Annual Report 2008

The 12 months since the 19th Annual Conference in 2007 have been marked by two major achievements—the settlement of the national multi-employer collective agreement (MECA) covering members employed in the 21 DHBs and the conclusion and signing of the 'Time for Quality' Agreement with the DHBs. Since the settlement of the national DHB MECA much of the effort of the Association has been spent on preparing for the independent commission on sustainable and competitive terms and conditions of employment for members covered by the MECA along with the newly established National Consultation Committee, both key outcomes of the MECA settlement.

The full National Executive is:

- Jeff Brown, National President, MidCentral DHB
- David Jones, Vice President, Capital and Coast DHB
- Brian Craig, National Secretary, Canterbury DHB
- Gail Robinson, Waitemata DHB
- Judy Bent, Auckland DHB
- John Bonning, Waikato DHB
- Paul Wilson, Bay of Plenty DHB
- Torben Iversen, Tairawhiti DHB
- Iain Morle, Hawke's Bay DHB,
- John MacDonald, Canterbury DHB

The National Executive has met on seven occasions since the last Annual Conference, the last meeting immediately preceding this Conference. In addition to the five planned meetings there were two special Executive meetings — the first on 14 December to consider the outcome of the ballot on limited industrial action to break the impasse in the MECA negotiations, and the second on 25 March to consider the provisional agreement reached between Association and DHB representatives during the informal meeting facilitated by the Minister of Health.

On 20-21 February the National Executive held its annual two day meeting to discuss strategic directions, the first day being informal. The impasse in our national DHB MECA negotiations was a feature of our informal day and included:

- A session with the then new Minister of Health, Hon David Cunliffe.
- A session with the National Party's health spokesperson, the Hon Tony Ryall, on his party's health policy along with a separate session on this subject.
- Reviewing the performance of the National Executive over the past year with a view to looking to the future.
- The development of an audit tool on SMO in DHB decision-making.

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

- The Minister of Health again primarily to discuss our national DHB MECA negotiations (the first being the informal meeting on 20 February and the second being much of the second special Executive meeting on 25 March.
- Dr Claire Matthews (Massey University Banking Studies) at the 24 July meeting on the Association's financial investments in light of the difficulties faced by Dominion Finance.
- Professor John Campbell, Chair of the Medical Council (and Chief Executive Philip Pigou) at the 11 September meeting on the draft guidelines on disruptive doctors, the new rural hospital vocational scope of practice, and fitness to practice.

It has been a busy 12 months for the national office with the added pressure of the national DHB MECA negotiations including the ballots for industrial action and ratification followed by the impact of the bargaining fee process. Other key activities were the Joint Consultation Committees in the 21 DHBS, collective bargaining with non-DHB employers and individual employment-related cases and disputes.

The national office now comprises eight full-time staff — Ian Powell (Executive Director), Angela Belich (Assistant Executive Director), Henry Stubbs (Senior Industrial Officer; four days/32 hours per week), Sue Shone (Industrial Officer), Lyn Hughes (Industrial Officer – commenced May), Yvonne Desmond (Executive Officer), Kathy Eaden (Membership Support Officer), Leigh Parish (Administration Officer – commenced in March) 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.

On top of the usual workload demands the national office also had to cope with the additional pressure of the sudden and considerably increased membership levels arising out of the national DHB MECA negotiations. In recognition the National Executive adopted the following resolution at its 24 July meeting:

> *That the national office administrative staff be thanked for their excellent work under considerable pressure in handling the rapid influx of membership applications.*

Bruce Corkill QC, barrister, continued to provide valuable counsel and support. Due to Bruce Corkill's appointment as Chair of the Health Practitioners Disciplinary Tribunal we also use Bartlett Partners for back up employment law and medico-legal advice.

This year two valued employees departed. Administration Officer Barbara Narasy left in December to take up a position in the Ministry of Defence. She had been with the Association since 2004 and had impressed with her competence and cheerful personality. Industrial Officer Jeff Sissons resigned in April to travel overseas with his partner before settling in England. In almost two years with the Association he impressed with his willingness and proficiency to undertake any task. In this short time he made a very favourable impression with the National Executive and with the members he assisted and advised. He is presently working with the British Medical Association in London. His replacement Lyn Hughes was previously a legal adviser to the Police Association and prior to that worked in a legal firm servicing unions in the United Kingdom.

Settlement of the National DHB MECA

At the time of the last Annual Conference our national DHB MECA negotiations were at an impasse despite having completed highly successful and unprecedented national stopwork meetings. This led to the need for the Association to consider industrial action (the national stopwork meetings had given the Association an overwhelming mandate to conduct a membership ballot on industrial action). Consequently the 2007 Annual Conference adopted the following two resolutions (the first unanimous and the second with 12 dissents and three abstentions):

That the Annual Conference fully supports the National Executive's decision to conduct a national ballot on limited industrial action.

That the Annual Conference recommends a 'yes' vote in favour of limited industrial action in the national ballot.

Meanwhile, in the week of the Conference, the Prime Minister, as part of a wider cabinet reshuffle, replaced the Hon Pete Hodgson with the Hon David Cunliffe as Minister of Health. Mr Cunliffe adopted a fundamentally different approach to this dispute compared with Mr Hodgson and during Conference itself made informal contact with the Executive Director, and the National President, seeking to meet soon to discuss possible ways forward.

Formal Facilitation Application

As reported in the 2007 Annual Report one challenge the Association's negotiating team has had to address was the DHBs seeking formal 'facilitation' under the Employment Relations Act (ie, non-binding arbitration) by the Employment Relations Authority. The Authority has the discretion to make recommendations and, if it so determines, publish them. The Association was not attracted to this for reasons previously reported, including an expected reluctance by the Authority to challenge employers' claims of affordability which would disadvantage our position.

However, at a formal hearing before the Authority in December where the Association was represented by the Executive Director, Vice President, Industrial Officer Jeff Sissons and barrister Bruce Corkill, we persuaded the Authority to adjourn consideration until the effect of possible Ministerial intervention was known. Subsequent events meant that the DHBs' application was withdrawn. It is most likely that had the Authority accepted jurisdiction, as it probably would have, the outcome would have been inferior compared with the eventual settlement.

Industrial Action Ballot and Ministerial facilitation

While Mr Cunliffe's approach was encouraging it did not deter the National Executive from proceeding with the ballot. In addition to producing extensive background material for consideration in the ballot, the Association also engaged additional temporary staff to undertake telephone reminders to members about voting. On 14 December a special meeting of the Executive was held to consider the outcome of the ballot which overwhelmingly supported limited industrial action. The following three resolutions were adopted:

1. *That the National Executive notes the overwhelming mandate for limited industrial action from the ballot with a response rate of 75% and 88% voting to support industrial action (with the lowest vote in the 21 DHBs for industrial action being 77%).*
2. *Noting that the holding of the ballot has given impetus to the negotiations, the decision on implementing the mandate for limited industrial action is deferred until the next National Executive on 21 February 2008.*
3. *That the Association continues to explore all further opportunities for resolution of the dispute, including the resumption of formal negotiations on 11-12 February 2008.*

On 20 February Mr Cunliffe met the National Executive at its informal meeting and requested a delay from the Association in giving formal notification of industrial action by a month in order that he might have the opportunity to personally intervene in order to facilitate a resolution between the parties. At its formal meeting the following day the Executive resolved to accept the Minister's offer but still plan for industrial action in the event that his intervention did not succeed. The following three resolutions were adopted (the first with one abstention):

1. *That the National Executive resolves to accept the Minister of Health's offer to actively facilitate a resolution of the impasse between the Association and DHBs including his request to defer notice of industrial action for one month.*

2. *That, should it be necessary, a Special National Executive will be held on Thursday 25 March commencing at 9.30am except that the National President has the authority to convene a teleconference instead.*
3. *That, should it be necessary despite the Minister of Health's intervention, the limited industrial action would commence on Thursday 29 May and continue on Tuesday-Wednesday 3-4 June, and Tuesday-Thursday 10-12 June 2008.*

The informal meeting facilitated by the Minister was held on the evening of 5 March and early morning of 6 March. The ASMS was represented by National President Jeff Brown, Vice President David Jones, National Secretary Brian Craig, fellow Executive members Torben Iversen and John MacDonald, and Executive Director Ian Powell. The DHBs were represented by 'lead' national Chair Dennis Cairns, then Counties Manukau (now Auckland) Chair Pat Snedden, 'lead' national Chief Executive David Meates (Wairarapa), and fellow chief executives Gordon Davies (Canterbury) and Garry Smith (Auckland). Director-General of Health Stephen McKernan also participated along with an official each from the Ministry of Health and Minister's office. This meeting led to a provisional agreement between the representatives present to be taken back, in the first instance, to the National Executive for consideration at its special meeting on 25 March. Prior to this special meeting Ian Powell and Assistant Executive Director Angela Belich met David Meates and the DHBs' advocate Fiona McMorran (DHBNZ; replaced Nigel Murray late 2007) to work on various wording issues.

