

ANNUAL REPORT

2011

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Annual Report 2011

The major challenge since the 22nd Annual Conference in November 2010 has, for the second successive year, been the national DHB MECA negotiations. Other challenges included organisation of the branch elections under the amendment to the Constitution adopted at last year's Conference to facilitate the revitalisation of our branches and defending Lakes District Hospital in Queenstown from privatisation and doctor staffing cuts. More recently the work of Health Benefits Ltd and Health Workforce New Zealand's proposal for the prioritisation of training funding for medical specialties have also emerged as important challenges.

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

President	Jeff Brown (MidCentral)
Vice President	Julian Fuller (Waitemata)
Region 1	Judy Bent (Auckland) Carolyn Fowler (Counties Manukau)
Region 2	Andrew Darby (Waikato) Paul Wilson (Bay of Plenty)
Region 3	Hein Stander (Tairāwhiti) Tim Frenidin (Hawke's Bay)
Region 4	Brian Craig (Canterbury) John MacDonald (Canterbury)

All were elected unopposed. Brian Craig was subsequently re-elected National Secretary by the National Executive at its 5 May meeting in accordance with the Constitution. The standing down of long serving National Vice President David Jones deserves special mention. He has made an outstanding contribution to the leadership of the Association first joining the National Executive as a Region 3 representative in 1993. This included two separate periods as Vice President – the first under Peter Roberts and the second under Jeff Brown. One of his last major activities for the Association was the development of the *Business Case* (discussed further below). Two other members of the previous Executive also did not stand for re-election – John Bonning from Region 2 first elected in January 2006 in a by-election (he was the first emergency medicine specialist to be elected to the Executive and is now Chair of the New Zealand Committee of the Australasian College of Emergency Medicine) and Himadri Seth from Region 1 who served one term. The National Executive is appreciative of the constructive contribution of both members to the Association. There are now three new members on the National Executive – Julian Fuller (Vice President), Carolyn Fowler (Region 1) and Andrew Darby (Region 2).

The National Executive has met on four occasions in Wellington since the last Annual Conference, with a fifth meeting to be held immediately preceding this Conference. On 4-5 May the National Executive held its annual two day meeting to discuss strategic directions, the first day being informal. The informal day included:

- Preparing for the national DHB MECA negotiations, including strategic direction and the draft claim.

- Session with the Health & Disability Commissioner, Anthony Hill.

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

- Health & Disability Commissioner, Anthony Hill as above.
- Murray Horn and Chai Chuah, Chair and National Director respectively, National Health Board (Ministry of Health) at the 1 September meeting.

Other key activities were the Joint Consultation Committees in the 20 DHBS, collective bargaining with non-DHB employers and individual employment-related cases and disputes.

The national office 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), Yvonne Desmond (Executive Officer), Lyn Hughes (Industrial Officer; nine days a fortnight), Lloyd Woods (Industrial Officer), Kathy Eaden (Membership Support Officer; nine days a fortnight), Terry Creighton (Administration Officer) and Ebony Lamb (part-time Administration Assistant). We also engage additional accounting support on a weekly basis to assist with financial accounting and reporting.

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.

National DHB MECA Negotiations

The renegotiation of the third national DHB multi-employer collective agreement (MECA) has continued to be the National Executive's major priority since the 2009 Annual Conference. The current (second) MECA expired on 30 April 2010 but continued in force under statute for a further 12 months. With negotiations still continuing the DHBS have committed in writing to offer the MECA as an individual employment agreement to new appointees since 30 April 2011. That obligation continues while negotiations continue.

The Association's negotiating team is led by the Executive Director as advocate and Assistant Executive Director as assistant advocate. In addition to Executive members it comprises Drs Rod Harpin (Northland), Athol Steward (Whanganui), Stephen Purchas (Hutt Valley), Derek Snelling (Capital & Coast), Geoff Lingard (Nelson Marlborough), Matthew Hills (South Canterbury), and Peter Christmas (Southern). It also includes former National Executive members David Jones, Himadri Seth and John Bonning.

We have endeavoured to keep members informed during these protracted and unusual negotiations through our electronic publication *ASMS Direct* and the *Bargaining Bulletin* which is mailed to DHB employed members. Given the current situation it is appropriate to summarise the situation before the 2010 Annual Conference.

The Association's overall strategic direction in these negotiations was based on the following resolution overwhelmingly adopted by our Annual Conference in December 2009:

That the Association's strategic direction for the forthcoming national DHB MECA negotiations be based on the following statement:

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 clear pathway to competitive terms and conditions of employment for senior doctors and dentists;*
- 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.*

At the 2010 Annual Conference we reported on the developments in our MECA negotiations including the preceding informal meetings with the DHBs on how to better progress negotiations in contrast with the 2006-08 negotiations, the joint workshops held during April-July 2010 on underpinning issues, the 'variation' to the MECA in September (a 'holding pattern'), and the development of the joint business case, *Securing a Sustainable Senior Medical and Dental Officer Workforce in New Zealand: The Business Case* (November 2010).

At the 2010 Annual Conference the following resolution was adopted unanimously:

That Annual Conference endorses the National Executive's actions in the national DHB MECA negotiations including development, jointly with the DHBs, of a business case for investment in the retention and recruitment of the senior medical and dental workforce.

Since last year's Annual Conference the DHBs continued to work through their two-tier structure – an overarching Employment Relations Strategy Group (ERSG) responsible for all their collective negotiations and a negotiating team. Its composition has changed including its chair (from Karen Roach, Northland chief executive, to Graham Dyer, Hutt Valley chief executive). Two Board chairs have also been added to the ERSG. There have also been changes to their negotiating team (including advocate – due to her departure Fiona McMorran was replaced by Mick Prior in September) largely due to attrition but also the decision of the DHBs to add two chief executives to it.

Also during the negotiations the Association raised additional claims as a result of Parliament adopting amendments to the Employment Relations Act, with particularly reference to the application of the 90-day trial period ('fire at will'), which is non-applicable due to the current three months' notice requirement in the MECA, and union access to workplaces. These have been satisfactorily resolved.

Below is a summary of developments since the 2010 Conference:

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|-------------|---|
| 29 November | DHB chief executives accept the <i>Business Case</i> in principle with only two qualifications – further work wanted on a supplementary document fleshing out further details ('operationalising' it) and would not refer it to the government because they would fund the investment out of their baseline funding rather than seek additional funding. This was confirmed in writing (1 December) to the Association and also at a subsequent informal meeting in early December. Significantly no concerns were raised over funding the financial investment required. |
| 9 February | Formal negotiations resume for a fifth day; includes start of discussions on implementing funding allocated in <i>Business Case</i> for MECA settlement (\$40m, \$80m and \$80m over three years from 1 July) through costing scenarios. |
| 8 March | At national meeting of Ministry of Health, DHBs and CTU affiliated health unions (Health Sector Relationship Agreement Steering Group), the Ministry passed on Minister of Health's advice that the February Christchurch earthquake would not change their funding allocations for the 2011-12 financial year (which were advised late November). |
| 15 March | Formal negotiations resume for a sixth day including costing scenarios; DHBs' team stated desire to resolve negotiations (subject to ratification) by end of April (ASMS agrees); and two salary scale scenarios (one from DHBs and one from ASMS) are costed with both well within the financial allocation of <i>Business Case</i> .

Later in day DHBs' negotiating team advises that they can't continue because they are uncertain of their mandate from the chief executives. |

- 23 March Informal crisis meeting held between ASMS and DHB representatives (led by chief executives Karen Roach and Graham Dyer); agreed to form small joint group to work on supplementary 'operational document' and to resume formal negotiations in late April; agreed objective to conclude negotiations by end of April (subject to ratification by the parties respective processes).
- 31 March Small joint DHBs-ASMS group meets to work on 'operational document' and relationship with MECA; DHBs team led by chief executives Graham Dyer and Jim Green; ASMS team comprises National President, National Secretary, Executive member John MacDonald, Executive Director and Assistant Executive Director; DHBs agree that *Business Case* is not to be called a 'discussion document'; ASMS advises DHBs that we needed to forward the *Business Case* to members and asked whether they had any problems (DHBs advised no problems and that they understood our position).
- 10 April Second informal meeting of joint DHBs-ASMS group; 'operational document' virtually agreed (now described as an implementation document); agreement reached on proposal over implementation of *Business Case* for inclusion in MECA to recommend to ASMS negotiating team and DHB chief executives (ASMS again advised DHBs that we would soon forward the *Business Case* to members; again no concerns raised).
- 18 April ASMS negotiating team endorses recommendation of 10 April informal meeting; chief executives meet concurrently; formal negotiations resume for seventh day following both meetings; DHBs proposed variations to 10 April recommendation which are unacceptable to ASMS (due to too much conditionality and chief executives shifting goalposts).
- 19 April Informal meeting with DHBs which successfully progresses the small number of unresolved non-fiscal issues in negotiations.
- 26 April ASMS forwards jointly *Business Case* electronically to members (and on website) with an accompanying positive description in *ASMS Direct*.
- 27 April Major turning point in the negotiations occurred when DHBs (Karen Roach) on *National Radio* (Radio NZ) endeavoured to distance themselves from *Business Case* by claiming (for the first time) that it was unaffordable and demeaned it as only a "discussion paper"; also reported as being surprised at the Association's release of it.
- 28 April DHBs cancel eighth day of negotiations scheduled for following day arguing that they needed more time to develop a proposal for settlement.
- 4 May Immediately prior to the commencement of the National Executive's informal strategic planning day, in a teleconference with the Executive Director chief executives Karen Roach and Graham Dyer advise that the DHBs would be making a proposal for settlement based on a 1.77% salary increase for 12 months commencing 1 July 2011 plus more working parties (they agreed to forward this in writing by the end of the day noting that the Executive would be meeting formally the following day).
- 5 May Immediately prior to the National Executive meeting the ASMS receives the above proposal in writing; the Executive considers it to be a radical departure from the *Business Case* and unanimously rejects it; the following resolutions are adopted:
1. That the National Executive rejects the DHBs' offer received 5 May as it is not consistent with the jointly agreed *Securing a Sustainable Senior Medical and*

Dental Workforce in New Zealand: the Business Case intended to address the medical workforce crisis in DHBs.

2. That the National Executive calls on the chief executives of the DHBs to acknowledge and honour the work jointly undertaken developing *Securing a Sustainable Senior Medical and Dental Workforce in New Zealand: the Business Case* and continue to negotiate the national DHB MECA based on the *Business Case*.
3. That the Executive Director is authorised to obtain and engage public relations advice to assist with the promotion of the *Business Case*.

It was also agreed in the covering letter advising the DHBs of the Executive's response to this proposal to refer to their obligations in Clause 8.3 of the MECA in respect of the *Business Case* and the negotiations. Further, it was agreed to seek a meeting with the Chairs of the Chairs and Chief Executives groups of the 20 DHBs.

Later DHBs' representatives Graham Dyer and Doug Martin (external adviser) join the Executive for 'free and frank' discussion.

