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PRACTITIONER PAPER

The Experience of Collective Bargaining for Salaried Senior Doctors Under the Employment Contracts Act

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Introduction

Salaried senior doctors (also known as senior medical officers) employed by the 14 area health boards (subsequently replaced on 1 July 1993 by 23 crown health enterprises) have had to adapt to three different industrial legislative environments since the Labour Government's 1988 state sector restructuring, two of which (the focus of this paper) were under the Employment Contracts Act.

The first, 1989-1991, was the period of coverage under the Labour Relations Act in which the State Services Commission exercised its powers under the Area Health Boards Act 1983 (as amended in 1988). The major focal point was the 1990 award negotiations. The second phase, during 1992 and the first six months of 1993, was when the Commission operated under the Employment Contracts Act and exercised its marginally adjusted role under that legislation. The third period was from 1 July 1993, again under the Employment Contracts Act, with the Commission's role radically changed and its health sector infrastructure substantially reduced. Crown health enterprises acquired considerably more power and autonomy that their predecessor area health boards consequential to the Health and Disability Services Act 1993. This article focuses on the second and third phases. The first has been discussed elsewhere.[1]

Prior to the 1988 restructuring senior doctors' terms and conditions of employment were delivered collectively through determinations, specifically the M10, issued by the Higher Salaries Commission. These paid rate documents left minimal scope for individual arrangements.

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1 Powell, Ian (1991), *Labour Market Flexibility: The Challenge Facing Senior Medical Officers in New Zealand*, Geneva: ILO.

However, this changed radically in 1988 when senior doctors, along with other state sector employees, for the first time came under the auspices of the Labour Relations Act 1987 and were covered by minimum rate awards rather than paid rate determinations. This provided the legislative environment which pitted their newly registered union, the Association of Salaried Medical Specialists (ASMS), against the State Services Commission (the SSC or the Commission) whose authority derived from the Area Health Boards Act (as amended in 1988).

The Commission vigorously advocated moving from collective to individual bargaining for senior doctors in the 1990 negotiations for the Area Health Boards Senior Medical and Dental Officers Award (Document: 2015). Its more general arguments advocating individual bargaining for subordinate managers and senior advisers, which by implication applied to senior doctors, were detailed in a letter to the NZ Nurses Association during the Nurses Award negotiations of the same year.[2] The arguments included greater personal accountability for specified roles, a personal commitment for goals and objectives, the need for these employers to have a "pro employer" perspective, and the facility for individual performance expectations, assessment procedures and methods for rewards and sanctions. In the Commission's view collective bargaining was unsuitable for this new relationship and process.

In a letter to the ASMS,[3] the SSC declared:

> Given the status and key role of senior medical officers in the utilisation of resources (through individual clinical decisions and involvement in management), it is a logical progression that the exact nature of their job and attendant conditions of employment be subject to agreement between the individual and employer concerned. The practice of negotiating conditions of employment in an award environment has inherent disadvantages for all parties because of the pressures this "industrial" process brings to bear. (emphasis added)

Senior doctors themselves were not attracted to individual bargaining. Running alongside an individualistic streak among this highly skilled professional occupational group is also a parallel streak of collectivism. Many members of the senior medical workforce are also members of professional bodies such as the New Zealand Medical Association and the various specialist royal colleges. There is a strong tradition of collective professional unity in the delivery of medical/surgical care in New Zealand which is encouraged by the fact that, in the public health service, the senior medical workforce works together in team and cooperative situations. There is also a strong commitment to, and practice of, inter-specialty cooperation in response to the need for integrated service organisation and delivery.

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2 Letter from State Services Commission to NZ Nurses Association, 8 June 1990.

3 Letter from Assistant Commissioner, State Services Commission to Association of Salaried Medical Specialists, 23 May 1990.

Thus there is both a tradition of professional unity and a practice of cooperative team work which helped provide a framework for a receptiveness rather than antipathy towards collective bargaining.

When the Commission and general managers advocated initially an end to, and subsequently an undermining of, collective bargaining and the award, it incurred the strong opposition of the senior medical workforce. However, this framework was only part of the explanation. There were also six specific and significant contributing factors.