Provisional Agreement

The provisional agreement presented to the special Executive meeting on 25 March was unusual in that the term of the proposed new MECA was 34 months (1 July 2007-30 April 2010) but the total settlement was for the 46-month period from the expiry of the previous MECA (1 July 2006) to the expiry of the new agreement (30 April 2010). In addition to the various matters previously agreed prior to the 2007 Annual Conference, the other new details were:

- The independent commission into sustainable and competitive terms and conditions of employment (terms of reference not completely resolved until the 25 March Executive meeting) under the auspices of the Director-General of Health which will report to the Minister of Health, Association and DHBs by 30 April 2009 (discussed further below).
- Inclusion of the principles of engagement of the Time for Quality Agreement (discussed further below).
- Three annual base salary increases during the term each of 4.25% compounding at 13.3%.
- Two new additional salary steps (14th and 15th) taking effect on 1 July 2008 and 2009 respectively.
- The $10,000 lump sum payment (taxed and pro rata) paid out as a 'continuity of employment' or 'retention payment' for those currently employed but in recognition of the 'lost' year of 2006-07.
- Increasing the level of CME expenses by $8,000 (staged) to $16,000 per annum by 1 January 2009.
- The Association and DHBs to jointly develop and agree guidelines for the application of CME leave by 1 January 2009.
- Eligibility of full reimbursement of CME expenses for part-time members without private practice.
- Application of the time-and-a-half hourly rate for members working on after-hours' shifts (primarily emergency departments and intensive care units).
- Application of the protected Auckland DHB minimum rate for members covering unexpected and immediate RMO absences to all DHBs (largely in place prior to the settlement anyway).

- Explanatory working over the opportunity to split superannuation contributions into KiwiSaver.
- Explicit extension of the role of the Joint Consultation Committees to recruitment and retention strategies, staffing, workforce development, and supporting professional development and education.
- Withdrawal of all DHB counter-claims (only one outstanding at the time – watering down of consultation rights).

The matters which had already been agreed, prior to the 2007 Annual Conference were:

- 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.

Ratification Process

Despite clashing with a cabinet meeting the Minister joined the National Executive for the first part of its special meeting on 25 March. An important part of the discussion was on the terms of reference which, by the end of the meeting, were able to be resolved. The Minister also agreed to take a 'noting paper' to cabinet which would be linked to the negotiation of the MECA in order to further enhance the status of the independent commission. After considerable discussion and debate, towards the end of the meeting the Executive adopted the following three resolutions:

1. *That the national office forward information about the proposed settlement of the national collective agreement negotiations to DHB employed members.*
2. *That the National Executive approves the conduct of an indicative postal ballot of DHB employed members over the proposed settlement of the national collective agreement negotiations.*
3. *That the National Executive recommends that DHB employed members approve the proposed settlement of the national collective agreement in the postal ballot.*

The first two resolutions were carried unanimously while the third was carried by majority (6-2 with one abstention and one member absent). The ballot itself was conducted during April with the national office again putting a considerable amount of resource into it including the provision of background material and engaging additional staff to assist reminding members to vote. Despite some debate and challenging of the National Executive's recommendation, the result of the ballot was overwhelmingly in favour with 88% voting to ratify and 12% voting against. There were majorities in all 21 DHBs and the national response rate was 74%.

The main reasons for the membership ratification of the recommended settlement would appear to be a combination of:

- The potential opportunities provided by the independent commission.
- The assessment that the enhanced terms and conditions were a pragmatic outcome and move in the right direction given all the circumstances.
- The need for closure and moving on.

It may also be that the Time for Quality Agreement, including the incorporation of its engagement principles into the new MECA, was also a factor.

As a consequence of this mandate and after much deliberation the National Executive adopted the following resolution on 8 May:

> *That the National Executive ratifies the proposed new national collective agreement covering senior medical and dental officers employed by district health boards...*

The achievement of our second national DHB MECA has been a long challenging journey, at times dramatic and traumatic. However, we got there in the end. The National Executive is very appreciative of the non-Executive members of the Association's negotiating team, in particular Drs Rod Harpin, Carolyn Fowler, David Grayson, Athol Steward, Stephen Purchas, Anthony Duncan, Derek Snelling, Geoff Lingard, Matthew Hills and Peter Christmas. Each and all made an invaluable contribution to our efforts to achieve the outcome.

In addition to the practical and longer term achievements of the MECA settlement it is also worth emphasising that at the end of the progress the Association has emerged in a significantly stronger position than when negotiations commenced. In part, this is reflected in significantly increased membership and, in the medium term, an improved fiscal position. In part, the successful national stopwork meetings and the strong mandate of the industrial action ballot also gave political parties and DHBs a powerful message. At a national level the Association is now in a stronger position with DHBs than was previously the case.

The ratification of the proposed settlement was not the end of the matter with further issues to be followed through (discussed immediately below). For the first time in our collective bargaining we and the DHBs resolved to develop an agreed 'Terms of Settlement' document which proved to be a considerable asset in implementation matters. The role of the Assistant Executive Director was critical in this achievement. Much of the 'Terms of Settlement' focussed on bargaining fee arrangements but also covered the lump sum payment and deadline for payment of the salary increases (four months after the date of ratification) following the experience of the first MECA settlement where members in some DHBs faced much longer delays. Following the settlement the Executive Director also wrote to all chief executives with a comprehensive list of the various changes to the MECA that required both immediate implementation and an understanding of them.

In addition to the other matters expressly discussed immediately below there are also the significant issues of the focus on 'what it takes to stay', the bargaining fee, independent commission and the National Consultation Committee (discussed separately).

Other Matters

Fiscal Impact

Although the negotiations, particularly the national stopwork meetings, were responsible for our financial deficit (2007-08), they have not undermined our fiscal viability. Aside from the Association's fiscal prudence in building up reserves over several years, we have ended up with a stronger basis because of increased membership and also the bargaining fee. Since 1 April 2006 our DHB employed membership has increased by over 700, over 26% (around 16% since 1 April 2008).

CME Guidelines

Part of the settlement is the obligation by the parties to attempt to reach agreement over guidelines for CME (referred to above). While this might have been a useful opportunity to clarify and enhance some useful policy issues, the DHBs' un-streamlined process of selecting its representatives on the joint working group has proved unwieldy and there are now doubts whether this objective will be achieved, particularly given the time frame of 31 January 2009. However, recent further discussion between the Association and DHBs has led to a more focussed

and less cumbersome joint ASMS-DHBs working group which is due to have its first meeting later this month.

Application to University Employed Medical/Dental Practitioners

In July the Association received an enquiry from an academic medical practitioner employed by the University of Otago about joining us. This was influenced by the Association's MECA settlement. While we reiterated the constitutional membership exclusion, we also approached those DHBs with clinical schools to encourage their relevant university to pass on the MECA entitlements to academic medical and dental practitioners also working in the DHBs and who were members of the Association of University Staff. To date, the Capital and Coast, Canterbury and Otago DHBs have agreed to pursue this with the University of Otago. Members were advised of this initiative by *ASMS Direct*.

Lump Sum Payment

The application of the one-off lump sum payment posed particular challenges for the Association. One question requiring clarification was who is an 'employee' for the purpose of eligibility. In addition to those who are actually working for their DHB, under the Employment Relations Act 2000 it also includes a 'person intending to work'. That is, one who is offered and has accepted a position but has yet to commence working. However, eligibility also includes being a member of the Association but there was no capacity in this for 'intendings'. Further issues included what the cut-off date would be and the position of members who were on leave without pay. In response the National Executive adopted the following resolutions (the essence of which was also agreed with the DHBs) at it meeting on 8 May:

> *In accordance with its powers under Clause 8.2 of the Constitution, the National Executive approves a reduced membership fee of $100 for persons intending to work. This reduced fee is payable by those prospective members who might otherwise not be entitled to receive the one-off continuity of employment payment in Clause 11.1 of the national DHB collective agreement.*
>
> *In accordance with its powers under Clause 8.2 (and noting Clause 5.4 – Lapse of Membership) of the Constitution, the National Executive resolves to waive the Association's annual subscription for those members who take approved leave without pay from their employer. This waiver shall only apply to those members who are financial at the time they take their leave and only until they resume salaried medical/dental employment in New Zealand that falls within the Association's membership rule as provided in the Constitution.*

'What it takes to stay'

The National Executive was conscious that although the settlement of the MECA would provide some stability and the independent commission some hope, there needed to be a sharper focus on encouraging senior doctors and dentists to remain employed in their DHBs. Consequently, immediately after ratifying the proposed MECA settlement on 8 May, it also adopted the following resolution:

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

The focus is largely on the following activities:

- Our work with the independent commission (discussed further below).

- Supporting members in job sizing where already there have been several cases of remuneration increases ranging from moderate to significant and enhanced staffing arising out of job sizing reviews. The revision of the *ASMS Standpoint on Hours of Work and Job Sizing* to improve its practical focus for members' use has been part of this objective as has the time and efforts of our industrial staff.
- Promoting the enhanced clinical engagement and leadership envisaged by the Time for Quality Agreement (discussed further below). The use of *The Specialist* to improve awareness of the significance of this agreement and the unfolding of the half-day workshops on enhancing members' engagement and leadership in their DHBs forms part of this focus.
- Promoting the increased engagement and influence envisaged in the joint National Consultation Committee (discussed further below).

