Annual Report 2007

In a year that has been dominated by the national DHB collective agreement (MECA) negotiations (including the ground-breaking stopwork meetings), the National Executive has met on four occasions since the last Annual Conference with a fifth meeting immediately preceding this Conference. One of these was the regular two day meeting (3-5 May) to allow for an informal strategic planning session on the first day, covering the year's expected work including the impasse in our protracted national DHB collective agreement negotiations. In addition, over the two days the Executive met the new Director-General of Health Stephen McKernan; President of the Medical Council Professor John Campbell; outgoing and incoming national DHB lead chief executives Murray Georgel (MidCentral) and David Meates (Wairarapa); and NZNO Executive Director Geoff Annals (on the subject of the industrial climate). At its other meetings the Executive also met the Hon Pete Hodgson, Minister of Health; Karen Barnsley from media consultants CABIX for a debriefing after the stopwork meetings; and new NZMA Chair Dr Peter Foley (and Chief Executive Cameron MacIver).

In the biennial elections concluded in March the following were elected unopposed:

President	Jeff Brown (MidCentral)
Vice President	David Jones (Capital & Coast)
Region 1	Judy Bent (Auckland)
	Gail Robinson (Waitemata)
Region 2	John Bonning (Waikato)
	Paul Wilson (Bay of Plenty)
Region 3	Torben Iversen (Tairawhiti)
	Iain Morle (Hawkes Bay)
Region 4	Brian Craig (Canterbury)
	John MacDonald (Canterbury)

Brian Craig was subsequently re-elected National Secretary by the National Executive at its 4 May meeting in accordance with the Constitution. Longstanding National Executive member Alastair Macdonald decided not to stand for re-election. The National Executive is appreciative of the cerebral humour and insights of Dr Macdonald during its deliberations over the years, particularly in the context of the values of professionalism. While sad to lose his input at its meetings the Executive is pleased that he accepted the invitation to act as one of two commentators on the President's Address in the Opening Proceedings of Annual Conference.

The national office continues to be a busy place with a demanding workload. However, the employment of additional industrial staff has improved the capacity to cope with this pressure. This year its activities continued to centre on application of the national DHB collective agreement (MECA), Joint Consultation Committees in the 21 DHBS, renegotiation of the national DHB MECA, collective bargaining with non-DHB employers, and individual employment-related cases and disputes. The biggest challenge for national office staff was the massive task of organising and coordinating the unprecedented national stopwork meetings held over a four week period during July-August. This challenge dominated the workload of the national office some weeks in advance in order that critical preparation was undertaken as well as during the four week period.

In February this year our second Industrial Officer Sue Shone commenced work with the Association joining fellow Industrial Officer Jeff Sissons and Senior Industrial Officer Henry Stubbs (who reduced to a four day week in May). In March the Association employed Ebony Lamb on a casual part time basis, initially to assist with the office relocation on an as required basis of about 10-15 hours per week but this has become more regular with about 20-25 hours per week in administration support.

Consequently the national office now comprises eight full-time staff—Ian Powell (Executive Director), Angela Belich (Assistant Executive Director), Henry Stubbs (Senior Industrial Officer; but four days/32 hours per week), Jeff Sissons (Industrial Officer), Sue Shone (Industrial Officer), Yvonne Desmond (Executive Officer), Kathy Eaden (Membership Support Officer), Barbara Narasy (Administration Officer) and Ebony Lamb (part time Administration Assistant). We also engage additional accounting support on a casual basis, usually to coincide with National Executive meetings, to assist with financial accounting and reports.

Bruce Corkill, barrister, continued to provide valuable counsel and support. Due to Bruce Corkill's appointment as Chair of the Health Practitioners Disciplinary Tribunal we have arranged to use Bartlett Partners for back up employment law and medico-legal advice and made use of them several times this year. The Association congratulates Bruce Corkill on his recent appointment as a Queens Counsel.

After nine years in its previous location, the Association shifted to new premises in April in response to the need for additional space and an expected rent increase in our previous premises. The new offices are conveniently located in central Wellington (the Bayleys Building on the corner of Brandon St and Lambton Quay).

Renegotiation of the National DHB MECA

The current national DHB MECA expired on 30 June 2006. Negotiations for a new agreement commenced on 24-25 May 2006 and the last prior to Annual Conference are scheduled for 24-25 October 2007. In total, by the time of Conference, this will have involved 28 days of formal negotiation (14 of which involved an external independent mediator). There have also been a number of other informal meetings and discussions involving the Executive Director (and on occasions some other members of our team) and DHB representatives including at times other chief executives and on one occasion DHB chairs. CTU President Ross Wilson participated in some of these informal meetings and also joined our negotiating team in one session of mediation.

Executive Director Ian Powell is the advocate supported by Assistant Executive Director Angela Belich. In addition to the National Executive, the negotiating team also includes Drs Rod Harpin, Carolyn Fowler, David Grayson, Athol Steward, Stephen Purchas, Anthony Duncan, Derek Snelling, Geoff Lingard, Matthew Hills and Peter Christmas.

The overall objective of the Association is to achieve an outcome that better places New Zealand to cope with our medical workforce recruitment and retention crisis. This was highlighted by the fact that an Association survey revealed that from January 2006 until mid-2007 DHBs have lost at least 80 specialists to Australia, an average of around one a week. In addition, we are losing specialists to the private sector in New Zealand, either partially or totally. The Australian challenge, in response to their own serious shortages, also threatens New Zealand's ability to compete in recruiting from other countries. Further, there are increasing reports of 'trainee' specialists taking their first specialist position in Australia on significantly superior terms and conditions with little prospect of returning, thereby helping dry up another source of recruitment.

Since the last Annual Conference the following main developments have occurred:

- The Association referred the impasse to mediation commencing in February 2007.

- In April the Christchurch Hospitals Medical Staff Association placed a full page article in the *Press* expressing concern about the continuing and increasing industrial upheaval in DHBs.
- During mediation the mediator made two separate proposals for settlement (for 12 and 24 month terms) which, with some misgivings, the Association's negotiating team was prepared to recommend that members accept. However, both were rejected by the DHBs' negotiating team.
- The then DHBs' advocate falsely reported to chief executives in April that the Association had withdrawn from mediation. Prior to the national stopworks this was arguably the most blatant of several misrepresentations of our position (and the DHBs').
- The DHBs had several counter-claims remaining at the time of the 2006 Annual Conference (undermining time for non-clinical duties; restricting eligibility for sabbatical; disempowering the role of Joint Consultation Committees; increasing accountability of senior medical staff in service management and clinical leadership roles; removing grandparented entitlements to enhanced remuneration for average hours worked on rostered after-hours call duties for new appointees in the Waitemata and Bay of Plenty DHBs; and gutting current MECA consultation rights). Some other counter-claims were withdrawn prior to the 2006 Conference. Subsequently all but one (the last) have been withdrawn; the attempt to gut the current MECA consultation clause has been amended to a less harsh but still unacceptable watering down.
- The DHBs slightly amended their position in April and by June had further revised it. The difference between their position at the time of the 2006 Annual Conference and their revised position that was taken back to the national stopwork meetings can best and most simply be summarised as follows: if all the increase monies were put into base salaries only, the improvement was from between 2% and 2.9% per annum over 36 months (plus six remaining counter-claims) to 3.8% per annum over 46 months (plus a one-off pro rata lump sum payment of $5,000) along with only one remaining counter-claim. At the time of the national stopwork meetings the Association's position was based on a 24-month term.
- The DHBs' negotiating team (and chief executives) considered this to be a significant improvement and asked that the Association take it back to our members. However, the Association's negotiating team concluded that this revised position was only a minor improvement on a totally inadequate and unacceptable position and further did nothing to assist recruitment and retention. Consequently it was resolved to implement the 2006 Annual Conference resolution to hold national stopwork meetings (discussed separately below) including taking back the DHBs' revised position. The meetings overwhelmingly rejected the DHBs position and similarly authorised the Association's negotiating team to organise a postal ballot on limited industrial action should the impasse in negotiations continue.
- Following the national stopwork meetings mediation resumed but, with only minor modification the DHBs still expected the Association to accept their position despite its overwhelming rejection by members at the stopwork meetings. This modification has included developing other potential processes to supposedly address recruitment and retention.
- On our initiative then Council of Trade Unions President, Ross Wilson, took an alternative Association position to government based on an alternative 36-month term. The government has been reluctant to intervene and, while keen to see this negotiation settled especially before election year, is caught in a bind by (a) the fiscal pressures it had put on DHBs and (b) the reluctance of DHB chairs and chief executives to have their autonomy encroached upon.

