

# The Specialist

THE NEWSLETTER OF THE ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

## Ministerial intervention—new potential dynamic in MECA negotiations

On 20 February the Hon David Cunliffe, the relatively new Minister of Health, met the ASMS National Executive for an informal discussion over the impasse in our lengthy and bitter national DHB MECA negotiations. The National Executive were forthright in their advocacy to him of the seriousness of the medical force crisis, the approach and position of the DHBs, and the strength of feeling of senior doctors over taking industrial action, as mandated so strongly in the national ballot.

The Minister engaged actively with the National Executive who was impressed with his sincerity, conviction and apparent determination. Mr Cunliffe pleaded with the Executive to put its intention to give notice of limited industrial action on hold for a month in order for him personally to facilitate a resolution of the dispute between us and the DHBs.

### Recalling 'Sideline Stan'

Direct and explicit intervention by the Minister of Health in an industrial negotiation is unprecedented for a good two decades. While there have been rare and occasional political interventions in the past, they have been secretive and certainly not in the open.

Up until the mid-1980s there was a statutory authority for the Minister of Labour to convene a compulsory conference of the parties in the event of a breakdown or otherwise serious situation in negotiations. However, this changed with new legislation that decade when the then Minister of Labour, Stan Rodger (of the Labour government of that decade), adopted a new position, choosing deliberately not to intervene. He was derided by his political opponents at the time as 'sideline Stan' but rode it out and wore the attacks as a 'badge of honour'. He was vindicated to the extent that his critics subsequently stuck to his approach when they assumed the Treasury benches.

### Political risk for Mr Cunliffe

The Minister has embarked upon a high risk strategy because of the risk of embarrassment if he fails. What stands out the most is his explicitness and openness. His political opponents were silent when the news broke out

but, should he not succeed, the boots and knives will be out. The National Executive's assessment of his desire to intervene is that it was sincere. He also expressed genuine appreciation of the importance of senior medical staff in the ability of DHBs to move forward.

But there is no doubt that the Minister's initiative is in direct response to the 88% vote late last year in the ASMS national ballot in favour of limited industrial action. Mr Cunliffe was acutely aware that the Executive was on the verge of confirming formal notification of industrial action as much as he was also acutely aware of the fact that it is election year.

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In recognition of this unique opportunity and his recent reputation as a 'head banger' with Telecom as Communications Minister, the National Executive at its formal meeting the following day resolved to accept his invitation. This has been confirmed by us and the Minister in writing (refer to page 3). A special Executive meeting has been scheduled for 25 March to assess whether Mr Cunliffe has been successful in his objective.

### Intervention an indictment of DHBs' industrial relations strategy

Mr Cunliffe's offer of intervention is an indictment of the failure of the DHBs industrial relations strategy and their failure to work together effectively at a national level. This failure is a consequence of DHBs nationally being no greater than the sum of their parts and dragged down to the lowest common denominator.

It has been evidenced by past behaviours of (a) 'managerialist' counter-claims that sought to fetter

### ASMS

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senior medical staff professionalism, rights and influence, and professional development and education, and (b) disingenuous and at times downright dishonest public relations spin.

**Mr Cunliffe's offer of intervention is an indictment of the failure of the DHBs industrial relations strategy and their failure to work together effectively at a national level**

The Minister's difficulty is, despite widespread perceptions to the contrary, that his statutory levers on DHBs are limited. The power to sack a board, appoint new board members and appoint a commission does not extend across to all parts of DHB roles and responsibilities. His levers are not as direct as in his previous immigration portfolio. Nor are they as direct as in the education portfolio where, unlike the Ministry of Health, the State Services Commission is an official 'employer party' (which it formally delegates to the Ministry of Education thereby bringing in the Education Minister) for collective agreement negotiations covering primary and secondary schools. Nevertheless, if not formal levers he is not without significant influence.

### ASMS focus

The focus of the ASMS's position in this unique process will be on:

- An enhancement of existing terms and conditions, including salaries, to provide a temporary clamp or slowdown on the current bleeding of senior doctors to Australia and elsewhere.
- Achievement through an investigatory 'commission of inquiry' of a new 'pay fixing' process to address New Zealand's recruitment and retention vulnerability in light of the threats to our public health system posed by the far superior terms and conditions of employment in Australia and the private sector in New Zealand.
- Retention of existing rights under threat from the DHBs, particularly consultation rights.