Independent Commission on Competitive and Sustainable Terms and Conditions of Employment

The achievement of the independent commission was a major success of our national DHB MECA negotiations and critical to membership acceptance of the proposed settlement and subsequent ratification. It has become our major priority since the conclusion of the MECA settlement. The idea of a commission was initiated by the Association late during the negotiations late last year but the initial response was to water down our proposed terms of reference to minimise the focus on competitive terms and conditions of employment. However, as discussed above, with the assistance of the Minister of Health we were able to reach a satisfactory resolution.

The agreed terms of reference are:

> COMMISSION ON COMPETITIVE AND SUSTAINABLE TERMS AND CONDITIONS OF EMPLOYMENT FOR SENIOR MEDICAL AND DENTAL OFFICERS EMPLOYED BY DHBS
>
> *The Director General of Health, with the endorsement of the Minister of Health, will establish a commission to recommend to the Minister of Health (through the Ministry of Health), district health boards and the Association of Salaried Medical Specialists, a national recruitment and retention strategy that will provide a sustainable pathway to competitive terms and conditions of employment for senior medical and dental officers (SMOs).*
>
> *This joint commitment to establish the Commission recognises New Zealand's potential vulnerability as a small, relatively geographically isolated country in:*
>
> *a) Retaining current senior medical and dental officer employees,*
>
> *b) Recruiting and retaining medical and dental officers trained in New Zealand, and*
>
> *c) Recruiting and retaining international medical graduates.*
>
> *In reaching its recommendations, the Commission will have regard to, but not necessarily be bound by, other national conversations and work programmes, including tripartite initiatives and the work of the Medical Training Board. In its deliberations the Commission will take into account:*
>
> *a) Drivers of demand for the SMO workforce, including population health need and models of service delivery.*
>
> *b) National and international supply of SMOs, including opportunities for employment, and the terms and conditions of employment for SMOs in Australia and other countries.*
>
> *c) Employment opportunities available for SMOs in both the private and public health sectors.*

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

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

f) The Government's priorities and health targets.

g) Any other factors it considers relevant.

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

It is pleasing to report that notwithstanding the acrimony during the preceding negotiations there has been a high level of cooperation between the DHBs and Association to the extent of making joint recommendations to the Director-General of Health on the appointment of commissioners and also on a possible expert advisory group. Although taking longer than we would have liked, the Director-General has made an excellent choice. The commissioners are Len Cook (Chair of the Medical Training Board and former New Zealand Government Statistician and United Kingdom Deputy Government Statistician), Ross Wilson (Chair of ACC, board member of Kiwi Rail and former President of the Council of Trade Unions), and Dwayne Crombie (former Chief Executive of Waitemata DHB). We expect to have an initial meeting with the Commission this month.

Our overall work is being coordinated by the Assistant Executive Director working closely with the Executive Director (who has been actively involved in discussions relevant to the formation of the Commission). In preparation the Association has engaged the services of experienced health researcher Lyndon Keene (former senior advisor to the Hon Ruth Dyson in portfolios which have included accident compensation, associate health, labour, and child, youth and young people). He has been working on a substantial paper for presentation to the Commission. The National Executive has been impressed with the quality of his research and analysis. Meanwhile the Industrial Officers are undertaking job vacancy surveys in a number of DHBs including Northland, Waikato, Tairawhiti, Lakes, Taranaki, MidCentral and Southland. Our work will also include comparisons with Australian collective agreements and packages and, to the extent possible, the private sector.

Bargaining Fee

In 2005 the Annual Conference authorised the Association to seek a bargaining fee for inclusion in the new MECA in accordance with the provision in the Employment Relations Act. This was achieved and agreement on implementation was reached in the 'Terms of Settlement'. The National Executive set the fee at the same level as the membership subscription and, in return, those who paid it would be eligible as of rights to all benefits of the MECA settlement including the lump sum payment. In summary, the process was:

1. A secret ballot of all eligible senior doctors and dentists (members and non-members). The ballots were conducted by the DHBs with the Association providing scrutineers (the National Executive is appreciative of our delegates who kindly performed this role).
2. Where the result of the ballot in a DHB was in favour of the bargaining fee, non-members had a four week window to indicate if they did not wish to pay the fee.
3. The deduction by DHBs of the fee would be in four equal instalments which would be remitted to the Association beginning on the first pay period after 10 July 2008 and annually thereafter for the term of the MECA.

In all DHBs there were strong majorities in favour of the bargaining fee with good response rates. Concerns of low turn-outs following the two previous national ballots on industrial action and ratification did not materialise.

To date 219 non-members have opted to pay the bargaining fee although we are still waiting for fees from West Coast DHB. Of this number 118 were unknown to us, were not in our membership

database and consequently had never been invited by us to join. We will need to consider next year an approach to some of them to consider joining. The revenue to the Association from these fees is expected to be around $130,000 per annum for the three year term of the new DHB MECA.

National Consultation Committee

The National Consultation Committee (NCC) is a creation of the new national DHB MECA. It is a joint DHBs-Association national committee comprising six representatives from each party (one of whom must be a DHB chief executive and one who must be the Association Executive Director. It is to meet at least quarterly and the DHBs are to meet the travel costs of the members who attend as Association representatives. To date two meetings have been held – 7 August and 25 September. Further meetings will be scheduled for 2009.

Despite some scepticism over how useful they might be, we have been impressed with the potential opportunities the NCC provides. There has been a significant improvement in the conduct of the DHBs towards the Association at a national level. To a limited extent this became evident following the change of advocates during the MECA negotiations (the public attacks and misrepresentations of our position ceased) but the improvement has accelerated since the settlement. It appears that nationally at least the DHBs have come to the collective conclusion that it is more useful to work with the Association in a collaborative framework on national issues of importance to the health system.

The DHBs have assembled an impressive team comprising David Meates (national 'lead' chief executive, outgoing Wairarapa and incoming Canterbury chief executive), Gordon Davies (retiring Canterbury chief executive - a respected contributor to the health system over many years), Warrick Frater (Hawke's Bay chief operating officer), Joy Farley (Taranaki chief operating officer), Pat Hartung (Taranaki human resources), and Jim Wicks (Capital and Coast human resources). The Association's representatives are the National President, available Executive members, and the Executive Director (the Assistant Executive Director also attends).

At the first meeting the Association was asked by the DHBs to identify at least three subjects that we considered the NCC should work on (outside matters which fall under the ambit of the Time for Quality Agreement). The National Executive identified:

1. Recruitment and retention strategies to facilitate permanent SMO employment and reduce undue reliance on locums.
2. The primary-secondary interface including 'seeing patients without seeing patients'.
3. Information technology standardisation.

These subjects were discussed at the second NCC meeting with encouraging progress being made. The discussion on information technology focussed on the potential effectiveness of a national patient management system and it was agreed that a joint letter would be sent outlining the importance and advantages and recommending that the Ministry of Health take a lead role in working with DHBs on it.

The discussion on the primary-secondary interface extended into the productivity debate. Many activities that improved effectiveness were not counted and therefore not recorded as productivity gains. It was agreed that the NCC would prepare a paper for distribution to a range of bodies such as Treasury, Ministry of Health, applicable inter-departmental committees, Health Sector Tripartite Forum, and media.

However, we ran out of time to seriously consider recruitment and retention strategies although the critical role of the independent commission was noted. There was also a useful discussion on the effect of negative managerial attitudes on dissatisfaction and retention.

The NCC has also considered the viability of a single consent form for all DHBs which has also been considered by the DHBs' chief medical advisers group. It was agreed to follow it up with the latter group.

The NCC is also allocating a session of each of its meetings to discuss the application of the Time for Quality Agreement including its work plan. This is attended by the Ministry of Health and is discussed further below.

This initial progress is encouraging especially when compounded by the positive attitude taken by both parties. It also has the potential to consider a number of employment related matters some of which arise out of discussions and developments in the individual DHB based Joint Consultation Committees (discussed further below). But it will need some secretarial resource and also to streamline meetings by the use of co-chairs as provided for in the MECA.

Time for Quality Agreement

In the 2005, 2006 and 2007 Annual Reports we reported the Association's persistent efforts to persuade the Government to actively support a health professional led approach to the provision of secondary and tertiary services. This included facilitation of the formation and strengthening of national and regional clinical networks and making specific recommendations on resource utilisation, organisation and provision of elective, chronic and acute services in each of the DHBs. Despite the interest of the Prime Minister (and the active support of then CTU President Ross Wilson) the Health Minister Pete Hodgson was largely inactive and as a result no progress was made. However, the appointment of the Hon David Cunliffe made a substantial difference. He worked hard on the DHBs including meeting the DHBs and Association separately and then together soon after his assuming the portfolio.

The next step was for the Association and DHBs to organise an evening meeting on 28 November 2007. In addition to the National President, Vice President and Executive Director, Association members Anthony Duncan (Capital and Coast), David Grayson (Hawke's Bay) and Charles Hornabrook (Capital and Coast) participated (as did former Association President and Principal Medical Adviser to the Minister of Health Dr David Galler); the National Executive is appreciative of their contributions.

This gathering produced the document titled 'Time for Quality'. The premise was that the health system requires quality to be its driver which requires health professional leadership which requires sufficient time for health professionals to provide this leadership. There are key principles of engagement based on teamwork between health professionals and managers including certain lead roles for the former. It also has a work plan.

