Annual Report 2009

The 12 months since the 20th Annual Conference in 2008 have seen three main challenges – promotion of clinical leadership and engagement in DHBs (including the application of the *Time for Quality* Agreement between the ASMS and the 21 DHBs and the *In Good Hands* policy statement); responding to the report of the Ministerial Review Group on 'Performance and Quality in the Health System'; and preparation for next year's negotiations of the national multi-employer collective agreement (MECA) covering members employed in the 21 DHBs, including the commission on sustainable and competitive terms and conditions of employment (SMO Commission). Much time has also been spent reviewing the function of Association branches.

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

President	Jeff Brown (MidCentral)
Vice President	David Jones (Capital & Coast)
Region 1	Judy Bent (Auckland)
	Himadri Seth (Waitemata)
Region 2	John Bonning (Waikato)
	Paul Wilson (Bay of Plenty)
Region 3	Torben Iversen (Tairawhiti)
	Tim Frendin (Hawke's Bay)
Region 4	Brian Craig (Canterbury)
	John MacDonald (Canterbury)

With the exception of Region 2, all were elected unopposed. In Region 2 there were three candidates for the two positions. The election outcome was both sitting members re-elected. Brian Craig was subsequently re-elected National Secretary by the National Executive at its 14 May meeting in accordance with the Constitution. Longstanding National Executive member Gail Robinson resigned from the National Executive effective prior to the last meeting of the previous biennial term (12 February) in order to take up a position in Queensland. The National Executive is appreciative of the constructive contribution to the Association, made with good humour, of Dr Robinson over the years, both on the Executive and at Waitemata, and wishes her the best in this new stage in her professional career. Similarly Iain Morle also resigned from the National Executive prior to its last meeting of the biennial term because of his retirement. Dr Morle was a member of the Executive for one term and his contribution nationally and at Hawke's Bay is also appreciated. As they had been already been elected unopposed for the next biennial term, the National Executive co-opted Drs Tim Frendin and Himadri Seth for the final meeting of the old term.

The National Executive has met on four occasions since the last Annual Conference, with a fifth meeting to be held immediately preceding this Conference. This included, a two day meeting (22-23 July), in order to allow sufficient time to consider our response to the report of the SMO Commission and to commence our preparation for next year's national DHB MECA negotiations.

On 13-14 May the National Executive held its annual two day meeting to discuss strategic directions, the first day being informal. The informal day included:

- A session with the Chair of the SMO Commission, Len Cook.
- Actioning clinical leadership in light of the *Time for Quality* Agreement and *In Good Hands*.
- Shape of the next national DHB MECA claim.
- The role of Association branches.
- Reviewing the performance of the National Executive.

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

- Len Cook, Chair of the SMO Commission on 12 February (in addition to the above informal meeting).
- Minister of Health, Hon Tony Ryall attended the 14 May meeting.
- Professor John Campbell and Phillip Pigou (Chair and Chief Executive respectively) of the Medical Council attended the 22-23 July meeting.

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), Lyn Hughes (Industrial Officer), Yvonne Desmond (Executive Officer), Lloyd Woods (Industrial Officer – commenced January), Kathy Eaden (Membership Support Officer), Jo Jourdain (Administration Officer – commenced in April) 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. In January Industrial Officer Sue Shone resigned to take up a new position. The National Executive is appreciative of her work advising and supporting members from Tairawhiti and Taranaki down to Southland.

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

Promotion of Clinical Leadership in DHBs: From Time for Quality to In Good Hands

In 2008 the landmark signing of the *Time for Quality* agreement between the Association and the 21 DHBs marked a significant step forward in our promotion of clinical leadership. It is appropriate to recall the important role of former Minister of Health Hon David Cunliffe in facilitating this. In recognition the National President formally wrote to Mr Cunliffe expressing the Association's appreciation for his work (as well as for helping facilitate resolution of the national DHB MECA negotiations earlier that year). The Association also succeeded in getting the engagement principles of *Time for Quality* included as part of the MECA.

On 10 February the Executive Director wrote to all 21 DHBs outlining our understanding of the application of the *Time for Quality* agreement (and the inclusion of its engagement principles in the MECA) describing it as a paradigm shift for senior medical staff leadership, engagement and consultation. This caused some angst among a number of chief executives and led to correspondence with the chair of the chief executives national group, Garry Smith. In summary, they argued that the Association was taking a contractual approach to what was a relationship issue. We considered this a false distinction.

It is pleasing that Minister of Health Tony Ryall is also supportive of *Time for Quality* and quickly sought to work with the Association in building on it. To this end immediately prior to Christmas he established a task group headed by National President Jeff Brown to provide further advice on clinical leadership in DHBs that would be linked to his annual Letter of Expectations to DHBs. Their report was titled *In Good Hands*. For logistical reasons *In Good Hands* was not attached to the Minister's Letter of Expectations as intended but instead sent to the DHBs separately with his endorsement. *In Good Hands* included both core principles and transformation requirements which are reinforced by requirements to report on their implementation and performance. A feature of *In Good Hands* is that it is about extending clinical leadership at all levels of DHBs, including at the individual unit of work or department level. It is less about formal clinical leadership positions and more about empowering clinicians at the workplace in decision-making.

The Minister has been clear to the National Executive that *In Good Hands* forms part of government policy on clinical leadership. The Association has been actively promoting it in various ways including in the Joint Consultation Committees, the National Consultation Committee, the joint ASMS-DHB engagement workshops, and in 'The Specialist'.

Subsequently the Minister wrote to all 21 DHBs enquiring about their implementation of the *In Good Hands* report although only 18 replied. In its analysis of the responses the Ministry of Health identified gaps including:

1. Lack of planning for reporting on clinical outcomes or clinical effectiveness.
2. Lack of planning on how to report on the establishment and effectiveness of clinical leadership.

It was interesting that in its reply to the Minister, Bay of Plenty DHB alleged that historical agreements such as the "ASMS MECA are a barrier to change." It claimed that whereas the focus on the MECA is promoted as being quality, it is "often used for the protection of rights" and it rewards "inputs" rather than "outputs or outcomes'!

On 23 June the National President and Executive Director had a very productive meeting with the Minister largely focussed on the implementation of the *In Good Hands* policy statement. Following this meeting Mr Ryall set up a group to advise him on reporting guidelines on clinical leadership in DHBs (which we had recommended to him). The group included National President Jeff Brown. Its work has been completed and its advice presently with the Minister who has referred it to DHBs for feed-back.

Report of Ministerial Review Group on 'Quality and Performance in the Health System'

In January the Minister of Health established a Ministerial Review Group to report on quality and performance in the health system. It was headed by banker, Business Roundtable member, and former chief executive of The Treasury, Dr Murray Horn. The Group also comprised Chai Chuah (Hutt Valley DHB Chief Executive), Dr Virginia Hope (public health specialist and elected member, Capital & Coast DHB), Dr Tom Marshall (immediate past Chair of ProCare IPA), Dr Pim Allen (until recently Chief Medical Officer, Southland DHB), Hayden Wano (Hauora Taranaki PHO Chief Executive), Sally Webb (member of the former Health Funding Authority), and Stephen McKernan (Director-General of Health).

The Group's role was to:

- Assist the Minister and Ministry of Health by providing advice on further progressing the Government's priorities around clinical leadership, productivity and quality patient services.
- Review the existing systems for infrastructure and prioritisation and advise improvements.

- Help meet serious Vote Health financial challenges by providing a fresh examination of health sector spending with a view to identifying low priority/poor quality spending that can be moved to improve frontline health services.

The process and time frame of the Ministerial Review Group did not lend itself to effective consultation with the health sector in that there was no formal process for considering and making submissions and the deadline for the report was July. Nevertheless the Group did meet the National President for an informal discussion.

The Group's report went through several drafts which also involved discussion with the Minister of Health. The drafts reveal a number of issues that did not make it through to the final report probably because they were political unpalatable. These included certain private hospitals being designated "trial private hospitals" to test the premise that "hospitals be funded on the basis of convenience to the patient rather than DHB management" and be placed on a "level playing field" with public hospitals; primary care budget-holding for diagnostic services; and medical tourism where foreign nationals came to New Zealand and paid for elective services.

The Report's Proposed Solutions

The report's full title is 'Meeting the Challenge: Enhancing Sustainability and the Patient Consumer Experience within the Current Legislative Framework for Health and Disability Services in New Zealand' (also known as the Horn Report). It was presented to the Minister according to schedule who publicly released it on 16 August and allowed an opportunity of around six weeks for representations to be made. It included a main report but also five equally important annexes (essentially part of the report) and over 170 recommendations.

The Group was not unanimous in its conclusions and recommendations. Bearing some resemblance to the OECD Report published earlier in the year (discussed further below), it proposed what would have amounted to radical restructuring. In summary, this included:

1. A new national health board as a crown entity separate from the Ministry of Health to strategically plan and plan the funding of future capacity (eg, information technology, workforce, capital and facilities); fund national services presently funded by the Ministry of Health and services deemed to be national; monitor DHBs partly by requiring them to develop the top three or four productivity measures that are important to them; and arbitrate any dispute as to whether services should be national, regional or local. The NHB would also include a National Health Workforce Board, an Investment Committee, and a National Information Technology Board.
2. An independent crown entity, the National Quality Agency, to subsume the Quality Improvement Committee, report directly to the Minister of Health, and eventually become entirely funded from charges for its services.
3. Pharmac would take over a nominal budget for medical supplies and a new national agency would be established for the procurement of supplies not managed by Pharmac.
4. A new National Shared Service Agency to take over so-called back room functions of the DHBs (eg, payroll) and the national operations functions of the Ministry such as HealthPac.

The Report also promoted forms of privatisation of public hospital services, particularly in the shifting services to primary care, diagnostic services, the allocation of some elective funding to primary care organisations, and using the terminology of a 'level playing field' between private and public hospitals.

