effect has been the same as with the constructive engagement framework. DHBs will protest and say, what about the establishment of clinical boards? Well, what about them?! Some work well and are based on a genuine level of health professional engagement; others are managerially dominated and overly top-down; some tend to be cast in a reactive rather than proactive role.

Third, in response to the Health Minister's approval of the privatisation of the hospital laboratories in the Otago and Southland DHBs in 2006, the ASMS initiated a review of the government's provider selection policy. Although it did not go as far as we would have wished, the new outcome was an improvement particularly with its more explicit emphasis on public provision for longer term arrangements. However, our subsequent experience (hospital laboratories) is that DHBs have simply looked for means of avoiding the policy by either sidestepping it or confining the selection to different forms of privatisation.

Further, the Health Ministry gives this behaviour the 'once over lightly', 'wink is as good as a nod', scrutiny, and simply takes the assertions of DHB bosses at face value. The Health Ministry has a narrow view on what constitutes a DHB, narrowing it down to the top echelons of the hierarchy; the experience and expertise of health professionals does not fit its paradigm and therefore the Ministry disregards them.

This is reinforced by the Health Minister accepting the Ministry's advice. Ironically this Minister maintains that he supports public provision of core secondary health services but he has approved or turned a blind eye to creeping privatisation. The level of privatisation that has occurred during his nearly two years' watch exceeds that which occurred under the decade of the pro-privatisation National government in the 1990s.

Managerialism in the driver's seat

What all this confirms is that despite worthy words on paper the top-down culture of managerialism is as prevalent today as it was in the damaging commercial experiment of the 1990s. Managerialism is based on the premise that those at the top of the hierarchy know best and that decision-making processes are shaped accordingly. Consultation is relegated to the courtesy of being able to express a view and has little to do with effective engagement and partnership in decision-making.

There was a time at the commencement of the current decade when this appeared to be turning around for the better and that managerialism was on the wane. However, the last couple of years at least have demonstrated that this is not so and that managerialism is alive and well; it is in the driver's seat. It certainly rests comfortably with the current Health Minister. It is also evident in the appalling counter-claims of the DHBs in our national DHB MECA negotiations which sought to deprofessionalise and disempower senior doctors in areas such as consultation rights, time for non-clinical duties, and sabbatical.

Marriage proposal to ASMS; relationship agreement

Now the ASMS has been asked to sign another worthy document. This time the worthiness is in the form of a proposed tripartite relationship agreement between the CTU health unions, DHBs and government. The catalyst for this agreement was the ASMS's health professional leadership initiative to government. If adopted this initiative would have led to a strong policy statement requiring a shift to health professional leadership in DHBs including mechanisms to make this happen.

However, the National Executive at its last meeting on 30 August voted not to sign the proposed agreement even though its wording is innocent and reasonable. The reasons for this decision are three-fold:

1. It is inconsistent with the approach of the DHBs and Government to our escalating dispute over our MECA negotiations, including their failure to recognise the crisis facing the medical workforce.
2. Although it was its catalyst the ASMS's health professional leadership initiative has fallen through a huge trapdoor and is no longer part of the proposed agreement. This is due to insufficient support from the Health Minister, the narrow interpretation of DHBs towards their statutory obligations, and the challenge our initiative represents for managerialism.
3. There is a significant difference between the ASMS and this government over the importance of public provision of core secondary care services and conversely privatisation. This has come to the fore over hospital laboratories.

Perhaps a suitable analogy is marriage. For those who elect this sort of relationship there are usually two sorts – marriages of love and marriages of convenience. With this government at the moment and with the prevalence of managerialism, there is not much love in the air and no observable convenience in signing the proposed relationship agreement.

Ian Powell
Executive Director

KiwiSaver update

The ASMS has received many enquiries about KiwiSaver since the recent changes were announced. As of 1 July, all employers are now required by law to allow their employees to opt in to KiwiSaver schemes.

This article is intended to provide a brief update on the ASMS's discussions with the DHBs regarding KiwiSaver implementation. The June issue of The Specialist contains a primer on KiwiSaver and the national DHB collective agreement (the MECA). Please refer to that article if you have any questions or contact the Association directly. We are unable to give financial advice regarding the pros and cons of various superannuation schemes.

A key issue for many of our DHB members is the possibility of splitting their employer contributions (an option which may maximise the benefits of the MECA allocation). The DHBs have been delaying a decision on whether to permit this option while they check whether doing so complies with their legal obligations. For several DHBs allowing splitting will necessitate changes to their payroll system.

The DHBs have wisely established a national working group on KiwiSaver. It has sought the ASMS's assurance that we view compulsory employer KiwiSaver contributions (phased in from 1 April 2008) as part of the existing MECA entitlement, not an additional benefit. We have given them this assurance.

Our basis for doing so was a clear signal from the Government and the Inland Revenue Department that employers who currently make superannuation contributions (equal to or greater than the statutory minimum) will not be compelled to pay further contributions on top. The Government has recently confirmed their intention that existing employer contributions shall count towards compulsory contributions. We envisage that legislation to this effect will be passed before compulsory employer contributions are phased in.

Several DHBs have recently taken encouraging steps towards allowing full splitting. Progress is being made daily and we are aware of the following initiatives at the time of writing:

- Canterbury DHB is allowing splitting of employer contributions (at least in relation to the particular scheme brought to our attention);
- The three Auckland DHBs have notified the ASMS that they will now allow splitting of employee contributions and (more significantly) that they intend to allow employer contributions so long as they can meet their legal obligations.