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| 6 May | Executive Director writes to the DHBs outlining the Executive's concerns over recent developments, calls for further negotiations picking up from where informal discussions on 10 April left off, and seeks a meeting with Gregor Coster (Chair of DHBs national chairs group) and Kevin Snee (Chair of DHBs national chief executives group). |
| Late May | ASMS obtains professional public relations advice for a longer term campaign over the implementation of the <i>Business Case</i> in the MECA settlement according to its tenor. Graham Dyer releases media statement criticising ASMS and misrepresents our position (less strident and vitriolic than subsequent attacks and considered at the time to be an aberration). |
| 16 June | National President, Vice-President (Julian Fuller) and Executive Director meet Gregor Coster and Kevin Snee (also Graham Dyer and Sally Webb, Bay of Plenty Chair); Gregor Coster confirms DHBs support for the <i>Business Case</i> with the only issue being the cost of investment (\$360m); agreed that DHBs would take some time to consider their approach and the composition of their negotiating team. |
| 23 June | National Executive further considers and adopts a strategic direction leading up to Annual Conference (discussed further below). |
| 28 August | ASMS releases first <i>Specialist Workforce Alert</i> based on the <i>Business Case</i> on the extent of the specialist workforce crisis with an accompanying media statement. |
| 30 August | Graham Dyer releases vitriolic media statement attacking the ASMS (and Executive Director) including rejecting key principles of the <i>Business Case</i> and making several deliberately false claims and allegations.

In evening another informal meeting of DHBs and ASMS held. The ASMS are represented by the President, Vice President, Executive Director and Assistant Executive Director. The DHBs representatives are Kevin Snee, Graham Dyer, Sally Webb, Doug Martin and their advocate Fiona McMorran. Some tension in the meeting but agreement reached to resume formal negotiations focussing on the implementation document and remuneration. [ASMS unaware of DHBs' media statement] |
| 31 August | A national meeting of the new ASMS Branch Presidents and Vice Presidents votes unanimously to call on the DHBs to honour the <i>Business Case</i> and negotiate the MECA based on it. |

Towards the end of this meeting the ASMS becomes aware of yesterday's media statement from the DHBs and issues a firm response.

- 1 September The National Executive adopts unanimously the following two resolutions:
1. That the National Executive suspends the Association's involvement in the Health Sector Relationship Agreement Steering Group due to the DHBs' behaviours in their negotiations with us which are inconsistent with the principles of the Agreement.
 2. That the National Executive is concerned that the DHBs appear to be walking away from their commitments to the *Business Case* and affirms the resolve of our branch Presidents and Vice Presidents to negotiate a national collective agreement based on the *Business Case* already agreed between the parties.
- The Executive also agreed to suspend its involvement as an observer on the National Bipartite Action Group.
- The Executive further agreed to proceed with the following actions:
- Endeavour to organise some special branch meetings involving the National President on the *Business Case*.
 - A summary for members on how the *Business Case* was developed, including the involvement of DHB representatives.
 - A summary of the *Business Case* in a format similar to the Association's job sizing pamphlet.
 - A background video on the *Business Case*.
- Later that day Graham Dyer issued a second media statement similar to the first including expanding on deliberate misrepresentations of the ASMS position. These two statements were fully analysed and reported to members through the next *ASMS Direct*.
- 11 September ASMS releases our second *Specialist Workforce Alert* which discusses the effects of the crisis and the shortages. Again this is followed by a similar aggressive media statement from Graham Dyer on behalf of the DHBs continues and intensifies this theme of deliberate misrepresentations. Again this is reported to members in *ASMS Direct*.
- 25 September ASMS releases our third *Specialist Workforce Alert* which discusses the costs of the shortages followed by the standard style of response from Graham Dyer.
- 30 September After a long hiatus negotiations resume for an eighth day. The newly constituted DHBs team includes new advocate Mick Prior, chief executives Craig Climo (Waikato) and Phil Cammish (Bay of Plenty), and HR general managers Sam Bartrum (Waitemata) and Denise Hutchins (Nelson Marlborough). The ASMS team comprises the Executive Director, Assistant Executive Director, National President, Vice President, and Executive members Judy Bent, Andrew Darby and Tim Frendin. The discussion includes an assessment from the ASMS perspective of the circumstances that have led to the situation the parties are now in from Ian Powell which DHB representatives describe as helpful, fair and accurate. It is agreed that the focus of negotiations should be on the implementation document and remuneration. Further, it is agreed that the DHBs will produce a draft new implementation document before negotiations resume. The DHBs acknowledge the importance of the ASMS Annual Conference and three further dates are scheduled for 19 October, 3 November and 10 November with the aspiration that there will be a proposal for the ASMS to report back to Conference. At the end of

this session Craig Climo makes a personal statement describing the way the ASMS has been treated as “unsatisfactory” and personally apologises.

- 11 October ASMS releases our fourth *Specialist Workforce Shortage Alert* which discusses the training crisis. On this occasion there is no media response from the DHBs.
- 19 October Negotiations resume for a ninth day. Hawke’s Bay chief operating officer joins the DHBs team. ASMS President Jeff Brown is unavailable but National Secretary Brian Craig and Executive member John MacDonald join our team. The discussion focuses on the new draft implementation document prepared by the DHBs which the ASMS has several concerns about including its disconnect with the *Business Case*. It is agreed that the ASMS will prepare another draft for consideration at the next day of negotiations. It is agreed that remuneration will also be discussed.
- During the negotiations a spontaneous discussion occurs on the DHBs’ commitment to the *Business Case*. This leads to a number of acknowledgements and admissions by DHB representatives of difficulties in their internal processes. Despite some confusion over commitment the two chief executives make it clear that they support the *Business Case* with the main issue of concern being cost.
- 27 October ASMS releases our fifth *Specialist Workforce Alert* which discusses the retention crisis.
- 3 November Negotiations resume for a 10th day. Progress is made in concluding the implantation document. The DHBs then tabled a salary offer which was not acceptable to the ASMS negotiating team because it failed to provide the necessary investment in the senior medical workforce to help achieve the capacity to achieve the objectives of the operational document. Discussion will continue on the 11th day of negotiations on 10 November.

Strategic Direction adopted by National Executive (23 June)

The National Executive critically examined the Association’s strategic direction towards the MECA negotiations in light of the deterioration since late April but also noting the Association’s informal meeting with the chairs of the DHBs’ chairs and chief executives’ groups held exactly a week earlier. Three broad options were considered by the Executive:

1. Accept the DHBs’ offer made in May or some minor variation to it (in summary, this is a 1.77% salary increase plus further new working groups). In effect this would have meant abandoning the *Business Case* including in respect of its blueprint nature.
2. Escalating to industrial action reasonably soon (August-September) commencing with national stopwork meetings.
3. Slower escalation first focusing on ensuring ‘hearts and minds’ of members with a view to using Annual Conference as an ‘event’ such as calling for national stopwork meetings.

Option 1: Accepting the DHBs’ Proposal

To a large extent the option of accepting the DHBs’ offer or some minor variation to it had been overtaken by the informal meeting with the DHBs on 16 June described above. Nevertheless the risks of acceptance needed to be considered.

- If the Executive had accepted it a significant part of our membership would be dismayed and concluded that the Association has backed down in response to DHB after having been ‘strung along’ since last September with the *Business Case* process. This would be especially so given that the National Executive previously rejected it (at its 5 May meeting) and would

have followed on from the failure of the SMO Commission to deliver on the expectations of the last settlement.

- It would mean abandoning the *Business Case* and also the potential of collaborative joint work with the DHBs nationally on substantive issues for the working life of most, if not all, National Executive members.
- The inclusion of the working groups would make the National Executive a laughing stock in that this is what we did last year (and would follow in the SMO Commission aftermath). If we were going down this path the DHBs would probably have to expect that the working groups were not part of the settlement.
- Our ability to improve the 1.77% by even a little would be very difficult (made worse by the fact that by then we would then be negotiating from a position of weakness) because this was the annualised 'National Terms of Settlement' increase involving the other CTU unions in the health sector. It would also have implications for the current 'managed bargaining' between the DHBs and CTU health unions (which has subsequently fallen over but was a live issue at the time). The DHBs would have been fearful of flow-on risks to the large majority of its workforce.

Option 2: Escalating Industrial Action

Escalating industrial action commencing with national stopwork meetings in August-September was an option aimed at achieving a settlement based on the *Business Case* to be followed by a ballot on industrial action later in the year. The reasons for not accepting this option were two-fold:

- The state of the economy and the impact of the Christchurch earthquakes had influenced the thinking of many members, not just those in Canterbury.
- The Business Case had not been able to be sufficiently 'socialised' with our members. Feedback from members had been positive but many were still largely unaware of its substance.

Option 3: Slow Escalation in the Direction of Industrial Action

Slower escalation first focusing on ensuring 'hearts and minds' of members with a view to Annual Conference being an 'event' to debate future directions (eg, calling for national stopwork meetings to be held next year). It also included a communications strategy developed for us by external public relations advisers Cabix with the purpose of socialising the *Business Case* with our members, the media and opinion leaders. An important component was the publication of 'alerts' to our members, the media and others based on different features of the *Business Case* and accompanied by media statements.

It also included a new event of a national meeting involving the Executive, the rest of our negotiating team, and our newly elected branch Presidents and Vice Presidents with the focus being on our negotiations, including the *Business Case*.

In essence it would be part of a dual strategy with the other part being trying to pursue the possible momentum established at the 16 June meeting discussed above. The Association could not afford to either ignore or rely on the latter.

The qualification is that while the latter remains viable our communications strategy should not involve criticising the conduct of the DHBs (or relitigate previous criticisms despite their validity). The Association can't engage effectively and attack at the same time. However, we can socialise both the workforce crisis and the *Business Case* as a 'blueprint' solution.

After lengthy and constructive debate the National Executive resolved to adopt the third option.

Commencement of DHBs Attacks on Association

Below is a summary of the aggressive attacks on and misrepresentations of the Association by the DHBs in the name of Graham Dyer on 30 August (these and subsequent attacks have been reported to members in *ASMS Direct*):

1. The DHBs' statement asserted that the "ASMS promotes myths". The truth is that these so-called myths were directly taken from the jointly developed *Business Case* and none of these "myths" were subsequently challenged by DHB representatives including during the development of the implementation document.
2. The Association was accused of "seeking a 20% salary increase over three years". There is no truth in this whatsoever. The ASMS had not made any salary claim (nor had the DHBs until May this year). In his second media statement Mr Dyer tried to justify this falsehood by referring to salary scenarios developed during negotiations in February-March. But, to avoid misunderstanding and confusion in addressing an issue of complexity, both parties agreed that they would not treat or misrepresent each others costing scenarios as claims. The Association has respected that. So has the DHBs' negotiating team. But the DHBs' media statement consciously chose not to. Further, both scenarios were costed on filling vacancies as well as remuneration increases through translation to a new scale and the final scenarios came well below the figure in the *Business Case* that Mr Dyer referred to.
3. The statement claims that "Mr Powell is selectively using OECD statistics". But the data cited (concerning the number of specialists per 1,000 population) was directly taken from the jointly developed *Business Case* which assessed it as among the best intelligence available.
4. They alleged that the "average salary package for specialists is \$249,000" (in their second statement they asserted that the evidence was in their November 2010 payroll data and that this was "confirmed in an SMO remuneration report developed by the National Health Board."). The implication is therefore that the non-existent 20% increase is on \$249,000. This had never been raised by their negotiating team despite many opportunities and there has been no discussion with the Association on the veracity, let alone the accuracy. The Association was subsequently advised by the NHB that it does not have the resources or capacity to confirm the veracity of SMO remuneration data and they never did. The NHB was asked to report to the Director-General of Health on the subject matter and they asked the DHBs for data which they then included in their report. The NHB described the DHB data but did not confirm it.