- In a surprise and controversial development the DHBs' advocate left New Zealand for a position in Canada. Subsequently Wairarapa chief executive David Meates (also by then overall lead chief executive) has become the lead chief executive for these negotiations and has assembled a new negotiating team. The DHBs' advocate is now Fiona McMorran (DHBNZ).
- Following discussions between the DHBs' and Association's advocates, the parties have agreed to resume mediation on 24-25 October. The DHBs will be presenting a new proposal involving a full response to all the unresolved issues.

Also in the meantime, MECA settlements were reached for resident medical officers (however new negotiations have subsequently commenced), nurses, service and food workers, radiation therapists, radiographers and laboratory workers.

In summary the main fiscal issues of contention between the parties involve:

- The term of the MECA.
- The size of the salary increase and the structure of the salary increase.
- Moving to double-time for average hours worked on rostered after-hours call duties and extending this to after-hours shifts (eg, emergency departments).
- Increasing the ceiling on reimbursement of CME expenses.

Other important but less fiscally significant or non-fiscal issues include:

- The DHBs' claim to water down consultation rights.
- Compensation for absences of RMOs.
- Explicit negotiating capacity in vulnerable DHBs.
- Removing the discrimination against part-timers without private practice in the reimbursement of CME expenses.
- Rationalising the system of pro rata calculation of remuneration.

The following issues have been agreed between the parties:

- More emphasis on years of experience and qualifications for the first placement on salary scale.
- Bargaining fee ballot for non-members.
- Extension of paid leave from professional associations and colleges to "recognised activities" (eg, exams, teaching on courses).
- Provision of good quality overnight accommodation (specifics identified).
- Extended scope of appointments clause including to clinical leadership positions.
- Formation of a joint national consultation committee.

One challenge the Association's negotiating team has had to consider following the stopwork meetings is the interest of the DHBs in seeking 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 decide to accept the case, would be heard by the Employment Relations Authority. The Authority has the discretion to make recommendations and, if it so determines, publish them.

The Association 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) not to challenge employers' claims of affordability which would disadvantage our position.

If the Authority accepts jurisdiction the Association would have to participate. However, if the Authority was to recommend the DHBs' position the Association would have no option but to reject it anyway because of the compounding effect it would have on the workforce crisis and its overwhelming rejection by members at the stopwork meetings. At this point, with the resumption of mediation, this question is in effect on hold and its likelihood unclear.

This year's Annual Conference will have a critical role in determining the Association's position in response to any developments in the resumed negotiations on 24-25 October and also in a possible ballot on industrial action as authorised by the national stopwork meetings.

National Stopwork Meetings

The holding of 26 stopwork meetings over nearly four weeks from 17 July to 9 August in the 21 DHBs was the largest logistical challenge faced by the Association in its 18-year history. The Executive Director spoke at 20 meetings while the Assistant Executive Director spoke at the remaining six (she also participated in the first three). Members of the negotiating team participated in meetings in their own DHBs. In addition, Gail Robinson, Carolyn Fowler, John Bonning, Paul Wilson and John MacDonald participated in meetings in neighbouring DHBs. Further, in addition to his own DHB, the National President also spoke at the North Shore, Waitakere, Tairawhiti, Canterbury and Auckland meetings. Similarly the Vice President also spoke at the Taranaki and Wairarapa meetings.

The organisational challenge was immense and fully stretched the Association's resources, including the administrative staff. The total estimated cost was nearly $116,000 with the main component being around $81,500 on media management. The next two larger components were travel (over $13,500) and publications (nearly $12,400). It will inevitably mean that we will have to draw upon reserves to meet this unbudgeted expenditure. However, the Association's financial strategy over the years of building up our reserves means that this was readily sustainable and that we are also well placed to resource a higher expenditure campaign in the event that industrial action is embarked upon.

Some of the organisational features included:

- Intensive preparation in advance of the stopwork meetings coordinated largely by the Assistant Executive Director. This included (a) a substantive letter to all DHB chief executives outlining our position and the differences between the parties and (b) a substantial background document for members and the media. We also circulated the DHBs' position in their own words to members in advance of the meetings.
- The Executive Director speaking at stopwork meetings each day of the nearly four week period (two on both the first and final days).
- The development of a special stopworks page on the website containing relevant background information and updating on developments.
- The engagement of media consultants CABIX to draft key material and many media statements. The National Executive was impressed by the quality of the advice and support provided by CABIX.
- Two half page advertisements in the *Sunday Star Times* and *Herald on Sunday* immediately preceding the commencement of the stopworks.
- Three 30 second advertisements which were played a total of 20 times for each stopwork meeting on Newstalk ZB, Classic Hits and other local commercial radio stations.
- A membership-based survey of actual specialist departures for Australia revealing a minimum of 80 in the around 18 months since January 2006 (an average of one a week).

- A series of media statements, on occasions two a day, with both national and local messages.
- Regular electronic communications, around two a week, to members reporting on ongoing developments during the stopworks campaign.
- The temporary engagement of additional staff to ring most members in advance of each meeting reminding them of it.
- A centrally co-ordinated form letter from many DHBs seeking to control what services were to continue during the stopworks which was handled by outlining that acute and emergency services would continue and having local Association representatives proactively attempt to engage with management.

The importance and outcome of the meetings justified this level of additional organisation and the expense. The meetings were a great success and an achievement of which the National Executive is proud. We hope they may encourage increased membership self-confidence and empowerment. 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 in Auckland Hospital (arguably the largest meeting of New Zealand senior hospital doctors).

The mandate provided by the meetings could not have been more explicit. A mere four members (0.23% of attendees) voted against rejecting the DHBs' proposal for settlement. This is despite the fact that in advance of these meetings the Association 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.

In what was thought to be the most contentious issue, the ballot on industrial action (limited by the exclusion of acute and emergency care), less than 50 attendees (around 3%) voted against the National Executive's recommendation. In several 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 and it was over whether to hold a ballot rather than the actual taking of industrial action. The mandate is based on a high level of trust which must be respected and not abused.

The DHBs 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 Association's position). But these aspirations were quickly destroyed by the first stopwork meeting at North Shore with its high attendance, unanimity of support for the National Executive's recommendations, and enormous media publicity.

Consequently, in response, their advocate announced to the media that the DHBs wanted the Association to agree to 'final offer' arbitration. 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). Our response was that this was an attempted 'con job' seeking to deflect members away from the meetings and away from further consideration of the industrial action ballot. In the subsequent meetings it became clear that this call failed to achieve this objective.

Next, in response to the coverage of the Association's Australia survey in the *Sunday Star Times*, their advocate sought to undermine its credibility with the false claim that it was based on a ring-around of our delegates. In fact, the survey was an empirical understatement of the situation.

Finally their advocate made 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 specialist earnings. It created a few cheap media sound bytes but was buried as the Association exposed these false claims. While it was neutralised in the media, many members, however, were deeply offended by this dishonest accusation of

greediness. At the Auckland DHB stopwork meeting members responded quickly with a resolution expressing no confidence in the DHBs' choice of advocate. Subsequently the Association prepared an analysis of these and other false claims that has been forwarded to members, journalists, DHBs and MPs.