Following the agreement reached at this informal gathering the National President and Executive Director flew to Auckland in December for a further meeting with the Minister of Health (the DHBs were represented by the Chair of Auckland DHB Pat Snedden). The Minister was pleased with the outcome and agreed to use his efforts to persuade the DHBs to support it. Consequently, at its meeting on 14 December the National Executive voted to approve 'in principle the 'Time for Quality' document'.

The Minister kept his word and actively encouraged the DHBs to support the proposal. It is appropriate to recognise the efforts of then 'lead' national DHB Chair Dennis Cairns (Southland) and Auckland DHB Chair Pat Snedden to persuade the DHBs to support it. Without their efforts (and the Minister's) agreement would not have been achieved. One of the consequences of this exercise is that it enhanced the relationship between the DHBs and the Association to help find a way through the impasse in our MECA negotiations and, in fact, the 'Time for Quality' engagement principles were without controversy included in the MECA but with particular reference to senior medical staff rather than more broadly health professionals.

The Time for Quality Agreement itself was signed by the DHBs and the Association on 7 August in a public launch hosted by the Director-General of Health. In addition to Dennis Cairns on behalf of the DHBs and Dr Jeff Brown on behalf of the Association, the Minister of Health also spoke and signed the Agreement as a witness. The Agreement was the main feature of the September issue of *The Specialist*.

Responsibility for progressing the Agreement currently resides with the National Consultation Committee (discussed above). The Ministry of Health has a resource responsibility for supporting the application of the Agreement and Margie Apa, Deputy Director, Capability and Innovation, has attended for a session at each of the two meetings to date. Between now and the next NCC meeting the Ministry, DHBs and Association will meet informally to discuss how to give practical effect to the Agreement's work plan. The NCC will also receive Ministry advice on the number and range of clinical networks currently in place and clinical improvement initiatives currently linked to the Ministry.

Tripartite Process: Health Sector Relationship Agreement

In the 2007 Annual Report we reported on 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.

At its meeting in August 2007 the National Executive 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 in the national DHB MECA negotiations along with the adversarial position, including the use of serious misrepresentations, of the DHBs, (b) the omission of our health professional leadership initiative in the proposed Health Sector Relationship Agreement, 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 Association's decision caused some angst with the DHBs and Government.

However, at its meeting on 8 May the National Executive rescinded this decision with the following resolution adopted: 'That the Association sign the proposed Health Sector Relationship Agreement.' This was in response to the achieving of the first two objectives – the settlement of the MECA and the Time for Quality Agreement. The Agreement was subsequently signed in an official launch by the Minister of Health, Council of Trade Unions and DHBs in September.

The Tripartite Health Forum has continued to meet with four meetings to date this year (the Executive Director has attended three of them) which a fifth scheduled immediately prior to Annual Conference. The Forum comprising representatives of the Ministry of Health, DHBs and CTU affiliated health unions provides a potentially very influential body. As the meetings have progressed the quality of discussion and engagement has improved.

Examples of the issues discussed to date are:

- The increasingly coordinated focus of the Ministry of Health in respect of DHBs.
- Concerns over some DHBs offering superior terms and conditions than provided in the service and food workers' MECA to members of non-CTU affiliates (the Service and Food Workers' Union is affiliated to the CTU) but declining to pass them on to SFWU members.
- Nervousness by DHBs about resource implications and nursing expectations over the NZ Nurses Organisation's internal educational safer staffing campaign.
- The DHBs approach in the resident medical officer MECA negotiations.
- A stocktake on the legislative health sector code of good faith which led to recommendations for amendments involving life preserving services. The main change is a requirement for the parties to a collective negotiation to appoint a clinical adjudicator before bargaining can commence. Another change is to require written adjudication decisions.
- The judicial review of the Minister of Health's decision on aged care funding.

The Health Sector Relationship Agreement also provides for a series of projects. One ambitious project seeks to enhance constructive engagement in DHBs between management and the workforce. Currently initial exploratory visits to DHBs are underway with a view to possible regional workshops next year. Another involves 'measuring productivity'. This has not been well thought out and its direction has been challenged by the Association. After much debate it has been agreed to rework, to shift from measuring productivity to focussing on high performance workplaces. Improving the value of low paid work in the DHB sector is a further project.

The Association has also challenged the direction (or rather lack of direction) of another project on 'new approaches to setting terms and conditions' which risked getting bogged down in a 'single relativity-based' approach somewhat akin to the 'pay spine' in the 'Agenda for Change' agreement in the British National Health Service (the medical and dental professions are not covered by it). However, it has been steered more sensibly into examining the challenges and difficulties in the collective bargaining process which might end up offering practical improvements.

Activity in the Non-DHB Sector

The non-DHB sector forms a small part of our membership but generates intense periods of work for industrial staff. The immediate aftermath of the settlement of the DHB MECA heralded one such period. Our strategic aim has been to match DHB salaries and conditions as much as possible and we have had some success with that. The exceptions have been CME expenses which are worse than the DHBs as a rule and salaries for doctors without vocational registration which have to be better than DHBs Medical Officer scale to match the market. The backdating of the DHB MECA has caused some problems for these small collectives which have been variously solved.

Employer	Membership	About the Collective
NATIONAL HEALTH SERVICES		
New Zealand Family Planning	28 members and 12 potential members	Expiry is 31 October 2009
NZ Blood Service (NZBS)	5 members and 3 potential members	Expiry is 30 June 2010. An availability allowance is currently being negotiated.
HOSPICES		
Hospices MECA	32 members and 10 potential members.	Expiry is 30 June 2010. A bargaining fee clause now applies.
RURAL HOSPITALS		
Oamaru Hospital (Waitaki Health Services)	2 members and 3 potential members	Expiry date is 31 August 2008.
Dunstan Hospital (Central Otago Health Services Ltd)	6 members and 1 potential member.	The collective agreement expired on 30 June 2008 and a variation has been agreed to.
UNION HEALTH CENTRES		
Waitakere and Otara Union Health Centres	3 members and 1 potential member.	Expiry date is 30 June 2009.
Wellington Primary Health Care Services MUCA	20 members and 3 potential members.	Expiry date was 30 June 2008. A final version of the new MUCA is currently being circulated for signature.
Union & Community Health Centre (Christchurch)	6 members.	Expiry is 30 June 2010.
Roskill Union & Community Health	5 potential members	Potential members have been approached and invited to join.
IWI AUTHORITIES		
Ngati Porou Hauora	6 members and 3 potential members.	The collective agreement expired on 31 January 2008 and negotiations are underway.
Raukura Hauora o Tainui	2 members and 3 potential members.	There is no collective agreement yet.
Ngati Whaatua o Orakei Community Health Services	2 members	The collective agreement expired on 31 May 2008. A new claim is being developed.
Te Oranganui Trust (Inc.) Wanganui	3 members.	Expiry is 31 December 2009.
Te Runanga O Toa Rangatira (Ora Toa)	8 members.	Expiry is 30 June 2009.
OTHER		
Hokianga Health Enterprise Trust	4 members and 4 potential members.	The collective agreement expired on 30 June 2008.Bargaining is underway.
Q E Hospital Limited (Rotorua)	3 members and 1 potential member.	Expiry is 31 August 2009.
Compass Health – Sexual Health Service (formerly WIPA)	5 members and 1 potential member	The collective agreement expired on 30 June 2008. Negotiations for a new collective have almost concluded.
West Fono Health Trust (West Auckland)	1 member and 4 potential members.	Expiry is 31 January 2009.

Industrial Team's Activities

In the course of the year Industrial Officer Jeff Sissons resigned to travel overseas and was replaced by Lyn Hughes who is an experienced employment lawyer and industrial advocate. The four members of the Industrial Team are: Angela Belich (Assistant Executive Director); Henry Stubbs (Senior Industrial Officer) who works four days a week and Industrial Officers Sue Shone and Lyn Hughes.

Job Sizing

Offering advice and practical support to members on their individual and service job sizes continues to be a very important part of the industrial team's regular work. The Association updated its *ASMS Standpoint* on job sizing. This publication is available on the website and is a practical guide for members about job sizing and how to undergo and implement a review of their job size.

Job size reviews can be frustrating exercises; in the past some managers and human resources departments have been reluctant to adopt the ASMS model however increasingly the ASMS model (as outlined in our *ASMS Standpoint* publication) has been accepted by DHBs and is now widely used throughout the country. It is pleasing to see that as members become more familiar with the process, they are also acquiring the confidence to undertake the step-by-step approach outlined in *Standpoint* with only occasional back-up support from the Association and are achieving job sizes that are both robust and, for the most part, accepted by management.

Nevertheless, difficulties do arise at the implementation and transition phases of job-sizing and industrial officers are often called upon to assist members and departments negotiate these phases with management.

Throughout the year successful job size reviews with good outcomes for members have been completed (with ASMS assistance) in many DHBs; the Association is currently actively supporting members at various stages of job sizing in the following DHBs: Waitemata; Auckland; Counties-Manukau; Waikato; Hutt; Canterbury, Nelson Marlborough, West Coast and Otago.