The Association has now seen the report that Mr Dyer refers to. Not only does it not refer to an average package of \$249,000, it does not refer to any average at all. Subsequently it has been obtained how they came to the figure of \$249,000 under the Official Information Act. In fact, it was a particularly disingenuous figure based on specialists who work longer hours (including on after-hours call rosters and shifts). Further, it included superannuation, additional enhancements for a relatively small number of specialists because of recruitment and retention imperatives, chief medical officer salaries, special clinical leadership provisions and, most likely, higher paid locum salaries in order to fill vacancies. It amounts to an attempt to link a nonsensical salary claim on a highly dubious and inapplicable quantum.

5. The DHBs' media statement makes the following accusation: "Mr Powell appears to want to make engagement in clinical leadership, quality initiatives and service improvements contingent on the salary movements". This is particularly offensive to the Executive. The Association has been the main driver for the holding of joint workshops with many DHBs on enhancing engagement of senior medical staff in DHBs. These have generally been successful events. Clinical leadership, quality and service improvements are fundamental to them. They

have been a major part of the Association's work programme for some years and several DHBs have expressed their appreciation to the Association for this initiative.

Revitalisation of Association Branches

In order to facilitate the revitalisation of Association branches last year's Annual Conference amended the Constitution on branch functioning and elections. The objective was to enhance the role and minimise the operational obligations of branches.

Following this the National Executive organised the elections for the new created positions of president and vice president in the 23 branches. Executive Officer Yvonne Desmond was the Returning Officer. Nominations closed on 31 May. Sufficient nominations were received for all positions (ie, elected unopposed) except for the positions of Vice President in the Tauranga and South Canterbury branches. Further elections were subsequently held with former contested and the latter elected unopposed.

The National Executive resolved to hold a special meeting of branch presidents and vice presidents (along with Executive members and other members of our national DHB MECA negotiating team) on 31 August. The main focus was the difficulties in the MECA negotiations and the *Business Case* but it also played an orientation function including the role of branches under the amended Constitution, the work of our industrial officers, and job sizing.

Life Preserving Services

In the 2010 Annual Report we reported on the cumulative effect of the over 700 notices of partial strike action affecting diagnostic services given mainly by APEX, but also the Medical Laboratory Workers Union, in their collective agreement negotiations with the DHBs which raised serious concerns of patient safety among Association members. It also put much pressure on the application of life preserving services (including risk of permanent injury and disability) agreements under the 'Health Sector Code of Good Faith' which is a schedule to the Employment Relations Act. This also led to debate over the right to strike in the health system.

Those industrial disputes concluded earlier this year. But the issue of life preserving services arrangements remained. The Association played a constructive role in the CTU affiliated health unions, reaching a common position with the DHBs that amending the Health Sector Code of Good Faith was an overreaction to the emotions created by these industrial disputes and that the concerns could be addressed by focusing on its application. Arising out of this consensus it was agreed to set up a small working group (chaired by NZNO Executive Director Geoff Annals and including Senior Industrial Officer Henry Stubbs). That group is continuing its work.

At the National Executive's June meeting the Senior Industrial Officer reported on a recent Employment Relations Authority's Determination in the NZ District Health Boards' case against APEX relating to the role of 'gatekeepers' under the life preserving services agreements (under the Code of Good Faith) between DHBs and those unions who have given notice of strike action. The Authority ruled in favour of the DHBs and against APEX.

The effect of the Authority's decision is that DHBs are not required to agree with the striking employees' union:

- that a particular patient's clinical condition requires life preserving services; or
- that a particular person (ie, a 'gatekeeper') should make that decision; or
- that a particular person (ie, a 'conduit') should communicate the decision that is ultimately made to the striking employee.

This is an important decision and is consistent with the Association's advice to members and DHBs that the decision as to whether a particular test, treatment or procedure was required in a given situation was for the treating clinician to make, without having to justify their decision or have it challenged by the union through a 'gatekeeper'.

It seems that the roles of 'gatekeeper' and 'conduit' may have developed to suit the interests of the unions concerned. What is certain is that they are not requirements of the Code of Good Faith or Life Preserving Services agreements.

Health Sector Relationship Agreement

Six meetings of the tripartite Health Sector Relationship Agreement (HSRA) Steering Group have been held this year although the Association has not participated in the final two as a result of the National Executive's decision (discussed above) to suspend participation on the Steering Group. The participants are the Ministry of Health (through the National Health Board), all 20 DHBs, and each of the CTU affiliated four main health unions (NZ Nurses Organisation, Public Service Association, Service & Food Workers Union, and the Association. All are signatories to the HSRA. The Association has been represented at the first four meetings (three by the Executive Director and one by the Assistant Executive Director). The significance of this body is the primary means by which the government, DHBs and health unions engage on a national level.

The main issues and agenda items in the first three meetings have been:

- Regular reports from the National Director of the National Health Board on NHB issues.
- ASMS concerns over the lack of commitment in some DHBs to clinical leadership.
- Reviewing life preserving services arrangements (discussed above).
- The recent amendments to the Employment Relations Act and their impact on the Code of Good Faith (schedule to the Act).
- The work of Health Benefits Ltd including the impact on consultation with the health unions.
- The 'managed bargaining framework' (successor to NTOS).
- Endeavours by the NHB to develop an adaptation of the survey of Association members last year by Dr Robin Gauld on the application of In Good Hands to be applied to all DHB employed health professionals and the difficulties of resolving it with all chief executives.
- A session with Health Workforce New Zealand Executive Chair Professor Des Gorman.
- A session with the Director-General of Health.

Activity in the Non-DHB Sector

We have 184 members spread across 45 workplaces representing national health services (Family Planning and New Zealand Blood Service), hospices, rural hospitals, union health centres, iwi authorities, and general practice and sexual health services. The negotiation of settlements for the 149 of these members who have their employment conditions set by collective agreements other than the national DHB MECA is cyclical and the 2010-11 year saw 12 of the 15 agreements under negotiation. All of these are influenced in some way by the DHB MECA conditions with some sharing many aspects including salary scales.

In some cases (Waitaki and Central Otago Health Services) there has been 'pass on' of the 2% won through the DHB MECA and applied as of 31 January 2011. In others negotiations concluded have tended to gain small percentage salary increases while we wait for the MECA outcome.

Particular noteworthy this year was the successful establishment of a collective agreement for our 21 members employed by ACC. This was a difficult negotiation but eventually concluded to our satisfaction albeit as a work in progress.

Another new collective was successfully established at the Otago Community Hospice for five members as part of the strategy to join them in with the nine other hospices who are parties to the Hospice Palliative Care MECA. Terms of settlement from the hospice MECA negotiation are currently out for ratification with among other smaller changes a 2% salary increase, addition of secondment leave and finally having achieved parity with the DHB MECA for CME expenses of \$16,000.

In terms of other agreements the Wellington Primary Health Care multi-union collective agreement was finally signed off with small improvements for our members and the Ngati Porou Hauora collective concluded with a very good increase of CPI for 2011 which worked out as 5.6%. Christchurch Union & Community Health won 2.8% but largely 'rolled over' otherwise. Hauora Hokianga settled with a 1.7% increase in 2010 (backdated) and a 1% increase in 2011.

The Blood Service, Family Planning, Queen Elizabeth Hospital, Compass Health, Te Runanga Ora Toa and Central Otago Health Services are all in the process of negotiation as this report is prepared.

This year advocates from the Association have been Angela Belich, Lyn Hughes and Lloyd Woods. Special thanks go to all of the various members who joined or assisted negotiating teams. Their input and assistance is key to continued successful bargaining. The DHB MECA has a huge effect on the terms and conditions of senior doctors throughout New Zealand and these smaller collective agreements continue to spread this influence into general practice and other workplaces.

Industrial Team's Activities

The Association has a strong and very experienced industrial team to advise members about their various employment entitlements, to assist them in the application and interpretation of their employment agreements and to advise, represent and otherwise support them as they respond to complaints arising from their employment. The industrial team is led by Assistant Executive Director Angela Belich and has been fully staffed throughout the year by senior industrial officer Henry Stubbs and industrial officers Lyn Hughes and Lloyd Woods. The industrial officers operate from their base in the Association's national office in Wellington but travel frequently throughout the country, meeting members in their workplaces and holding discussions with management.

Members of the industrial team meet regularly, usually once a fortnight, to review delicate or complex cases and to discuss particular issues to ensure they offer consistent advice on routine matters and carefully considered advice on the more challenging cases and obscure issues as they arise.

A notable feature of the industrial team's work this year appears to be that despite a significant increase in serious and time-consuming cases, no case was referred to the Employment Relations Authority and there was a reduction in (a) the number of "involuntary" terminations of employment and (b) legal fees incurred.

Job Sizing

Many of the major DHB-wide job sizing reviews and adjustments have now been completed and those that remain to be completed or undertaken tend to be in smaller services or services where clinical workloads have slowly but relentlessly increased in recent years or where recruitment and retention issues have surfaced and forced the issue.

Services where industrial officers have been actively engaged in assisting job size reviews in the past year have included: radiology, anaesthesia, ICU, emergency departments, paediatrics, radiation oncology, medical oncology, general medicine, renal, and general surgery.

Advice to New Appointees

The industrial officers continue to provide useful and welcome advice to senior medical and dental practitioners contemplating appointments in New Zealand and to many applicants as they go through the appointments process. New appointees are very grateful for this service and almost without exception go on to join the Association once they take up their appointment. The Association website is also a very useful source of information and advice for prospective appointees.

Complaints by or about Members

There appears to have been an increase in serious cases involving complaints of one sort or another, by or against members. Frequently the complaint is couched in terms of bullying or harassment; these are difficult and elusive concepts and such complaints often generate a great deal of emotion on the part of one or both of the complainant and victim. Not infrequently, this “distress” requires periods of “stress leave” and occasionally some form of professional help before it is relieved. It is not unusual for both the complainant and the member complained about to become stressed and take time off.

In the year under review the industrial officers have advised and otherwise supported 21 members in major cases involving what might be described as “inappropriate” behaviour, including allegations of: abusive relationships, serious lack of collegiality, failure to carry out a clinical director’s reasonable instruction, misuse of sick leave and undertaking private practice while on sick leave.

Long-term illness & “return to work” plans

We have supported 17 members who had difficulties of these kinds. This would appear to be an increase over previous years. Such cases can also be quite time-consuming and emotional for the member concerned. Underlying problems have included: members facing terminal illnesses, coping with chronic illness or diagnoses of serious illness, the emotional impacts of being “bullied” by others, stress associated with the Canterbury earthquake or other traumatic incidents (including the death of a patient). Outcomes usually involve professional treatment followed by a gradual return to work and may include a return to work on a reduced job size or coming off the acute call roster.

Medical Council Health Committee

We have supported three members with health issues (two cases of addictions and one of terminal cancer) that were referred to the Health Committee of the Medical Council. These cases were managed in conjunction with the Medical Protection Society and also involved careful navigation through their employers’ processes and policies relating to paid sick leave, managing workplace risk, discipline and gradual returns to work.

Suspensions & Clinical Competence Reviews

We have supported five members facing restrictions on their clinical practice following concerns about their clinical practice. In each case the employer’s initial reaction was to impose clinical restrictions and seek a clinical investigation under the national DHB MECA (Clause 42).