The ASMS, through a bulletin distributed to its members in March 1990,[4] concluded that:

> The real drive for individual contracts as an alternative to award coverage is to change the nature of bargaining or negotiation from collective to individual. Awards involve negotiations between two collective parties - the Association as the union party and the employers. Individual contracts as an alternative to the award involve the employee negotiating individually on the one hand but the general manager as a collective entity negotiating on the matter. Changing from award to individual contract negotiation involves a change in negotiating strength with the employee moving from collective to individual while the employers' collective strength remains unchanged. (emphasis added)

The 1989-90 award negotiations were protracted and difficult. On the one hand, the Commission advocated initially individual contracts and then reduced award coverage. On the other hand, the ASMS sought to enhance the award, including in the thorny area of compensation for rostered duties.

The ASMS was successful on the critical issue of award coverage in that there was no change. All senior doctors employed by area health boards, regardless of responsibility or relationship with their employers, would continue to be covered by the renegotiated award.

The ASMS also succeeded in achieving the inclusion of a number of additional clauses and amendments to the award. These included salary parity between dental and medical officers, reducing restrictions on the capacity for full-time senior medical and dental officers to work privately, increased paid continuing education leave for senior dental officers, and a new clause on employment termination notification. However, there were other claims for award inclusion which the ASMS failed to achieve.

A compromise was reached on the important issue of rostered duties. The following new clause was added:

> When determining employees level of remuneration for rostered duties as part of their contractual arrangement the parties' attention is drawn to the relevant section of the statement.

The "statement" was a statement of the parties attached to the award (also referred to as the Memorandum) which provided, as the central feature of the settlement, a framework for a

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[4] Association of Salaried Medical Specialists, Contract Employment for Senior Doctors and Dentists, *Information Bulletin*, No. 1, March 1990.

new system of remuneration containing a mix of collective and individual bargaining, the latter underpinned by the former. It began with the following introductory statement:

> This statement provides a framework in a process which will lead to individual contracts underpinned by the award conditions. It provides for an implementation and review process in order that the system may be finally and fairly determined.
>
> The award provides minimum conditions of employment which may be varied to the extent that their variation is in advance of the award provisions. Contractual arrangements will directly relate to the job description.

These two paragraphs contained the kernel of the settlement. From the ASMS stand-point it was consistent with its view that individual contracts could be negotiated over and above existing award provisions.

For the Commission the settlement was inconsistent with its immediate objective of reducing the application and content of the award. However, it enabled a long-term possibility of reducing the relevance of the award if individual contracts became more widespread. If the individual contracts were to replicate the content of the award, the latter's relevance may disappear.

The Memorandum then went on to address remuneration, professional matters and job descriptions. Salary scales, increased by four percent, remained in the award. Remuneration was to be based on a process of job sizing in which the size of the senior doctor's job was to be defined by adding together required average routine hours of work, average hours worked in recall to workplace, and average hours worked at other locations as a direct result of rostered duties.

A new provision of an availability allowance was also included in the remuneration section for rostered senior doctors. This was to be paid by virtue of the fact that a senior doctor was on the roster. It did not compensate for work done as a consequence of being on the roster which was to be addressed under job sizing. Recognition of merit was also detailed in the remuneration section.

Prior to the new award there were no equivalent processes and mechanisms relevant to remuneration for job sizing and the availability allowance. Both provided an ability to compensate for rostered duties that did not previously exist.

The Memorandum contained a provision for mutually agreed job descriptions stating relevant duties and responsibilities. For many years senior doctors had been frustrated by either the non-existence or inadequate detail of job descriptions. At the same time managers acknowledged that this was necessary if meaning was to be given to the drive for increased accountability and performance. The ASMS saw job descriptions, in part, as an alternative to stand-alone formal individual contracts.

The settlement was achieved because both parties believed it provided the means for eventually fulfilling their conflicting objectives through a model (Award plus Memorandum) promoted by the mediator during negotiations. It was generally recognised as innovative,

unique and forward-looking. In an address to the ASMS 1990 Annual Conference in June it was praised for its flexibility and innovation by the Council of Trade Unions Vice President. On behalf of the Department of Health, the Chief Medical Officer also commended the settlement at a meeting on 11 March 1991 involving the Associate Minister of Health and ASMS representatives.