The Report's recommendations on clinical leadership were generally consistent with the *In Good Hands* policy statement.

Association's Response

The Association's approach can be broadly summarised as:

- Generally supportive of the functions recommended but not of the structures, with specific reference to the National Health Board. Instead we argued that the NHB should be part of the Ministry of Health.
- Supportive of the culture of clinical leadership.
- Concerned about the promotion of privatisation in the Report.
- Concerned about the impact of the Report's recommendation of fewer larger Primary Health Organisations on those 'access' PHOs covering the most deprived populations and where most of the Association's general practitioner membership works.

The Association made two written representations to the Minister – the first provided a general assessment of the Report and the second (based on differentiating function, culture and structure) focussed on the recommendations. In the second letter we included the following comments:

The National Executive believes that the Report should be considered from three angles:

1. *Culture – we support the culture of the Report strongly endorsing clinical leadership embedded at all levels, not just positions of formal leadership.*
2. *Functions – the functions recommended in the Report have broad support from us.*
3. *Structures – we strongly believe that some key structural changes recommended by the Report undermine the achievability of the proposed functions, would weaken rather than strengthen of the culture of embedded clinical leadership, and would have unintended risks for the government and the health system.*

The real change that the New Zealand public health system needs, a change you have clearly articulated and we have embraced enthusiastically, is change away from a culture of managerialism to a culture of clinical leadership. Operationalising clinical leadership at national and regional level is achieved, in part, by establishing health professional led clinical networks. You have clearly articulated both before and after last year's general election your support for this approach. This required change is challenging and is causing some discomfort in DHBs, in the Ministry and in other sectors. A change in culture is hard. It will be hard to make the change and hard to make the change stick but once embedded it will, we believe, deliver results in the form of better and more cost effective healthcare for New Zealanders. The National Executive supports you in these efforts. The risk, however, is that restructuring proposed by the Report could cause diversion from these efforts and in doing so allow the culture of managerialism to reassert itself in new bureaucracy and new transactions.

The National Executive is entirely in accord with the view, expressed in the Report, that it is high time to place long-term planning and coordinated national delivery at the core of our public health system. This needs to happen quickly and with minimal disruption. However they believe that the functions needed for this planning and coordination should be the foundation for any change in structure. Structure should follow function, not the other way round. Any change in structure should only be contemplated if the new structure is highly likely to deliver better than existing structures. Suggestions of modest benefit are not sufficient justification, given that a change in structure inevitably creates costs and disruption and shifts the focus to the process of restructuring itself rather than the urgent work that needs to be done.

There is no point in centralising many functions unless they are performed in a pervasive culture of clinical leadership. For example, we believe that nationally available patient-centred clinical records should be driven by models of care and a shared view between clinicians both at primary and secondary level of how patient care should be delivered.

The National Executive carefully analysed how changes should occur, starting from the function that needs to be performed rather than starting from the structure that might or might not be needed to perform it.

The functions that should be done centrally are: procurement (of medical devices, pharmaceuticals and other supplies), information technology, capital accumulation and building, workforce planning (including clinical training), the setting of quality standards, the funding of small volume services, support for autonomous national clinical networks with authority to act operationally, public health, population health and national screening systems.

In our view this work should and could be done by an active and empowered Ministry of Health. We have shared the sector-wide concern about the Ministry which, at times, seems to speak a language of its own and is too removed from what is happening close to the point of service organisation, provision and delivery. We believe that this culture can be changed and that there is evidence of improvement in recent times.

The Ministry is more equipped to perform the functions proposed for the National Health Board that the proposed board would be. Rather than creating a new bureaucratic structure with some current Ministry functions along with the new ones recommended by the Report, it would be more practical and much less disruptive to empower the Ministry to undertake these new functions and internally re-organise its directorates to enable this to happen.

For all the criticisms that can legitimately be made of Ministry performance over the years, it has to be recognised that much of what the Ministry does, and does not, is determined by government policy decisions. The government of the day determined that its role should be largely regulatory and policy advice in the 1990s, the government of the day determined that it assume the functions of the disbanded Health Funding Authority, and the government of the day determined that it not (nor anyone else) provide the new leadership functions subsequently recommended for the National Health Board.

The Association campaigned vigorously within this context including the forwarding of eight electronic 'Parliamentary Briefings' to all MPs covering various concerns and direct parliamentary lobbying. We were the only medical organisation take this approach although it was shared by the health unions affiliated to the Council of Trade Unions.

The Association's advocacy proved successful in that the Government has announced that the National Health Board will be based within the Ministry of Health. We hope that this has considerably lessened the disruptive effects that the original recommended restructuring would have generated.

Health Workforce: Establishment of Clinical Training Agency Board

On 6 August the Minister of Health released a report from a ministerial taskforce chaired by Professor Des Gorman which reviewed how the training of the health workforce is planned and funded. It included a proposal to reconfigure the Clinical Training Agency. It found that New Zealand had significant problems in recruiting, training and retaining an adequate health and disability service workforce and that these problems were likely to worsen. The report acknowledged that the workforce situation was in crisis and noted that "career choice distortion" arises because of remuneration anomalies within New Zealand and between Australia and New Zealand, and student debt.

It recommended the establishment of a single agency to fund or direct the funding for the training of all health and disability employees, along with planning and monitoring their training. It wanted the agency to eventually become a crown entity separate from the Ministry of Health. Also recommended were permanent reference groups for medicine and nursing, and as needed for other parts of the workforce.

On the same day Mr Ryall announced the formation of a new national health workforce training board, currently called the Clinical Training Agency Board (CTAB) with Professor Gorman its chair. The full board has subsequently been appointed and is presently located in the new National Health Board as part of the Ministry of Health. The Ministerial Review Group had recommended that this group form part of the NHB. Although no decision has yet been made

this suggests it is more likely that the CTAB will remain where it is rather than become a separate crown entity. The CTAB also subsumes the Clinical Training Agency.

The National Executive has been broadly supportive of the formation of the CTAB although has not adopted a view on whether it should be an arms length separate crown entity or part of the Ministry of Health as it presently is. In our advice to the Minister of Health on the Ministerial Review Group report, we recommended that this matter be further debated.

The Executive Director has already had an encouraging informal meeting with Professor Gorman who expressed interest in the CTAB working closely with the Association which he considers to be a key player in workforce development.

Minister of Health's Letter of Expectations

On 19 February the Minister of Health sent his annual Letter of Expectations to the 21 DHB Chairs for the 2009-10 year. It is the primary mechanism for a Health Minister to proactively set out expectations for all DHBs in contrast to reacting to annual or five year plans from the DHBs. Mr Ryall's Letter was shorter than previous Letters, provided limited explanation in some areas, and is a key part of his endeavours to stamp the new direction he wants to see DHBs take.

It features included:

- Requiring a focus on hospital services this year. In principle this was welcomed by the National Executive given the previous lack of emphasis on public hospitals despite an extensive hospital rebuilding programme and new initiatives. Singled out were increasing elective volumes and reducing waiting times; reducing waiting times for cancer treatments; and reducing waiting times for discharges and in-hospital admissions from emergency department (subsequently known as the six hour target).
- Transferring some secondary services to the primary care sector but at no cost to patients in 2010/2011. This has been subsequently rebranded by the government as 'devolution' (discussed elsewhere).
- Establishment of multi-disciplinary 'Integrated Family Care Centres' in 2010/2011 which appear to have some similarity with the proposed polyclinics in England (a mix of primary care and 'lower level' secondary care).
- Improving the retention of frontline clinical staff by developing cultures that value frontline clinical staff and promote trust and demonstrate this by increased retention, genuinely reduced vacancy rates and greater staff satisfaction.
- Actively fostering a culture of clinical leadership, including the support of clinical networks and regional co-operation (this was followed up by *In Good Hands*).

Clinical Networks

In September the Minister of Health approached the Association for advice on a report he had received on the development of clinical networks in New Zealand. In our response we observed:

- In Australia, Scotland and New Zealand clinical networks with strong clinical leadership have demonstrated the ability to improve clinical outcomes with better access to appropriate care, more efficient use of resources, and more engaged patients and clinicians. Unfortunately the networks in New Zealand have been few and late.
- Unfortunately the Ministry paper failed to recognise that fundamentally clinical networks are the delivery of health care, not some temporary administrative process.
- The paper correctly identified that clinical networks can strengthen vulnerable services, improve regional and national service integration, and support resource allocation fairly. The most valuable section is an outline of key components of clinical networks. Supporting and strengthening these components should be core Ministry business.

- The paper was coy in its failure to mention that the Ministry's efforts have been marginal and minimal for over a decade despite clinicians clamouring for them such as paediatric tertiary services, and the Association's own representations.
- While agreeing with the Ministry's advice that a consistent, targeted and coordinated approach to clinical network development is required, we disagreed with their assertion that extensive work is required before any further clinical networks are supported. We noted that many 'informal' networks now exist across DHB boundaries where health professionals have responded to exigencies of staffing or resourcing. These may well just need formal support and strengthening of integrated management. Other networks have been proposed after extensive multi-disciplinary efforts from clinicians (eg, Paediatric Society) and need coordinated national support.
- Mandated networks will be required to address areas identified as nationally vulnerable, but these will need to be many more than the current limited few.
- We rejected the Ministry's advice that clinical networks are not directly responsible for service delivery. Service planning, development of standards, working for equity of access, development of referral pathways, and advising on workforce development are all valid network responsibilities. But all these stem from the actual delivery of services by clinicians, supported by managers. When those (clinicians) leading the networks are the clinicians delivering the care, the leadership will be truly distributive and the network will be robust and sustainable.
- The need is for coordinated and strong managerial support for the clinicians to develop blueprints into agreements and guidelines. This support may be best provided centrally (such as from the Ministry) or from a lead DHB providing the majority of the service. Either way the network is the important thing. As networks mature they will become self evidently the best clinical practice, and the funding models will need to be flexible enough to reflect this best practice.