- In two cases we successfully resisted calls for further investigation on the grounds that the concerns did not meet the necessary threshold and the restrictions were quickly lifted;
- In one case we successfully argued that the behaviours complained of could be more effectively addressed under a formal and strictly monitored “performance improvement

plan". The suspension was lifted and the member was transferred to another service. The Medical Council was also involved in aspects of this case, for which the member had MPS assistance;

- A fourth member is still awaiting a College practice review which will probably be followed by a performance assessment undertaken by the Medical Council. He continues to do limited clinical work; and
- The fifth member worked in a very small specialty and, at our suggestion, the matter was referred to the Medical Council who after an appropriate assessment found his practice to be seriously deficient in several respects. This member was eventually persuaded to retire and give up practice.

These cases usually require an immediate response as soon as we become aware of them. They also require a lot of time (at least in the initial stages) and close liaison with MPS.

"Involuntary" Termination of Employment

Involuntary terminations might include: dismissal, resignation or retirement in anticipation of dismissal (usually to avoid a disciplinary process or investigation of some kind). They might also include redundancy.

This year we have dealt with four involuntary terminations, which included two retirements following investigations into clinical practice and two redundancies. One of the redundancies involved a medical officer with a small appointment and the other a role reduction which rendered the position unsatisfying and the member concerned chose to take full redundancy.

This year's total of four compares with twelve cases in 2010 and two in 2009.

Salary Overpayments

In the course of the year, we have advised seven members who have been called upon to repay significant sums received as salary overpayments, most of which have occurred over several years. In almost all cases, the overpayments arose from human error in HR or payroll, e.g. salary was not reduced correctly after a change in job size or on-call; an allowance was not discontinued after a change in role or a mistake was made when the member was on a period of ACC.

These can be frustrating and intensely irritating issues for the member concerned and in several cases the overpayment continued long after the member drew it to the attention of management.

Government Superannuation Fund (GSF)

The GSF is a "defined benefit" scheme and was closed off to new members in 1992. A significant but diminishing number of Association members are also members of the GSF, which is both Government backed and guaranteed; its rules are very prescriptive and set out in statute. From time to time (but quite infrequently) issues arise as to what is superable salary and whether or not a member may remain in the scheme as they transfer from one DHB to another or from a University appointment to a DHB. We have had three enquiries about GSF issues in recent months, two of which are ongoing.

Application of Historical Agreements

In the early days of the Association, well before our first national DHB MECA, many highly service-specific local agreements were made. Some of them were quite "creative" as the service developed solutions that mingled recruitment and retention issues job sizing, roster frequency and after-hours work. Some of those deals have come back to haunt management as they endeavour to apply the MECA consistently across services and within regions.

Sadly for the DHBs involved, changes in personnel over the years and inadequate documentation have made it very difficult (if not impossible) for them to understand what the components of the

specific deals were and why they were entered into. Fortunately, the ASMS memory is longer and our documentation generally better; this gives us an edge in the process of deconstructing or preserving such agreements.

In the past year we have spent a lot of time on three such matters, involving the paediatric service at Waitakere Hospital, the locum agreement at Whakatane and a large mental health service. We have been successful in two and the third is ongoing.

Mediation & Legal Costs

No matters were referred to the Employment Relations Authority although we did refer three matters to mediation:

- A member's claim that the offer of salary (on obtaining vocational registration) was manifestly unfair having regard to the dealings between the parties when the member was appointed. Resolved in the member's favour;
- A member's claim for back-pay following a job size review. The member had left the job after the job size exercise was completed but before it was implemented. Employer paid up 48 hours before the scheduled mediation; and
- An employer sought to unilaterally increase a member's clinical work load following a job size review. The employer failed to recognise (or honour) a prior agreement with the member at the time of his appointment. Resolved in member's favour.

It is pleasing to note that the industrial team was able to complete their work in the past year and resolve most issues themselves with very little need to seek outside legal advice. Legal fees for the year were \$3,900 compared with \$29,100 in 2010, \$25,100 in 2009 and \$53,800 in 2008.

There are currently no outstanding cases that are expected to proceed to the Employment Relations Authority or the Court although there is one and perhaps two matters that might yet be referred to mediation.

Developments in Continuing Medical Education in DHBs

Last year's 'variation' to the national DHB MECA saw changes to Clause 36 (Professional Development and Education) which explicitly allows agreement with individual DHBs for members to apply their accrued CME funds to purchase laptops and other electronic aids whose "main purpose" is to support the member's continuing medical education and which would not otherwise be provided by the employer under MECA Clause 53 – Facilities and Equipment.

Since then the Association has secured major breakthroughs with stand-alone agreements with both the Auckland and Canterbury DHBs for the use of CME expenses to purchase information technology to be used for CME purposes and the class of travel available to members when travelling overseas for CME purposes.

The new Auckland DHB agreement includes the following statement:

ADHB recognises the use of Information Technology as a means of educating and developing SMOs and in principle approves the use of CME funds for the purpose of acquiring relevant items that support this.

The Otago DHB policy is closely aligned to that of Canterbury and almost all other DHBs now allow the use of CME funds to purchase items of IT equipment for CME purposes.

Both the Auckland and Canterbury agreements allow members to choose the class of air travel subject to journey time being in excess of four hours, there being sufficient funds available and the additional expenditure not compromising the member's College and Medical Council MOPS and recertification requirements.

In September 2011, the Association issued a revised *ASMS Standpoint* on Professional Development and Education which was sent to all members and is available on the ASMS

website. In addition to recording members' entitlements and placing them in the context of their professional and ethical obligations the *Standpoint* offers practical advice on the interpretation and application of their professional development and education entitlements and comment on problematic issues.

In a second important development during the year, the Association obtained a 'national ruling' from the DHBs' General Managers HR Group, which reinforced our own interpretation, that CME entitlements (both leave and expenses) would continue to accrue during periods when a member was on approved parental leave.

National Consultation Committee

The National Consultation Committee is set up under the national DHB MECA and is supposed to meet at least quarterly. In 2011 until the date of writing there had been only one meeting (24 August). The first suggested meeting did not take place because of a misunderstanding between the parties and the second meeting was cancelled by DHBs. A further meeting is scheduled for 23 November. After a period in 2010 when the NCC was beginning to develop some traction, DHB chief executives appeared to have placed a lower value on the NCC. It is planned to redraft the terms of reference for the NCC as part of the MECA.

At the only meeting for 2011 the NCC agreed the principles for regional and national service delivery for senior medical staff that had been under discussion for some time. The full text of the agreed guidelines is on the ASMS website.

They include an expectation that there will be agreed clinical service plans as a starting point based on the *Time for Quality* agreement and clinical engagement. Time and resources are to be allocated for the development of plans which need to be sufficiently detailed so that members understand what is expected and the plans need to be reflected in job descriptions. Travel requirements need to be included in job sizes and arrangements for accommodation and other expenses need to be made clear. Safe levels of senior doctor cover need to be considered as do health and safety and lifestyle impacts. Appointments need to be made in accordance with the MECA and with senior medical staff representatives from all relevant sites (Clause 52 of the MECA). The preference is for senior medical staff to have one employing DHB, recognition for extra responsibilities needs to be negotiated based on the MECA, and individual members job descriptions and employment arrangements can only be varied as allowed in the MECA. In most cases this will mean that job descriptions can only be varied by agreement.

Other issues discussed were the use of credit/debit cards for CME expenses, consultation obligations to ASMS in light of the Bipartite Action Groups which comprise the other CTU health unions, Waitemata DHB fee for service arrangements at Waitakere, Health Benefits Ltd, and issues arising at local JCCs.

Joint Consultation Committees (JCCs)

This is now year six of full operation for the DHB-ASMS Joint Consultation Committees. All JCCs, with the exception of the Wairarapa, have had, or are scheduled to have, at least three meetings by the end of this year. Members (and management) absences led to the cancellation of the third Wairarapa meeting. Members at Southland and Otago continue to have separate JCCs for practical reasons despite the merger of the two former boards into Southern DHB.

The Executive Director is normally scheduled to attend two out of the three JCCs at each DHB with the Assistant Executive Director attending the third (the Senior Industrial Officer has attended two JCCs this year in their absence). Industrial Officers try to attend at least one JCC in each DHB a year but often attend more frequently. Chief Executives normally attend the JCCs and report on what they consider the main issues for the DHB. This year regional planning and regional and sub-regional services have formed a substantive part of the agenda at each DHB.

Overall there has been good attendance at JCCs by members who have become JCC 'delegates'. In some DHBs, however, we have on occasions struggled to get sufficient numbers of members present. Ensuring good attendance might be a task undertaken by the new branch officers.

The JCCs have provided an opportunity to discuss national issues in terms of their local impact or the attitude that local Chief Executives and DHBs take to them. Among these issues discussed have been:

1. The local DHBs results in the Otago University survey of clinical leadership conducted by Robin Gauld and the questions around distributive clinical leadership that it raises. That conversation about clinical leadership has continued in all DHBs at nearly every JCC in some form whether as a discussion of clinical councils, clinical leadership in regional planning, new clinical leadership positions, clinical leadership structures or the job descriptions of clinical heads of departments.
2. The Minister of Health's 'Letter of Expectations' to DHB chairs.
3. Discussion of the 90-day 'fire at will' amendment to the Employment Relations Act at each DHB revealed that there was no intent at present in any DHB to use this provision with respect to senior medical staff (and little inclination to use it for other staff). Please note above comment about application of three months' notice of employment clause in the MECA.
4. Health Workforce New Zealand initiatives such as the prioritisation of funding for medical training, career planning for RMOs, GP registrar training and regional training hubs have been discussed at all DHBs.
5. Primary and secondary integration.
6. Health Benefits Ltd more recently have been discussed at a number of DHBs and should have been discussed at all of them by the end of the year.
7. Productivity and quality improvement initiatives have been discussed in all DHBs in one guise or another as have local and regional IT projects.
8. On the industrial front JCCs have discussed policies on CME expenses (the breakthroughs achieved on this front are discussed in more detail separately) and job sizing. We have also used the JCC to check on pending reviews and to ensure DHBs do not attempt to short circuit our consultation provisions by using the Bipartite Action Groups (DHBs and the other CTU health sector unions) as their only consultation mechanism.
9. RMO shortages have arisen as an issue at Northland, Waitemata, Auckland and Counties Manukau DHBs.
10. A number of DHBs have discussed hospital or facilities development plans (Northland, Bay of Plenty, Hutt Valley, Canterbury, South Canterbury, West Coast). Northland, Otago and Southland JCCs discussed SMO involvement in recruiting new chief executives.
11. There have been some issues arising from the Canterbury earthquake principally accommodation and other issues in Canterbury and some capacity and finance issues for neighbouring DHBs (West Coast, South Canterbury, Nelson Marlborough).

Issues specific to a particular DHB that have been discussed include:

- Renegotiation of the agreement for payment of SMOs covering for RMOs (Northland)
- Recruitment 'pause' (Auckland)
- Clinician control of clinics (South Canterbury)
- Second job policy and 'solo' SMO services (Hawke's Bay)
- Quality performance measures (MidCentral)

- The 'Rutherford' process for improving efficiency and their policy for dealing with bullying (Nelson Marlborough)
- Buller Integrated Family Health Centre (West Coast)
- Neurosurgery services (Otago)
- Wakatipu Review (Southland)

Joint ASMS-DHB Engagement Workshops

Since 2008 the ASMS and individual DHBs have been holding joint workshops on enhancing senior medical/dental staff engagement in their DHB. They are generally half-day (afternoon) with non-acute/non-emergency services not scheduled at the time, and have been well attended and successful. This year there have been 12 workshops with a further two scheduled later this year after Annual Conference.