In the meantime, however, the National Executive has determined the form and dates of limited industrial action in the event that the Minister's intervention does not succeed this month. The form of action would be consistent with the ballot outcome. However, no written notification will be given to DHBs during this one month period. By its special meeting on 25 March the National Executive will be in a position to assess whether Mr Cunliffe's initiative has succeeded and whether the industrial action button needs to be pressed.

This is a most unusual situation to be in and David Cunliffe is a most unusual and hopefully refreshing Minister. He is very self-confident but the proof will be in the eating of the MECA.

**Ian Powell**  
Executive Director

**MEDIA  
RELEASE**

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## Ophthalmologist shortages

*On 4 March the Royal Australian and New Zealand College of Ophthalmologists made the following media statement, in the name of Dr Jim Stewart, expressing serious concern about the level of workforce shortages.*

The New Zealand Branch of the Royal Australian and New Zealand College of Ophthalmologists (RANZCO) has expressed concern about recently highlighted shortages of ophthalmologists in Dunedin and elsewhere in New Zealand.

There are currently 16 unfilled public hospital vacancies nationally for ophthalmologists. This national shortage of ophthalmologists is not due to a reduction in the numbers of specialists being trained, except temporarily

in Dunedin where trainee numbers have had to be reduced because of the shortage of consultant ophthalmologists.

The College wishes to establish more training posts and has done the preparatory work for this, but new positions are dependant on the funding of salaries and the provision of clinical space and operating theatre time in our public hospitals.

We have a steady loss of New Zealand-trained ophthalmologists to Australia, where they can earn twice as much. For instance, there have been recent departures from Auckland, Palmerston North and Timaru.

## Ministerial correspondence on requested intervention in MECA negotiations, 21 February 2008

MINISTER CUNLIFFE TO ASMS

Dr Jeff Brown  
President  
Association of Salaried Medical Specialists  
PO Box 10763  
Wellington

Dear Jeff

Thank you for the opportunity to talk to your executive yesterday. I found it a useful exercise and hope you did also.

I understand that you are deferring any decisions on any action your members might take in order to utilise the opportunity I suggested to facilitate directly a meeting between you and the DHBs to work towards an early settlement of your MECA dispute. I understand the mandate you have and am grateful for your co-operation. Senior doctors play a key role in the provision of a quality public health service.

At the meeting (or meetings) I am proposing the opportunity will be taken to work towards an early settlement. I am looking for a final result, if possible, within a month.

I will copy this letter to the District Health Boards and will publicly confirm that I have written along these lines.

I would be grateful for your early confirmation of your acceptance of this.

Yours sincerely  
**David Cunliffe**  
Minister of Health

ASMS TO MINISTER CUNLIFFE

Hon David Cunliffe  
Minister of Health  
Parliament Buildings  
Wellington

Dear David

Thank you for your letter of 21 February acknowledging the National Executive's deferring of industrial action.

You propose an opportunity to work towards an early settlement within a month.

We accept your proposal including your personal facilitation of this opportunity.

The National Executive has scheduled its next meeting on 25 March 2007.

Yours sincerely  
**Dr Jeff Brown**  
National President  
ASMS

## PAN PROFESSIONAL MEDICAL FORUM

March 6, 2008

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Wellington

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Email: cmc@cmc.org.nz

**MEDIA  
RELEASE**

### Doctors warn of workforce crisis

Doctors' representatives met this week to discuss the state of the medical workforce.

The organizations were the Council of Medical Colleges, the New Zealand Medical Association, the New Zealand Resident Doctors' Association, the Association of Salaried Medical Specialists, and the New Zealand Medical Students' Association, who between them represent all doctors and medical students, said Associate Professor Phil Bagshaw on behalf of the Pan Professional Medical Forum.

The Summit was held on the 3<sup>rd</sup> March and organized by the Pan Professional Medical Forum.

The Summit concluded that the New Zealand medical workforce is in crisis because of its inability to train and retain enough doctors to provide the health services that New Zealanders deserve.

The Summit calls on the Minister of Health to publicly recognize the seriousness of the problem.

"We want him to actively work with us in developing an effective strategy to train and retain more doctors in both the short and long term. We acknowledge Mr Cunliffe's expressed willingness to do so. We want this to become a commitment to take action.

"Letting the crisis continue is not an option. It will burn out the remaining medical workforce and deny New Zealanders basic rights of access to quality patient care."