Although we have not received a formal response to our representation to the Minister, informal observations from the Ministry of Health at the last National Consultation Committee suggest that our comments have been taken on board, particular in reference to clinical networks and service delivery.

Government Policy on Devolution of Secondary Care Services to Primary Care

This is a rather arbitrary policy of the government first announced through the Minister of Health's Letter of Expectations to DHBs earlier this year. Initially DHBs were supposed to be responsible for this and were given funding (around $6 million nationally) to support this work. However, the Minister subsequently revised his plans by withdrawing the funding and instead formally calling for 'Expressions of Interest' from the primary care sector for proposals in this area.

His argument was that primary care organisations were claiming they had good ideas for improving the health system which were not being heard and consequently this was his way of providing them with the opportunity. One of the consequences, however, was to marginalise DHBs from the process even though it might be the services they currently provide and their funding that might be affected. Some primary care organisations making proposals opted to consult with their DHB while others did not. The Minister of Health expects about 30% of the population to be covered by this policy although what this means is unclear.

'Expressions of Interest' were due by 14 October with successful applicants advised by 4 November. These (nine in total) have been announced by Mr Ryall on 4 November. He described them in the following words:

Canterbury Clinical Network *- a consortium of PHC providers covering half a million people. The proposal focuses on evolving general practice into IFHCs, developing the wider team of primary health care professionals and improving cooperation between primary and secondary care.*

Greater Auckland Integrated Health Network *- a consortium of 274 general practice teams, 11 PHOs and 3 DHBs delivering primary health care to a million Aucklanders. The consortium is committed to working together to achieve better health outcomes, better patient experience and better use of money, establishing up to 12 IFHCs over the next three years.*

Health+ Alliance PHO *– three Pacific PHOs providing primary care services at 17 clinics. The proposal highlights new opportunities for Pacific primary care to better coordinate its services and workforce regionally and to build critical mass for the Pacific sector, including three IFHCs.*

Kawerau PHO *- All 3 PHOs in the Eastern Bay of Plenty, merging into one PHO. They propose one Integrated Family Health Centre in Whakatane within the next three years and two smaller Whanau Ora Centres in Opotiki and Kawerau.*

MidCentral PHOs *- all four MidCentral PHOs (Otaki, Horowhenua, Manawatu and Tararua). They propose five Integrated Family Health Centres (IFHCs), collaboration across health and social organisations, mainstream and Iwi providers, more clinical leadership, management of long term conditions, focus on care of the elderly, care of the young and care of those with mental health issues.*

Midland Network *- 11 providers from Taranaki, Waikato, Tairawhiti and Lakes districts which cover an enrolled regional population of around half a million people. The proposal identifies consolidating $66 million worth of services that are currently purchased and managed by four of the Midland region's DHBs and their provider arms that could be devolved into the community. Also developing 9 IFHCs.*

National Maori PHO Coalition *- 11 PHOs from around the North Island. The proposal aims to devolve services and government-held resources to Maori communities. The Coalition aims to develop a national network of Whānau Ora models of care including IFHCs, new care pathways, health and social service integration.*

Wairarapa Community PHO *- A partnership of Wairarapa organisations, including the seven GP practices, the primary health care nurses group, Wairarapa Hospital clinicians and iwi providers. It is clinically led, and aims to establish the Wairarapa Integrated Family Health Model of care as an integrated health system for Wairarapa people.*

West Coast PHO *- The proposal is centred around Integrated Family Health Centres, workforce retention and devolution of suitable hospital based/DHB owned services. The proposal aims to build on existing initiatives including: nurse-led clinics; the PHO Long Term Conditions programme; rural/generalist and rural immersion programmes for Doctors; Clinical and Rural Nurse Specialists.*

These selected organisations are now required to develop a detailed business case, including costings, and a development pathway by 15 February 2010. Evaluation of these business cases is to be completed by 28 February. Those that meet the standard would move into contract negotiations while others will be invited to re-submit. The whole process, including approval of business cases and signing of contracts is required by government to be completed in May 2010.

For the first time DHBs are now to become directly involved. Their agreement on the business plans will be required. This creates some major difficulties. DHBs will be forced to consider proposals developed by external bodies which, in some cases, they had no or minimal involvement in. Further, the expectations, time frame (14 February) and time of the year make it impractical to genuinely apply the requirements for clinical leadership according to the tenor of the *Time for Quality* agreement and *In Good Hands* except where there has already been a high robust level of engagement with secondary care health professionals in the development of the proposals (as appears to be the case with some).

Recently this has become a matter of discussion in the Joint Consultation Committees. The approach taken by the Association in these and other discussions is that there should be three key

thresholds – clinical appropriateness; fiscal sustainability; and avoiding fragmentation and disintegration and its consequences (eg, on teaching).

The Association has also raised more general concerns in reference to:

- Confusion over what new developments in general practice can be charged to patients and what can't (things arising out of the evolving nature of general practice can be charged to patients but things arising out of this political initiative can't).
- Possible budget-holding thereby given more entrepreneur primary care business interests fiscal leverage over the DHB (including where DHBs lose funding but retain costs).

In the main most of the proposals appear laudable in intent. However, the Midland proposal raises serious concerns with the desire of an independent practitioners association to control around $66 million of secondary care funding. This is likely to be very contentious. Further, these proposals have been described as the first wave suggesting more waves are coming. It is possible that this issue may emerge as a key issue for the Association next year.

In the meantime the Independent Practitioners Association Council (IPAC) has approached the Association for discussion on the devolution issue although IPAC prefers to call it 'integrated care'. There have already been informal discussions with the Executive Director and a group from the National Executive will meet the IPAC executive later this month.

Health Funding In the 2010/2011 Financial Year and Beyond

The Treasury has given presentations to the Tripartite Steering Group and to Council of Trade Union meetings on the government's planned spending in the next financial (and, by implication) out years. This started off with statements in the last budget that, while the new government would maintain health spending at $750 million new spending in this financial year, the sector could expect a much tighter approach in the next financial year when all new spending would be limited to $1.1 billion. Vote Health could accordingly expect a decrease in new spending from the $750 million spending that it has received over the last few budgets. Figures for what will be allocated to health in the next budget are now ranging from $500 million to as low as $200 million in a clear effort to decrease expectations most especially for the next collective agreement negotiations.

The Ministry of Health analysis suggests that for some years health costs have increased by 6% a year while the future funding track has delivered slightly in excess of 3% each year. For some DHBs the difference has been delivered by the demographic adjustor. The shortfall has been made up through funding various special initiatives or debt. Consensus forecast suggest that the CPI movement in 2009/10 and 2010/11 will be just under 2%. Costs in the health sector are made up to a large degree of wages and it is clear that the government believes that it is within its power to keep these increases close to zero and limit new spending as a result.

Commission on Competitive and Sustainable Terms and Conditions of Employment for Senior Medical and Dental Officers

The achievement of the SMO Commission was a major feature of our national DHB MECA negotiations and was critical to membership ratification. It became our major priority since the conclusion of the MECA settlement. The three Commissioners were Chair Len Cook (Chair of the Medical Training Board and former New Zealand Government Statistician and United Kingdom Deputy Government Statistician), Ross Wilson (then Chair of ACC and board member of Kiwi Rail, and former President of the Council of Trade Unions), and Dwayne Crombie (former Chief Executive of Waitemata DHB). The report was due to be completed by 31 March 2009 but with the consent of the Association and the DHBs this was extended to 30 June.

Our overall work was coordinated by the Assistant Executive Director working closely with the Executive Director. In preparation the Association engaged the services of experienced health

researcher Lyndon Keene who was largely responsible for the Association's submission to the Commission titled 'Repairing the Leaky Bucket'. This submission was also made available to members and received much positive feed-back. Further, the Industrial Officers undertook job vacancy surveys in Northland, Waikato, Bay of Plenty, Tairawhiti, Lakes, Taranaki, MidCentral and Southland DHBs which formed part of our submission. It also included comparisons with Australian collective agreements and packages.

The National Executive met Commission Chair Len Cook on two occasions. Further, the Executive Director and Assistant Executive Director attended some of the meetings the Commission held with senior medical and dental officers in a selected number of DHBs.

Although it was supposed to be a report to the three parties responsible for establishing the Commission (Minister of Health, the 21 DHBs and the Association), in practice it became a report to the Minister who insisted on receiving it about two weeks before the revised deadline and was only, after some persuasion, given to the other two parties the day before its release.

The National Executive was disappointed with the report. As a generalisation it:

- Usefully describes the 'push' factors, particularly disengagement.
- Was deficient on the 'pull factors', largely due to its failure to appreciate the significance of the senior medical workforce crisis in DHBs and that DHBs are operating and competing in an Australian medical labour market (and to understand what this market is). It also accepted too uncritically DHB provided information.
- Was significantly and unduly influenced by the economic recession which were outside its terms of reference.

Consequently, at its meeting on 22-23 July the National Executive adopted the following resolution:

> *That, while encouraged by a number of the recommendations of the Senior Medical Officers Commission, the Association is disappointed that it did not fulfil its terms of reference with regards to a sustainable pathway to competitive terms and conditions of employment for senior medical and dental officers.*

The National Executive resolved to make a formal response to the Commission's report for the record even though the Commission is no longer in existence. Lyndon Keene was engaged to draft this which will be published in the form of a *Health Dialogue*. This is expected to be available for Annual Conference. It was forwarded in draft form to the three commissioners for comment and two took up this opportunity. Their observations have been taken into account. The failure of the Commission to fulfil its terms of reference has meant that the Association will need now to undertake this work as part of our preparation for the forthcoming MECA negotiations (discussed below).