Since the last Annual Conference workshops have been held in Northland, Waitemata (3), Waikato, Lakes, Tairāwhiti, Taranaki, Whanganui, MidCentral, Capital & Coast and Canterbury, with two workshops scheduled later in the year after Annual Conference in Hutt Valley and Lakes (second). The only DHBs where no workshops have been held at all since their inception remain as Auckland (although the holding of a workshop is currently being considered), Counties Manukau and Nelson Marlborough.

The subject matter has been wide ranging depending on the challenges facing each particular DHB. They have included general discussions on clinical leadership, devolved structures, regional (and sub-regional) clinical service planning, workforce flexibility and resolving local issues, reports of particular service and departmental issues and developments, primary care and the DHB's health services plan, reviewing the community laboratory testing contract, health funding, primary care overview, 'hospital after-hours', across-the-organisation projects, and the identification of three additional organisation-wide clinical key performance indicators.

MidCentral had a novel workshop held late afternoon-early evening focused on developing primary-secondary collaboration (including clinical pathways, information technology, and professional development and education) and involving both senior medical staff and general practitioners.

National Bipartite Action Group

As part of the 'National Terms of Settlement' (NTOS) in 2010 between the 20 DHBs and the three other main health unions affiliated to the Council of Trade Unions (Public Service Association, Nurses Organisation and Service & Food Workers Union), an agreement called the 'Bipartite Relationship Framework' was reached to "guide and support partnership activity". Further, the National Bipartite Action Group (BAG) was established to "oversee the framework and related activity including support for local DHB bipartite groups". Each DHB also has its own local BAG with the three unions. The BAG meets quarterly with 'face to face' meetings plus one hour teleconferences in some other months. The CTU and Ministry of Health also attend.

In January the National BAG wrote to the Association inviting us, as a CTU affiliated union to become a member. The Association had also been encouraged to participate in some local BAGs (particularly Hawke's Bay but also Bay of Plenty).

The National Executive considered this invitation at its February meeting but deferred it until its May meeting when it resolved to accept the invitation but as an observer.

The Executive Director attended the next full meeting of the National BAG on 13 June. Features of the meeting were presentations from the Health Quality & Safety Commission, Health Benefits Ltd, and Health Workforce New Zealand along with discussion on progress in the development of

national services. Subsequently, as discussed above, owing to the conduct of the DHBs in our MECA negotiations, the National Executive has suspended our involvement on this body.

Surveying Full-Time DHB Senior Medical Staff Base Salaries

Each year the Association surveys the base salary of SMOs. These surveys have been going since 1993 when local bargaining began and continued over the two national MECAs negotiated. The comparison incorporates advancement through the salary scales plus changes to the scales.

This survey is the 18th we have undertaken and gives a count as at 1 July 2011. The overall increase over the last four years has been 21.8% for specialists and 20.2% for medical officers:

- The annual increase between 2010 and 2011 was 2.7% for specialists and 3.5% for medical officers.
- The average base rate has increased for specialists by 2.7% to \$176,705 (\$168,965 for women and \$180,185 for men) between 1 July 2010 and 1 July 2011. The average base rate for medical officers has increased by 3.5% to \$137,495 (\$138,453 for men and \$136,330 for women).
- Specialists in the Wairarapa DHB on average have the highest base pay and those in Waitemata the lowest. Medical officers have the highest average base pay in South Canterbury DHB (albeit with only 6 in total) while those in Auckland have the lowest average base pay.
- The top step of both scales has the greatest number of doctors on it of any step with 1,145 specialists on the top step (out of 3,685) and 201 (out of 565) medical officers.

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 other special enhancements.

Surveying DHB Senior Medical Staff Superannuation Entitlements

Superannuation has been surveyed now for 11 years with the 11th survey being reported this year. As expected the pattern over the period has been a gradual decrease in members who are in the closed GSF and NPF schemes and an increase in those who receive the 6% subsidy under the MECA clause. As at July 2011 430 were in GSF and NPF (a decrease of 35 from 1 July 2010) with 3,171 receiving the 6% contribution as at 1 July 2011.

Wakatipu Health Services: Lakes District Hospital

An important activity of the Association, including active involvement by both the Executive Director and Assistant Executive Director, was endeavouring to prevent the privatisation of Lakes District Hospital in Queenstown and the reduction of senior doctor numbers by Southern DHB. It included the production of a *Health Dialogue* which fully set out the issues. The hospital had been under threat of privatisation for sometime. In 2010 Association intervention through insistence on compliance with the consultation obligations in the MECA led to the establishment of an agreed review run by a working group called a clinical advisory group. That group did not recommend privatisation when it completed its report last December and made a series of recommendations about moving forward. However, the then chief executive rejected this advice.

The controversy came to a head earlier this year with a proposal from management to set up an 'Integrated Family Health Centre' at Remarkables Park in conjunction with the largest primary care practice in Queenstown (Queenstown Medical Centre) to which hospital services would be transferred and where access to no-charge emergency care would be through a primary care triage. It included reducing senior medical staffing by 25% through cutting out the "swing shift" of doctors at the hospital from 1 July 2011 (there would have also been a reduction in nursing

staffing). By insisting on adherence to consultation obligations under the MECA the Association, with the support of the NZ Nurses Organisation, was able to challenge the DHB leading to agreement to establish a review to assess and advise on medical staffing levels.

However, the wider controversy attracted considerable media publicity with the opposition to privatisation by the Association, the Wakatipu Community Trust (who were in contact with the Association) and the second main general practice in Queenstown. This included Radio New Zealand (such as being the subject of an *Insight* documentary), *Otago Daily Times*, *Southland Times* and the local *Mountain Scene*. The culmination was a very well attended public meeting called by the DHB but leading to strong heated scepticism and criticism of its proposal. One feature of the meeting was the DHB's repeated reference to it having to adhere to the consultation obligations to the Association under the MECA.

This led the Ministry of Health, through its National Health Board, to set up an expert panel to advise on the future of health services in the Wakatipu region including Lakes District Hospital. Officially this was at the request of Southern DHB but in reality it was in response to chaotic consultation and planning by its management and the consequent loss of confidence in the DHB by the local population (and by its health professional staff in Queenstown). Concern was also evident from senior medical staff in both Dunedin and Invercargill. When the NHB exercise commenced the Association and Southern DHB agreed to suspend the staffing review (now abandoned because it was overtaken by events).

Panel members were Peter Foley (former Chair of the NZMA and Chief Medical Officer Primary, Hawke's Bay DHB), Angela Pitchford (Clinical Director of Emergency Medicine, Canterbury DHB), Mike Ardagh (Professor of Emergency Medicine, Canterbury) and David Russell (long time consumer representative who was also on the South Island neurosurgery panel).

The Executive Director and Assistant Executive Director had two meetings with the panel members (the second to discuss their recommendations in the week before the review became public). These meetings went well and it became clear that our *Health Dialogue* had a positive influence.

The panel's report was publicly released on Monday 29 August. Its major recommendations were:

- A clinical services plan across the Wakatipu region to ensure as far as possible equity of access and comparable outcome.
- Southern DHB to retain responsibility for governance and funding of Lakes District Hospital with a tier two manager with responsibility for Central Otago and LDH with responsibility for providing services independent of historic boundaries. A community reference group is to be established which the DHB is to consult early in the planning of any clinical service.
- The DHB to "retain and enhance services at Lakes District Hospital' which is to retain an emergency department and be further developed on its existing site. Other recommendations seek enhanced services at the site including a CT scanner, an invitation to other providers of health services to relocate to the site and more out patient clinics at LDH.
- The roster of medical staff is to remain at eight FTE as a minimum of which two may be registrars. Their time line has discussion with the Association and the hospital clinicians occurring in October 2011 (this has yet to occur).
- Several recommendations for a clinical services forum for the Wakatipu and increased cooperation with Dunstan Hospital (which is one hour's drive away).

This was a particularly successful campaign and the Association's role has been commented on favourably in the media. The Association's advocacy (including media, insistence on compliance with the MECA, collaborative relationship with the local community trust, and our publication)

were critical. The unity and determination of our members at Lakes District Hospital (and their nursing colleagues) was vital and the role of their delegate James Reid deserves special mention.

Trans Pacific Partnership Agreement

The Trans Pacific Partnership Agreement is an agreement under secret negotiation between New Zealand, Australia, United States and six other countries. Their objective is to complete negotiations by the end of this year. It was considered by the National Executive at its February and May meetings where it was agreed that the Association should use its normal channels, including communications, to raise its concerns. There are three main areas of special interest to the Association.

- Pharmaceuticals and the lobbying of large United States pharmaceutical companies to limit the use of generic drugs and competitive purchasing by Pharmac.
- The possibility that insurance companies that took over ACC could use disputes procedures to get compensation if future governments sought to reverse privatisation.
- Actions that could be taken by companies like tobacco or alcohol companies to limit public health initiatives such as plain labelling, restrictions on advertising, or restricting access because they damage that company's business.

The Association's concerns have been raised with the Director-General of Health, reported to members in *Executive Direct*, been the subject of an article in *The Specialist*, and a media statement.

Medical Council Matters

During the past 12 months the National Executive has considered a number of Medical Council matters.

Preliminary Competence Inquiry: Pilot

In February the Association was advised by email from the Medical Council of a 12-month pilot from 1 February 2011 of a new type of investigation, known as a 'Preliminary Competence Inquiry' or (PCI) into concerns about a medical practitioner. The pilot will run for 12 months from. This was considered by the National Executive at its February meeting.

The ostensible purpose is to enable the Medical Council to quickly and by a potentially cost saving means, obtain further information about concerns that have come to their attention about a medical practitioner, with a view to determining whether a more elaborate three-person performance assessment should be undertaken. The PCI would be undertaken by a single medical practitioner in a face-to-face interview of the medical practitioner about whom the concerns have been raised. The National Executive resolved to advise the Council of its concerns which were:

1. It does not attempt to assess the specific competence concerns but it is very difficult to see how this might be avoided unless those concerns were actually excluded from discussion at the interview. As a matter of natural justice, it is even more difficult to see how the concerns would not be discussed when they are the very reason for the PCI.
2. The interviewer is to look into the concerns and provide a report to Council. It is very difficult to believe that the report can avoid making any conclusions or judgement on the specific concerns if the report is to be the basis on which the Council goes on to make its subsequent decision to proceed or not with a full Performance Assessment Committee.
3. If the initial concerns do not disclose sufficient information on which to make a decision to order a Performance Assessment Committee, the Council should not embark on a 'fishing expedition' (by means of a PCI) to search for more information that might allow them to do so.

4. How is it possible not to investigate the initial concerns when the “interviewer will be asked to look into the concerns.” The phrase “looking into concerns” is simply another way of describing an “investigation”.
5. It is unlikely that any identification and commentary of a medical practitioner’s “weaknesses” will not implicitly (at least) include recommendations, or point the way, for further action.
6. The real test of the PCI’s benefit will be if the Medical Council decides not to proceed to a more formal and extensive Performance Assessment Committee in a significant number of cases.
7. The statement that the creation of a further layer of inquiry into a doctor’s practice will provide “better outcomes and support for the doctor” is open to question.

Proposal for Pre-Vocational Training

The Medical Council has initiated a review of pre-vocational training based on four options that include a change from three month to four month runs. All options include a requirement for certification in advanced cardiac support. The National Executive has some concerns with this proposal and has conveyed them to the Council.