One of the most interesting features of the stopwork meetings was the series of resolutions from the floor describing the current medical workforce situation (not just specialist) as a crisis. Factors that led to this widespread collective assessment included 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, and 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) has having responsibility for resolving this crisis. The most explicit was at the Otago meeting:

> *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.*

During the period of the stopwork meetings the Association was pleased to receive messages of support from kindred doctors' unions in Australia, the United States and Holland.

Given some confusion with industrial action and their unprecedented nature, there were some concerns that the decision to hold national stopwork meetings would be controversial and divisive leading to membership loss. However, these concerns did not materialise. As a result of the decision six members resigned while there was an increase in the rate of our membership growth during and around the period with a total of 63 new members.

Association's Health Professional Led Initiative

In the 2005 and 2006 Annual Reports we reported that the Association had prepared a paper which the Council of Trade Unions endorsed and enclosed with its briefing paper to the incoming government in October 2005. The paper recommended a health professional led approach to the provision of secondary and tertiary services through a clinically led taskforce established to facilitate the formation and strengthening of national and regional clinical networks and make specific recommendations on resource utilisation, organisation and provision of elective, chronic and acute services in each of the DHBs. Despite the pretence of interest, however, the Minister of Health's direction and conduct has been in the opposite direction. Unfortunately our initiative can only succeed with explicit political support and leadership which has not been forthcoming.

In an attempt to overcome this ministerial hurdle the Executive Director initiated informal discussions with the Prime Minister who had previously expressed interest in the Association's initiative. This led to a meeting convened by her which also included the Association National President and Executive Director, Minister of Health, Director-General of Health, CTU President, and senior advisers to both the Prime Minister and Minister.

It was a productive meeting in which the net result was an agreement to develop a memorandum of agreement (working title only) between the Government and the CTU health sector affiliates based on enhancing relationships and including the heath professional leadership initiative. This would be a stand-alone agreement that would then feed into the various instruments of government policy such as the Ministry of Health's Operational Policy Framework and the Minister of Health's annual letters of expectations to DHBs.

The Prime Minister asked that the parties work together to provide a recommended draft agreement to her by the end of April which would then feed into the cabinet process. This work was undertaken by the Executive Director and CTU President.

The Prime Minister's timeframe was met. But in late April the Minister of Health was approached by DHB chairs anxious about the industrial climate in DHBs at that time. He then referred the draft agreement to them and very quickly the process changed from bipartite (which the DHBs would be expected to adhere to) to tripartite (with the DHBs able to shape and influence rather than inherit the agreement). This led to the derailing of the process with considerable revisions to the draft agreement including the disappearance of the health professional leadership initiative due to DHBs' concerns about encroaching upon their roles and accountabilities and lack of political enthusiasm. This is discussed further below in relation to the proposed health sector relationship agreement.

Tripartite Process: Proposed Relationship Agreement

In its first term the Labour-led government set up a process known as the Tripartite process comprising the Ministers of Health and, initially at least, Labour on behalf of the government, DHBs and the Council of Trade Unions (health sector affiliates). The Executive Director usually attends these meetings although they are irregular. The intent was to provide a mechanism(s) for the implementation of a culture of constructive engagement throughout the health service. Its most noteworthy success was the health sector code of good faith which now comprises a schedule to the Employment Relations Act as part of the 2004 amendments to the Act.

The main success since the 2006 Annual Conference was an amendment to the provision for life preserving services in the code of good faith removing any ambiguity that the definition included risk of permanent injury. This followed a Tripartite meeting on 28 November 2006. The amendment required a process of consultation with the parties to the Tripartite process and the Executive Director played an important role in achieving this outcome.

The other main activity has been the attempt to establish a health sector relationship agreement signed by the three parties—the government (Health Minister and Director-General of Health), all 21 DHBs, and each of the CTU affiliated health unions including the Association. Ironically the catalyst for this proposed agreement was the Association's advocacy of our health professional leadership which, for reasons discussed above, is no longer part of it. The Association's initiative intersected with the DHBs approaching the Minister of Health in late April over difficulties in the 'industrial round'.

This led to four Tripartite meetings between late April and mid-August. The first was attended by the President and Assistant Executive Director, the second by the Assistant Executive Director, and the other two by the Executive Director. This led to a draft health relationship agreement about which there was a high level of consensus over the wording. However, the health professional leadership initiative which was supposed to be an attached appendix was no longer part of it.

While the wording was innocent enough the proposed agreement lacked substance and did not resonate with actual behaviours either by government or DHBs. Consequently the National Executive at its meeting on 30 August resolved not to sign the proposed agreement although it was noted that this decision may be reviewed if circumstances changed. The reasons for this decision were (a) the continued impasse and adversarial nature of our national DHB MECA negotiations, (b) the omission of our health professional leadership initiative, and (c) lack of commitment of the government to public provision of core secondary and tertiary services most evident in politically approved or accepted hospital laboratory privatisation. The Prime Minister was given early warning of the possibility of such a decision in a letter dated 17 August.

The Association's decision has caused some angst within DHBs and government but it is unlikely that the circumstances will change sufficiently for the National Executive to review it. The next Tripartite meeting is scheduled for 8 November.

The Non-DHB Sector

This year saw an important development with the negotiation of the Association's second multi-employer collective agreement (MECA) the hospice doctors' MECA. If the current employment law survives next year's election this may be followed by a rural hospital doctors MECA covering doctors working in non-DHB rural hospitals and perhaps regional general practitioners MECAs. The DHB MECA is the standard for salaried medical employment and in addition is increasingly referred to by non-salaried GPs.

Last year we noted the expansion of our membership and bargaining to three new GP employers. All three of these now have collective agreements in place. We are now organising in one further Iwi authority but have not kept up the organising momentum by expanding our membership to other employers. All of these new agreements have separate scales for vocational registrants. As far as salary is concerned they are arguably better than the DHBs (certainly for non-vocationally registered doctors and because of shorter scales with a higher starting point possibly for vocationally registered doctors). There is still considerable distance to make up for other conditions such as leave and CME.

An emerging problem in the non-DHB sector has been the casualisation of employment with very small employers decreasing their reliance on salaried doctors and increasing their reliance on locums normally employed as contractors and not as employees. Some of these locum appointments are of very longstanding. Part of the reason for this is that while employers are resistant to incorporating decent salaries in a collective agreement they are happy to pay more to contractors who are not entitled to leave and other benefits and who are easy to get rid of.

Salaried General Practice

Hokianga Health Enterprise Trust

The Association has four members employed by the Trust. A collective agreement is in place until June 2008. After hours call is still incorporated into salary and there is no separate scale for vocational registrants.

Auckland Union Health Centres: Otara and Waitakere

The Association has four members at Otara. This has been a protracted and difficult negotiation.

Financial difficulties at the Waitakere Centre led the employer to give management over to the PHO and to encourage patients to drop in without an appointment. The pressure went on for shorter consultations culminating in one doctor being given a disciplinary warning. This was withdrawn after the Association took up the case. This doctor and her two colleagues both left. The centre was then staffed by locums supposedly employed on contract. The Association was not able to accept their membership because they were not employees. One, after insisting that standards were adhered to, did not have his contract renewed and a further two left on the same day a few weeks later.

A claim was lodged in June 2006 but not responded to by the employer until over a year later. An offer has now been received and responded to.

Ngati Whaatua Ki Orakei Hauora

The Association has two members employed by Ngati Whaatua Hauora. There is a collective agreement in place until December 2007. The employer has been tardy in paying the new salary rates and ongoing problems have been experienced with one member's sick leave arrangements.