Preparation for the next National DHB MECA negotiations

In the 2008 Annual Report the National Executive extensively reported on the settlement of the national DHB MECA. As part of preparation for the next negotiations (the current MECA expires on 30 April 2010) the Executive adopted the following resolution at its two day meeting in July:

> *That the Association promotes the right of equal access for all New Zealanders to high quality public health services. Both access and quality are threatened by the medical workforce crisis in our district health boards. Critical to resolving this crisis are:*
>
> *(a) a clear pathway to competitive terms and conditions of employment for senior doctors and dentists;*
>
> *(b) recognition that district health boards are competing in an Australian medical labour market; and*
>
> (c) *recognition that the Government is responsible for resolving the crisis.*

The Executive also decided to undertake the following pieces of work as part of our preparation:

1. Engage additional resource to investigate the loss of New Zealand trained senior registrars to Australia in order to take up their first specialist appointments. We have engaged Lyndon Keene and this work is currently underway.
2. Analysing future medical specialist workforce trends in Australia in light of enhanced terms and conditions of employment, increased medical intakes, and increased number of medical schools, with respect to time frames and projected capacity. We have received useful insights and material from the Australian Medical Workforce although the latter has yet to be analysed.
3. Collecting data on resignations in order to work in Australia for the 2009 calendar year based on membership data and Association 'exit interviews' along with a possible membership electronic survey similar to that conducted in 2007.
4. Locum (including internal locum cover) costs. This work is underway with a survey sent to 235 clinical directors or equivalent.
5. Seeking initial public relations advice. This has occurred with a meeting with Cabix which to whom we contracted for public relations advice over our stopwork meetings. The core of their advice was to keep the focus on New Zealand's medical workforce crisis.
6. Investigate the fiscal attraction of salary sacrifice in Australia. This work is underway and is also covered in the *Health Dialogue* on the SMO Commission's report. We are grateful for the assistance of the Australian Medical Association and Australian Salaried Medical Officers Federation.
7. Locating statements by the government Minister of Health and the Prime Minister on the medical workforce crisis in New Zealand including when in opposition.
8. Working on projections on the future specialist medical workforce required to meet New Zealand's needs.

Possible 'central pay settlement' deal

Arising out of the Tripartite process involving the Ministry of Health on behalf of government, the 21 DHBs and the CTU health unions, the parties have embarked upon a process to see whether some form of 'central deal' of the various collective agreements might be possible. Discussions are presently underway with the unions involved being the NZ Nurses Organisation, Public Service Association, and Food and Service Workers Union. The expectation that there will be a 'small' pay increase; what 'small' means is not clear other than it will not exceed 2% for 12 month (ie, arbitrated outcome for the police).

The Association has consciously stood aside from this process because of the distinct nature of the medical workforce crisis in DHBs, because the recession has not affected recruitment and retention pressures, and because we are in a highly competitive Australian labour market. However, we are not opposed to the other unions achieving a 'central deal' for their members if they wish. Those involved have an aspiration on concluding a provisional agreement by late November which would then be taken to government for consideration. While they would have preferred that the Association was part of the proposed 'central deal' the DHBs have readily accepted this was not the case and there have been indications of interest in the National Executive's emphasis on 'pathway' in the context of Australian terms and conditions.

Continuing Medical Education Guidelines

Part of the last MECA settlement was the obligation by the parties to attempt to reach agreement over guidelines for continuing medical education. A working group was established with the Association represented by the Senior Industrial Officer, National Executive member Judy Bent, and Derek Snelling (a member of our MECA negotiating team). However, the consensus of the working group was that the outstanding problems relating to the application and interpretation of continuing medical education MECA provisions were now relatively uncommon largely because most issues had been resolved by agreement and common sense. It was agreed that should a new

issue or local dispute occur, the parties should deal with them locally having regard to the principles of the MECA and interpretations and practices that have been agreed elsewhere.

National Consultation Committee

The National Consultation Committee (NCC) is a creation of the second (current) 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. Two meetings were held in 2008 and four meetings this year – 4 March, 12 May, 12 August and 10 November. Further meetings have been scheduled for 2009.

In last year's Annual Report we observed that there had been a significant improvement in the conduct of the DHBs towards the Association at a national level. This has continued in the NCC. The DHBs' team comprises Garry Smith (Chair of the national chief executives' group and Auckland chief executive), David Meates (Canterbury chief executive), 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). The Ministry of Health has attended for a session in three of the four meetings.

The issues discussed to date include:

1. Medical workforce data. This information has been provided by the Health Workforce Information Programme (HWIP) based in DHBNZ. Our last national MECA negotiations exposed the serious limitations of this data when discussing the extent of specialist shortages. Arising out of this discussion it has been agreed that Warrick Frater and Joy Farley would draw upon their practical experience and develop a new format for data collection reporting to the NCC. Work on this is underway.
2. The *Time for Quality* agreement and clinical leadership.
3. The Association used the NCC to feed through some practical problems with the original time frames for the Professor Des Gorman 'road show' visits to the 21 DHBs.
4. The frustration of the continuing failure to reliably measure productivity.
5. The *In Good Hands* report on clinical leadership.
6. Government policy on devolution of secondary services to primary care including the 'Expressions of Interest' process for primary care providers.
7. Ministry of Health work on clinical networks.
8. A national patient management information system.
9. The Ministry of Health's workforce work.
10. Looking to develop an agreement for possible inclusion in the next national DHB MECA on arrangements and facilities when one has to stay overnight at another workplace in either the same DHB or another as part of a regional service or clinical network.

While the discussions have generally been good and positive, neither the Association nor the DHBs are maximising the NCC's potential. There is consensus that the NCC needs to be more outcome focussed. To assist this the terms of reference will be revisited with a view to greater relevance.

In 2008 the NCC 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. However, we have been advised that the chief medical advisers group is no longer focussed on this issue.

Tripartite Process: Health Sector Relationship Agreement

Four meetings of the Tripartite Steering Group have been held to date along (a fifth meeting is to be held on 8 December) with a special meeting on collective bargaining. The participants are the Ministry of Health, all 21 DHBs, and each of the CTU affiliated health unions including the Association; all are signatories to the Health Sector Relationship Agreement. The Executive Director has represented the Association at all meetings (the Assistant Executive Director also attended the special meeting in collective bargaining on 28 September to discuss a possible 'central deal' for the collective agreements negotiated by the CTU health unions discussed further above).

The Steering Group meetings have generally been constructive and have gone a long way to improve relations, communication and engagement at a national level between key unions, the DHBs and the Ministry of Health.

Examples of the issues discussed to date are:

- Briefings from The Treasury on the state of the economy.
- The Government's primary care initiatives including 'devolution' and the 'Expressions of Interest' process.
- The new national health workforce group, Clinical Training Agency Board.
- Project work on 'productive engagement' in DHBs.
- The six hour target for emergency departments.
- Involving local DHB-union consultation mechanisms in District Annual Plan planning.

There was an awkward debate on developing an agreed statement on government priorities for the health sector including baseline funding limits. The Association believed that the draft was too close to the government's position and could be used against us in next year's MECA negotiations. Although not satisfactory the draft was amended in order to avoid this. There are positive proactive reasons for the Association to participate in the Tripartite Steering Group but this instance also provided an example of the need for us to be there to protect our interests.

Activity in the Non-DHB Sector

This year saw the wrap up of the 2006 wage round with the settlement of the last remaining collective agreement based on the MECA, the collective covering doctors at Oamaru Hospital. The delay was because of difficulties getting funding from Otago DHB. In previous years most of the negotiations were done by Assistant Executive Director, Angela Belich. This year the bulk of the negotiations were done by Industrial Officers Lyn Hughes and Lloyd Woods as the heavier policy workload that came with the election of a new government began to bite.

Two collectives agreements covering GPs in Auckland (West Fono Health and Ngati Whaatua Health) expired and were not renewed because we did not have two members (the minimum for a collective). A further practice (Waitakere) which is covered by the same collective as the Otara Community Health Centre has no members. We have difficulty recruiting because of high numbers of contractors of one sort or another who are uninterested in conditions and move in search of high pay. Our remaining GP collective agreement in Auckland (covering doctors employed at the Otara Union and Community Health Service) is proving difficult to renew as the employer is in extreme financial difficulty and is threatening to close the centre unless we agree to claw backs in the doctors' conditions.

Activity on individual cases in the non-DHB sector is dealt with in other sections of the report.