Furthermore, a private consultancy firm active in the health service, Deloitte Ross Tohmatsu, in analysing the settlement in its publication *Vital Signs,* observed that, with regard to the efficient employment of medical and dental staff, the settlement including the provision for above award individual contracts "... encourages such flexibility and creates significant opportunities to resolve some long-standing problems."[5]

Part One - Bargaining with Area Health Boards under the ECA

Implementation of the Memorandum agreement had realised only minimal progress when, in December 1990, the Employment Contracts Bill was introduced into Parliament. While the Council of Trade Unions organised a vocal and well supported campaign against the Bill, CTU health sector affiliates (including the Nurses Association, Public Service Association, Service Workers Union and ASMS) were involved in discussions with the State Services Commission over the forthcoming industrial round. The large majority of awards in the health sector had expiry dates of 30 June or soon after.

The outcome was a centrally negotiated settlement, also known as a "roll-over", between the CTU and the Commission which involved no changes to terms and conditions of employment, except for agreed standard clauses to be inserted into all documents covering union recognition, right of entry, and an obligation on employers to offer the relevant collective employment contract (CEC) to new employees.

The CTU-Commission settlement was therefore transported into existing, but about to expire, awards registered under the Labour Relations Act. These, in turn, came within the ambit of the transitional provisions (Part IX) of the Employment Contracts Act.

The settlement gave health sector unions a valuable 12 months breathing space to adapt their organisations to the new industrial legislation and to absorb the health restructuring anticipated in the forthcoming Budget. The Commission and general managers had a similar incentive with the additional factor that managers would be heavily preoccupied with the implementation of the anticipated health restructuring. All parties considered it difficult to be involved in industrial bargaining at a time when they were having to cope with both radically new industrial law and a major restructuring of the public health service.

In early 1992 the CTU, on behalf of the health sector affiliates, endeavoured to establish a dialogue with health employers in order to renegotiate their national collective employment contracts. After some initial confusing signals the Minister of State (also Minister of Labour and subsequently, 12 months later, Minister of Health) the Hon. Bill

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[5] *Vital Signs*, Deloitte Ross Tohmatsu, Issue 3, August 1990.

Birch outlined official government policy in a keynote address to health managers on 26 March 1992.[6]

He advised that the Commission was to delegate its statutory authority for negotiating collective employment contracts to general managers and then specifically instructed them on how to negotiate. This included a prohibition on national or multi-employer bargaining.

The health unions were then forced to abandon efforts to seek multi-employer bargaining. The ASMS, however, made a last unsuccessful attempt through a compliance order application to the Employment Tribunal requiring the State Services Commissioner to negotiate a national collective employment contract. The central point of argument was whether the State Services Commissioner was the employer, at least for the purpose of CEC negotiations.

While it was clear that the Commissioner had the real power and influence in CEC negotiations this did not, in the view of the Tribunal, constitute employer status. Prior to the Employment Contracts Act, the Commissioner had the status of "employer party" in the public, health and education services. However, the reference to "employer party" was deleted for both the public and health sectors as a consequence of the new Act. Despite retaining its extensive powers, the Commission's status had nominally altered to the extent of having a significant interpretive impact.

Although unsuccessful the ASMS at least achieved a sympathetic recognition of its plight when the Tribunal described the power of the Commissioner as being "... something which may be described as a puppet master in the background rather than the direct negotiator as it was under the Labour Relations Act 1987. The Employment Contracts Act has changed the industrial environment."

While this "... may make it harder for the union to negotiate with the State Services Commissioner on matters on which it issues directives ... [it] would appear, however, that such a circumstance is permitted and may even be contemplated by the legislation."[7]

Bargaining with the boards

As a consequence of the Employment Tribunal ruling it was now no longer feasible for the ASMS to seek a national multi-employer collective employment contract covering all area health boards. The union was left with no option but to pursue single employer CECs. The real question was to what extent would area health boards be prepared to bargaining collectively, given the role of the Commission and its dislike for collective bargaining. Similar claims were lodged with all 14 boards.