Pasifika West Auckland

The Association has two members employed by Pasifika. After protracted negotiations a collective agreement has been settled which runs until January 2009 but with a CPI movement on salaries in 2008. There is a vocational registrants' salary scale and some 'doctors' rights' clauses. However leave and some other conditions are not up to standard. The protracted negotiations saw two of our four members leave.

Te Oranganui Hauora Wanganui

The Association has four members employed by Te Oranganui Hauora and a collective agreement in place until May 2008.

Ngati Porou Hauora (Gisborne)

There are six Association members employed by Ngati Porou Hauora. A collective agreement has just been signed. The settlement includes separate payment for after hours, the DHB specialists scale for vocationally registered GPs, a non-vocationally registered GPs' scale better than the current DHB MECA medical officers scale and most of the doctor-specific clauses (patient safety, investigations of clinical practice, conflict of interest, public debate and dialogue) from the DHB MECA.

Ngati Toa Hauora (Wellington)

The Association has nine members employed by Ngati Toa Hauora and we have recently settled their first collective agreement. The terms of settlement included pay increases of between 8-21% for the members but perhaps more importantly a host of new 'doctors' rights' clauses such as engagement in the running of the practice and proscribed consultation times, session lengths and maximum patient numbers. We have been impressed by management's willingness to support their doctors and to invest in their development. This has resulted in a practice almost totally staffed by vocationally registered GPs.

Wellington Primary Health Services

The Association has 19 members employed by four employers (Newtown (8), Porirua (4) and Hutt (2) Union Health Centres and Whai Oranga (5) in Wainuiomata) covered by this collective agreement. This multi-union, multi-employer collective agreement covers the single largest number of salaried GPs. The agreement runs until June 2008. All salaries in the agreement have been increased by a CPI movement of 2% as at June this year.

Union and Community Health Centre (Christchurch)

This collective agreement covering four doctors has been renegotiated. The doctors opted to forego a salary increase this year in exchange for agreement by the employers to pay a 4% contribution to KiwiSaver now rather than when they are obliged by legislation to do so (phased in by 1% per year till 2011).

Hospices

There are 20 members who will be covered by the next hospice MECA. A further two members are employed by other hospices that are not presently party to the hospice MECA.

Negotiations for the hospice MECA have been hampered significantly by the lack of a settlement in the DHB MECA negotiations because the hospice MECA is tied to the DHB MECA terms and conditions. We had hoped to base our claim on the DHB terms of settlement but we have had to base our hospice claim on the latest version of the DHB claim instead. The previous hospice MECA was inferior to the DHB MECA in a number of ways (superannuation, CME expenses, annual leave, sick leave and redundancy) and we have claimed to rectify this imbalance also. We

have again claimed for one year in order that the next set of negotiations may be done according to the DHB settlement.

New Zealand Blood Service

The Association has five members in the NZ Blood Service. The other six doctors employed by the service have not joined the Association. The NZ Blood Service members voted to join the DHB MECA and the employer was cited as an employer party to the MECA negotiations. The NZ Blood Service was represented by an advocate at several negotiating sessions but does not wish to be covered by the MECA. We have had one negotiating session with them where the deficiencies in the Blood Service collective were pointed out and have invited them to produce an offer which will tempt the members to settle separately if this is what they wish.

Family Planning Association

These doctors remain the lowest paid among our membership and we understand that this is causing some significant recruitment difficulties in areas. The Association has 26 members at FPA. We have developed a claim that would address many of the issues FPA faces and will meet the employer to discuss them on 21 October.

Community Hospitals and Health Services

The Community Hospitals have historically had their salaries and CME leave tied to the DHB MECA and it is the intention to retain that link. However the prolonged failure to settle the DHB MECA has lead to difficulties in this sector. We are now beginning to reach settlements that are tied to the DHB MECA when it settles.

Dunstan Hospital

There are eight members at this hospital. A collective agreement has been reached for a two year term backdated to the previous agreement's expiry in June last year. A 5% lump sum on salary has been agreed with respect to the 2006-07 year and an agreement reached that the DHB MECA salary scales will apply from July 2007 when they are agreed. CME has gone up to $11,000 per annum with agreement that this will also be aligned to any DHB MECA agreement. The agreement also introduces a vocational registrants' scale pending the introduction of a rural hospital doctors' vocational scope of practice.

Wellington Independent Practice Association

The Association has four members in the sexual health service of Wellington Independent Practice Association (WIPA). A collective agreement has been reached for a two year term replacing the agreement which expired on June 30 last year. Salaries were increased by 4% from July 2006, and by a further 3% from July 2007. There was a commitment to meet to negotiate the alignment of salaries and expenses once the DHB MECA has been agreed. Two new clauses established were for parental leave and for the employment of locums.

QE Hospital

The Association has three members at QE Hospital in Rotorua. Historically salaries and CME expenses have followed the local DHB. In view of the protracted negotiations of the DHB MECA a settlement was reached this year backdated to September last year. The settlement has a one year term with a 4% increase to salary and allowances (already superior to DHB MECA rates); three additional steps on the salary scale and an increase from $8,000 to $10,000 for CME expenses.

Oamaru Hospital

There are two Association members employed at this hospital. We have had one meeting so far to negotiate a new collective agreement to replace the agreement that expired in August last

year. Historically this agreement has also been tied to DHB collective agreements. This is a hospital which has had huge difficulties recruiting and worse difficulties retaining staff.

Industrial Team's Activities

The industrial team is now composed of the two industrial officers (Jeff Sissons and Sue Shone), the Senior Industrial Officer, Henry Stubbs, who provides additional expertise and experience, and Assistant Executive Director, Angela Belich who has overall responsibility for the leadership of the team. Members of the team have primary responsibility for enquiries in a clutch of DHBs with Henry Stubbs having responsibility for the more complex cases including those involving medico-legal issues, serious relationship difficulties and performance or behavioural concerns. Other members of the team share responsibility for negotiating in the non-DHB area. We have continued with weekly industrial team meetings to allocate work, discuss difficult issues and ensure consistency of advice. The Industrial Officers have both been engaged in structured training during the year with Sue Shone having successfully completed her law professionals (she will be admitted to the bar on the last day of conference) and Jeff Sissons having successfully completed the Foundations of Organising course run by the CTU. The industrial team is now bedded down and members should be noticing a quicker turn around time for enquiries.

Job Sizing

The provision of advice to members about job sizing and participating in job size reviews has become a "bread and butter" issue for the industrial team. Most, if not all DHBs are conducting job size reviews of one sort or another and we are pleased to note that for the most part, they accept and approve the Association approach to job sizing, set out in the *ASMS Standpoint* of 2005. Several significant problems have emerged from these job sizing exercises:

- In a number of very busy services, job sizing has identified a serious shortage of SMOs. Management may well agree "in principle" to increase the budgeted number of FTEs for the service but funding will be phased in over two or more years.
- In other cases, funding may be available but the service is unable to fill the vacancies because of world-wide shortages of SMOs in the particular speciality or the DHB is unable (or refuses) to offer sufficiently attractive packages to entice suitable candidates to accept an appointment in New Zealand or that particular DHB.
- In a number of difficult cases, management has refused to increase the SMOs' job size and expects the affected SMOs (or the service) to "manage the demand" by putting more patients onto waiting lists and sending more and more quite unwell patients back to their general practitioners for management.
- A pleasing development is the increasing readiness of DHB's to allocate more time for non-clinical duties. Although the 30% minimum is being recognised and implemented sporadically throughout the country there is mounting resistance by DHBs to allocate the full 30% for non-clinical duties. However, the debate is around the margins and non-clinical allocations of 20-25% are becoming much more common. We still have a long way to go but it is unlikely we will be able to secure the full 30% for non-clinical duties for all SMOs until many more SMOs have been recruited. As a compromise, members appear to be willing to accept less than 30% rather than cut back clinical duties. Where this does occur, we endeavour to ensure that management and the service acknowledge this is a temporary measure and a compromise based on the SMOs' professionalism and commitment to their patients and communities.