Employer	*Membership*	*About the Collective*
NATIONAL HEALTH SERVICES		
ACC	19 members	No collective as yet
New Zealand Family Planning	26 members 11 potential	The Agreement was renegotiated in November and should be ratified in early December with expiry in November 2011. Salary increase 6% for two years.
NZ Blood Service (NZBS)	8 members 3 potential	Expires 30 June 2010. New availability allowance clause negotiated on same terms as MECA for ADHB.
HOSPICES		
Hospices MECA	35 members 11 potential	Expires 30 June 2010. Membership includes 1 from Marlborough Hospice and 1 from Otago Hospice, both of whom are not included in the collective.
RURAL HOSPITALS		
Oamaru Hospital (Waitaki Health Services)	3 members 3 potential	Expires 31 August 2010. The settlement of this collective in June meant that the 2006 pay round was finally concluded.
Dunstan Hospital (Central Otago Health Services Ltd)	7 members 1 potential	Expires 30 June 2010. The previous collective was varied in order to accommodate the same lump sum payment as the MECA and a new collective negotiated to mirror other elements of the MECA.
UNION HEALTH CENTRES		
Waitakere and Otara Union Health Centres	4 members	Expired 30 June 2009. Currently under negotiation.
Wellington Primary Health Care Services MUCA	21 members 4 potential	Expires 30 June 2010.
Union & Community Health Centre (Christchurch)	5 members	Expires 30 June 2010.
IWI AUTHORITIES		
Ngati Porou Hauora	10 members 3 potential	Expires 31 January 2010. The new collective agreement has been agreed based on the MECA. The agreement has a slightly truncated version of the MECA specialists scale and a scale for non-vocationally registered GPs that is better than the MECA (bottom step ($119,565 top step $164,000 as at 1 July 2009), CME expenses of $8,000 a year and 6 weeks annual leave after 5 years service.
Te Oranganui Trust (Inc.) Wanganui	3 members 1 potential	Expires 31 December 2009.
Te Runanga O Toa Rangatira (Ora Toa)	9 members 6 potential	The collective agreement was successfully negotiated and ratified and expires 30 June 2011. Salary increase 3.5% for 2009 and the 'Future Funding Track' increase for 2010.
OTHER		
Hokianga Health Enterprise Trust	6 members 2 potential	Expires 30 June 2010
Q E Hospital Limited (Rotorua)	3 members 1 potential	The collective agreement was successfully negotiated and ratified in November 2009. Salary increases of 2.5% for 2009 and a further 2.5% for 2010 plus increased CME to DHB MECA levels were main gains.
Compass Health – Sexual Health Service (formerly WIPA)	5 members	The collective agreement was successfully negotiated and ratified and expires on 30 June 2010. The salary scales replicate those in the MECA. CME expenses increase to $12,000 from January 2008 and $16,000 from January 2009. Superannuation employer subsidy of 4% in 2008, 5% in 2009 and 6% in 2010. New provision for paid leave to meet professional obligations, occasional teaching and examination requests. An improved locum cover provision was also agreed.

Rural Hospital Generalists

This year saw the beginnings of the impact of the new vocational branch of rural hospital medicine (under the auspices of the Royal New Zealand College of General Practitioners). Most of the new fellows are Association members either employed at DHBs or non-DHB rural hospitals where we have collectives in force. This meant that those members who are presently on the medical officer scale have to be placed appropriately on the specialist scale. The first group to experience this transition were our members at Dunstan (non-DHB employer). A transition mechanism was negotiated into their collective. This formula is rather better than that hitherto had been used in the DHBs which has been to the salary step with the next highest dollar amount. We are making an effort to spread this translation to the medical officer scale in the small DHB hospitals.

Industrial Team's Activities

In the course of the year covered by this report, Industrial Officer Sue Shone completed her law degree and the legal professionals' program and resigned to embark on a legal career. Fortunately we were able to quickly replace her with Lloyd Woods, who is an experienced senior union official and former President of the Association of Staff in Tertiary Education (ASTE). With his background in the tertiary education sector, he has fitted in very quickly and well. The four members of the Industrial team are: Angela Belich (Assistant Executive Director), Henry Stubbs (Senior Industrial Officer), and Industrial Officers Lyn Hughes and Lloyd Woods.

A Difficult Climate to Work In

The national political and economic scene have both contributed to the difficulties members face on a day to day basis and made it more difficult to resolve many of the underlying problems, in particular: staff shortages; senior medical staff recruitment difficulties in the face of and contributing to increasing clinical workloads. Undoubtedly these particular problems have also contributed to workplace tensions and relationship difficulties that have resulted in a number of members requiring time off to deal with anxiety, stress and other health-related disorders.

Advice to New Appointees

This continues to be a small but important part of the Industrial Officers' work. Despite the difficulty in filling vacant positions and the significant discrepancy between "unbudgeted" positions and the FTEs identified by job sizing as being required to meet the clinical needs of the service, we are disturbed by the attempts of some DHBs, particularly those in Auckland, to hold starting salaries down and cap the level of relocation assistance offered to new appointees. There is little room to negotiate and prospective employees are frequently faced with the "take it or leave it" option.

Complaints of Bullying and Harassment

Possibly because of the pressures the health service is under and the aging medical workforce, there seems to be an increase in the number of members complaining of bullying or harassment or finding themselves the subject of complaints of bullying or harassment. There is no obvious pattern to these complaints other than that the complainant is in a subordinate position. The complaints may be "doctor on doctor", "doctor on RMO", "doctor on nurse or other health professional", "manager on doctor" and even "doctor on manager".

Invariably emotions run very high in these situations, which can be very difficult to investigate and resolve; there is usually a high level of denial on the part of the complainant and occasionally a naïve simplicity on the part of the complainants, who are not accustomed to having their work or personality traits challenged or criticised.

Perhaps most worryingly, the complainant is often poorly advised or has sought no advice before making their complaint. Invariably they have no sense of how the matter might be resolved without further straining the relationship between complainant and "victim".

Clinical Leadership under Pressure

We have been disturbed by the number of clinical directors who have come under pressure from their managers (two instances) or their colleagues (two instances) to stand down from their clinical director roles. In the former cases, the senior managers have challenged the clinical directors' performance, which is code for saying they are fed up with the clinical directors' strong advocacy of their service and constant reminders of the need for more staff or other resources. In the latter cases, the pressure on clinical directors has come from their colleagues and reflects longstanding and unresolved antagonisms and relationship issues.

The Association's line has long been that clinical leadership is ineffective without the support and confidence of at least the majority of the senior medical staff in the service. We have also argued that there should be good respectful working relationships between clinical leaders and their senior managers; however that does not mean that clinical directors must display subservience to their manager.

Rehabilitation and Return to Work Plans

In the course of the year at least ten members have had prolonged periods off work because of illness, including anxiety and stress. These cases have all required a combination of sensitive support for the affected member and firm negotiation with the employer over rehabilitation and return to work plans. In some cases there was no return to work for the member, who chose to leave the service and DHB.

Discipline

A small number of members found themselves "suspended" in one form or another during the year following concerns about their behaviour or clinical performance. The Association's approach in all these cases is to endeavour to secure a return work as soon as possible to avoid damage to reputation and professional reputation. We are also very conscious of the need to protect the public and to minimise risk of possible patient harm. To this end, a number of investigations of clinical practice under the MECA (Clause 42) have been undertaken or are currently underway.

During the year one member was dismissed and one member agreed to resign, with no real prospect of a return to medical practice.

Support for Members in the Non-DHB Sector

The Association has supported six members from the non-DHB sector who encountered serious problems with their employer. Four members worked for Maori health providers; one in Family Planning, and one in ACC. We are pleased report that our Industrial Officers are becoming more involved in the non-DHB sector and gaining valuable experience while forming reasonable and increasingly effective working relationships with managers in these organisations. However, the ACC continues to be a very hard nosed employer characterised by an authoritarian management style that can be quite distressing for employees.

Job Size

Advice about job sizing continues to be an important part of the industrial team's work, and can be quite challenging when the outcome of the service job size discloses a significant shortage of clinicians, as is increasingly the case. This is a big problem in the Auckland DHBs where job

sizing in big departments, such as anaesthesia, medicine, radiology and mental health has identified or is likely to identify large SMO shortfalls.

It is pleasing to note however that many services and members are now regularly seeking our advice as they undertake service and individual job sizes. It is also very encouraging to note that many services have done a great deal of good work, based on the revised *Standpoint* (available on the ASMS website) before they seek our advice or endorsement of what they have done. Our involvement increasingly is limited to the negotiation phase with management and the development of strategies to deal with management intransigence or that will enable the service to manage until additional staff are approved and arrive.

Variations to the MECA

Two variations to the national DHB MECA have been agreed with the employers during the year. The first was to rectify an oversight and put the schedules relating to availability, car parking and long service leave at Northland DHB into the MECA. The second was the result of a negotiation over availability allowance at Nelson Marlborough DHB. This has been signed by the Association and Nelson Marlborough DHB but is still in the process of being signed by the other DHB chief executives. We have also recently reached agreement with Hawke's Bay DHB over intellectual property rights but the variation is expected to be made in conjunction with the next MECA negotiations.

Joint Consultation Committees (JCCs)

The DHB-ASMS Joint Consultation Committees (set up under Clause 55 of the DHB MECA) have continued in their fourth year of full operation. All JCCs have had, or are scheduled to have, at least three meeting by the end of this year. The Wairarapa JCC went into abeyance in 2008 but is now fully functioning again. Most JCCs have been attended by the Executive Director but in some cases, especially 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 increasingly 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.

Issues discussed in the JCCs have included:

- Organisation and follow-up on engagement workshops (discussed below).
- The Minister of Health's Letter of Expectations to DHBs.
- District Annual Plans.
- Government policy on (a) 'devolution' of secondary care to primary care and (b) six hour target for emergency departments.
- Development of clinical networks and regional services.
- Clinical leadership and clinician engagement including the application of *In Good Hands*.
- Job sizing.
- Engagement of senior medical and dental officers in reviews.
- Adequacy of DHB facilities, including practical measures to ensure compliance with the MECA.
- Information technology requirements and support.
- Provision of overnight workplace accommodation for senior medical and dental officers.

In addition there have been some specific successes such as agreement to establish a senior doctors' lounge (Northland); regular reporting of CME balances (Waitemata, Waikato and

MidCentral); review process for clinical governance structure (Waitemata); agreement over being more flexible over working at home arrangements (Auckland); clarification over the use of business class and the DHB's travel agency for CME travel (Counties Manukau); review of decision-making at Whakatane Hospital (Bay of Plenty); review of administrative support for senior medical staff (Bay of Plenty); agreement for the DHB to actively promote senior medical staff undertaking sabbatical (Taranaki); new policy on ownership of intellectual property rights (Hawke's Bay); guidelines where there is no cap on reimbursement of CME expenses (Wairarapa); correction of previous non-implementation of telephone allowance under the MECA (Wairarapa); revision of availability allowance (Nelson Marlborough); revising sabbatical application forms for consistency with the MECA (Canterbury); reviewing placement on the salary scale for more longstanding specialists (South Canterbury); and agreement about compliance with the MECA appointments clause in respect of the involvement of the Senior Medical Staff and its application to clinical leadership positions.