Progress on this issue has been slower than we would like. This is not entirely the fault of the DHBs: they have been attempting to deal with a situation whereby the law is not yet settled. We are now waiting to hear back from their national working group. Despite the delays, we remain optimistic that the best outcome for our members will be reached eventually.

Jeff Sissons
Industrial Officer

Non-DHB bargaining update

The ASMS has recently concluded a number of collective agreements for our members in the primary healthcare sector. An important development is that we are starting to negotiate pay scales for our members that are higher than those in the DHBs. Pay rates do not tell the whole story and conditions such as CME expenses, annual leave and superannuation are generally higher in DHBs but to us this reflects a significant change in the market. Two examples will serve to illustrate the point.

Ngati Toa Hauora

While the Ngati Toa pay scales are considerably shorter than the hospital scale (six steps as at 1 January 2008), vocationally registered general practitioners can expect to be paid between $1,500- $6,500 more than their public hospital counterparts for the first six years.

Ngati Toa doctors without vocational registration have a six step scale (again as at 1 January 2008). This scale ranges from $104,000-$119,000. The Ngati Toa Hauora steps are over $20,000 higher on average than the first six steps on the DHB medical officers' scale.

Ngati Porou Hauora

Vocationally-registered general practitioners at the Ngati Porou Health Centres are appointed on a scale equivalent to the specialist scale minus the bottom three steps (i.e. a 10-step scale with a starting rate of $125,500).

Their colleagues without vocational registration fare even better relative to medical officers in the DHBs. They have a nine step scale ranging from $110,015 to $144,800. This compares very favourably to the 13 step DHB medical officer scale which ranges from $82,500-$127,500. The Ngati Porou Hauora steps are over $31,000 higher on average than the first nine steps on the DHB medical officers' scale.

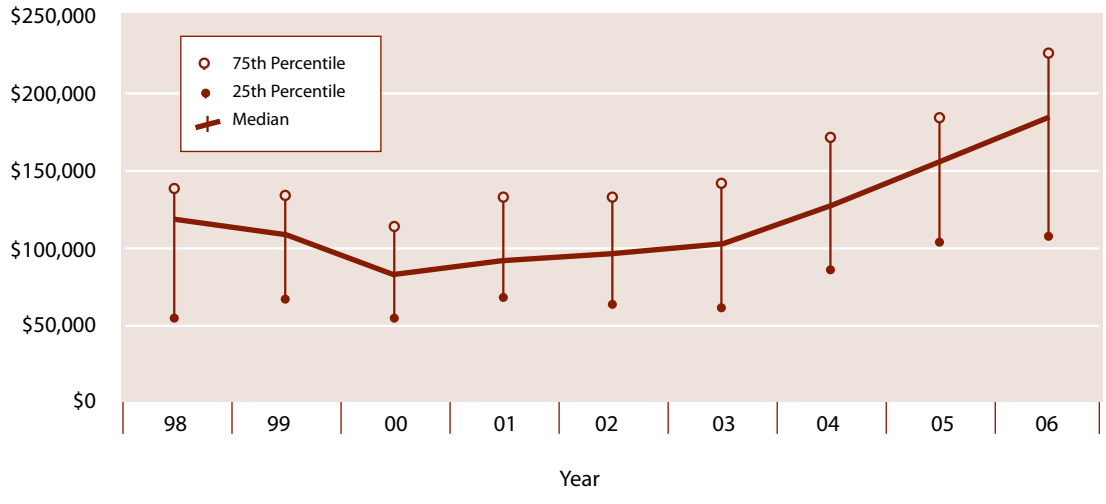
We think this is evidence of two things:

- There has been a significant shift in the market for general practitioners in the past few years. The table on this page is extracted from a speech by Stephen McKernan, Director-General of Health, to a Health Workforce Conference in June. It shows that the median net profit per GP owner rose by 20%+ each year from 2004-2006 from $103,368 in 2003 to $186,616 in 2006. Clearly GPs are much closer to parity with many hospital specialities than they have been in the past.
- It seems to us that the DHB medical officers' scale is far too low relative to the wages that non-vocationally registered doctors receive in primary care.

A challenge for the ASMS is that many of our other primary care collective agreements are linked to the terms and conditions of the DHB MECA in some way. For example, the Hospice MECA and several of the private hospitals (such as Queen Elizabeth, Dunstan and Oamaru hospitals) have a historical parity with the hospitals. The protracted nature of the MECA bargaining has made it difficult to negotiate these agreements with any degree of certainty.

Jeff Sissons
Industrial Officer

Net Profit per GP owner showing medians, 25th and 75th percentiles



ASMS 19th Annual Conference

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. It will be held at Te Papa on 1-2 November (Thursday, Friday).

Dinner and Pre-Conference Function

In addition to the Conference there is a Conference dinner 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 to plan for another great Conference and to assist with travel and accommodation reservations by taking a minute to fill out this form and either post, fax or email the details back to our Membership Support Officer, Kathy Eaden, at ***ke@asms.org.nz.*** The ASMS meets these costs for delegates.

Name: .....

Employer: .....

Address: .....

.....

.....

Email: .....

Phone: .....

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.

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