#### Contact details:

Associate Professor Phil Bagshaw  
Facilitator PPMF  
Phone: 027 233 3791

**ASMS**



### ASMS services to members

#### As a professional association we promote:

- right of equal access for all New Zealanders to high quality health services
- professional interests of salaried doctors and dentists
- policies sought in legislation and government by salaried doctors and dentists

#### As a union of professionals we:

- provide advice to salaried doctors and dentists who receive a job offer from a New Zealand employer
- negotiate effective and enforceable collective employment agreements with employers. This includes the collective agreement (MECA) covering employment of senior medical and dental staff in district health boards which ensures minimum terms and conditions for around 3000 doctors and dentists, over 90% of this workforce.
- advise and represent members when necessary
- support workplace empowerment and clinical leadership

### Other services

#### [www.asms.org.nz](http://www.asms.org.nz)

Have you visited our regularly updated website? It's an excellent source of collective agreement information and it also publishes the ASMS media statements.

We welcome your feedback as it is vital in maintaining the site's professional standard.

#### ASMS Job Vacancies Online

##### [www.asms.org.nz/system/jobs/job\\_list.asp](http://www.asms.org.nz/system/jobs/job_list.asp)

We encourage you to recommend that your head of department and those responsible for advertising vacancies, seriously consider using the facility.

Substantial discounts are offered for bulk and continued advertising.

#### ASMS email Broadcast

In addition to *The Specialist* the ASMS also has an email news service, *ASMS Direct*. This is proving to be a very convenient and efficient method of communication with members.

If you wish to receive it please advise our Membership Support Officer, Kathy Eaden in the national office at [ke@asms.org.nz](mailto:ke@asms.org.nz)

### How to contact the ASMS

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President's Column

## Cooking the books

Your negotiating team has endured almost two years of spreadsheet manipulation backing DHB manoeuvres between cost postures for any future funding of you. Eventually we have come to ask:

**How can they not see the blindingly obvious? The bleeding out of a specialist workforce.**

### What are the costs?

The experienced experts eventually packing up their lifestyles and moving to where they have close colleagues, lifelong professional linkages. And the ability to return to their offspring and offspring's offspring for significant life events. Or just for recreation.

### What are the costs?

The new but disillusioned dynamos dropping kiwi aspirations for the lure of more support, bigger departments, more resource, wider research opportunities and overall optimism for careers of caring. And the ability to return to their ancestors and roots for significant life events. Or just for renovation.

### What are the costs?

Add in the illusory locum-filled landscape whose cracks and chasms are papered over with short term, agency-fuelled patches. Add the dwindling applicant lists for vacancies even for the "plum" jobs in the big centres.

### What are the costs?

The multiplier effects of diminished full time complements left to assess and examine, to plan and manage, to investigate and report, to supervise and mentor.

### What are the costs?

The divisive demands of unfilled resident rotas, of gaps in continuity of teams. The lack of consistent colleagues to educate and hand on the torch of professionalism.

### What are the costs?

The desperate local solutions to beg, borrow or steal any warm body and brain to prop up a service. And pay any above or below the table odds to keep off the front pages of the papers.

### What are the costs?

In any sensible spreadsheet these costs would be factored into any amortisation of awards or offers. How can they not see the blindingly obvious?

Perhaps because the human cortex is wired to cook the books. We see what we expect to see. And the more

stressed we are the more we see what we want to see. Experiment after experiment shows us that accounting for life is a pretence at reality, prefaced by all our expectations and desires. We cook the books.

When oenophiles are given white wine tinted with red food colouring they enthuse with the descriptors redolent of red wine appreciation. When branded analgesics are openly used they have more effect than cheap generics. When intelligent observers expect to count basketball bounces they fail to see the gorilla in their midst.

Our daily existence depends on unconscious "filling in" and "filtering out" of sensory input. All modulated by experience and belief systems. All strongly modified by those we spend our days with.

So a CEO floundering between a CFO and a Board, between a public and a Ministry, and believing in the safety of the Consensus of 21, will unsurprisingly act in concert quite differently from how they act when solo. Privately hurting and hunting for solutions, together they cannot see the blindingly obvious.

That all their accounting forecasts for MECA solutions are predicated on worst possible financial scenarios with no factoring of the current excesses which may be reduced. That all their risk avoidance actually maximises chances of system meltdown with no allowance for the rich returns resulting from medical morale.