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6 Hon. W.F. Birch, Address to Conference of Area Health Board Managers, 26 March 1992.

7 Employment Tribunal, *Association of Salaried Medical Specialists* v *State Services Commission*, WT 34/92, 18 June 1992.

The Commission did not adopt a total oppositional position to collective bargaining. Although its stated preference was for senior doctors not to have CECs, it did not use its statutory powers to prevent any board from engaging in negotiations.

The ASMS was able to initiate negotiations early on with the Auckland and Canterbury Area Health Boards which, between them, covered about 40 percent of the national senior medical workforce. Three other boards (Manawatu-Wanganui, Nelson-Marlborough and Otago) also subsequently agreed to collective negotiations. Remaining boards followed the Commission's line and refused to negotiate.

The Otago Area Health Board was significant in that its previous management was steadfastly opposed to collective bargaining and totally committed to individual contracts. However, towards the end of its formal existence there was a change of management personnel as key managers departed. The new crown health enterprise management came in earlier than anticipated and assumed the functions of the Board in its final days. It did not share, at least to the same intensity, the ideological opposition of its predecessor to collective bargaining.

By 30 June 1993 CECs were completed in five out of the 14 area health boards covering over 50 percent of the senior medical workforce. When converted into crown health enterprises (CHEs) on 1 July, the CECs covered 10 of the 23 CHEs.

Outcomes of collective bargaining with Area Health Boards

In general the new CECs were little more than fiscally neutral except where the 1990 Memorandum had not been implemented. The outcomes included the obligation to offer the CEC to new employees, party status for the union, and the right to research and share professional knowledge notwithstanding the new competitive health environment. In two settlements the right to participate in public debate and dialogue relevant to professional expertise was contractually affirmed. It was not achieved in the other three settlements because of employer opposition.

The ASMS was also able to use these CEC negotiations to put in place the implementation of the 1990 Memorandum, specifically compensation for rostered duties. Although unsuccessful in Auckland, the ASMS concurrently achieved success in negotiating implementation of that Memorandum in Canterbury and Otago where it had not been previously enacted. In Manawatu-Wanganui and Nelson-Marlborough the Memorandum had already been largely implemented. A major success for senior doctors was that, with the exception of Auckland, in all cases the key principles and entitlements of the Memorandum were also inserted in the text of the CECs themselves, rather than as attached documents, making them permanently and collectively enforceable.

In general the settlements reached with area health boards prior to 1 July 1993 (i.e., the date of the formal introduction of the internal market and the replacement of boards by CHEs) achieved little other in terms of material by enhanced conditions of employment. Salary

levels remained unchanged. In the Canterbury and Otago Boards the implementation of the Memorandum may have added around 15 percent to their senior doctor salary costs.

The main emphasis was on the consolidation of existing conditions and procurement of key procedural rights. There was some limited enhancement of annual leave in Nelson-Marlborough along with, for the first time, the specification of an entitlement to expenses for continuing education leave in two of the settlements. There were also some minor advancements in the calculation of allowances and additional rostered hours and, in Nelson-Marlborough, the establishment of a mechanism for advancement through previously discretionary higher salary gradings.

Experience of individual contracts

By 30 June 1992, when the last national collective employment contract covering senior doctors expired, efforts at the implementation of the 1990 Memorandum had had only limited success. Nine of the 14 area health boards had either implemented it extensively or to a large degree, or had firm agreements in place on time-frames and processes for implementation. The remaining five included the four main metropolitan areas (Auckland, Wellington, Canterbury and Otago) which covered around 60 percent of the area health board senior medical workforce.

And further, there had been anomalies in implementation. Significant groups within the Waikato senior medical workforce were still waiting. In Bay of Plenty senior doctors in Tauranga were compensated for rostered duties in excess of the Memorandum while their colleagues in Rotorua and Whakatane received less than the agreed provisions. Also underpaid were senior doctors in Northland.

As part of its subsequent area health board CEC negotiations the ASMS was successful in concurrently negotiating the implementation of the Memorandum in both Canterbury and Otago. By the end of the formal existence of area health boards on 30 June 1993, three area health boards (Auckland, Wellington and Hawkes Bay) had failed to implement it.