The options are:

- Registration in a general scope after 12 months with runs in medicine in general and surgery in general and a choice of community care (community care includes general practice, community mental health, accident and medicine practice and drug and addiction) or emergency care. Registration in a general scope of practice will still occur after one year so this option would not risk losing a few cohorts of graduates to Australia before Australia puts restrictions on international interns, as is the case in the other options.
- Registration in a general scope after 16 months with runs in medicine in general and surgery in general, community care and emergency care.
- Registration in a general scope of practice after 12 months limited to preclude emergency medicine or general practice until they have completed runs in these disciplines, with runs in medicine in general and surgery in general and one additional run of their choice.
- Registration in a general scope after two years with runs in medicine in general, surgery in general, community care, emergency medicine, psychiatry and one additional run of their choice.

Former National President Dr Peter Roberts and the Assistant Executive Director represented the Association at a meeting with Medical Council on 19 July to discuss their paper. It became clear at the meeting that one of the main concerns for the Council was extending their control to PGY2. At present, because general registration occurs at the conclusion of PGY1 as a rule, PGY2 is out of the purview of the Council.

The Association’s concern, which was subsequently forwarded to the Council in writing, is that the paper puts the ‘cart before the horse’. The timing and construction of PGY1 and PGY2 will not improve until there are sufficient specialists with sufficient time to give resident doctors good quality training and sufficient specialists with sufficient time to undergo adequate training themselves on how to give resident doctors good quality training. General practitioners are themselves grappling with shortages and are unlikely to be in a position to take up much of the training burden.

We made the point that the ratio of resident medical officers to specialists has become increasingly unbalanced with the latest data (published in the *Business Case*) showing 24% of the total medical

workforce as resident doctors where the optimal balance is widely believed to be 8% to 12%. Some DHB data suggests that DHBs employ more RMOs than specialists.

The Association also emphasised that a higher proportion of locums (either SMO or RMO) makes the non-clinical burden including training fall on fewer specialists and that this will get worse before it gets better. More students, more junior RMOs (including GP registrars) and requirements for more explicit training for trainees will mean the service burden falls more heavily on specialists.

Proposals for Clinical Audit

In October the Medical Council sought the Association's views on a proposed definition and criteria for clinical audit. The proposed definition would be used in its resources, when assessing College recertification programmes for accreditation and when they audit recertification for doctors registered under a general scope. Initially, therefore, discussions would be with Colleges seeking accreditation for their recertification programmes.

At present each doctor must do at least one clinical audit per year to be recertified. The Medical Council says the criteria it proposes are congruent with that used by the Royal Australasian College of Surgeons.

However, the proposal has caused some concern among the Wellington and lower Midlands peer review group of child psychiatrists. They are particularly concerned that the requirement will require more non-clinical time than they presently have and that this will impact on the time available for patient care. Several psychiatrists, in the course of the email debate, have mentioned that even their current low level of non-clinical time is regularly interrupted by clinical demands and that there is not sufficient DHB administrative and other support to enable it to occur without being an unreasonable imposition.

Medical Council Fees: International Medical Graduates

At its June meeting the National Executive considered correspondence from the Medical Council asking for feedback on a proposed increase in the fees charged to international medical graduates seeking provisional vocational registration for the assessment of documents and interviews. The Council passes on these fees in their entirety to the Colleges it uses to assess IMGs. These fees had not been changed for seven years and there is a strong argument made that this has been unfair on the Colleges.

The Council proposed to increase them from \$177.78 to \$653 for the assessment of documents and from \$1511.11 to \$2,365.00 for an interview and to introduce two new charges of \$508 for a revaluation fee and \$75.00 for advice on a supervisor or employment.

The MECA provides for DHBs to reimburse vocational registration fees relevant to duties and responsibilities with the employing DHB. As long as the IMG has had an offer and acceptance and has terms and conditions set by the MECA at least part (and often all) of this fee will normally be paid by a DHB with respect to their employees. Please note that the MECA wording before the September 2010 'variation' was for vocational registration fee (once only). The Council's letter did not exhibit any awareness that the cost is likely to fall substantially on DHBs.

Request for Proposal for Recertification Requirements of Doctors with a General Scope of Practice

In March the Medical Council called for proposals from organisations to run a recertification programme for general registrants. This programme includes a requirement for a collegial relationship; an assessment of professionalism and cultural competence; a three yearly practice review (previously called a practice visit); and a yearly clinical audit. It will apply to most of the

Association's medical officers (but not to resident medical officers). The National Executive decided not to make a proposal, it being outside the Association's role.

Review of Policy on Registration within a Special Purpose (Post-Graduate) Scope of Practice

- The Medical Council has reviewed its policy on special purpose registration, in particular post-graduate (the other types of special purpose registration are teaching as a visiting expert, research and locums). The Council's concern was that the purpose of this scope of practice, which is to provide registration for doctors wishing to obtain knowledge and skills to take back to their own country, was not being adhered to. The changes include reducing the period of registration from two years to one and requiring two hours per week protected teaching time and attendance at tutorials and grand rounds. The main impact appears to be on resident medical officers from the United Kingdom. Although the National Executive considered this at its February meeting, it resolved not to make a representation leaving this to the colleges and other professional bodies.

Proposed Restructuring of 'Responsible' (Regulatory) Authorities: Medical Council

The Health Practitioners Competence Assurance Act 2003 established authorities to protect the health and safety of the public by ensuring that health practitioners are competent and fit to practice their professions. The Medical, Dental and Nursing Councils were among these. These are referred to in the Act as 'responsible' authorities but are also often referred to as 'regulatory' authorities.

The National Executive at its April meeting considered a paper prepared by Health Workforce New Zealand at the behest of the Minister of Health proposing that the Medical Council and all other responsible authorities are reduced in size and that all the authorities go from having separate secretariats to a shared secretariat. The proposal was projected to make savings of \$3.5 million annually for DHBs through less costly Annual Practising Certificates, decreasing the size of the Councils themselves, and having one secretariat to service all 16 boards.

The paper canvassed five options while coming down firmly in favour of the option of both decreasing the number of members on the authorities and having a joint secretariat for all the authorities. A change in the Act to allow for this may be one of the outcomes of the 2012 (or 2011-12) review so this issue will most probably be dealt with at that point as at least the Medical and Nursing Councils are likely to oppose the proposal thus making voluntary compliance unlikely.

This is probably the least acceptable part of the proposal for Association members. The Act specifies that the authorities may have between 5 and 14 members and that the majority must be health practitioners and that there must be at least three laypeople if the authority has more than nine members (and two lay people if the authority has eight or fewer members).

At present the Medical Council has 12 members, four are lay members appointed by the Minister, four are health practitioners appointed by the Minister of Health and four are medical practitioners elected by the profession. The discussion paper proposed that this number decreases to nine members. Three will still have to be lay members and four still must be elected (while the regulations on elections remain in force). With nine members it is hard to see how the numbers will stack up so a change in the regulations allowing elections must be a possibility as fewer members will make it harder to have a good spread over various scopes of practice, general practice and academics. The proposal for the Dental Council, probably because of the wide range of professions on the Council, was a decrease in membership from 10 to nine. Again three of these must be laypeople.

For the Medical Council the cost savings for this decrease in members are minimal and are likely to be offset by the need to seek specialist input when required that may be currently unavailable from within the Council itself.

The other part of the proposal was to amalgamate the secretariat of all the responsible authorities and this is where the paper sees considerable savings. However the risks include loss of expertise and an even less responsive Medical Council.

The National Executive approved a submission from the Association. As yet, the outcome of the government's deliberations is unknown.

Physician Assistant Pilot

In the 2010 Annual Report we covered the setting up of the Health Workforce New Zealand supported physician assistant pilot in Counties Manukau DHB involving two physician assistants recruited from the United States working in its general surgery department on acute admissions (not electives as originally envisaged but changed after determined opposition from the general surgeons). It is generally referred to as a pilot although HWNZ refers to it as a demonstration.

The 12-month pilot is now over and the two physician assistants have returned to the United States. In June the Association was contacted by Pam Oliver Associates advising that they had completed the formative evaluation of the pilot but that their contract with HWNZ had been terminated for the next part of the project (the summative evaluation). They said the summative evaluation was to be made available through the Ministry of Health. The Association made a request for the formative evaluation and the reasons for the termination of the contract under the Official Information Act. Eventually we received a copy of the formative valuation.

The key points in the formative evaluation are:

- A positive view of the practical arrangements for the trial.
- Very positive view of the impact of the two American trained physician assistants "performing at the level of a high performing house officer" but with "added maturity and significantly greater knowledge".
- No objective assessment of cost effectiveness as yet although the evaluation mentions a plan to obtain data on workflow and productivity impacts.
- Identification of longer term benefits should the pilot lead to the establishment of the role in New Zealand.
- Absence of clear goals for the trial and disjointed project management.
- A qualified yes in answer to the question of whether the physician assistant role was suited to the New Zealand health workforce but caveats to do with the special nature of the surgical team and DHB that the physician assistants were working in and the interpersonal skills and experience of the individual physician assistants involved in the pilot.
- Participants were clear that the role would need to be piloted in a range of settings before firm conclusions could be reached as to the suitability of the role in New Zealand.
- Remuneration paid to the participants was NZ\$130,000 (\$100,000 base salary, \$20,000 living away from home allowance and \$10,000 for staying the whole 12 months) in order to recruit whereas the salary levels mooted for the role in New Zealand were "a 15 step scale from \$51,000 to \$100,000.
- The pilot participants worked long hours and were clear that this could not be maintained indefinitely.

The Association sought the advice of the clinical head of general surgery who was enthusiastic about the individuals. Further:

- They were very experienced individuals and he doubted that someone who had just completed physician assistant training could have performed at the same level.
- The positions would need to be regulated under the Health Practitioners Competence Assurance Act as it was too onerous on the supervising specialists if they were not.
- They had had the effect of freeing house officers and registrars from paper work and thus considerably enhancing the training of the RMOs. However, this could be done by people with other clinical backgrounds who were recruited to do these tasks.

The summative evaluation is now being done by an Australian consultancy Siggins Miller who interviewed the Assistant Executive Director as part of the stakeholder evaluation. They are also being used for similar evaluation work in Australia. The Association has written to HWNZ outlining our views, based largely on the advice of general surgeons involved in the pilot, and advising caution in interpreting the evaluation. The response from HWNZ, however, ignores many of our points.

Health Workforce New Zealand Proposal for the Prioritisation of Training Funding for Medical Specialties

On 1 June the Association received an email from HWNZ which had attached draft prioritisation for determining its investment in medical postgraduate training for investment in 2011-12 and out years. However, the Association was not able to comment because of the very short deadline (11 days) and because of the difficulties of comprehending it.

In September HWNZ sent out to a range of organisations, including the Association, a paper outlining the process they are considering for prioritisation of medical disciplines for funding by HWNZ and seeking feed-back by the end of October. The Association has outlined these concerns in a letter sent recently to HWNZ.

The Association has put the HWNZ paper on the agenda for JCCs that have occurred since the proposal was circulated and we have sought to gain DHBs views on the paper. This has involved most DHBs. HWNZ is requiring the DHBs to send in only one response from all of them.

There was sometimes sympathy for what HWNZ was trying to do and a feeling that Colleges sometimes had too much influence without a wide enough view of future national needs. But there has been an overriding concern over the linking of funding prioritisation for training, which requires a long-term approach, to shorter term government target objectives which are largely shaped by the circumstances of the time, the policy of the government of the day, and the inclinations of the health minister of the moment. It also appears that the Medical Council has similar concerns including the authors' understanding of the data. The Association has also received feed-back from members, including at the JCCs.