That their specialist workforce is bleeding out. To Australia and private domains. That stemming that bleeding is far cheaper than transfusions. And safer for the patient. It is blindingly obvious, when your cortex expects and believes, that cooking the books fools only those who prepare to be fooled.

### What are the costs?

But walk and work with those you need to keep, and the solutions are more brave and more sage.

**Jeff Brown**

National President

\*This article was written prior to the commencement of the 'negotiations' with the Minister of Health and DHBs earlier in March.





Henry Stubbs, Senior Industrial Officer

## HDC shines a torch on SMO appointment processes—a cautionary tale

*A DHB has a duty of care to exercise reasonable care and skill when employing staff...*

*The fact that written references were old and, in the main, not from [clinicians in the same specialty], should have been queried....*

*What happened when employing Dr Hasil was a departure from usual practice....*

*The credentialing committee then simply “rubber-stamped” the application and failed to adequately scrutinise the documentation....*

*The evidence discloses a general lack of rigour on the part of the DHB in the appointment of Dr Hasil. In my view, the referees.... should have been independently checked and Dr Hasil’s last known employer and/or supervisor should have been contacted..... The DHB failed to take these steps.*

### **HDC Report: Dr Roman Hasil and Whanganui DHB 2005-2006.**

The recent report of the Health and Disability Commissioner into Whanganui DHB’s obstetric service: Dr Roman Hasil and Whanganui District Health Board 2005-2006 is a salutary reminder of the need for employers of senior medical officers to have robust and transparent appointment processes and to rigorously apply them.

It may also have caused some of our members to whisper under their breath: *there but for the grace of God....*

The appointment of SMOs is far too important a matter to be left entirely in the hands of managers and HR practitioners; in an environment of true clinical governance, the shape and design of each service, the clinical component of each SMO position, and the recruitment and appointment of each SMO within the service should be driven and led by the other senior medical officers in the service.

This is particularly important in the present environment of SMO shortages, when the temptation may be to leave the responsibility to service managers or humble HR practitioners. No matter how diligent they may be, no matter how admiring and sympathetic they are to you and your overworked colleagues they simply do not have the same interests as you in filling an SMO vacancy as quickly as possible.

We all know of appointments that have fallen through and locums that have been lost to the service because a manager or HR staffer failed to follow up on an email or return a phone call to a willing appointee. We also know that the consequence of those failures was not more work for the manager or HR consultant who failed to follow-up with the prospective appointee; no, the consequence fell on you and your colleagues as you worked longer and harder, struggling to provide the service by plugging the gaps on the roster and juggling more acutes on top of your own clinical workload.

No one has a greater interest in filling SMO vacancies than the SMOs left to soldier on in the distressed and struggling service. For that reason alone, if for no other, the ASMS strongly advises members is to seize control of the appointments process and drive it to its conclusion. In this way you may be certain that every opportunity and lead is followed up and every suitable prospective candidate is contacted, encouraged, supported and made to feel wanted. Don’t leave it to your manager or the HR department, unless you actually ride shotgun over them to ensure they diligently follow up every lead and every opportunity.

MECA clause 53 could be stronger but it still has plenty of teeth. We encourage all members and every clinical director to familiarise themselves with this clause and to ensure it is followed to and beyond its letter:

### **In practical terms**

What does this mean in practical terms? How should you and you colleagues implement clause 53 and give effect to its spirit, in addition to its letter?

Each service should assign responsibility for case-managing each vacancy or new appointment to an individual and energetic SMO within the service: don’t just leave it to the Clinical Director, who has many other duties and responsibilities. Perhaps this responsibility should be given to the most recent appointee in the department; who is better placed than them to understand the process and what needs to be done to improve it?

This case manager should draw up a list of all the steps that must be followed in the process, a list of those responsible for each of those steps and a tight but nonetheless realistic timeline to ensure that each step is followed in a timely manner. The case-manager will need to work with the Clinical Director, the HR department and the Chief Medical Officer (as the trouble shooter) to build

up the appointment's momentum and carry it through, right up to the time the new appointees arrives on the scene.

As an aside, but an important one, this same process should be followed whether the appointment is for a new Clinical Director or a short term locum.

There was a time when no permanent appointment would be made until the prospective appointee had visited the hospital and inspected the unit. Of course this was always a two-way process and gave the service an opportunity to inspect and assess the would-be appointee. Wherever possible, this is still the preferred course but, if it is not to be adopted the onus on the appointments committee, the reference checker and the follow-up credentialing committee becomes that much more important.