Joint ASMS-DHB Engagement Workshops

In the 2008 Annual Report we reported the successful holding of a half-day joint ASMS-management workshop on enhancing senior doctor engagement in Northland DHB. These workshops have now taken off. The next was held in Hawke's Bay soon after the 2008 Annual Conference.

This year workshops have been held in nearly every DHB, in particular, Northland (again), Waitemata (2), Bay of Plenty, Lakes, Tairawhiti, Hawke's Bay (again), Taranaki (2), Whanganui, MidCentral, Wairarapa, Hutt Valley, West Coast, Canterbury, South Canterbury, Otago and Southland. A workshop is also scheduled for Capital & Coast immediately prior to Conference. The Executive Director has attended almost all of these workshops (in his absence the Assistant Executive Director) along with, in most cases, one of the Industrial Officers. They have been largely very constructive and well attended. Workshops are also being planned for 2010. Only one DHB (Waikato) has expressed rejected holding a workshop.

The subject matter has been wide ranging depending on the challenges facing each particular DHB with the emphasis as much as possible on engaging senior medical and dental officers. They have included *In Good Hands*, clinical leadership (including structures and successful examples), service delivery improvements, regional services and planning, rebuilding programmes, quality improvement, government health spending, information technology, internal DHB decision-making processes, research, hospital benchmarking, and the primary care 'Expressions of Interest' process. A number also broke into small working groups while some also had open forums.

Surveying Full-Time DHB Senior Medical Staff Base Salaries

The Association has completed its 15th annual survey of full-time equivalent (FTE) salaries for DHB employed senior medical staff based on our negotiated collective agreements effective on 1 July 2008. The survey provides a helpful comparison of the salary gains that have been made since the commencement of local bargaining in 1993 through to the last two national negotiations. The comparison incorporates advancement through the salary scales and changes to the scales. This is the fourth survey undertaken since the implementation of the first national DHB MECA. The 16th survey (salaries as at 1 July 2009) is currently underway.

On 30 June 1993 the mean FTE specialist base rate was $85,658. By 1 July 2008 this had increased to $159,863 (a raw increase of about 86.6% since 1993). This represents a 10.2% increase on the 2007 mean. The mean female salary is $153,303 compared with the mean male salary of $162,782. Since 2005 the female-male salary gap has increased from $5,904 to $9,479.

For medical and dental officers the equivalent salary movement to 1 July 2008 was from $67,457 on 30 June 1993 to $125,061 (a raw increase of about 85.4%). This represents a 9.3% increase on the 2007 mean. The mean female salary is $122.582 compared with the mean male salary of $127.240.

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.

Surveying DHB Senior Medical Staff Superannuation Entitlements

We undertook our 8th survey of superannuation entitlements in DHBs, effective on 1 July 2008, which covers 3,165 senior medical staff receiving subsidised superannuation. The largest group receiving subsidised superannuation are the 2,518 members whose schemes are based on the MECA entitlement (compared with 1,926 in 2007). The next largest group, 479 (down through attrition from 522 in 2007), is in the former government and legislation-based superannuation schemes, National Provident Fund and Government Superannuation Fund (access for new entrants to these schemes was closed off in 1992). The balance of members in super schemes is covered by other subsidised arrangements.

Association Branches

Over the past year, beginning with its first meeting, the National Executive has considered the current state of Association branches. This consideration arose out of preceding discussion over the role of Association delegates on the Joint Consultation Committees in each of the 21 DHBs. While the Association has to one degree or another reasonably functioning groups of delegates on the JCCs, our branches do not conform to the requirements of the Constitution, particularly with reference to Clause 16. In part this is due to the role of our delegates on the JCC and in part due to the role of senior medical staff bodies which are almost completely comprised of Association members.

The National Executive is proposing more minimalist and practical obligations for branches consistent with the reality. A Conference discussion paper has been prepared to assist the discussion at Annual Conference. The envisaged time frame is:

1. Discussion on the Conference paper on the recommended principles at the 2009 Annual Conference.
2. Arising out of this discussion preparation of an amendment to the Constitution for consideration at the 2010 Annual Conference.

Resident Medical Officers Workforce Commission

On 6 August the Minister of Health released the report of the Resident Medical Officers Commission (RMO Commission) which was chaired by Don Hunn (a former State Services Commissioner), Angela Foulkes (member of the Remuneration Authority and former CTU Secretary), Professor Peter Crampton (Wellington Clinical School), and Professor Des Gorman (Auckland School of Medicine). Professor Gorman was a later addition to the Commission by the Minister. The interlocking membership of the RMO Commission and the Ministerial taskforce on the health workforce (discussed above) has meant that the recommendations were relatively congruent. The RMO Commission has focused on the employment of RMOs assuming training will be dealt with by the new Clinical Training Agency Board.

The main recommendation was that resident doctors should have a single employer while they are training. The RMO Commission considered four options - the status quo, a regional employment model, a stand alone national body, employment by the national training body - and favoured a stand alone national body as the employer.

In his media statement when releasing the report Mr Ryall described the newly announced Clinical Training Agency Board as answering the Commission's call for a single national training body. He did not, however, endorse (or reject) the recommendation for a single national

employer and said he was referring it to DHBs for comment. Although no decision has subsequently been made, the indications are that he is not attracted to it.

The RMO Commission report had a better focus on its terms of reference than the SMO Commission report and is buttressed by some very interesting background papers that were attached to the report as appendices. It notes that all of the medical workforce reports (including their own) of the last few years have been commissioned by one Minister of Health and reported to another which may be one cause of the patchy implementation of recommendations.

Of central importance is its recommendation for the subordination of service provision to training for RMOs and that DHBs ensure that senior medical officers have 'protected time' to train. It also notes that the optimal proportion of RMOs to SMOs is between 8-12% whereas at present it is 24% and is concerned about continuity of care adding to the pressures on senior medical officers. If this recommendation was actioned it will require the recruitment of additional senior medical officers.

Other points of interest were:

- Though it does not have a recommendation to this effect the Commission suggests strengthening the role of the 'medical officer' to "provide a better recognised career option for resident doctors who choose not to pursue vocational training".
- In contrast to the comments of the SMO Commission about senior medical and dental officers, the RMO Commission commented that "few [RMOs] were able to articulate a coherent set of values about the New Zealand public health system." They recommended the development and articulation of a New Zealand health system ethos.
- It recommended making permanent work more attractive than locum work as an aim for a collective agreement and recommended that locum work not be used to fulfil training requirements. They also are concerned about locums who are also employed by DHBs (up to 90% of RMO locums) working excessive hours and the effect of the locum market diverting RMOs from vocational training.
- It recommended that training opportunities in the primary health care sector are increased but also discussed increasing opportunities for training in the private sector while maintaining the public sector ethos.

Medical Council Elections

Last year the Pan Professional Medical Forum had managed to convince the then Minister of Health (David Cunliffe) of the need to restore the right of doctors to elect some positions to the Medical Council only for the initiative to fail at Cabinet. New Minister of Health, Tony Ryall, announced at our Annual Conference in 2008, immediately after receiving his ministerial warrant, his intention to restore the right to election. This undertaking was delivered by the promulgation of the Health Practitioners Competence Assurance (Election of Members of Medical Council of New Zealand) Regulations 2009 in March 2009.

Review of Health Practitioners Competence Assurance Act

The Health Practitioners Competence Assurance Act (HPCAA) includes a statutory obligation to undertake a review. Late in 2007 a review was initiated by the Ministry of Health. The Association's made a submission outlining the risk we believed the HPCAA posed for political and bureaucratic control. The Ministry held a round of workshops and promised a consultation document. Instead they unilaterally determined to report directly to the Minister of Health in February 2009. Along with other organisations the Association objected to this approach and the new Minister of Health (Tony Ryall) allowed a brief window for organisations to comment on the advice of the Ministry. A brief submission was sent welcoming the opportunity for feed back emphasising that the views of the profession concerned should be the main consideration when

deciding whether to have elected positions on an authority, that the impact on health services should not be used to tip authorities into admitting people to regulated professions who do not meet standards. Some changes in the HPCAA have been signalled as the result of the review but are not yet before Parliament.

Medical Council: Regulatory Reform

As part of its confidence and supply agreement with ACT the government agreed to a regulatory reform programme which was initially postulated to include:

- possible amendments to the HPCAA to clarify the powers of Authorities to prescribe individual scopes of practice;
- the use of Ministerial audit powers;
- options for increasing the speed of processing for applications for registration by overseas trained health practitioners; and
- carrying out a review of the registration practices for overseas trained health practitioners under the HPCAA.

The main target of this appears to have been the Medical Council. The Association had begun to work with the Pan Professional Medical Forum on the issue. While recognising the process of registration for international medical graduates, there was some disquiet that the DHBs were trying to address the medical workforce crisis by pressuring the Medical Council to define its role of protecting the health and safety of the public as ensuring that DHBs were fully staffed irrespective of the standard of applicant.

In the event, Cabinet decided not to proceed with the more draconian parts of the proposal and instead concentrate on looking at the Medical Council's speed and efficiency in processing applications. The National Executive discussed this issue with Medical Council Chair Professor John Campbell.

Medical Council: Consultation

Practice Visits

The Medical Council consulted the Association in early 2009 on the proposal for practice visits as a part of the colleges continuing professional development programme. The Association replied saying that we supported the concept so long as it was not mandatory for a college to do so, pointing out that any such visits would require extra resourcing and that we would be interested in any research that indicated that practice visits were effective at identifying underperformers.