Following the expiry of the national CEC on 30 June 1992 health managers had their first opportunity to employ individual contracts without a collective underpinning. It became a critical test as to whether new contracts offered to new appointees would be underpinned by the expired CEC. While many boards continued to offer collectively underpinned individual contracts, several did not.

In its advice to members over the role and purpose of individual contracts without collective underpinning, the Association observed that:

> ... the real drive for individual contracts is to ensure one-way flexibility for management and power over senior medical staff. If the collective underpinning is taken away then senior managers will have increased their authority and influence over senior medical staff who can, where it is perceived to be necessary, be picked off individually. Senior medical staff

> are in a much more vulnerable negotiating position if left to act solely as individuals rather than collectively.[8]

Although the "window of opportunity" for being "picked off individually" was restricted by subsequent collective agreements negotiated with crown health enterprises, it was applied to new employees in six of the 14 boards and, in Hawkes Bay, for around 15-20 currently employed specialists with a high level of rostered commitments where the 1990 Memorandum had not been implemented. Other conditions for these Hawkes Bay specialists were also "traded" for partial implementation of the Memorandum.

The ASMS was involved in many individual disputes, including overseas recruitments. It decided to advise international medical organisations, such as the British and Australian Medical Associations, about the potential vulnerability of overseas applicants over individual contracts in the absence of any form of "blanket coverage" by a collective contract. This had some effect as, for example, advertisements published in the internationally prestigious *British Medical Journal* alerted applicants to these concerns.

In December 1992 the ASMS reported to its members[9] what it regarded as a series of managerial abuses through individual contracts since the expiry of the former national CEC on 30 June and the absence of any lawful requirement to offer new employees those same terms and conditions.

The ASMS reported a clause it had discovered in an individual employment contract offered by the Hawkes Bay Area Health Board which stated that "The General Manager shall review the remuneration of the employee annually to determine whether or not it should be more, less, or remain unchanged."

Following publicity given to this clause by the ASMS it was eventually withdrawn but, from the union standpoint, it was evidence of a major concern.

Other incidents reported were individual contracts containing the following inferior conditions:

- reduction of the salary for a position by more than $10,000 per annum compared to what it would have been under the former national CEC by altering the method of calculating pro-rata income;

- appointment of new senior doctors on the lowest possible salary step while denying them previous rights to certain specified automatic annual increments;

- reduction of the sick leave entitlement;

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8 *ASMS Newsletter*, No. 9, June 1992

9 *ASMS Newsletter*, No. 11, December 1992.

- deletion of provisions for bereavement leave, long service leave, and a retiring gratuity; and

- removal of the employer's responsibility to provide locums when short-term vacancies occurred.

These examples, many of which were found in individual contracts proposed to new appointees in at least six area health boards, served to reinforce the ASMS's assessment of the vulnerability of senior doctors in individual bargaining.

Part Two - Bargaining with CHEs under the ECA and the internal health market

Commencement of new trends

The formal commencement of the Government's health restructuring, through the establishment of crown health enterprises replacing area health boards effective 1 July 1993, provided a new and unanticipated environment for the ASMS and the senior doctors it represented.

A report on progress of CEC negotiations to the ASMS's Fifth Annual Conference on 28 October 1993 reported a significant new trend as the Association found itself operating in a substantially different environment.[10] This was attributed to the coupling together of the Employment Contracts Act with the Government's "health reforms". The former, in the view of the report, rested on the assumption that, through unemployment and constraining state sector expenditure, employees would be in a vulnerable negotiating position in that employers were able to control the labour market.

However, a new emerging, perhaps unintended, pattern for senior doctors was a diversity of labour market options. The ability to, through the internal market, fund the private sector for the provision of health services and the fragmentation of the bargaining environment created new opportunities for the ASMS. There had always been an alternative international medical labour market as New Zealand was well short of competing with the terms and conditions of employment being offered to senior doctors in comparable parts of the world such as Australia, Western Europe and North America. However, this was offset, at least until the early 1990s, by the high international reputation and comparative stability of the New Zealand public health service.