As Whanganui DHB (and several other DHB that remain nervously quiet) will attest: the cost of getting it wrong always greatly exceeds the cost of doing it once and doing it right.

### The appointments committee

Perhaps the most important step is the interview process itself; who should be on the appointments committee? There should always be a majority of doctors, at least two of whom should be from the speciality into which the appointment is being made. The Chief Medical Officer or someone from an allied or associated speciality to that of the service making the appointment should also be involved, as a matter of

routine. If this means bringing in one or more outsiders, from the College, a neighbouring DHB or the Specialty Society, so be it.

### The reference checks

New Zealand does not enjoy the luxury of having many (appointable) applicants for each SMO vacancy. That should make the issue of reference checking even more important. If there is not a reference from the applicant's last hospital, the question should be asked: "Why not?" In this situation, the HDC's comments in the Dr Hasil-Whanganui DHB Report should be noted: independent and direct enquiries should be made of the applicant's last employer and perhaps also the most recently applicable registration authority, wherever it may be.

### The last word

If all this seems like too much effort, ask yourself these two questions:

"How much more effort will we be put to, if we miss the opportunity to appoint an applicant who was otherwise willing and available to join us?"

"How much more effort we will be put to, if we make a bad appointment by not making the effort now?"

### Henry Stubbs

Senior Industrial Officer

## ASMS MECA Clause 53

### 53 Appointment Processes

53.1 Prior to a decision being made regarding the need to fill or create a senior medical or dental officer position, whether to a permanent or temporary position, the employer shall consult other affected employees, (i.e. those on the same roster or in the same department or service) as to the need for such an appointment, the nature and level of skills and experience sought and the job description for the appointment.

53.2 The appointment committee shall be convened by the chief executive (or their nominee) who shall ensure that:

- (a) The clinical director or delegated senior medical staff member of the relevant department is part of the appointments committee;
- (b) The Senior Medical Staff Committee (or equivalent body agreed with the Association) is invited to appoint at least one member of the appointments committee who shall be from the same or similar discipline to the position advertised; and

(c) In appropriate circumstances, an independent external senior member from the relevant professional college or association may be invited to be part of the appointments committee.

53.3 The parties acknowledge the importance of thorough checking of qualifications and other relevant details of the candidate about to be appointed including accuracy and veracity of referee reports.

53.4 Credentialing requirements at the district health board should be included as part of the appointment process.

### 53.5 Fixed Term Appointments

An employee may be engaged for a fixed-term provided there are genuine reasons based on reasonable grounds for the particular fixed-term appointment. The employer shall advise the employee of those reasons at the time of the appointment and record them in the letter of appointment or job description.



Helen Kelly, President, CTU

## A union perspective on state sector governance

*Below is an article written for The Specialist by Helen Kelly, the new Council of Trade Unions President. She also spoke to the ASMS Annual Conference last November on this theme.*

How state sector agencies are governed is an issue as important to workers as it is to government. An inclusive, high performing state sector is vital for the achievement of a broad range of policy objectives and calls for a reconsideration of the current dominant form of governance structure in the state sector.

The CTU would propose that the current pure corporate governance model is not either an appropriate model for the state sector or the most productive one and that the better elements of it can be incorporated into a governance model that has public sector values at its core – it is our view that a more socially responsive and democratic form of governance is needed and that a change in governance models is consistent with and necessary for the implementation of current government policy objectives.

### New model of public sector governance

This new model of “public sector governance” should be promoted as the most appropriate for public services. The CTU does not distinguish between trading and non trading bodies of the State. Crudely put, they all perform core functions of the state that cannot be performed as efficiently, effectively or as fairly as the private sector. They exist either because society would be incoherent without them or because there is a risk that if they were run by private business their resources would not be used in the best interest of the nation.

The CTU is a great believer in the value of the public service to New Zealand’s wellbeing as a nation– and as a first point we would insist that any person involved in state sector governance is also a believer. After that the rest is easy.

A new form of governance would mean different questions would be asked by governance bodies when decisions are being made. Below by way of example are two different questions that might be asked under the two different models by a governing board considering the contracting out of laboratory services:

**Corporate governance question:** Will this be good for this corporation?

**Corporate governance answer:** Yes – we will save money and remove our responsibilities for the staff and the quality of services offered.