The Association was asked for further feedback at the time of the Council 'Road Show' on this issue (and the new supervision framework for International Medical Graduates – IMGs). Disappointingly at this point it became clear that it was the Council's intention that practice visits be funded from our members CME expenses. These issues were discussed with Medical Council Chair Professor John Campbell and Chief Executive Phillip Pigou when they attended the National Executive meeting in July. At that meeting they agreed that the practice visits would not initially be compulsory and that evidence would be collected from those colleges that put them in place as to their effectiveness.

Supervision of International Medical Graduates

The Association gave feed-back to the Medical Council on their proposals for accrediting employers or groups of employers as 'approved practice settings' pointing out the different role a senior medical officer would have if they were acting as an agent of their employer compared to acting as an agent of the Council.

Statement of Collaboration with DHBs

The Association has offered feedback to the Medical Council for their review of their statement of collaboration with DHBs focused on specifying what is required of an assessment post for IMGs, induction, supervision, up-skilling and the allocation of time.

Physician Assistants

The Association responded to a Medical Council consultation paper on a new role of physician assistants pointing out that the role would not solve the medical workforce crisis. We commented that a simpler solution would be to give adequate administrative support to senior medical officers and that if the role became established as a regulated profession in New Zealand it should not come under the Medical Council.

Revised Credentialling Framework for the Health and Disability Sector

The Association had responded to the earlier draft credentialling framework pointing out a number of concerns with the terminology (especially the terms 'organisational credentialling' and 'organisational scope of practice') used in the report, the focus on individuals rather than services, moves toward the standardisation of processes and the potential clash with the national DHB MECA (Clause 35.2), appropriate use of consumer representatives, burden of compliance, our concerns with the credentialling of locums, and some DHBs' reluctance to implement the outcomes of credentialling.

The new draft includes a much tighter definition of terms largely eschewing the term 'organisational credentialing', using scope of practice as it is used in the Health Practitioners Competence Assurance Act and giving nursing related definitions for terms such as 'extended' scope of practice and 'expanded' scope of practice. Performance assessment is also defined and appears to be distinguished appropriately from credentialling.

Provider Selection Protocols

In August 2006 the Association, working through the Council of Trade Unions, persuaded the then Minister of Health Pete Hodgson to amend the government's provider selection protocols (eg, DHB's use of the private sector) in two important ways:

- Preference for long-term (longer than one year) public delivery of services where public and private options were equally effective.
- Where a DHB is considering shifting services to a non-DHB provider, it must actively and constructively engage with the health professionals involved in the provision of the service about the objectives the DHB is trying to achieve and whether there are other more cost effective means of achieving those objectives.

In June Minister of Health Tony Ryall announced new protocols which removed both of these additions. Disappointedly there was no discussion with the Association and it was contrary to the Minister's support for clinical leadership and engagement.

The new protocol includes the following new provisions:

- A new clause allowing DHBs to purchase services that best meet the needs of their population, including using the private sector to complement their own service delivery without undermining the long-term viability of their own resource.
- A change from requiring any shift in services to a non-government provider (or if a DHB starts providing services previously provided by a non-government provider) to be signalled in strategic and annual district plans to such a shift requiring a simple approval of the Minister of Health. This also removes a previous requirement for any such change to be listed in a DHB's annual report.

- A new clause requiring a DHB to ensure that there is no cross subsidy of non-government/'independent' providers by the public sector.

OECD Report

The Organisation for Economic Co-operation and Development (OECD) surveys member countries every one and a half to two years. This year they surveyed New Zealand's health system. Work on the survey generally starts one year before publication and is heavily influenced by contact with government officials in particular by Treasury. On this occasion there was a high level of overlap with those primarily responsible for the Ministerial Review Group (Horn) report. Rather than necessarily reflecting the views of the current or previous government it is probably more usefully viewed as reflecting the views of key economists employed in the public sector and the kind of advice that they will be giving to governments.

The OECD reported that "rising health – care cost are the biggest threat to long-run fiscal sustainability" and that despite rapid growth in spending this has happened "without significant increases in health outputs". Most of the increase, they say, went to increased pay for doctors and nurses and increased capitation to primary care doctors.

The report's main recommendation is somewhat contradictory in that it urges removing central control over purchasing and greater contestability among public hospitals and with private providers to stimulate hospital efficiency but that the sector should build on initiatives for greater collaboration and regional planning. They also recommended a bigger role for private provision and private insurance. New Zealand should compare itself to countries with similar GDP per capita like Greece, Korea, the Czech Republic and Slovakia rather than the United Kingdom and Australia.

The OECD suggested:

- Greater autonomy to DHBs including decentralised pay bargaining.
- Allocate all health spending on the same basis as PHARMAC.
- Evaluate public ownership of hospitals with, at a minimum outsourcing of hospital management to an independent national or regional agency.
- Purchase and provision functions should be decoupled so that private competition is encouraged.
- Capitation that follows the patient and mechanisms for sharing risk such as purchaser provider contracts and paying hospitals on a performance basis.
- DHB flexibility and accountability would be strengthened by allowing each DHB to negotiate its own wages rather than through multi-employer agreements. Overall they strongly advocated limiting the use of MECAs in the public sector and that future wage increases be tied to productivity increases.
- Paying hospitals on a budget holder approach.
- Primary Health Organisations should be eliminated or be given the responsibility to develop new clinical models with funding devolved from DHBs.

A large part of the report focuses on pay for hospital doctors and even specifically on specialists. This may have been based on a misunderstanding of how our MECA is funded. They recommended that "Hospital doctors pay should be determined within the budget envelope set by the output based payment system rather than by national level bargaining as at present." The authors go on to say "this might also imply salary plus pay – for performance or output contracts for specialists."

The report also suggested:

- Increasing the number of slots for medical students.

- Accepting more foreign students.
- "To the extent that New Zealand cannot offer international-level specialist wages it should work harder to create a satisfying and innovative clinical environment, giving doctors a high degree of autonomy and interaction with other professionals in the new collaborative care settings".
- Productivity needs to be benchmarked and may be linked to more senior doctors and nurses (rather than junior doctors and nurses).
- Incentives for higher physician productivity and improving geographic and specialisation distribution.
- Because of the unique agency relationship between doctor and patient cooperation with professional stakeholders is more important than other sectors and their acceptance of reforms is critical. "Health professionals must be involved in design and execution of reforms and not be bypassed as they may have been on some occasions in the past."

The Association's public response was largely critical describing it as a desire to return to the era of the 1990s.

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 three meetings since the last Annual Conference with a fourth scheduled prior to Conference. The meetings are now facilitated by new CMC chair, Dr Jonathan Fox.

The PPMF has been less active than previous years but nevertheless has served a useful purpose. Professor John Campbell (Chair) and Phillip Pigou (Chief Executive) from the Medical Council attended the third meeting in September to discuss a number of Council matters including its continuing professional development programme. Other subjects discussed include:

- The reports of the SMO and RMO Commissions (discussed elsewhere).
- Regulatory Reform Programme and narrow scopes of practice (discussed elsewhere).
- Discussions between the Royal New Zealand College of General Practitioners and the RDA over employment protections and rights for resident medical officers working in general practice.
- The role of the doctor in the context of 'task substitution' proposals.

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 (three meetings held to date) included:

- The state of the economy.
- The 'job summit'.
- Work groups established by the CTU to look at (a) bargaining frameworks, (b) union change, (c) union leadership development, and (c) union resourcing.
- Review of the Holidays Act.
- Service & Food Workers Union national MECA negotiations with the DHBs.
- The Telecom dispute.

The Association was represented at the CTU Biennial Conference on 21-22 October by Assistant Executive Director Angela Belich and Industrial Officer Lloyd Woods. The Prime Minister and Leader of the Opposition addressed the Conference. The most significant development at the conference was a presentation and workshops on an alternative economic policy. This included ideas for the reform of monetary policy to discourage speculation and raising the top tax rate.

Meetings with Director-General of Health

The Executive Director continued his regular informal meetings, usually monthly, with Director-General of Health Stephen McKernan with 10 held to date (another meeting is scheduled for later this year). There have also been several informal discussions based on a particularly constructive dialogue and relationship between them.

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:

- The Ministerial Review Group on 'Performance and Quality in the Health System', including its recommendations and outcome of the Government's deliberations.
- The *In Good Hands* report including its reporting guidelines.
- Minister of Health's Letter of Expectations to the 21 DHB chairs.
- Government policy on transferring secondary services to primary care.
- National Consultation Committee (DHBs and the Association).
- Clinical networks.
- Senior Medical and Dental Officers Commission, including its report.
- Resident Medical Officers Commission, including its report.
- Government's cap on administrative and management positions.
- Regulatory Reform Programme and narrow scopes of practice.
- New protocol on DHBs use of private sector.
- H1N1.
- Process for implementation of Government policy on the 20 additional theatres.
- New Zealand Resuscitation Council.
- Role of 'purchase adviser' in Ministry of Health.
- Tripartite Steering Group (and Health Sector Relationship Agreement).
- Resident Medical Officer levels in the Auckland region.
- Cervical cytology provision in the South Island.
- The Otago-Southland amalgamation consultation process and the proposed Nelson Marlborough-West Coast relationship.
- Specific internal DHB problems (eg, Waitemata, Waikato, Bay of Plenty, Hawke's Bay and Southland).

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 Freemantle in April. Issues discussed of particular interest included the state industrial relations systems and the

expanded national system, a new four year settlement in Victoria, tensions between the AMA and ASMOF in Queensland, and increased medical school numbers.