Personal Grievances and Disputes

In the course of the year the industrial team has assisted numerous individuals and groups of members who have found themselves in difficulties or dispute with management or colleagues. We pride ourselves in being able to resolve many of these issues, generally to the satisfaction of the member(s), by low-key and persistent negotiation and discussion. We seldom have to refer matters to mediation, the Employment Relations Authority or the Employment Court.

For the most part our relationships with senior managers and HR departments are very good and our credibility is such that we are often able to conduct our negotiations or discussion, on behalf of members, with management from positions of strength or near equality. Although a "dispute" may initially be referred to mediation it is unusual for us not to eventually resolve it in direct, focussed discussions with the relevant senior managers.

In the course of the year, two new matters went to mediation: one involved the laboratory restructuring at Whanganui DHB and the other an individual personal grievance which was resolved.

One long-standing dismissal came before the Employment Relations Authority and was lost. The Association initiated an appeal to the Employment Court but the issue was eventually settled "out of court".

Another long-standing personal grievance involving a "restricted" clinician's right to return to his previous role following a period of retraining has been to mediation three times and the Employment Relations Authority once (where we were successful). The DHB in question has appealed to the Employment Court and this case is destined to drag on for quite some time.

Other Significant Individual or Group Cases

- A surgeon facing complaints about practice and behaviour from non-medical colleagues;
- Several instances of "dysfunctional" departments where members find themselves in difficulties with their colleagues, in which individuals have made complaints of a clinical and/or behavioural nature about one or other of their colleagues;
- Restructuring of a unit and demotion of its clinical director, arising from an external review of "poor" outcomes within the unit;
- With MPS, ongoing support for suspended member related to concerns about conduct and health;
- With MPS, negotiated return to full practice after a period of supervised "retraining" arising from concerns about clinical practice;
- Negotiated resignation arising from a misuse of credentialing process. SMO had a 0.2FTE role and it seemed he was being "forced out" for reasons that were not clear;
- Disciplinary proceedings against a member who cancelled a patient at short notice, following management interference in his decision to discharge another patient;
- Negotiated resignation of Clinical Director of a service following concerns raised by his colleagues about his style and behaviour;
- Support for several members facing enquiries into absences arising from long-term illness;
- Support for member facing "practice restrictions" and an investigation into his practice;
- With MPS, support for two doctors who resigned from their DHB in face of unreasonable restrictions following series of adverse outcomes.

Other issues of significance

- Advice to members about RMO strikes and shortages;
- Staffing crises threatening continuation of clinical services, eg, Capital and Coast DHB's paediatric oncology service;
- Inconsistency across services within particular DHBs of availability allowances and after-hour payments. eg, Canterbury; Nelson-Marlborough; the Auckland DHBs;
- Increasing attention by DHBs on the roles, job descriptions, job sizes and remuneration for clinical directors and clinical heads;
- We still encounter problems arising from DHBs improperly offering and making fixed-term appointments
- A number of CME concerns continue to generate a great deal of heat; they generally arise in the context of a "policy review" or a new manager trying to make a name for themselves. Issues of ongoing or periodic concern include: days-in-lieu for weekends; travel days; use of business class air travel; use of DHB travel agents; use of CME funds for purchase of lap-tops, i-pods, text books and journals etc.

Advice to New and Prospective Members

Members of the Industrial Team continue to provide an important advisory service to prospective appointees before they take up or, sometimes, are even offered clinical positions. Most of these enquiries are from overseas at the time of first contact. This service, although sometimes time consuming is very important for ensuring overseas medical graduates and other new appointees are familiar with the prevailing terms and conditions of employment with a service, a DHB and New Zealand generally.

Joint Consultation Committees (JCCs)

The DHB-ASMS Joint Consultation Committees (set up under Clause 55 of the DHB MECA) have continued in their third year of full operation. With the exception of the West Coast with only two meetings and Wairarapa with no meetings, JCCs will have met the requirement that they meet at least three times per annum and some will have met more frequently. Most JCCs have been attended by the Executive Director but in some cases, especially Capital & Coast, Hawke's Bay, West Coast and Nelson Marlborough, the Assistant Executive Director has attended. In some cases the Industrial Officers also attend. Generally the chief executive attends and a gives a verbal report on the immediate issues facing the DHB.

JCC delegates have become the mainstay of the Association's organisation. They are the group that the industrial staff works with, refer any new initiatives to and are used to back up members in trouble or groups of members facing difficulties.

The year 2008 saw the JCCs with two phases: before the settlement of the MECA the negotiations tended to overshadow other issues; the settlement of the MECA and the signing of the Time for Quality agreement have, at least initially heralded a more cooperative spirit by DHB managers. The immediate fruit of this enhanced relationship was the comparatively rapid payout of first the lump sum payment and then the new salary rates and back-pay by most DHBs. Longer-term issues are using the Time for Quality principles to shape a new relationship between SMOs and DHB management.

Clinical leadership in one guise or another was a theme throughout the year at each JCC. This was perhaps at its most critical at Lakes DHB with grim winter conditions and staff shortages led to acute SMO frustration with management. Engagement workshops aimed at enhancing clinical leadership have been held in Northland and Hawke's Bay and are being planned in a number of other DHBs including Waitemata, Taranaki, Whanganui, MidCentral, and South Canterbury.

Chief Executives have used the JCCs to brief SMOs and the Association on district annual plans, strategic plans, service planning processes and the development of new facilities. Increasingly this has included regional initiatives particularly between Otago and Southland, West Coast and Nelson Marlborough, and MidCentral and Whanganui. JCCs have been useful when management has used them to signal reviews at the early stage but this has been inconsistent. As a result the Association has had to challenge reviews at Auckland, Nelson Marlborough, Canterbury and South Canterbury. So far most have been successfully amended to meet SMOs requirements.

Throughout the year the JCCs have enabled SMOs to directly challenge senior DHB managers, for example an ill thought out conflict of interest policy and CME policy at ADHB. The JCC has also provided a venue for the Association to proactively pursue issues such as increasing insurance coverage for SMOs from 0.5 million to 1 million at the three Auckland DHBs, the provision of laptops at Hutt Valley and Whanganui and business class travel at Canterbury.

The JCC has also provided a mechanism for pursuing some of our industrial goals, for instance a new regimen for call at Tairawhiti, an amended rate for compensation for expected RMO absences at Northland, use of CME expenses for laptops at Waikato. Call and availability are also being discussed at Hawke's Bay and Nelson Marlborough though without any resolution as yet. Implementation of the clause providing good overnight accommodation has been raised now at most JCCs. Job sizing has been discussed as an issue at a JCC in nearly all DHBs as processes are set up and implemented.

Incorrect implementation of the MECA has been raised at some DHBs. Call has not been consistently included in the calculation of entitlements at Counties and at Nelson Marlborough. Telephone allowance has been an issue at Tairawhiti. An emerging concern has been the inconsistent use of salary scales, allowances for recruitment and retention and even job sizes (Canterbury and South Canterbury). Performance appraisal or reviews have been an issue in

Tairawhiti and Waikato and the Association has been successful in having them refocused to career development. Reasonable travel time and clear CME forms so that the distinction between travel and leave is easily made has come up at several JCCs. The implementation of the sabbatical clause has been discussed at Auckland and Bay of Plenty. Car parking remains an issue at Counties.

In DHBs where there are university employed doctors the Association has asked the DHBs, during the JCCs, to pass on the MECA (as well as through the letters referred to elsewhere in the report).

The recruitment and retention crisis at DHBs has been discussed with respect to SMOs (all DHBs but particularly Taranaki, Tairawhiti, Southland, Otago and Whanganui) and with respect to RMOs (Northland, Auckland, Capital and Coast and South Canterbury), allied staff (Auckland) and GPs (Hutt Valley). An improvement in recruitment was noted in MidCentral with the setting up of a Medical Administration Unit with a specialised person focussing on SMOs.

Joint ASMS-DHB Engagement Workshops

During a discussion at the Northland Joint Consultation Committee the idea developed to hold a half-day joint ASMS-management workshop on enhancing senior doctor engagement in the DHB beyond that of formal clinical leadership positions. This led to the holding of the workshop on the afternoon of 25 June. The event, in the assessment of senior medical staff and senior management attending, was an outstanding success with very high attendance. Key to its success was that it was held offsite, non-acute services were not scheduled for the period of the workshop, and the programme was relevant to the contributions members could make in the DHB. The Northland programme was:

- The planning process for reviewing the DHB's five year plan.
- How can SMOs genuinely influence service improvements and drive change rather than have it done to them?
- The MECA as a launch pad for SMO engagement.
- SMO staffing stock-take: where are the gaps?
- The site master plan.
- Supporting professional development and education.

A workshop along similar lines was held in Hawke's Bay on 7 November with the following programme which, in contrast, has fewer subjects:

- The MECA as a launch pad for SMO engagement.
- The DHB's planning process.
- How can SMOs genuinely influence service improvements and drive change?

Several other DHBs are considering and planning for similar workshops in early 2009. To date it has been an encouraging initiative and it will be interesting to see how they unfold and to what extent they contribute to the enhancement of a constructive engagement culture in DHBs. The size of each DHB may make a difference in how they work and how successful they are.