**Public governance question:** Will this be good for the health system, the nation and the state?

**Public governance answer:** No – by retaining the laboratory, we can use it to train new staff, we can cover for other laboratories for other DHBs when they are short, we can control new changes and new initiatives when we want to introduce them, we will have our own loyal and trained workforce who will have a good career in the DHB and who and can use their knowledge to add to other services we offer.

### Public v corporate governance

There are clearly some core elements of good governance that fits both models – transparency, accountability etc. The CTU does not dispute these as core elements but believe they are oversold in the corporate model as “the” core elements while other equally important elements are over looked and that because of that, opportunities are being lost.

One of these other elements is the role and potential contribution of unions and workers, in governance decisions. An under-utilisation of union experience and contribution results in both a loss of productivity improvement opportunities and a reduction in democracy. Almost every guideline and standard produced in the public sector has a special caution around employee participation at governance level and potential conflicts of interest. An inbuilt distrust of employee participation is inherent in the concept of corporate governance and these guidelines reflect that.

The CTU supports the development of the broader bottom lines included in a public governance model because they create positive environments to promote workplace issues, but particularly in the state sector because it opens up a place for a discussion about what “other” outcomes would be desirable for public sector agencies other than ensuring essential services are delivered in an effective and efficient way (not to downplay these as important outcomes either). It builds democracy and participation. It should enable more sophisticated cost benefit models to be developed for the sector and enable a better discussion about acceptable public sector outcomes.



## What would public service governance look like?

So in summary what would public service governance look like?

Firstly strict theories of corporate governance would be abandoned and replaced by a governance model recognising public value and the value of social partners.

The starting point would be a development of core public sector values based on an agreement that public services exist and can be used for the greater public collective good and that its potential for influence is huge and can be and should be legitimately used. It would be acknowledged that participation in the development and progression of the public sector builds democracy.

These values would be monitored from the centre and governors would have a commitment to them.

Unions and members of them would be part of that development and welcomed as participants in high level and workplace policies, strategies and processes.

### Helen Kelly

President  
Council of Trade Unions

## Support service for doctors

The Medical Assurance Society and Medical Protection Society have joined forces to bring their members an important support service. The support service provides access to a free professional counselling service. Doctors seeking help can call **0800 225 5677** (0800 Call MPS). The call will be answered by the Medico-Legal Adviser on duty who will then arrange counselling or support. The service is completely confidential.



## Superannuation/Kiwisaver update

The ASMS's discussions with the DHBs on the question of splitting superannuation contributions have continued since the article in the previous issue of The Specialist. It appears that this difficult issue can now be largely put to bed.

In December the DHBs announced that they would allow SMOs to split their own contributions between multiple schemes if they wished. More importantly they also signalled that they agreed in principle to the splitting of employer contributions, (the tax breaks for KiwiSaver and KiwiSaver compliant schemes are most significant for employer contributions). Implementation of the splitting of employer contributions was subject to further discussions with approved scheme providers to ensure that doing so would not violate the terms of their respective trust deeds. We understand from our discussions with DHBNZ that all approved scheme providers have confirmed that this is possible.

From our perspective therefore splitting of both employee and employer contributions should now be possible up to a maximum of 6% of your gross income. A possible

exception exists around defined benefit schemes: we are in discussions with DHBNZ as to how we will treat this issue.

We are also in discussions with DHBNZ and the MECA negotiating teams to amend the superannuation clause in the new MECA so as to clarify SMO's entitlements under the new legislative framework.

### Jeff Sissons

Industrial Officer

## New Administration Officer

We are pleased to welcome Leigh Parish to the role of Administration Officer commencing 25 March 2008. Leigh has a strong background in administration and was previously employed at the Ministry of Justice Strategic Policy Unit.



## Importance of unity and broad church

The ASMS has always prided itself on being a broad church of members while recognising that our membership comprises an extensive range of branches of medicine, highly variable sizes of employers from the large tertiary to the small rural DHBs (and the small community organisations that employ salaried GPs), different and changing attitudes towards the balance between work and the rest of life, and full-time and part-time DHB employment (including a small but discernibly growing number of part-timers without private practice largely for family reasons).

Occasionally and uncommonly we are accused of representing the interests of full-timers rather than part-timers. However, the practical experience does not bear this out. The collective agreements we negotiate apply to both with no special benefits to full-timers. Further, in the current national DHB MECA there is an important clause protecting rights of private practice and distinguishing it from the separate issue of conflict of interest. If anything a greater proportion of the time of the ASMS's industrial staff is spent on part-timers.