- The Executive Director visited the United States during 22-28 October (Boston and New York) primarily to attend a conference organised by the Physicians for a National Health Programme held in Boston. This provided an opportunity to become better informed on the healthcare debate in the United States, including the reform legislation promoted by the Obama Presidency based on mandatory health insurance and a 'public option'. It also provided an opportunity to speak briefly to conference attendees on the New Zealand health system at the Harvard Faculty Club. In addition, the trip was used to visit one of our two counterpart unions, the Doctors Council, as well as the Committee of Interns and Residents in New York.
- In September Senior Industrial Officer Henry Stubbs and Industrial Officer Lyn Hughes attended the sixth National Doctors Health Conference which was held in Adelaide. These conferences have proved to be beneficial to our industrial work. The Association has a small but significant number of members who find themselves facing disciplinary action of one sort or another and may also be unwell. This sometimes involves a range of psychological disorders from bi-polar and depression through to anxiety, stress and anger; some neurological conditions; and attempted suicide and drug or alcohol abuse and addictions. The two keynote speakers at the conference were Erica Frank (Professor and Canada Research Chair at the School of Population and Public Health and the Department of Family Practice at the University of British Columbia) and Geoff Riley (Winthrop Professor of Rural and Remote Medicine in the Faculty of Medicine, Dentistry and Health Sciences at the University of Western Australia and Head of the Rural School of Western Australia). The opportunity was also taken for them to visit the South Australian Salaried Medical Officers Association (ASMOF) and the South Australian AMA. The next conference will be in Auckland in 2011.
- The Executive Director visited Sydney in September to attend the second Industrial Coordination Meeting. Some of the issues he reported back on were Australian medical workforce trends, the National Health and Hospital Reform Commission's report, the salary sacrifice scandal in Western Australia, the proposed new Health Workforce Australia, the state of doctor unionism in Australia, and application difficulties of a new four year settlement in Victoria. He also visited the federal office of ASMOF and the New South Wales branch of AMA.

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:

- 'What it takes to stay' in New Zealand for senior medical staff.
- Striving for a paradigm shift in DHB decision-making in light of the MECA obligations, *Time for Quality* agreement, the Minister of Health's Letter of Expectations to DHBs concerning clinical leadership, and *In Good Hands*.
- Progressing *In Good Hands*.
- Preparing for the next national DHB MECA negotiations.
- The right to elections for the Medical Council.
- Minister of Health's address to Annual Conference (2008).
- Peter Glensor, national chair of the 21 DHB chairs, on leadership.
- Minister of Health's Letter of Expectations to the 21 DHB Chairs.
- ACC controversy.

- Understanding the 2009-10 Budget.
- Proposed new credentialling framework.
- The Horn Report and restructuring.
- SMO Commission report.

In addition there have been regular columns by the National President, Executive Director and the Medical Protection Society. The full text of the *In Good Hands* report was also published.

The *ASMS DHB News* 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 2,990. To date 19 issues have been produced this year. Much of this has focussed on National Executive elections, *In Good Hands*, the report of the Ministerial Review Group (Horn Report) and the SMO Commission (preparation for and response to its report).

Other subjects covered included:

- Warning DHBs about risks of cost cutting in response to economic recession.
- Medical Council elections.
- Nominations for Health Practitioners Disciplinary Tribunal.
- Association membership growth.
- H1N1.
- The Budget, specifically Vote Health.
- Credentialling framework.
- Funding public hospitals.
- DHBNZ medical workforce 'road show' (Professor Gorman).
- Health Minister's requirement for DHBs to share board members for greater collaboration.
- Launching of new health domain: .health.nz
- World Health Professionals Alliance on H1N1.
- Samoa.
- World Medical Association statements on climate change, patient safety & quality of care, and stress in the medical pressure.

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

At its meeting on 22-23 July the National Executive agreed to establish a new electronic publication, *Executive Direct*, to be sent to members after each Executive meeting along with the names and email addresses of Executive regional representatives. To date, two issues have been sent reporting on the July and September Executive members.

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

Membership

Once again the Association has had a record membership year (the tenth in succession). Membership, as of 31 March 2009 was 3481, compared with 2,995 at 31 March 2008, representing an overall increase of 486 (16%). It represents a 141% increase over the 1,440 members in our first year of existence (1989-90). The newly introduced bargaining fee attracted payments from 213

senior medical and dental staff; to date this financial year 32 of these have converted to full financial members.

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%), 2008-09 (486 - 16%) an overall increase of 98% 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 188 (9%). 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 3,470 (a decline of 11 members since 31 March 2009) although this is likely to have been affected by the subsequent resignation factors such as retirement that always occur at the end of our financial year. Although the growth of new members is likely to be a slow trickle we should exceed our 2009 numbers by 31 March 2010. 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 88% of our members pay their subscription by automatic salary deduction (about 84% 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. Those who were NZMA members at the time of joining the Association represent an estimated 12% of our current members. Just 6% of members who joined the Association in 2009 were also members of the NZMA compared with 22% in 1996.

Medical Protection Society

The Association has continued our close working relationship with the Medical Protection Society, including working together on several cases where our respective roles overlap or intersect. Much of this involves the Senior Industrial Officer and other industrial staff working with the MPS representatives and lawyers on specific cases. The MPS now provides a regular column for *The Specialist*. 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. 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 concerns with the Ministerial Review Group report, our forthcoming national DHB MECA negotiations, the SMO Commission report, *In Good Hands*, our joint engagement workshops in the DHBs, the Minister of Health's Letter of Expectations to DHBs, the Association's relations with the government, Pan Professional Medical Forum, and growing relations between the Society and the Medical Students Association. A fourth meeting is scheduled in December.

Association Finances

The Association's net surplus was $166,789 for the financial year ending 31 March 2009 was due to another stronger than expected growth in membership (3,213 full subscriptions - $1,913,515 actual compared to the 2,800 full subscriptions or $1,667,700 predicted). In addition to the unanticipated, escalation in membership, bargaining fees contributed $114,556 to the annual income.

Dominion Finance Group Limited (in Receivership) (in Liquidation)

As detailed in last year's Annual Report, the Association held an investment in Dominion Finance Group Limited (in receivership) ("Dominion") of $221,542 as at 31 March 2008. The investment has been frozen since this date and on 15 May 2009 Dominion was put into liquidation. A receiver's report dated 30 March 2009 provides an estimate of recoveries to investors to be in the range of 10% to 25%. In light of this report the entire investment has been written down to 10% of its balance at 31 March 2008; $22154.

Investment Policy

At its May meeting the National Executive adopted a revised investment policy that expressly excludes investments in shares or finance company deposits; in keeping with this policy, previous investments with finance companies have been put into term deposits as they matured.

Administration

The Association has an experienced and competent administration team with the appointment of Administration Officer Joanne Jourdain in April further strengthening the team and ensuring full support in the running of the Association.

The challenges of a constantly changing membership encourages system and procedural improvements throughout the year with a continual strive for efficiencies in all areas; examples of these are: regularly modifying the membership database to improve monitoring and allow automated reporting; converting to electronic banking; conducting surveys electronically where appropriate; introducing a total document management system to handle the Association's electronic records, greatly simplify the generation of lengthy documents and also improve the security and storage of documents and ensuring that equipment and information technology are regularly updated.

Website

Following a total makeover just over twelve months ago the number of visits to the ASMS website has increased to over 40,000 per month. The site continues to generate many positive comments on its fresh look and ease of use. The new software has also simplified the content management aspect; a special section was established to allow the National Executive access to lengthy documents with ease and speed.

Job Vacancies Online

The Jobs Online section of the website attracts about 30%of the total number of visits to the website. The service continues to generate enough income to adequately cover the costs involved with a monthly average of 50 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.

Other Matters

Draft Audit Tool on Senior Medical Staff Appointments

In the Annual Report to the 2008 Annual Conference it was noted that the National Executive was developing a draft audit tool on the extent and effectiveness of senior medical staff involvement in DHB decision-making. Although it was to be piloted, the Executive subsequently resolved to cease this work because it had been overtaking by the *In Good Hands* policy statement on clinical leadership.

Instead it was agreed to focus on an area not covered by *In Good Hands*, appointment processes for senior medical and dental officer positions. As a result an adult tool has been developed which is being trialled in Whanganui and Canterbury DHBs using survey monkey.

ACC Futures Coalition

The Association was invited to join the ACC Futures Coalition formed in order to campaign against possible privatisation of ACC and reductions to existing entitlements. While sympathetic to the goals of this organisation the National Executive resolved not to join especially as the Council of Trade Unions had joined.

Review Holidays Act

The government is presently reviewing the Holidays Act. The Council of Trade Unions is participating in the review. The National Executive has no immediate concerns and is satisfied with working through the CTU over this matter.

Feasibility Study about Establishing a Regional RMO Employer in Auckland

In the 2008 Annual Report the National Executive reported that it was monitoring the 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. This work appears to have ceased with the report of the Resident Medical Officers Commission and its recommendation for a single employer currently with government.

Employer Subsidised Private Health Insurance

The National Executive considered a request from a member to pursue employer subsidised health insurance for members. The Executive, however, declined to take up this matter. It was aware in this deliberation that some DHBs already have discount arrangements with some health insurance companies

DHBNZ document on clinical leadership

In May the National Executive discussed a document drafted by a DHBNZ official on clinical leadership in the context of *In Good Hands* and the national DHB MECA. The document had limited circulation but was informally forwarded to the Association. It contained a number of disparaging and negative comments about the role of the Association in its promotion of clinical leadership. Our concerns were raised with the national chair of the 21 DHB chairs who promptly investigated. It became clear that the document had no status, did not represent the views of the DHBs who were highly embarrassed about it (Chairs and Chief Executives had been unaware of it), and the document was destroyed. The Association received a full and unequivocal verbal apology from the DHBs.

Pay and Employment Equity

The taskforce established by the previous government has now been disbanded and the proposed bi-partite project between the Association and DHBs to examine differences in remuneration and rewards of female and male senior medical and dental officers, which had not received much priority in any case, will not proceed.

Brian Craig
ASSOCIATION NATIONAL SECRETARY

23 November 2009