In order to assist members in job sizing the industrial team is working on a revised *ASMS Standpoint* and other supplementary resources to give the current publication a greater practical focus.

Mediation

The Association has had less recourse to the mediation service in the past year than in earlier years, at least in respect of industrial cases. Mediation has however been used extensively in the MECA negotiations. Further:

- Mediation assistance was sought in respect of the Whanganui laboratory case in response to a dubious review leading to a recommendation to contract out and effectively privatise the hospital laboratory.
- Mediation was also used in two individual cases: one involving an Auckland DHB member (workplace relationship difficulties) and the other a Hawkes Bay DHB medical officer (dispute over workplace restructuring and changes to hours of work and shift pattern).
- Mediation was also sought in a Hawkes Bay DHB case involving a claim that two vocationally registered "medical officers" should be paid on the specialist scale. This case remains unresolved and will now be referred to the Employment Relations Authority for an investigation and determination.

Employment Relations Authority

One case was taken to the Employment Relations Authority. It involved a member who had been dismissed following the suicide of a patient recently under his care. This case was lost and we are in the process of taking the matter to a rehearing in the Employment Court. The important issue for the Association that is raised in this case is the extent that concerns about the management of a particular patient might be considered "serious misconduct" and thereby justify dismissal. Our view is that single episodes of care should not qualify as serious misconduct, except in the most extraordinary of cases.

Advice to New & Prospective Members

The Association's industrial staff continues to provide advice to new and current members contemplating offers of employment. The national office is in the process of developing a database of "new offers" that will allow us to monitor and record trends and practices in DHBs and particular services relating to starting salaries, the application of salary scales, job sizes, roster and on-call arrangements and any special conditions or "deals". This will enable us to provide even more detailed advice to prospective appointees at the time they are negotiating their remuneration and other conditions of employment.

We continue to emphasise the importance of members being willing to discuss with one another and their prospective new colleagues issues of job size, after-hours and acute roster details and resource problems within each service.

Joint Consultation Committees (JCCs)

The DHB-ASMS Joint Consultation Committees (set up under Clause 56 of the DHB MECA) have continued on their second year of full operation. Despite the additional workload of the national stopwork meetings and continuing burden of the national DHB MECA negotiations, most JCC s will have met the requirement that they meet at least three times per annum (Counties Manukau, Lakes, Whanganui, Wairarapa, West Coast and South Canterbury will have met only twice) and some will have met four times (Capital & Coast and Nelson Marlborough). Most JCCs have been attended by the Executive Director with Capital and Coast, Hawkes Bay, West Coast, Nelson Marlborough and the Wairarapa being attended by the Assistant Executive Director. In addition, as part of her orientation, Industrial Officer Sue Shone attended six JCCs and Industrial Officer Jeff Sissons has attended when he was dealing with other issues in the area. In most cases the chief executive attends and a gives a verbal report on the immediate issues facing the DHB.

The success of the JCCs is dependant on our members' perception of their effectiveness which is in turn dependent on how effective management is on acting on the commitments they make at the meetings. Much of the value of the JCCs this year has been in the way that they have been used by members to express their frustration over continuing recruitment and retention problems and the pressures that this puts on them as a result of the impasse in renegotiation of the DHB MECA. At several JCCs there has been explicit acknowledgement by both sides that a crisis exists. Also invaluable has been the pre meetings of members with the Executive Director and Assistant Executive Director which has enabled the discussion of local and national issues with the Associations "eyes and ears". It is important that representation comes from all areas of the SMO workforce rather than falling unfairly on a few.

Regular issues discussed at JCCs have been SMO involvement in planning processes especially with reference to the District Annual Plan, the workforce development taskforces (MECA Appendix 6.1) particularly issues arising with the process and granting of sabbaticals, either the completion of, or issues arising out of, the facilities survey (MECA Clause 54.1) with the most common issues being around a doctors lounge/SMO Common Room or equivalent and job sizing including agreement on a date for implementation and some issues to do with management inappropriately co-opting the process. Employer initiated reviews of services, including the using the "Request for proposal ", as a method of consultation were also a regular feature. In Southland the JCC was an important vehicle in recently generating awareness of the seriousness of that DHB's recruitment and retention crisis.

Other issues discussed included:

- Staff shortages including a chronic shortage of junior staff in most DHBs and compensation for the planned and unplanned absence of RMOs and the obligations of SMOs in that situation.
- Enhancing clinical leadership in DHBs.
- Provision of Broadband, laptops, PDAs and other electronic aids.
- Information on CME balances (both leave and expenses).
- Conflicts of interest forms.
- Car parking.
- KiwiSaver.
- Payroll performance
- Hospital redevelopments.
- Travel and accident insurance for SMOs.
- Relations with management.
- Sick leave policies.
- Supporting SMOs under attack.
- Reviews by the Ministry of Health in two DHBs.
- Appointment processes (particularly of Chief Medical Advisors) but also of SMOs and a Chief Executive.
- Telephone allowances.
- Medical officers on the specialists scale.
- Contact booking centre.
- Emergency and after hours care.
- Regionalisation of services.
- Managerialism.

- CME travel policies.
- Budget problems and DHB deficits.

Surveying Full-Time DHB Senior Medical Staff Income

The Association completed its 13th annual survey of full-time equivalent salaries (FTE) for DHB employed senior medical staff based on our negotiated collective agreements effective on 1 July 2006. The survey provides the most helpful comparative indicator of the salary gains that have been made since the commencement of local bargaining in 1993. It includes advancement through the salary scales. This is the second survey undertaken since the implementation of the national DHB MECA. The 14th survey (1 July 2007) is currently underway.

On 30 June 1993 the mean FTE specialist base rate was $85,658. By 1 July 2006 this increased to $143,310 (a raw increase of about 67.3%). This represents a 1.9% increase on the 2005 mean. The mean female salary is $137,942 compared with the mean male salary of $145,190. Since 2005 the female-male salary gap has increased from $5,904 to $7,248 (as a proportion of male specialist base salary the female average salary has fallen from 95.9% to 95%).

For medical officers the equivalent salary movement on 1 July 2006 was from $67,457 on 30 June 1993 to $114,664 (a raw increase of 70.0%). This represents a 3.2% increase on the 2005 mean. The mean female salary is $112,922 compared with the mean male salary of $116,101.

These are mean full-time equivalent base salaries and do not take into account hours worked in excess of 40 hours per week (i.e. recognised through job sizing), the availability allowance or any other special enhancements. The results were published in *The Specialist* and are available on the Association's website.

Surveying DHB Senior Medical Staff Superannuation Entitlements

We undertook our sixth survey of superannuation entitlements in DHBs, effective on 1 July 2006, which covers 2,250 senior medical staff receiving subsidised superannuation. The largest group receiving subsidised superannuation are the 1,569 members whose schemes are based on the Association's collective agreements. The next largest group, 647, is the former government and legislation-based superannuation schemes (National Provident Fund and Government Superannuation Fund) to which access for new entrants was closed off by 1992. The balance of members in super schemes is covered by other subsidised arrangements. The results were published in *The Specialist* and are available on the Association's website.

KiwiSaver Implementation

The Association has had discussions with DHBs, DHBNZ and superannuation scheme providers (particularly MAS) regarding the introduction of KiwiSaver in July 2007 and the potential benefits to our members. The introduction of KiwiSaver has been challenging for the DHBs because of the haste with which it has been introduced and the uncertainty as we wait for further announcements. Notwithstanding this, their implementation has been characterised by the delays that many of our members have found inconvenient and responses from a number of individual DHBs that have been unhelpful. Perhaps the most important outstanding issue for our members is whether they will able to split their employer contributions between their previous schemes and KiwiSaver compliant schemes (for many this maximises their benefits). We have been advocating splitting and the DHBs have announced that they support it in principle. However they are still working through the operational issues to get it working in practice at the date of writing.