**"in the current national DHB MECA there is an important clause protecting rights of private practice and distinguishing it from the separate issue of conflict of interest"**

### Unity in MECA negotiations

These national DHB MECA negotiations have proved to be the ASMS's biggest challenge in our 19-year history. Since the commencement of negotiations in May 2006 we have been confronted with a level of negative chief executive unity based on negativity and resembling more World War I generals than responsible health leadership.

It became clear early on that industrial action would have to be considered in a way that previously had not been necessary. But this depended on confidence in a high degree of membership 'buy-in' and preparedness to participate. Right from the beginning we were stymied by the angst and anger of many members against the week long RMO strike in mid-2006, some of which played out in the public arena. Even without this getting extensive membership support (albeit

reluctant), it was going to be difficult because of its unprecedented nature (the exception being South Canterbury in 2002 during a localised negotiation).

### Cautious gradual escalation

Consequently we have had to adopt a cautious gradual escalation approach through Annual Conference resolutions, the successful national stopwork meetings last July-August, and then the extraordinary national ballot in which 88% of voters supported industrial action. It was this ballot and the National Executive's preparedness to implement the mandate that propelled the Minister of Health, in an action unprecedented for around 20 years, to offer to intervene and facilitate a resolution.

Throughout this ASMS has had to establish and maintain a position of broadest support between those who are morally opposed to industrial action full stop (even though supporting the ASMS's objectives in these negotiations) and those who say enough is enough, we should have been into the industrial action sometime ago. This simplifies the range of views because there are many shades between these two spectrum poles. But they highlight the challenge.

DHB chief executives are hoping that ASMS members will fragment, knowing that if this happens they will succeed with their negative strategy. While there are no significant signs of such fragmentation, we must not let it happen if we want to go some reasonable distance in achieving our objectives. Unity is our strength and disunity or fragmentation our weakness.

**Ian Powell**

Executive Director

### 20th ASMS Annual Conference, 20–21 November – *Diary now!*

The 20th ASMS Annual Conference will be held in Wellington (at Te Papa) on 20-21 November (Thursday-Friday). You are encouraged to diary this important event. It is a unique opportunity to discuss the exciting mix of industrial, health policy, medico-legal and political subjects.



Sue Shone, Industrial Officer

## Update on pay and employment equity reviews in DHBs

Reviews of pay and employment equity (PaEE) conducted in district health boards over the last year are recent chapters in a lengthy story. Equal pay was introduced in the public service in 1960, and later came the 1972 Equal Pay Act and short-lived Employment Equity Act of 1990 (that Act was repealed just six months after its introduction).

In 2004 came the introduction of the Pay and Employment Equity Plan of Action for the Public Service, education and public health sectors. This was part of a strategy to increase women's participation in the workforce, and to enable women's skills and potential to be fully used. Shortages of skills in New Zealand were seen as a major inhibitor to economic growth and the removal of the gender pay gap was seen as an important goal. The theory is that both men and women benefit from greater pay and employment equity and that greater access to flexible working arrangements and better work life balance would benefit everyone.

A series of snapshots – in the form of PaEE reviews - have been taken from the pay and employment situations and experiences of women and men employed in district health boards. First a group was piloted and then the reviews were "verified" at all DHBs. These reviews are being looked at and more closely analysed by a working group made up of employee and employer representatives. Findings of these reviews should be available shortly. ASMS members may remember that the pilots (Otago, Taranaki, MidCentral, Auckland, Hutt Valley) suggest that female SMOs earn less than males and may start on lower steps on the salary scale, (though the data behind this was less than robust).

A draft report with recommendations for further investigation and action is currently being developed prior to preparing for Cabinet. One of the recommendations of the report is likely to be that ASMS meet with DHBs nationally to look at data and develop benchmarks.

Salary information about senior medical and dental officers employed by DHBs has been collated by ASMS since 1993, although it was not until 2005 that a gender breakdown of this information was available from each DHB. In the most recent salary survey the mean for both female specialists and female medical officers is below the mean for their male equivalents.

Strategies range from instituting flexible work arrangements, improving professional development and training, reviewing recruitment policies and welcoming women who have had primary responsibility for child rearing back into the workforce. Some of these strategies have considerable appeal to all SMOs looking for a balance between work and other aspects of their lives. However, with New Zealand's small SMO workforce, onerous rosters and recruitment and retention problems these issues have to be carefully thought through.