Surveying Full-Time DHB Senior Medical Staff Income

The Association completed its 14th annual survey of full-time equivalent salaries (FTE) for DHB employed senior medical staff based on our negotiated collective agreements effective on 1 July 2007. 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 third survey undertaken since the implementation of the first national DHB MECA. The 15th survey (1 July 2008) is currently underway.

On 30 June 1993 the mean FTE specialist base rate was $85,658. By 1 July 2007 this increased to $145,044 (a raw increase of about 69.1%). The July 2007 average represents a 1.2% increase on the 2006 mean. The mean female salary is $139,741 compared with the mean male salary of $147,084. Since 2005 the female-male salary gap has increased from $5,904 to $7,343 (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 2007 was from $67,457 on 30 June 1993 to $114,380 (a raw increase of 69.3.0%). This average represents a 0.2% decrease on the 2006 mean. The mean female salary is $112,878 compared with the mean male salary of $115,702. The slight decrease from 2006 to 2007 is likely to be affected by the number of more experienced medical officers either retiring or transferring to the specialist scale due to being vocationally registered in what is numerically a relatively small group.

These are mean full-time equivalent base salaries and do not take into account hours worked in excess of 40 hours per week (which are 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 7th survey of superannuation entitlements in DHBs, effective on 1 July 2007, which covers 2,557 senior medical staff receiving subsidised superannuation. The largest group receiving subsidised superannuation are the 1,926 members whose schemes are based on the MECA entitlement. The next largest group, 522 (down through attrition to 647 in 2006), 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.

Challenge to the Right to Strike in the Health Sector

This year the Health and Disability Commissioner released two decisions both involving the effect on neurosurgery patients at Dunedin Hospital of strikes by the APEX union. Both, one more so than the other, were critical of the effect of the right to strike in this case in terms of its effect of the rights of patients under the code of consumer rights. Although the Commissioner was not challenging the right to strike by health sector employees, he was challenging its application. This led to calls in some quarters, including the Chief Executive of the Otago DHB and the President of the Orthopaedic Association, to ban strikes in the health sector.

The Executive Director addressed this issue in an address to the Hospital and Community Dentistry Association in July, in the context of defending the importance of the right to strike in the health sector but emphasising the importance of unions executing it in a way that did not threaten patient safety. At its meeting on 24 July the National Executive agreed that this right to strike should be defended, particularly given the absence of satisfactory agreed alternatives.

Resident Doctors' Association and their MECA Negotiations

In April and May the RDA embarked on two two-day strikes in pursuit of their MECA claims. The Association's strong preference was not to comment on this dispute or become otherwise involved. Unfortunately the actions of the RDA dragged us unwillingly into it at times, both in the media and via *ASMS Direct*. The causes of this included:

- The timing of the strikes right in the middle of our ratification process without discussing this with us in advance or providing any other 'heads-up'. We learnt about the actions at the same time as the media. The RDA leadership was well aware of our process and the intent appears to have been to try to influence our ballot outcome (ie, for a vote against ratification).

- False claims in the media by the RDA General Secretary about threatened hospital closures which forced the Association to publicly refute the claims.
- Misleading and inaccurate statements by the RDA about comparisons with our MECA settlement.
- Implicit criticism in the *National Business Review* of the Association for not having its national office run by a private company (in contrast with the RDA) and suggesting that Association national office salaries were higher as a consequence.

With particular reference to the first two items above, on 23 April the RDA President wrote a letter to the Association strongly critical of our correspondence with members and our responses in the media. This, in turn, led to a strong response on 5 May from the National President refuting the criticisms. His letter was endorsed by the National Executive at its meeting three days later.

The RDA's MECA settlement itself has been previously reported in summary detail in *ASMS Direct*. While it is not appropriate to comment on the details of the settlement, it is appropriate to note that in essence the DHBs' position prior to the first two-day strike formed the basis of the final settlement except for an additional 2% salary increase and an extension of the term by six months. It appears that at least for the immediate period the approach to industrial action in this dispute may have given DHBs more confidence in responding to future industrial action.

In March the RDA requested that the Association forward a letter from the RDA to our members (but explicitly excluding clinical directors) about its MECA negotiations. A copy of the letter was provided. At its meeting on 25 March the National Executive adopted the following resolution:

> *That the National Executive declines the RDA's request to circulate their letter to Association members largely because of the risk of confusion in light of the sensitive stage of our national collective agreement negotiations. Further, differentiating clinical directors from the rest of Association members was unacceptable.*

Once formal notice was given of the first RMO two day strike the Association had to address the issue of financial compensation and other arrangements for members whose workload and work pressures would be affected by it. Negotiations with the DHBs was led by the Executive Director and concluded in what were difficult circumstances and notwithstanding some chief executive opposition and some membership disquiet (believing the rates were excessive), with an agreement that the Association's national recommendation was the only national recommendation. The nationally recommended rates were (a) $300 per hour for normal hours rendered more onerous between 8am and 6pm; (b) $500 per hour for extra hours worked and normal hours worked between 6pm and 8am; and $250 per hour when on-call between 6pm and 8am. Although it was not a legally binding agreement on DHBs, despite some resistance all eventually agreed to pay it (in a small number of cases members could elect a lower local DHB proposal or the higher nationally recommended rates). Some members opted to donate some or all of the payments to a charitable cause.

Resident Medical Officer Workforce Commission

In July, during the RMO MECA negotiations between the DHBs and Resident Doctors' Association (RDA), the Director-General of Health announced his intention to establish a commission to examine RMO workforce issues. He invited various organisations, including the Association, to comment on draft terms of reference. These were considered by the National Executive at its 24 July meeting which concluded that the proposed terms of reference were too 'industrial' and appeared to be an attempt to undermine the RDA in their collective bargaining process with the DHBs. Consequently the following resolution was adopted:

> *That because the proposed terms of reference overlap and clash with the RMO MECA negotiations between the DHBs and RDA, it is not appropriate for the Association to comment on them as it is a matter between the DHBs and RDA.*

The Director-General was advised of the above resolution which led to direct discussions between the Executive Director and Health Ministry officials. On 22 August the Director-General announced new final terms of reference which are separated out from collective bargaining and focus more on training and the sort of medical workforce that New Zealand should need. The Director-General has subsequently announced the commissioners – Don Hunn (Chair and former State Services Commissioner), Angela Foulkes (member of the Remuneration Authority and former CTU Vice President and Secretary), and Dr Peter Crampton (Dean of Wellington Clinical School).

Medical Council Elections

As previously reported in successive Annual Reports and discussed below in relation to the Pan Professional Medical Forum (PPMF), 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 (both the Association and NZMA had also made representations in their own right). Earlier this year when meeting the PPMF, Health Minister David Cunliffe advised that he was persuaded to endorse our position. He was influenced in no small part by the achievement of the Time for Quality Agreement and saw elected representation on the Medical Council as being consistent with its principles. Subsequently, on 28 May, the Minister wrote to the Association confirming that he had asked the Ministry to undertake the necessary work on regulations under the Health Practitioners Competence Assurance Act providing for a proportion of the Councils' membership to be elected.

However, in a discussion with the Minister's office on 23 September the Executive Director was advised that while the Minister had made two representations to Cabinet for approval on the proposed regulations, he was declined on both occasions. It appears that opposition came from middle level Ministry officials and the Nursing Council fearful of precedent with key cabinet members discreetly and effectively lobbied. Instead the matter has been referred to the wider review of the Act (discussed further below). On 15 October the Association wrote to the Director-General of Health outlining our concerns over this development and reiterating the case for elected representation to the Medical Council. The Council of Trade Unions has also written to the Ministry of Health expressing concerns over its process.

While the support of the Hon David Cunliffe is appreciated, the failure of his cabinet colleagues to support him was a retrograde action. Elected medical practitioners on the Medical Council will remain an important issue for the Association to pursue with the incoming government.

Medical Council Reviews

Last year we reported that, with the support of legal advice from Bartlett Brothers, we had urged the Medical Council not to proceed with its draft guidelines on 'disruptive doctors' because it was unnecessarily entering the minefield of employment law. This was further discussed with Professor John Campbell when he met the National Executive on 11 September. Our representations of last year were followed up with a substantial letter this year to the Council commenting on key aspects. While the Council is still proceeding with the draft guidelines it has significantly revised them to meet the Association's concerns. It was pleasing to read Professor Campbell's public acceptance of our concerns in an article by him in *NZ Doctor* (22 October 2008).

Review of Health Practitioners Competence Assurance Act

The Health Practitioners Competence Assurance Act (HPCAA) includes a statutory obligation to undertake a review. Late last year this was initiated by the Ministry of Health. The Association's work has been coordinated by the Assistant Executive Director. In December 2007 the Association made an initial submission based on a Ministry prepared questionnaire in advance of the expected preparation by the Ministry of a consultation document. This submission commented that the questionnaire did not fit well in terms of a basis of presenting the Association's concerns

with the HPCAA. Our overall concern was the risk it presented for political and bureaucratic control. The Review and the Association's concerns were reported to members in *The Specialist*.

Specific concerns related to protected quality assurance activities, reporting of health practitioners, elections to regulatory bodies (discussed separately above), restricted activities provision, single profession regulatory bodies (contrasting the multi-professional Dental Council with the single professional Medical Council), and scopes of practice.