National Senior Medical Workforce Development Group

As reported in the 2006 Annual Report the Association and the DHBs formed a joint national group to look at senior medical workforce development. The potential for this group included collecting reliable information in order to develop a profile of the senior medical workforce and the rationalisation of duplicated DHB processes such as consent forms. However, the work of this group was disrupted by the national DHB MECA negotiations which led the National Executive in June 2006 to put this group on hold until the negotiations were completed or close to completion.

Subsequently the DHBs have established a medical workforce strategy group. The DHBs invited the CTU to forward a nomination and also wrote to the Association on 10 August advising us of the group. The Resident Doctors' Association also received an invitation to nominate a resident medical officer. The National Executive resolved to advise the DHBs that this was not a partnership approach. Further, once the national MECA negotiations were over the Association would be willing to participate in the previous joint senior medical workforce. We also noted the scope and application of the proposed national consultation committee in the MECA negotiations. The CTU has advised the DHBs of its support for the Association's position. We understand the RDA sent the DHBs a blunt response declining the invitation and referring to the role of the joint DHBs-RDA executive committee established by the Memorandum of Understanding as part of the national RMO MECA negotiations last year.

Medical Council: Elections and Reviews

As reported last year and discussed below in relation to the Pan Professional Medical Forum, the Forum has successfully advocated to the Minister of Health the need to undertake a formal consultation process with a view to elected medical practitioner representation on the Medical Council. This consultation was initiated earlier this year and the Association made a submission strongly recommending provision for elected representation. We are waiting to learn of the outcome of this process.

The Association has made two representations to the Medical Council over the past year on draft guidelines distributed for consultation. The outcome of these consultative processes is not yet known although we are grateful that Council President Professor John Campbell will address Annual Conference. In both cases we reported these to members in *The Specialist.*

The first representation was on draft guidelines on 'disruptive doctors'. To assist our response we obtained advice from Bartlett Partners who specialise in employment and medico-legal law. The Association expressed strong concern about the draft document believing that the Council was unnecessarily entering the minefield of employment law. We urged the Council to discontinue its plan to proceed down this path. These concerns were raised directly with Professor Campbell when he met the National Executive. He agreed to discuss the issue with us further should the Council wish to proceed with it. It may be that the Council accepts the Association's advice.

The second representation was on a redraft of the Council's publication on 'good medical practice'. The Association raised concerns about confusing wording over what the redraft meant by supervision. In particular, we were concerned if the confusion might lead to an interpretation that senior medical staff had no option but to provide supervision.

In addition the Association responded critically to the Medical Council's consultation document on its pilot performance evaluation programme, questioning the relevance of such a scheme in New Zealand.

State Sector Code of Conduct

In 2005 the passage of the State Sector Amendment Act (No.2) expanded the role of the State Services Commissioner to crown entities including DHBs. The main change was to give him the power to issue a code setting out minimum standards of integrity and conduct for state servants including those working for DHBs. A draft code was issued for consultation. Much of it was general and aspirational but there were concerns over a section on 'impartiality' which appeared to be in conflict with the right to speak out provided in the national DHB MECA and the Code of Good Faith for the Public Health Sector (a schedule to the Employment Relations Act) and would undermine public confidence in the role of doctors as patient advocates.

The Association, in particular the Assistant Executive Director, took the initiative in working through the CTU in achieving an acceptable rewording of the offending section.

DHBs, as State Sector employers, are now obliged to review and amend their own codes of conduct to ensure they comply with the new State Sector Code. This process of review is already giving rise to some concerns as individual DHBs may seek to go further than is necessary and seek to particularise behaviours in their Codes that may be used against employees in subsequent disciplinary proceedings. The Association is currently engaged in a review of Capital & Coast DHB's Code of Conduct, following strong objections by CCDHB's unions to that DHB's failure to properly consult over changes to the CCDHB Code of Conduct. We anticipate that this work may provide something of a template for the Association and other unions to use in future reviews of codes of conduct.

Public Hospital Laboratories

Unfortunately privatisation of public hospital laboratories continued as a result of some DHBs floundering in their response to the devolution of community testing funding from the Ministry of Health to DHBs. While most have handled this in such a way as not to place their hospital laboratory at risk some others have not. Poor political leadership by the Minister of Health has also exposed serious hypocrisy in the government's criticism of the National Party over asset sales and privatisation.

In the 2005 Annual Report we reported on the privatisation of the Otago and Southland hospital laboratories with the approval of the Minister of Health. In different ways and forms privatisation of hospital laboratories has continued since the last Annual Conference in Nelson Marlborough, Tairawhiti and Whanganui (again with Health Minister either explicit or implicit approval) and with Lakes also believing that they have political approval to privatise although the Association and the Medical Laboratory Workers' Union are still contesting this.

In the main the decisions to privatise have been characterised by factors such as:

- High levels of pre-determination over outcomes.
- Questionable use of selection and evaluation processes and the marginalisation of health professional input.
- Decisions largely driven by funding and planning divisions operating under the ideology of the funder-provider split of the 1990s.
- The ability of the private companies to be a 'tail wagging the dog' in achieving their objectives.

In response to the Minister of Health's first approval of privatisation of hospital laboratories (Otago and Southland DHBs) the Association, working through the Council of Trade Unions, initiated discussions with the Ministry of Health which led to a new provider selection protocol that has a stronger emphasis on public provision of core secondary services including an express requirement for health professional engagement. However, this has proven to be ineffective because of the practice in subsequent privatisations where (a) the relevant DHBs have either

evaded or simply ignored the protocol, (b) the Ministry of Health when reporting to the Minister of Health have simply accepted what these DHBs say at face value, and (c) the Minister of Health has little commitment to public provision of core public hospital services.

Pay and Employment Equity

In 2003 the Government set up the Pay and Equity Taskforce, based in the Department of Labour, with a National Coordinator to investigate ways of addressing pay and employment inequities in the public service and public health and education services. The report recommended an action plan which included pay and employment equity reviews of a representative sample of employers. Five DHBs participated in these reviews—Auckland, Taranaki, MidCentral, Hutt Valley and Otago. The initial findings showed that female SMOs were earning less than male SMOs and that this is the predominant gender differential of the whole DHB workforce. The Association's own salary survey of average FTE salaries also showed a differential but smaller than revealed in these reviews.

But the salary gap is evidenced only in the quantitative data and there is inadequate qualitative data; in fact, what qualitative data exists (staff perceptions) disputes the existence of a gap. There are also doubts about the reliability of the data provided to the reviews. This is an ongoing exercise and the National Executive has resolved to continue to work with the Pay and Employment Equity Coordinator to consider the data gathered and to explore whether other pay and employment investigations may be necessary.

Pan Professional Medical Forum

In the last two Annual Reports we have reported on the work of the Pan Professional Medical Forum formed in 2005 and comprising the Council of Medical Colleges, the Association, Resident Doctors' Association and NZMA. The PPMF continues to be ably facilitated by CMC chair Associate Professor Phil Bagshaw. It has had three meetings to date this year with a fourth scheduled for late November (another meeting was also held late last year).

As reported last year a major achievement in 2006 was the persuading of the Minister of Health to initiate a consultation process on the introduction of regulations to provide for mandatory and binding Medical Council elections. The PPMF has continued to monitor this.

Other activities have included:

- The Minister of Health has accepted the advice of the PPMF and other medical organisations that the proposed medical training board, as recommended by the Minister's Workforce Taskforce, should not be widened and watered down into a more general health training board. Unfortunately there is only one position on it for a nominee from the medical profession.
- The PPMF has written to the Minister of Health about the stressful working environment of medical practitioners.
- The national support service for doctors. No further action has been taken on this in light of the new MPS-MAS service although Professor Bagshaw and the RDA were disappointed with the lack of consensus to wait and see how this unfolds.
- A media statement expressing concern about the deteriorating industrial climate in DHBs.