Perhaps unintentionally, but unsurprisingly, two new alternative sources of employment had arisen for senior doctors. The first was in competing CHEs, while the second was in the growing private sector. In many respects the greatest potential competition facing CHEs was from within their own ranks. The prospect was now emerging of senior doctors being

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10 Report of Executive Director to Fifth Annual Conference of Association of Salaried Medical Specialists, on Collective Employment Contract Negotiations, 28 October 1993.

in a position to transfer their skills elsewhere as the health service became increasingly more commercial. This new competition for senior doctors created sufficient real and potential recruitment and retention difficulties to enable a major breakthrough in collective negotiations.

The lack of specificity in the ECA with regards to collective employment contracts also provided the ASMS with an opportunity to overcome ideological barriers for those managers who were opposed to explicit formal CECs. The new Act did not require a collective employment contract to necessarily be named as such providing it was able to be defined as such, including in accordance with Section 2 which distinguishes between individual and collective contracts, and with Section 22 which requires collective contracts to have expiry dates.

Two other factors provided important opportunities for the ASMS in the internal market. First, as a consequence of the Health and Disability Services Act, the State Services Commission lost its statutory powers and was left only with a mere consultative rather than deliberative role. In addition, its infrastructure was drastically reduced, particularly in the health service. Further, some key staff departed forming a private consultancy agency, Martin Jenkins de Lore, which picked up some work previously done by the Commission.

Second, there was an influx of new senior managers, many of whom were from outside the health service. Of the 14 board general managers back in 1989, 13 had previously had worked in the public health service, either with a hospital board or the Department of Health. The fourteenth was recruited from the British National Health Service.

However, only four of the general managers (two were permanent appointees and two were in acting positions) were re-appointed as chief executives in the 23 CHEs. Another nine chief executives had middle or senior management positions in the former boards, while the remaining 10 had no previous employment in the health service. This rapid turnover of managers and influx of new managerial personnel meant that the values and perspectives of the Commission, with particular regard to individual contracts, was less likely to be inherited by the new breed of managers.

The breakthrough: remuneration and collective coverage

The new environment with the associated opportunities led to a major breakthrough in the South Auckland CHE (one of three derived from the former Auckland Area Health Board) with the negotiation of a new Core Conditions Agreement. The ASMS's CEC requirements were met in that it was not an individual employment contract, it specifically stated that it was a legally binding document to be applied as-of-right to ASMS members, and it had a review date.

The specific terms and conditions contained in the Core Conditions Agreement were to be provided through individual contracts "in accordance" with the agreement. ASMS members were entitled to such a contract and both the ASMS and the employer were to develop a mutually agreed generic individual contract.

More significant were the remuneration enhancements. As a departure from tradition the South Auckland settlement involved a flat salary rate ($100,000 for a 40 hour week) instead of salary scales. For most senior doctors in South Auckland this represented an increase of around 20 percent. In addition, the provisions in the 1990 Memorandum for compensation for rostered duties were incorporated into the Core Conditions Agreement and applied for the first time.

There were a number of significant factors leading to this agreement. Among senior doctors there had developed increasing hostility, frustration and loss of morale over the failure to implement the 1990 Memorandum. Among the new management there was a realisation of the importance of a motivated and cooperative senior medical workforce given their expertise and key role in the provision of health services in a competitive commercial environment.

The South Auckland settlement had a galvanising impact on senior doctors in other CHEs, placing them under considerable pressure, and became the catalyst for new developments elsewhere. It lead to a series of completed CEC negotiations in the three CHEs arising out of the former Wellington Area Health Board (Wellington, Hutt Valley and Wairarapa) along with Waitemata Health which arose out of the former Auckland Area Health Board.

These settlements were explicit CECs and had increases on the core salary rates of around 9-10 percent. Further, the settlements also involved significant changes to the method for advancing through higher gradings, something that had previously been totally at managerial discretion.

Through the culmination of increases to salary rates and restructured salary scales, these settlements provided for smaller initial salary enhancements than South Auckland, but larger increases over a period of time. New salary scales were negotiated, under which senior doctors had the possibility of advancing to a salary of about $120,000 for a 40-hour week after around 7-11 years of employment as a specialist.