Since then the Ministry has held an initial round of workshops. However, instead of preparing a consultation document the Ministry has instead unilaterally determined to report directly to the Minister of Health in February 2009. This approach appears to be based around ensuring that those Ministry officials driving the review achieve the outcome they desire. It does not give the Association much confidence.

Pan Professional Medical Forum

The Pan Professional Medical Forum, formed in 2005 and comprising the Council of Medical Colleges, the Association, Resident Doctors' Association and NZMA, has held four meetings since the last Annual Conference. A further meeting was scheduled in the week following Annual Conference but unfortunately has been cancelled because of other commitments of two of the participating organisations.

Since 2005 and for the first two meetings the PPMF was ably facilitated by CMC Chair Associate Professor Phil Bagshaw. However, his second term as CMC Chair has terminated. His successor is Dr Jonathon Fox (outgoing Chair of the College of General Practitioners) who facilitated the third meeting. It is unlikely the PPMF would have been formed in the first instance and continued as long as it has without the energy and commitment of Professor Bagshaw.

A major success of the PPMF was the organisation of a medical workforce summit in Wellington on 4 March. There were a series of interesting presentations including from a number of colleges. This led to a media statement being released on behalf of the PPMF.

Other activities have included:

- Election of medical practitioners to the Medical Council (discussed further above).
- A meeting with the Minister of Health (including the Association National President and Executive Director) to discuss Medical Council elections and the state of the medical workforce (following the workforce summit discussed above).

The future of the PPMF remains in doubt. Although the combination of the four organisations can be a considerable force, and was recognised as such by the Minister of Health, the chemistry between the organisations is not as strong as it should be and it is dependent on the attitude of the Colleges through the CMC. The PPMF is also severely impaired by the lack of its own resources. Nevertheless at its last meeting on 23 September the consensus was that it should proceed particularly given the news that the Minister of Health was unable to persuade his cabinet colleagues to support the issuing of regulations to enable elected medical practitioner positions on the Medical Council.

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.

Issues considered by the National Affiliate Council included:

- The CTU's work with the Government, Business New Zealand and Industry Training Federation in the development of a national skills strategy focussed on addressing New Zealand's skill shortages through (a) increasing workforce literacy, language and numeracy; (b) building the capability of firms to support managers and employees to better develop and use skills; (c) enhancing the relationship between the supply of and demand for skills; and (d) increasing the skills of young people in the workforce.
- Flexible working hours' legislation (amendment to Employment Relations Act).
- Exploitation of migrant labour, especially in the agricultural and aged care sectors.
- Climate change.

The Prime Minister also addressed the 28 August Council meeting.

Meetings with Director-General of Health

The Executive Director continued his regular informal meetings, usually monthly, with Director-General of Health Stephen McKernan with six held to date (another two meetings scheduled for later this year). There have also been several informal discussions with the development of a particularly constructive dialogue and relationship between them. The Association is supportive of Mr McKernan's efforts to support a cultural change and make the work and role of the Ministry more relevant to and supportive of DHBs. Following a keynote address by the Minister of Health the Ministry is now moving towards adopting a more practical 'hands-on' role although more in the ambit of effective coordination than central control.

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.
- The senior doctor commission on competitive terms and conditions.
- The commission looking at the resident doctor workforce.
- The Time for Quality Agreement.
- Health Sector Relationship Agreement.
- Medical Council elections.
- Long term sustainability direction in the health system,
- Cervical cytology provision in the South Island.
- Health and Disability Commissioner decision and right to strike in the health sector.
- Public hospital laboratory privatisation.
- Health Ministry restructuring.
- Hawke's Bay review.
- Specific internal DHB problems (eg, Lakes, Whanganui, Capital and Coast, and Southland).
- The hospice MECA settlement.

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 Brisbane in April. The trip provided an opportunity to be updated on various negotiations and settlements in the some states and territories, the Special Commission of Inquiry into Acute Care Services in New South

Wales, the MABEL project '(balancing employment and life' in medicine), and moves towards forms of mandatory reporting in New South Wales and Queensland. While in Brisbane he also met the Cognitive Institute and spent time with the Queensland Senior Doctors Union which included discussions about the process leading to their last collective agreement and preparation for the negotiations for its replacement.

- On 29-30 April he attended the second Australian clinical network collaborative in Bendigo, Victoria, which included presentations of the established and embedded clinical networks in Scotland, further developments in the 'bottom-up' networks in New South Wales, and moves to establish a stronger national infrastructure and direction in Australia. En route to Bendigo he also had meetings in Melbourne with the AMA Victorian branch, Australian Council of Trade Unions, and the National Tertiary Education Union.
- The Executive Director visited Europe, primarily Britain in June and early July. The main purpose was to attend the Annual Representative Meeting of the British Medical Association and its preceding craft conferences. In addition he visited counterpart doctors' unions in Ireland, Holland, Denmark and Germany; the Standing Committee of European Doctors in Brussels; and academics, researchers and other union organisations in England. It enabled him to be well briefed on industrial relations and health policy developments in Britain and other western European countries. Many of these have important lessons for New Zealand.
- The Executive Director visited Canberra in September to attend the second Industrial Coordination Meeting. The most interesting development was the recent settlement of the new South Australian collective agreement which produced increases comparable with the large increases in Queensland and Western Australia. Other issues included a more modest settlement in New South Wales, federal industrial relations changes, corporate medical practices, and mandatory reporting in New South Wales, and the AMA policy statement on 'hospitalists'.

Association Publications

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

- MECA negotiations: several balls in the air (the state of play immediately after the 2007 Conference and during the industrial action ballot).
- The Review of the Health Practitioners Competence Assurance Act.
- The main political parties' health policies and performance.
- Ministerial intervention in the MECA negotiations.
- Lessons of Health and Disability Commissioner decision (Dr Hasil and Whanganui DHB) and DHB appointment processes.
- A union perspective on state sector governance.
- Pay and employment equity reviews in DHBs.
- Post-MECA settlement initiatives.
- The Medical Training Board.

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 2,970. To date 29 issues have been produced this year. Much of this has focussed on the national DHB MECA negotiations, settlement and

implementation (including bargaining fee, lump sum payment, and the independent commission into competitive terms and conditions).

Other subjects covered included:

- The Time for Quality Agreement.
- Medical Council elections.
- National Consultation Committee including promotion of a national patient management system and understanding productivity and effectiveness.
- The National Executive's 'What it takes to stay' initiative.
- National Recommendation on Arrangements and Financial Compensation for Additional Work and Pressure during RMO strikes in April and May.
- The RMO MECA dispute including the strikes in April and May.
- RMO independent commission.
- Defending the right to strike in the health sector.
- National Executive decision to sign Health Sector Relationship Agreement.
- World Medical Association statements on calling for an increase in the training of doctors; world health professional organisations coming closer together; Declaration of Helsinki
- Report of Independent Review of Management of Conflict of Interest by Hawke's Bay DHB.
- New amendment to Holidays Act (shift work on public holidays).
- Politicians getting it wrong on hospital productivity.
- Council of Medical Colleges' media statement on patient safety concerns arising out of workforce shortages.
- New ASMS Standpoint on hours of work and job sizing.
- CTU media statement on National Party ACC privatision plans.
- 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 (the ninth in succession) and subsequently we exceeded 3,000 members for the first time. Membership, as of 31 March 2008, was 2,995 compared with 2,833 on 31 March 2007, representing an overall increase of 162 (5.7%). It represents a nearly 108% increase 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%), 2006-07 (95 – 3.5%) and 2007-08 (162 – 5.7%), an overall increase of 71% 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 86 (6.0%). 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 146 (7.4%).

Currently membership is over 3,470 (an unprecedented 480 or 15% new members since March 2008) 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 2009. 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 84% of our members pay their subscription by automatic salary deduction (about 80% of new members employed during the past year opted for fortnightly payments).

Again, despite incomplete information, it remains the case that few Association members are also members of the NZMA and these numbers appear to be declining. Those who were NZMA members at the time of joining the Association represent an estimated 12% of our current members. Just 3.5% of members who joined the Association in 2008 were also members of the NZMA compared with 22% in 1996.

Life Membership

The Association has two life members – Drs John Hawke and James Judson. At the Association's 20th Annual Conference the National Executive has great pleasure in nominating two further members—Drs George Downward and Allen Fraser. Both were key founders of the Association coming out of one of our predecessor organisations, the Whole-Timers Association. They were respectively our first membership elected National President and Vice President (1989-91). Dr Fraser was also our second National President (1991-95).

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.

While visiting London in June the Executive Director met the new Chief Executive of MPS based in London, Tony Mason. This was reciprocated in Wellington last month when Mr Mason visited the Association to meet the Executive Director (also attended by the Senior Industrial Officer). The signs are positive that our constructive and close working relationship will continue. 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 settlement, other negotiations, relationships between the medical organisations, the Society's administration of the MPS, Time for Quality Agreement, media coverage of Health and Disability Commissioner's decisions, and the MPS-MAS support service for doctors.