Comments included that the document lacked rigour and was based on the assumption that the current levels of specialists were sustainable; that the maths was wrong; that enclosure 6 made no sense; that it would be likely that the time required to train as a specialist would outlive any government's commitment to a set of health targets; and that, at best, setting priorities on the basis of current targets for around 10 years in the future built in an expectation that the current targets would not be met before then.

It seems possible to envisage a far more fine grained approach based on the medical workforce needed in 10 to 20 years as estimated in the analysis of health needs in the long-term that has been done by the Ministry of Health's National Health Board. Further, the approach set out in *Securing a Sustainable Senior Medical and Dental Officer Workforce in New Zealand: the Business Case* which compares the numbers in each speciality in New Zealand to the number we needed to reach Australian levels is more sophisticated. Neither does the approach pay much heed to the comments made in a number of the service reviews commissioned by HWNZ about the future needs of the medical specialities.

Finally the process does not address the question posed by the *Business Case* – even if this process gets the training in medical specialities to exactly match the future needs of the New Zealand health system – it will be pointless unless the trainees stay in the country when qualified.

Changes to the General Practice Education Programme

In 2010 the Association was approached to provide a representative for the reference group on revising general practice training. The National Executive approved Dr Peter Freeman to join the reference group. This process was being undertaken jointly by the Royal New Zealand College of General Practitioners, Medical Council, and Health Workforce New Zealand. However, any decision on changes to the training is the College's to make.

The changes proposed were considered necessary in order to bring general practitioner training in line with the vision set out in the National Health Board's paper *Trends in Service Design and New Models of Care* which envisages much more of a cross-over between care delivered in hospitals and care delivered in primary care settings. The expectation is that GPs will need to be better equipped to work in hospitals as specialists do more work in the community. The initial modules being developed for GP training are in mental health & addiction and care of the elderly (both are being developed in conjunction with the appropriate specialist colleges).

The main changes recommended were:

- a new division between year one and the advanced training for years two and three;
- eight months of hospital based training over the 36 months;
- availability of new competency modules for trainees and fellows;
- the introduction of a compulsory academic programme;
- changed assessments including practice based assessments and a change in the way the written PRIMEX is assessed but no change to the clinical component; and
- enhancement of the GP bursary to bring it closer to the conditions of other registrars.

There are clear implications for the Association with new demands for training GP registrars on already overburdened senior doctors. There are also longer term implications with an increasing part of the hospital based workforce being made up of GPs. This is already occurring in a minor way with the longstanding GP liaison positions being joined by GPs employed in part-time positions and clinical leadership positions at DHBs such as Hawke's Bay and Nelson Marlborough.

As long as these positions and those of specialists working in the community are as employees of the DHBs, the national DHB MECA will tend to protect their terms and conditions of employment (as long as MECA conditions remain attractive to GPs).

The Association provided generally supportive feed-back on the paper which focused on the need to address the recruitment and retention crisis among DHB employed specialists if increased hospital based training for GP registrars is to be successful.

Appointments Audit

In late 2010 the Association sent out a survey auditing of the appointments clauses in the national DHB MECA. A pilot had been undertaken earlier in the year of the Canterbury and Whanganui DHBs. The audit was delayed somewhat in order to avoid overlapping with the *In Good Hands* survey undertaken by the University of Otago.

Numbers are too small to make an inter-DHB comparison valid with the exception of Canterbury and Auckland. However, the overall conclusion is that in the opinion of senior medical staff DHBs do quite well at consulting senior medical staff on appointments and DHBs generally

ensure that senior medical and dental staff are represented on panels. In other respects the picture is not as good with fewer members reporting that management had always acted on their views.

Council of Trade Unions

The Association first affiliated to the Council of Trade Unions (CTU) in 1990. As in previous years the Association continues to benefit from our affiliation 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 although clashing commitments have made this difficult. We also participate in its Health Committee, along with the NZ Nurses Organisation, Public Service Association and Service & Food Workers' Union, although the functioning of this body is being reviewed. The work of the CTU on analysing health spending and Vote Health in the Budget has been very valuable.

National Affiliate Council

There have been three Council meetings to date but the Association has only been able to attend two of them (a fourth is scheduled after Annual Conference).

Issues considered by the National Affiliate Council, included:

- The Canterbury earthquakes with particular reference to employment issues and rights for employees.
- Pike River Mine.
- Hobbit dispute.
- Accident compensation changes.
- Trans Pacific Partnership Agreement including with reference to Pharmac.
- Formation of 'Together', a novel union being set up by the CTU to allow employees in workplaces without collective agreements and union presence to join at low cost.

Together

- Along with other affiliates the Association was invited to sign a Memorandum of Commitment to the CTU's newly formed 'Together' which is part of the CTU's building union membership strategy. The focus is on areas where the workplace is non-union and there is no collective agreement coverage. There are three main categories of members – family membership (existing union members pay the subscription on behalf of a family member); gift membership (from a union member to a friend); and self-initiated individual membership. The annual fee is \$52. It is supported by a call centre currently run by the Public Service Association). Together does not have its own structure and instead will come under the umbrella of the National Affiliate Council.
- For the Association the commitment would be light promotion and at most have minimal work for the national office (payment would be direct to the CTU/Together). The invitation was first considered by the Executive at its February meeting and then at its May meeting it was resolved to authorise the Executive Director to sign the memorandum.

Biennial Conference

The CTU's Biennial Conference was held on 17-18 August with the Association represented by the Executive Director, Assistant Executive Director and Industrial Officer Lloyd Woods. Overall the conference was well organised, well chaired and good tempered. The official theme was "Workers Rights in the 21st Century" though the theme that went through the conference was a feeling of disturbance that union membership had declined by 2.1% overall and by 0.1% in terms

of density. CTU membership had declined by 9,000 and 21 out of 37 affiliates had had a decline in membership. Two unions had experienced increases of more than 200 members NZEI (the primary teachers union) with an increase of 741 and NZ Nurses Organisation with an increase of 2521 members. In previous years much of the discussion has centred on the precipitous decline of unions in the private sector; this year there was more attention paid to threats in the public sector. So far most of this has been focused on employees who are organised in the Public Service Association.

Most participants viewed the highlight as being the panel of media personalities discussing perceptions of unions in the media. This was chaired by political scientist John Johansson, with Sean Plunket (formally of Radio New Zealand) and 'Bomber' Bradbury, a media commentator and comedian. Also on the panel was Helen Kelly.

Other speakers were Metiria Turei (Green Party), Phil Goff (Labour Party) and Ged Kearney, the President of the Australian Council of Trade Unions (the Prime Minister had addressed the previous conference).

Instead of usual omnibus conference resolutions, policy resolutions were done by a series of resolutions proposed by the National Affiliate Council including employment law and union change; the workplace, and public servants and the state.

Meetings with Director-General of Health

The Executive Director continued his regular informal meetings, usually monthly, with the Director-General of Health, now Dr Kevin Woods who commenced his employment in January (Stephen McKernan until his departure and then Andrew Bridgman acting in the role) with six held to date (two further meetings are scheduled for later this year). These meetings are very useful to the Association and the Director-General also identifies benefits.

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:

- Updating on our national DHB MECA negotiations.
- Health Workforce New Zealand's proposal on funding prioritisation for medical specialty training.
- Regional services planning.
- Southern DHB and the National Health Board interventions over Dunedin Hospital and Wakatipu.
- Health Benefits Ltd.
- Trans Pacific Partnership Agreement.
- SMO-DHB relations (partly in the context of the Robin Gauld survey of the implementation of *In Good Hands*).
- SMO engagement workshops.
- Christchurch earthquakes.
- Health Workforce New Zealand.
- Specific internal DHB problems.

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 Canberra in April. Issues discussed of particular interest included doctors union representation in Queensland, the new Western Australian staff specialists settlement, updating on the proposed new federal health policy, physician assistants, the AMA's 'role of the doctor' statement; and the AMA's survey on specialist trainees. He also visited AMA (NSW) and the Chief Executive of the New South Wales Agency for Clinical Innovation in Sydney.
- The Executive Director visited Hobart in September to attend the second Industrial Coordination Meeting. Some of the issues he reported back on were the Health and Hospitals Network Reform Agreement between the federal, state and territory governments in August, the 'four hour rule' for emergency departments, industrial changes in New South Wales under the new government, representation of resident medical officers in New South Wales, the New South Wales staff specialist settlement, physician assistants, industrial coverage of GP registrars, and the national rural generalist pathway.
- The Executive Director visited Europe during late June and July. The two main purposes were to look at how governments of developed countries have responded to their health systems in response to the global economic crisis and the British government's proposed restructuring of the National Health Service. Most of the time was spent in England meeting officials of the British Medical Association, academics and researchers (including European Observatory, Kings Fund and Rand Corporation) and other unions involved in the NHS. The visit also included Cardiff (British Medical Association's Annual Representative Meeting), Paris (OECD and Trade Union Advisory Committee), Geneva/Ferney Voltaire (World Medical Association, Public Services International and WHO), Amsterdam (Landelijke vereniging van Artsen in Dienstverband - Dutch doctors union), Brussels (European Observatory, European Federation of Public Service Unions, and European Standing Committee of European Doctors - medical associations), and Dublin (Irish Medical Association and Irish Hospital Consultants Association). It was also an opportunity to again meet the Medical Protection Association. The Executive Director found the visit professionally very rewarding and is preparing a full report for the National Executive.

Association Publications

The *Specialist*, the Association quarterly newsletter (generously sponsored by the Medical Assurance Society) is a cornerstone of our advocacy and communications work. Since the last Annual Conference our national DHB MECA negotiations (and *Securing a Sustainable Senior Medical and Dental Officer Workforce in New Zealand: The Business Case*) have been the feature of all four issues from December to September under the headings 'MECA cup getting closer to political lips', 'MECA negotiations on a cusp: but of what', 'Dictionary guide to negotiating with polymorphous DHBs' and 'Negotiating with an apparition'. Feature articles were on the following subjects:

- Dr Robin Gauld's survey on the application of *In Good Hands*.
- The senior dentist workforce.
- Understanding the crisis that can't be avoided: the Business Case as a blueprint for the future.
- Health Benefits Ltd - don't be fooled by the name.

In addition to further material on the DHB MECA negotiations and the *Business Case*, other issues covered included:

- Changes to the Employment Relations Act: what they mean for senior doctors.
- UnionAid.
- Trans Pacific Partnership Agreement – the end of Pharmac as we know it?
- The government's 2011-12 Budget.
- A public hospital in Queenstown.
- Misuse of medical workforce data.

In addition there have been regular columns by the National President, Executive Director and the Medical Protection Society.

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. It is increasingly being used by journalists as a resource and source of information and comment. *ASMS Direct* also links in with news items on the website homepage. The membership circulation list is 3,200. To date 25 issues have been produced this year. Much of this has focussed on the national MECA negotiations, *Securing a Sustainable Senior Medical and Dental Officer Workforce in New Zealand: The Business Case*, Medical Council reviews and initiatives, World Medical Association statements, branch elections

Other subjects covered included:

- DHBs' response to the Association's call for DHBs to support senior doctors in coping during MRT and laboratory workers strikes.
- Clinical Governance Development Index.
- Frustrated specialist turns to poetry.
- Pike River families support appeal.
- UnionAid.
- The Hobbit dispute.
- Medical indemnity and Medicus.
- Waikato specialist double-dipping allegation and unhelpful RDA comment.
- National Executive elections.
- Contribution from National President who was in Christchurch at the time of the February earthquake.
- Collective bargaining for non-DHB members.
- HWNZ and incorrect senior doctor workforce numbers claims.
- Lakes District Hospital (Queenstown).
- Medicines Adverse Reactions Committee: call for expressions of interest.
- Closure of physician assistant studies programme in Queensland.
- National Health Board interventions in Dunedin Hospital and Wakatipu.