A potentially significant venture is the provisional decision to convene next year a medical workforce summit of the around 35 medical organisations that first met in 2005 and led to the establishment of the PPMF. A special planning meeting of the PPMF will be held in Auckland on 25 October.

Although the PPMF is a positive development it does face difficulties. There is not always unity in approach between its constituents and the PPMF lacks a realistic resource basis despite secretarial services kindly provided by the CMC. It is very much dependent on the goodwill and energy of Professor Bagshaw. Its existence highlights the advantage of having a credible body that can advocate and articulate issues that unite rather than divide the profession. Its continued function will face a critical decision point when Professor Bagshaw's second term (maximum) as CMC chair ends next year because so much depends on him. The members of the PPMF will need to explore the challenges in how the PPMF might progress and be organised.

Council of Trade Unions

The Association continues to benefit from our affiliation with the Council of Trade Unions (CTU) at both a national office level and with the affiliates. The Executive Director (or in his absence the Assistant Executive Director) usually attends the CTU's quarterly National Affiliate Council while he (or the Assistant Executive Director) participates in the Health Committee along with the Nurses Organisation, Public Service Association and Service and Food Workers' Union. The CTU meets with DHB chief executives which the Executive Director attends as part of the CTU team although these meetings have been irregular and infrequent this year. The CTU has a financial membership of 278,291 (ftes) spread throughout 38 affiliates. There are 16 unions with larger memberships than the Association. The Association was represented at the CTU's biennial conference in Wellington on 15-17 October by the Assistant Executive Director and the two Industrial Officers.

The CTU has been an important way in which the Association has been able to advance specific issues such as concerns over the draft Code of Conduct from the State Services Commissioner and our health professional leadership initiative (both discussed further above).

CTU President Ross Wilson who was first elected in 1999 did not stand for re-election. He has been an outstanding success demonstrating gravitas and integrity from his first day in office. He is widely respected in government, employer (including DHB), and union circles. Further, he has been an excellent supporter of the Association in areas such as the clarification of the definition of life preserving services as part of the legislative code of good faith, our national DHB MECA negotiations, our health professional leadership initiative, and in difficult moments in relations with the Minister of Health. His appointment as the next chair of the Accident Corporation Commission is well deserved in terms of his vast experience in the area of occupational health and safety. We are pleased that he has agreed to address Annual Conference on the subject of employment relations in DHBs.

His successor is Helen Kelly who was the Vice President and also General Secretary of the Association of University Staff. The Association has had a good relationship with her and she has spoken at past Annual Conferences. We are pleased that she has also agreed to act as a commentator on the Presidential Address to Annual Conference. CTU Secretary Carol Beaumont was re-elected. Although less involved in the health sector she has also been supportive of the Association in our national DHB MECA negotiations.

Issues considered by the National Affiliate Council included:

- Flexible Working Hours Bill and the Coalition for Quality Flexible Working Hours.
- KiwiSaver.
- China-New Zealand Free Trade negotiations.
- A session with the Minister for Energy and Climate Change Issues, the Hon David Parker.

The Prime Minister also addressed the November 2006 National Affiliate Council meeting. The CTU is also planning to hold a two-day union leaders forum in February 2008.

Meetings with Director-General of Health

The Executive Director continued his regular informal meetings, usually monthly, with Director-General of Health Stephen McKernan with seven held to date. The unavailability of both of them at different times during the year has reduced the level of meetings but there has also been much informal contact. Since commencing the role late last year Mr McKernan has embarked upon a major restructuring of the Ministry of Health in order to support a cultural change and make the work and role of the Ministry more relevant to and supportive of DHBs.

The National Executive was impressed with Mr McKernan's presentation to them. However, the jury is still out whether this will make an effective difference. To date there has not been evidence of improved performance. The Health Ministry has continued to demonstrate inadequacy over hospital laboratory privatisation and was obstructive to Association attempts to seek further information on the Government's future funding track.

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

- Our national DHB MECA negotiations.
- Proposed health sector relationship agreement.
- Health Ministry restructuring.
- Public hospital laboratory privatisation.
- Draft State Services Commission code of conduct.
- Clinical networks in Australia.
- Specific internal DHB problems (eg, Hawkes Bay, Tairawhiti, Whanganui, Southland).

Policy Advice to Members

The National Executive has been reviewing three policy advice statements covering three separate issues—conflict of interest, when other health employees take industrial action, and speaking out. They were on our website and in our *Handbook* publication. It was resolved to withdraw the advice statement on conflict of interest because (a) it was seriously outdated due to being written at a time when contestability and tendering were promoted as the modus operandi of the health system and (b) it is superseded by the clause covering rights of private practice and conflict of interest in the national DHB collective agreement.

The National Executive has approved amended advice statements on the other two issues. Both have been revised to take into account changed circumstances such as the national collective agreement and the Employment Relations Act including the 2004 amendments. They will be presented to Annual Conference for information and explanation.

International Travel

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

- The Executive Director attended both of the twice yearly Industrial Coordination Meetings organised by the Australian Medical Association, in conjunction with the Australian Salaried Medical Officers Federation. The first was in Adelaide in April. The trip provided an opportunity to be updated on the impact of the controversial federal 'work choices' industrial legislation (based on a similar anti-collective bargaining ideology similar to the former Employment Relations Act of the 1990s and one of the most controversial issues in the forthcoming federal election) and other developments affecting the medical workforce in Australia. En route he stopped over in Melbourne and visited the industrial staff of the

Victoria branch of the AMA/ASMOF and the General and Deputy General Secretary of the National Tertiary Education Union. In Adelaide he also met the senior workforce and industrial relations advisers in the South Australian Premier's department, the new Director of Industrial Relations in the Health Department (formerly head of human resources at Waikato DHB) along with the state ASMOF and AMA branches. On the return trip he stopped over in Sydney and met representatives of ASMOF and the Australian Council of Trade Unions. In Sydney he also took the opportunity to attend the first Australian national clinical network collaborative at which the key speaker was the head of the health department and National Health Service in Scotland where networks are well established.

- The Executive Director's second Australian trip was to Canberra in October to attend the other Industrial Coordination Meeting. More so than the Adelaide meeting it also provided an opportunity to spend time with ASMOF officials. En route he also visited Sydney and attended a meeting of its New South Wales executive council.
- In May the Executive Director made a brief visit to the United States primarily to accept an invitation to attend the 50th convention of the Committee of Interns and Residents in Philadelphia. He also visited the Union of American Physicians and Dentists in Los Angeles (where he observed a bargaining recognition campaign in LA County) the Doctors Council in New York, and the two 'international unions' in Washington which encompass doctors' unions.
- Assistant Executive Director, Angela Belich attended the Australian Council of Trade Unions Organising Conference Campaigning to Win from 13-15 June. She also visited ASMOF in Sydney.
- Senior Industrial Officer Henry Stubbs attended the International Doctors' Health Conference in October which was convened by the Doctors' Health Advisory Service (NSW) and the Australian Medical Association (NSW). He has attended similar conferences in past years.

Association Publications

The Specialist, the Association quarterly newsletter (generously sponsored by the Medical Assurance Society) is a cornerstone of our advocacy work. Feature articles included:

- Annual Conference authorisation of national stopwork meetings.
- Nurses on strike action (NZNO).
- The DHBs' disastrous industrial relations strategy.
- Obligations of doctors during industrial action (MPS).
- Reflections on professional disciplinary proceedings (Solicitor-General).
- Medical Council draft guidelines on disruptive doctors.
- No alternative to national stopwork meetings.
- MECA negotiations post-stopwork meetings.
- Private and public patients (MPS).
- KiwiSaver.