Association Finances

Despite another stronger than expected growth in membership the Association recorded a deficit in excess of $50,000 for the financial year ending 31 March 2008. The main factors for the deficit were:

- Unplanned expenses of over $140,000 incurred by the stopwork meetings and ballot on industrial action; included in this was publicity ($80,000), printed material ($20,000) and additional staffing ($10,000).

- Last year's office relocation resulted in a loss on disposal of assets ($30,000) largely attributed to leasehold fixture and fittings.

Dominion Finance Group

The Association holds $221,542 in Dominion Finance Group debenture stock. Dominion Finance Group (DFG) was placed into receivership on 10 September 2008; the outcome is uncertain as we await information from the receivers.

Following the initial June announcement of DFG's liquidity problems, Claire Matthews (Senior Lecturer, Massey University's Centre for Banking Studies) was invited to address the National Executive at its July meeting. The session covered New Zealand finance companies in the current economic climate and was both informative and sobering. The following resolutions were adopted:

1. *That the Executive Officer prepares an initial draft investment policy to be distributed to National Executive members for their responses and then prepare a revised draft policy for consideration at the next Executive meeting.*
2. *That the National Executive approves the transfer of the maturing UDC ($219,901.34) and South Canterbury Finance ($146,136.00) investments to an appropriately rated bank and similarly approves the transfer of the UDC Call Account.*

The investment policy is intended to be uncomplicated yet prudent and is based on advice received from our auditors, Sherwin Chan and Walshe and Claire Matthews. It expressly excludes investments in shares or finance company deposits, in light of the current financial crisis or any ongoing period of financial instability.

Christchurch Hospital 'Annual Physicians Dinner'

In July the Association received a request for funds from the organisers of the 'Annual Physicians Dinner' at Christchurch Hospital. This was the first time we have been asked for a donation of this nature and the National Executive declined the request not wishing to set a precedent.

Administration

The resignation of Administration Officer Barbara Narasy coincided with the ballot on industrial action at the end of 2007 consequently we engaged temporary assistance until time permitted the appointment of a permanent replacement in March.

2008 has presented many challenges with the considerably increased membership levels arising out of the national DHB MECA negotiations placing additional pressure on the team. In the 8 months since the end of March 2008 the potential membership has soared by over 900 including 220 who have opted to pay the bargaining fee. Systems were devised to handle the new category of 'member' and further modifications to the membership database were required to ease the high volume processing of new members.

New Zealand Post's new address standards for improved machine sorting came into effect in June this year, requiring all mailing data to be compliant to qualify for reduced postage on bulk mail. Although the data purge was undertaken externally, preparing the database to accept the compliant data was reasonably time consuming with some modification to the database required. The acquisition of an electronic franking machine offered free of charge to high volume New Zealand Post customers was a timely incentive as the old machine was due for replacement.

The network server was also recently upgraded with more highly specified technology that should accommodate the Association's needs for the next 4-5 years.

Website

New technology and the desire to make the Association's services more immediate prompted a redesign of the ASMS website. Introduced in September the new site aligns with the Association's other publications and has generated many positive comments on its fresh look and ease of use. Although rewarding the recent refurbishment was a massive task taking about six months to complete.

Job Vacancies Online

The Association's Jobs Online section attracts a large proportion of the total number of visits to the website (18,000/month).

With a monthly average of 60 positions (mainly DHB) posted at any one time it is an efficient and economical method for employers to advertise senior medical and dental vacancies. Advertisements are linked to the employer's website and all enquiries are directed to the employer or its agent. In addition to covering the costs involved in managing the facility, the income derived from online advertising made a substantial contribution to the recent revamping of the website.

Other Matters

Remuneration for After-Hours' On-Call Duties and Responsibilities

At its meeting on 11 September the National Executive considered the issue of remuneration for after-hours' on-call duties and responsibilities (both hours worked and required to be available) and concluded that it carries little recognition for the disruption to normal family life or the interference in normal sleep patterns. This is the subject of a National Executive remit to Annual Conference. The focus is expected to be on what work is and what is not. A brief background paper has been forwarded to Conference delegates and the remit has also been circulated to members through *ASMS Direct*.

Draft Audit Tool on Senior Medical Staff Involvement in Decision-Making

The National Executive has established a group comprising Executive members Torben Iversen and Gail Robinson and the Assistant Executive Director to develop a draft audit tool on the extent and effectiveness of senior medical staff involvement in DHB decision-making. This was discussed in some detail at the informal strategic Executive meeting in February. A draft has been prepared and is expected to be piloted in Waitemata and Tairawhiti DHBs.

This work arises out of a provision of the previous national DHB MECA for the development of guidelines for senior medical staff involvement in DHB decision making. This provision, by the consent of the parties, was not carried over into the new MECA but the National Executive considers an adaptation of it to be a useful activity.

Proposed Medicines Campaign

Along with a number of other organisations the Association was invited by the Researched Medicines Industry Association to participate in a non-partisan campaign in the general election. The National Executive declined the invitation. It appears insufficient interest from the invited organisations meant that the campaign did not proceed.

Feasibility Study about Establishing a Regional RMO Employer in Auckland

On 11 September the National Executive considered a proposal from the Waitemata, Auckland and Counties Manukau DHBs to undertake a feasibility study about establishing a regional employer of the three DHBs for RMOs. It resolved not to take a position on the proposal, given that it was at the stage of a feasibility study but noted that senior medical staff should be actively

involved in the development of any proposal. We will be monitoring this development and may become more engaged.

Public Hospital Laboratory Privatisation

Despite its accusations against the National Party for favouring privatisation of health services, the Labour-led Government's soft approach to privatisation of hospital laboratories continued with the contracting out of the Rotorua Hospital laboratory to a joint venture between Lakes DHB and a private regional monopoly company contrary to the wishes of the laboratory staff and the failure to effectively engage with them and their unions, the Medical Laboratory Workers Union and the Association. The Association was, however, successful in ensuring that pathologists would remain employees of the DHB. To the best of our knowledge no further privatisation initiatives are on the horizon.

Employment Relations (Breaks and Infant Feeding) Amendment Bill

This was a positive bill which enhanced employment rights for many employees and was adopted by Parliament and now forms part of the Employment Relations Act. As there might be possible implications for hours of work of our members, we will be monitoring its application.

Pay and Employment Equity 2008

Pilot and verification reviews of pay and employment equity were conducted in DHBs as part of the programme which began, in 2003, with the Pay and Employment Equity Taskforce and continued through the work of a tripartite committee of representatives from DHBs, health unions and the Ministry of Health. Differences in average total remuneration between women and men across the sector have been identified including differences in total remuneration. The taskforce has recommended that a bipartite project of the Association and DHBs be established to further examine differences in remuneration and rewards of female and male senior medical and dental officers.

Clinical Hand-Over

One of the actions arising out of the Memorandum of Understanding attached to the resident medical officers' MECA (in the previous agreement and carried over to the new replacement) is an exercise examining clinical hand-over. The DHBs' 'lead' chief executive for this activity (Karen Roach, Northland) verbally invited the Association to be represented on the review group. However, as the review group already had two specialists (Kelvin Lynn, Canterbury, and Andrew Connolly, Counties Manukau), while appreciative we declined the invitation because of confidence that both individuals (also Association members) would provide quality specialist input into the review. Quality medical input was more important than formal Association involvement.

Official Information Act Requests for Detailed Information about Serious and Sentinel Events

In February the Quality Improvement Committee released detailed material sought under the Official Information Act by journalists about serious sentinel events. It attracted considerable media publicity. The Association was approached by the chief medical advisers' national group for support for this more transparent approach and this was given by the National Executive at its February meeting, and in the media by the National President.

Draft Role Delineation Model

The Association unofficially received papers about a top-down determined 'role delineation model' which is being established by a group convened by the DHBs. The express purpose of the exercise is to inform the Ministry of Health and DHBs on the use of this model to consider the (a)

application of the tertiary adjuster and (b) its possible use in understanding the distribution of services within DHBs, across regions and across New Zealand. It appears from the exercise that it is driven by DHB financial staff and lacking clinical input. The Association has raised its concerns at the National Consultation Committee.

CTU Discussion Paper on Improving Access to Health and Disability Support Services

In 2006 the CTU Health Committee, which includes the Association, decided that it needed to develop a position paper on the health system. Researcher Lyndon Keene was engaged by the CTU to undertake this work and the National Executive considered his draft at its February meeting and resolved to endorse it in principle. The paper is now available on the CTU's website.

Complaint from Minister of Health

Prior to the 2007 Annual Conference the Association received a complaint from then Minister of Health, Hon Pete Hodgson, concerning criticisms of some of his decisions, largely over hospital laboratory privatisation, by the Executive Director. At its meeting on 31 October 2007 the National Executive authorised the National President to reply defending the approach of the Executive Director. However, given the subsequent decision of the Prime Minister to replace Mr Hodgson as Minister of Health, at its meeting on 21 February the National Executive resolved that there was no longer a need to reply.

Branch Representation

At its meeting on 11 September the National Executive first considered the issue of Association delegates on the Joint Consultation Committees which then led to a discussion on the Association's branch committees. Arising out of the discussion it was agreed that the national office would prepare a paper for consideration at the first Executive meeting of 2009.

Brian Craig
ASSOCIATION NATIONAL SECRETARY

13 November 2008