Now that 31% of ASMS members are women, the persistence of any gender pay and employment inequity in DHBs has to be a concern. It is sometimes argued that it is only a question of time before the gender gap closes and the increased number of women in medicine will flow through to salaries and close the divide. One woman commented "Childbearing and child rearing account for a small period of time in comparison to a woman's working life, and yet time taken off for this purpose can guarantee ongoing disparity."

Over the next few months reports and recommendations will be circulated both within district health boards and nationally.

**Sue Shone**  
Industrial Officer

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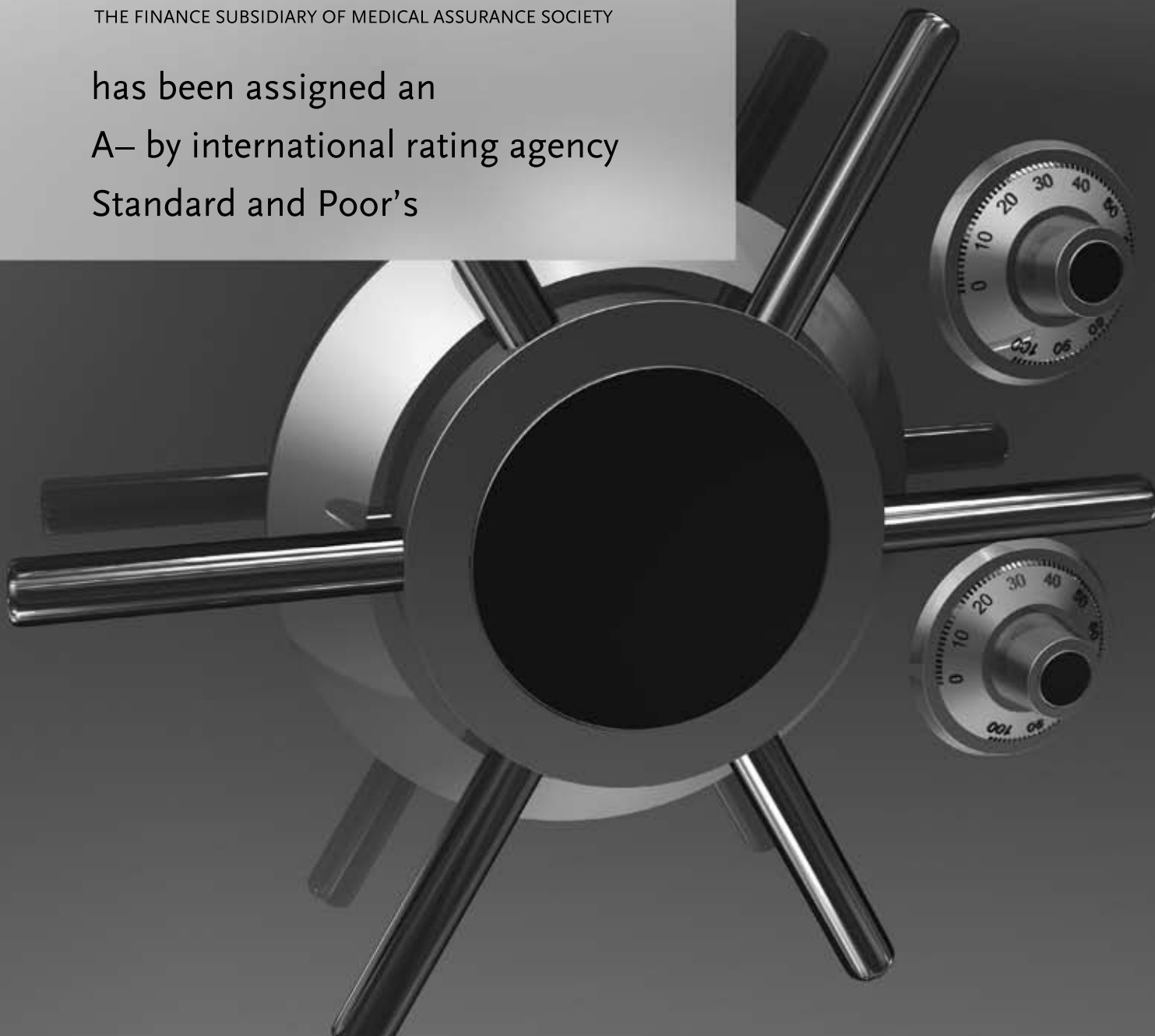
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