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

We have also continued our email publication, *ASMS Direct*, which is produced on an as-needed basis. The membership circulation list is over 2,270. To date 27 issues have been produced this

year. Much of this has focussed on the national DHB MECA negotiations (including the stopwork meetings) and other industrial disputes in the health sector.

Other subjects covered included:

- Medical Workforce Taskforce.
- Proposed health sector relationship agreement.
- Medical Council initiatives on pilot performance evaluation and cosmetic procedures.
- Hospital laboratory privatisation.
- Pan Professional Medical Forum.
- World Medical Association statement on online ethics course.
- Nominations for ethics committees and to Health Strategy Action Committee.
- Wanganui senior medical staff speaking out against attacks on public hospital.
- Activities of Southland DHB chief executive.
- Association membership growth.

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

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

Membership

Once again the Association has had another record membership year. Membership, as of 31 March 2007, was 2,833 compared with 2,738 on 31 March 2006, representing an overall increase of 95 (3.5%). It represents a 96.7% increase (almost doubling) over the 1,440 members in our first year of existence (1989-90).

It is interesting to note the annual membership pattern increase since 1998-99 (the last year where we had a membership decrease) – 1999-2000 (105 – 6%), 2000-01 (118 – 6.4%), 2001-02 (98 – 5%), 2002-03 (146 – 7%), 2003-04 (117 – 5%), 2004-05 (239 – 10%), 2005-06 (164 – 6.4%), and 2006-07 (95 – 3.5%) an overall increase of 62% over this period. Since our formation in 1989 there have been three years of membership losses – 26 (1.8%) in 1991-92, 47 (3%) in 1993-94, and 15 (0.8%) in 1998-99.

The annual average increase since our formation is 82 (5.7%). Under the period of the Employment Contracts Act (1991-92 – 2000-01) the annual increase was 61 (4.3%). Under the period of the Employment Relations Act, since 2000-01, to date the annual average increase has been 143 (7.2%).

Currently membership is over 2,950 although this may be affected by the subsequent resignation factors such as retirement that always occur at the end of our financial year and the slow trickle of new members between now and 31 March 2008. The combination of recruiting new members and strong membership loyalty continues to be the key to our effective representation in both collective and individual matters.

Currently about 87% of our members pay their subscription by automatic salary deduction (about 90% of new members employed during the past year opted for fortnightly payments).

The National Executive considered an interesting issue over membership eligibility. The Association's constitution allows the exclusion from membership of those undertaking a vocational registration programme. However, an issue arose over the position of medical officers working in emergency departments as medical officers but also completing the fellowship of emergency medicine. It also has applicability to overseas trained doctors who seek to complete their college vocational registration requirements in New Zealand while holding senior medical officer positions. The National Executive resolved that we needed to adopt a flexible position in

these cases in terms of membership eligibility. The issue may be reframed as a question of whether vocational registration can be completed without being designated as a house surgeon, house physician or registrar by regulatory bodies such as the Medical Council and the Colleges.

Again, despite incomplete information, it remains the case that few Association members are also members of the NZMA and these numbers appear to be declining. Those who were NZMA members at the time of joining the Association represent an estimated 14% of our current members. Just 2% of members who joined the Association in 2007 were also members of the NZMA compared with 22% in 1996.

Medical Protection Society

The Association has continued our close working relationship with the Medical Protection Society, including working together on several cases where our respective roles overlap or intersect. Much of this involves the Senior Industrial Officer and other industrial staff working with the MPS representatives and lawyers on specific cases. In an interesting move the MPS has purchased the Brisbane based Cognitive Institute.

The Chief Executive of MPS based in London, John Hickey, retired this year. The Association had a productive and enjoyable relationship with Dr Hickey over several years and we wish him well for his retirement. We are grateful for the generous decision of MPS to again sponsor the Conference dinner.

Medical Assurance Society

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

The quarterly advisory consultancy meetings between the Executive Director (and Executive Officer) and Society Chief Executive Martin Stokes continue. Discussions at these quarterly meetings have also included our national DHB MECA negotiations (and the national stopwork meetings), KiwiSaver, the MPS-MAS support service for doctors, the MPS's purchase of the Cognitive Institute, and the Association's advocacy of our health professional leadership initiative.

Association Finances

The Association recorded another higher than anticipated surplus for the financial year ending 31 March 2007.

In summary the main factors for the healthy surplus were:

- Another stronger than expected growth in membership.
- Interest on investments exceeding budget due to improved interest rates.
- Sundry income exceeded expectations largely due to the BMJ promotion of the online job service.

Administration

Of the many challenges of 2007 procuring suitable premises for the national office proved to be the most demanding. In a buoyant market, firmly favouring the vendor, quality space in the CBD remains scarce; consequently it took several months of investigation to find the appropriate property. Reconfiguring the new premises and relocating with minimum disruption was a challenge achieved with dedication and professionalism.

The national stopwork meetings also presented a huge logistical challenge, fully stretching resources to the point that six temporary part timers were required to meet demands.

Strong focus continues on communicating with members in a timely and efficient manner, ensuring that the membership database is accurate along with maintaining the professional standard of the Association's publications.

Website

The ASMS website complements the Association's other publications and has proved to be a valuable source of information for members and other interested parties particularly around the time of the stopwork meetings.

The front page has been revamped to reflect the principles and purposes of the Association. Considerable emphasis remains on ensuring that the website is kept updated with topics of special interest listed on the home page. Visitor numbers have steadily increased during the year to around 16,000 visits each month.

Job Vacancies Online

The Association's Jobs Online service continues to provide efficient and economical advertising of senior medical and dental vacancies with a monthly average of 60 positions posted at any one time. Advertisements are linked to the employer's website and all enquiries are directed to the employer or its agent.

The job section attracts approximately 60% of the total number of visits to the website and the steady source of income covers the costs involved in managing the facility.

Other Matters

Medical Workforce Taskforce

The National Executive considered the Taskforce's report *Reshaping Medical Education and Training* but resolved to take no further action leaving it to the colleges and working through the PPMF.

Guidelines for Senior Medical Staff Involvement in Decision-Making

This is a task expected of the current (expired) national DHB MECA but unfortunately no further progress has been made. The National Executive is looking at giving this important subject higher priority next year. It is looking at the proposed guidelines being based on an audit of compliance with the senior medical staff empowerment provisions of the MECA and other areas of clinical involvement such as clinical boards.

Health Minister's Letter of Expectations

The Minister of Health issues an annual letter of expectations to DHBs. This year's letter was generally imprecise and self-congratulatory but also signalled Ministry of Health restructuring (currently underway) and the use of targets (recently announced).

Changes in Taxation of Private Practice

The Association was approached by a member for support over the Department of Inland Revenue's way of estimating private sector income relative to public sector salaried income. The National Executive while interested in the subject matter concluded that it should not get involved.

Association Delegate System

The National Executive has been keen for some time to establish and formalise a delegate system but the preoccupation with the national DHB MECA negotiations has meant that it has yet to be

progressed. However, the Joint Consultation Committees are in effect becoming a de facto delegate training ground and have the potential to develop further in this respect.

Employment Relations (Probationary Employment) Bill

In the 2005 Annual Report we advised that the Association made a submission to Parliament's Transport and Industrial Relations select committee critical of the Employment Relations (Probationary Employment) Bill also known as the Mapp bill after its proposer, National MP Wayne Mapp. The Bill provided for a period of 90 days where no rights to personal grievances would exist. In practice the major impact would have been to take away any requirement for employers to give a reason for dismissal of employees in the first 90 days of their employment with an employer or any requirement to follow a procedurally fair process. This 90 day period would apply each time any employee changes employer. The Association's submission focussed on the Bill's basic unfairness and the implications for the health service including our dependence on international recruitment. As anticipated in the last Annual Report the Bill subsequently failed because of lack of parliamentary support.

Brian Craig

ASSOCIATION NATIONAL SECRETARY

23 October 2007