- ASMS comment on HWNZ service review reports.
- Health Quality & Safety Commission: medication safety fact sheet.
- Application to members of 90-day trial 'fire-at-will' amendment to Employment Relations Act.
- Use and misuse of medical workforce data by government.
- Persecution of Fijian union leader.
- Forfeiture of annual leave.

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

Four issues of our electronic publication, *Executive Direct*, have been sent reporting on the February, May, June and September Executive meetings.

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 eleventh in succession). Membership, as of 31 March 2011 was 3,572, compared with 3,496 at 31 March 2010, representing an overall increase of 76 (0.2%). It represents a 148% increase over the 1,440 members in our first year of existence (1989-90). The bargaining fee, introduced in 2008, attracted payments from 112 senior medical and dental staff this year; to date 54 bargaining fee payers 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%), 004-05 (239 – 10%), 2005-06 (164 – 6.4%), 2006-07 (95 – 3.5%), 2007-08 (162 – 5.7%), 2008-09 (486 – 16%), 2009-10 (15 – 0.4%) and 2010-11 (76 – 2.2%) an overall increase of 104% 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 102 (7.1%). Under the period of the Employment Contracts Act (1991-92 – 2000-01) the average 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 160 (8.1%).

Currently membership is 3,580, an increase of only 8 since 31 March 2011 however this figure does not include the 30 members who have yet to renew their annual membership, although membership growth in the latter part of the year is generally offset by subsequent resignation factors such as retirement that always occur at the end of our financial year, we expect the 31 March 2012 membership to exceed current numbers. 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 90% of our members pay their subscription by automatic salary deduction (about 86% 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 11% of our current members. Just 2.5% of members who joined the Association in 2011 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 Executive Director visited the MPS in their London office in June. The Association also met MPS Chief Executive Tony Mason and Dr Rob Hendry from the United Kingdom last month while they were visiting New Zealand. The MPS provides a regular column for *The Specialist*. We are grateful for the generous decision of MPS to again sponsor the Conference dinner. Further, the Executive is pleased that Tony Mason, who will soon be retiring, will be attending Annual Conference as an observer. The Association has had an excellent relationship with him during his time as chief executive and we wish him the best for the future.

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 (this sponsorship has been provided for several years).

The quarterly advisory consultancy meetings (three held to date with the fourth scheduled in December after Conference) between the Executive Director (and Executive Officer) and Society Chief Executive Martin Stokes (and Sales and Marketing Manager Glenys Powell) continue. Discussions at these quarterly meetings have also included our concerns with our national DHB MECA negotiations (including the *Business Case*), the continuing impact of the Canterbury earthquakes and MAS's work, our advocacy over Lakes District Hospital (Queenstown), developments in the Medical Protection Society's counselling service (administered by MAS in New Zealand), our branch revitalisation including the concluded elections.

MAS have also commissioned research from the Association on international medical graduates in New Zealand with particular reference to those that leave New Zealand within three years.

Association Finances

The Association's net surplus was \$482,730 for the financial year ending 31 March 2011 due mainly to the total expenses being under budget and interest earnings and bargaining fees exceeding expectations.

The ASMS Investment Committee comprising Executive member Paul Wilson, Executive Officer and MAS' Investment Products Manager (Daniel Callaghan) reviewed the investment strategy and, given the economic climate, agreed to continue placing reserves on reasonably short term deposits; currently these total \$2,805,801 over varying terms of between 6 to 15 months.

In March the Association received a letter from a member employed part-time by a DHB but without private practice. With an annual salary of around \$70,000 she believed the Association's abatement policy disadvantaged her relative to members who were full-time (her fortnightly deductions were over 50 cents less than full-time members). The Association's abatement policy, which is determined by the National Executive as enabled by the Constitution, is not pure pro rata. Instead it is the full subscription or 1% of annual gross salary, whichever is the lesser. This policy was first established by the National Executive in 1990 at 1.5% of salary (subsequently revised to 1.25% later that year and then to 1% in 1994 following a review by the Executive).

The member's initiative was appreciated by the Executive because it provided an opportunity to again review the policy. The outcome was to reaffirm the existing formula. It was noted members who paid the abated subscription still received full (rather than proportionate) representation and,

further, that part-time DHB employed members (without private practice) were entitled to full reimbursement of some entitlements, such as continuing medical education expenses, annual practising certificate and Medical Protection Society membership.

Following the Pike River mining disaster, and after electronic consultation with the National Executive, the National President authorised the donation of \$10,000 to the Engineering, Printing & Manufacturing Union's Pike River Miners Family Support Trust. The trust is for all families of those who lost their lives, not just union members. Half the money raised was forwarded to the appeal administered by the Grey District Council; the half went to an education trust for the families' children. The National President's decision was ratified by the Executive at its February meeting.

At its May meeting the National Executive considered financial support for the victims of the Canterbury earthquakes. It was noted that Auckland DHB had provided a facility for its staff to donate a portion(s) of their pay. It was agreed to write to the Chair of the Chief Executive Group of the 20 DHBs recommending that if they do not already do so, all other DHBs should be encouraged to provide this facility and to advise members of this. The Association's letter was favourably received by the DHBs (some other DHBs had already provided a similar facility).

Administration

The administration team, led by Executive Officer Yvonne Desmond, is an experienced and dedicated team ensuring that the office runs smoothly and the industrial team is well supported.

Strong focus continues on communicating with members in a timely and efficient manner, striving for efficiencies in all areas along with maintaining the professional standard of the Association's publications (including the *StandPoint*, *Health Dialogue* and *Specialist Workforce Alerts*). The salary and exit surveys are also conducted on a regular basis.

Website

Maintaining and regularly updating the ASMS website remains a key focus with the homepage continually evolving to accommodate the relevant news and information. As well as providing the latest health sector news, the improved site continues to serve as a 'one stop shop' for SMOs seeking advice and current industry information; attracting 1,500-2,000 visitors each month. Excerpts from a recently filmed staff PR video will soon be added to the 'About Us' section, enabling members to associate names with faces.

Job Vacancies Online (jobs.asms.org.nz)

For most senior doctors and dentists seeking employment in New Zealand the ASMS website is their first point of contact; it has New Zealand's most comprehensive listing of specialist and medical/dental officer job vacancies (80 on average). Because jobs.asms.org.nz is a service rather than a business venture, the rates are very affordable with proceeds put into growing the market and enhancing our services to both jobseekers and their prospective employers. Regular advertising with BMJ Careers continues and we are encouraged by the increased number of DHBs utilising the service.

Other Matters

Associate Membership

Clause 7 of the Constitution provides for former members no longer eligible for membership to apply to the National Executive to become associate members (\$100 per annum subscription). The main benefit is receipt of Association publications and the right to attend Annual Conference as an observer. Dr Don Mackie applied to join as an associate member. He has been a member since

1996 through his employment at the Wairarapa, Hutt Valley (where he was also a JCC delegate) and Counties Manukau DHBs (as Chief Medical Officer). He has also attended some past Association Annual Conferences. However, his recent appointment as Chief Medical Officer by the Ministry of Health meant that he was no longer eligible (Association membership does not cover government departments and ministries). His application was accepted at the September Executive meeting. He is the Association's first associate member.

Requests for Support

The National Executive received requests for financial support from the organisers of the 'Health of the Health Professional' conference in Auckland (November) and promotion support for the University of Otago (Christchurch) 40th anniversary celebrations (February 2012). While the National Executive considered it went beyond the role of the Association to provide financial support for the first event, both have been promoted in *The Specialist* and *ASMS Direct*.

Chief Medical Officers Draft Statement on Professional Standards of Behaviour

The national DHB chief medical officers group has prepared a draft statement on professional standards of behaviour which was considered by the National Executive at its September meeting. The Executive's concerns were around uncertainty over what behaviour in particular it was aimed at and why it is needed in addition to the other codes and statements in the profession (such as the colleges) as well as the State Sector Code of Conduct and DHB specific policies.

General Practice New Zealand

Following an informal meeting with the Executive Director last December the Association received a request from General Practice New Zealand seeking to build on the joint statement between the two organisations (reported to the 2010 Annual Conference) and the session on primary care at the last year's Conference involved Dr Bev O'Keefe (GPNZ Chair). In particular, the request was to co-host DHB based workshops involving DHB employed senior doctors and general practitioners. The objective was to enhance clinical leadership in primary-secondary collaboration. Unfortunately preoccupation with our national DHB MECA negotiations has prevented progress on this although Dr O'Keefe attended the MidCentral engagement workshop on primary-secondary integration discussed above.

Pan Professional Medical Forum

The Pan Professional Medical Forum comprises the Council of Medical Colleges (which convenes it and provides secretarial services), NZ Medical Association, Resident Doctors' Association and the Association. However, no meetings have been held this year through a combination of late calling of meetings and unavailability of the various organisations. There appears to be a lack of interest in the PPMF meeting and the National Executive has doubts over its future utility.

Budget 2011-12

The Assistant Executive Director prepared a summary analysis of the Budget announced in May for the June Executive meeting. It included the forecast that the government will return to surplus in 2014-15; the dependency for economic recovery on the rebuild of Christchurch following the earthquakes; the financial cuts in the state sector outside health and education; ceasing the States Services Commission's funding superannuation payments to state employers (eg, DHBs) for KiwiSaver; the estimate of the approximate \$127 million under-funding of health services; and the increase of minimum compulsory employer and employee contributions to KiwiSaver in 2013.

Medicines New Zealand

On 10 August the Executive Director and Assistant Executive Director met with Kevin Sheehy Chief Executive Officer of Medicines New Zealand at his request. Medicines New Zealand used

to be known as the Researched Medicines Association and its member companies include Pfizer New Zealand, Bayer Schering Pharma, Roche Products (New Zealand), Merck Sharp and Dohme (New Zealand) plus another 11 pharmaceutical companies. Most of the time was spent on discussing the Trans Pacific Partnership Agreement negotiations. He said that his organisation did not have an issue with the existence of Pharmac but that not enough new products were getting to the market in New Zealand. Medicines New Zealand describes what it is seeking in respect of Pharmac as being more funding for medicines, transparent scientific debate, an appeals process and clear time frames.

Health Workforce New Zealand Service Reviews

At its June meeting the National Executive considered the six health workforce services reviews commissioned by HWNZ which was interested in pursuing the following proposals:

- Expanded scope of practice for anaesthetic technicians (anaesthesia).
- Expanded role of optometrists to manage patients with chronic eye conditions (eye health).
- Advanced physiotherapist practitioner role to manage non-surgical musculoskeletal patients (musculoskeletal).
- Testing the role of nurse endoscopy in the New Zealand environment'
- A number of other projects resulting from other initiatives.

The National Executive decided to take no further action on these matters but will monitor their progress.

ACC

The National Executive considered government proposals to change the accredited employer scheme. While there were concerns it was resolved not to make a submission recognising that the Council of Trade Unions would be.

Brian Craig
ASSOCIATION NATIONAL SECRETARY

9 November 2011