All these settlements were in areas where the 1990 Memorandum had not been implemented, and the ASMS was successful in ensuring that its implementation formed part of each settlement. Subsequently similar settlements were achieved in CHEs where the Memorandum had already been implemented. In some instances (for example, Eastbay, Taranaki, Waikato, Northland and Southland), owing to the sensitivity over collective and individual contracts, the settlements were called core conditions agreements as with South Auckland. These tended to be CHEs with a significant carry-over of managers previously employed in area health boards.

A variation was Auckland Healthcare, the largest CHE, (based at Auckland, Greenlane and National Womens Hospitals) where a new management persuaded local ASMS representatives to not use an industrial advocate in negotiations. The outcome was collectivised in the form of an agreed "Letter of Understanding" and standard individual contracts containing provisions generally comparable with the other settlements but, for the first time, some lost conditions.

The "Letter", to be incorporated into each individual contract, was not a CEC in any form and its legal status was uncertain (except where an individual contract was signed incorporating its contents). It may constitute a pre-contractual agreement by means of offer and acceptance, but this remains untested.

Relationship between individual and collective contracts

The settlements also stated explicitly the relationship between collective and individual contracts in accordance with the senior medical perspective. That is, the former was a minimum rates document that underpinned the latter. For example, the Wairarapa CEC stated in its preamble:

> This document sets out core terms and conditions of employment for senior medical and dental officers employed by the Wairarapa Crown Health Enterprise. It provides a set of minimum terms and conditions of employment which underpin the individual employment contracts that each employee shall have.
>
> All the terms and conditions herein are minima only. Any agreement between the employer and any one or more employee(s) which provides for terms and conditions as favourable or more favourable to that employee or those employees is hereby deemed to be not inconsistent with this document.

Performance-related pay

The negotiations also focused on performance-related pay. Previously the Commission had argued that individual contracts were necessary for this objective and that collective bargaining was an anathema to it.

Performance-related pay created some difficulties for senior doctors. While it may be more appropriate in procedurally based occupations and where the objective was competence rather than excellence, in medicine there was an expectation that clinicians were always required to perform, at least clinically, at a standard of excellence. Serious pragmatic difficulties were raised when attempts were made to measure shades of excellence for the purpose of setting remuneration levels, especially when the assessors were non-clinicians.

The ASMS therefore took the approach that it was impractical and anomalous to expect non-clinical managers to attempt to measure the performance of highly specialised clinicians, within shades of excellence, for the purposes of remuneration. Rather the actual rate of pay itself should be set at a level of excellence.

The union sought to match performance-related pay to progression through higher salary grades. Since 1990 the ability to progress through these higher gradings was solely on managerial discretion which had led to increasing frustration and discontent over perceived and real lack of movement.

A useful precedent had been set in the ASMS's CEC negotiations with the Nelson-Marlborough Area Health Board through a change to higher salary grading progression. A system was agreed where, after certain identified periods of time, the onus was on management to demonstrate why a senior doctor should not move into or through the steps of the higher gradings. This marked a major change from the previous system where the onus was totally on senior doctors to demonstrate why they should advance further.

Further refinement and advancement of the Nelson-Marlborough system was achieved in subsequent collective negotiations. The effect was that where agreed requirements and expectations had been met, a senior doctor could reasonably expect to move through the higher gradings after specified intervals of time. For some, progression was biennial (e.g., Waitemata, Hutt Valley, Wairarapa and Wellington), while for others it was annual but with more steps (e.g., Northland and Waikato). The key test was meeting the requirements of job descriptions (or performance agreements relevant to them) which were to be mutually agreed.

The Wairarapa CEC provides an example of the strongest type of wording involved to achieve this objective. Clause 3.2(ii) states:

> Advancement into and through each of these higher gradings above shall be at two yearly intervals subject to satisfactory compliance with the provisions of Clauses 38 and 39 below. Advancement may be more frequent than two yearly in the case of exceptional circumstances or performance.

The ASMS proved successful through these settlements in establishing that a particular form of performance-related pay was inclusive and part of collectively bargained contracts contrary to the approach of individual contracts as advocated by the Commission.

The ASMS also had success in strengthening senior doctors CECs and core conditions agreements and enhancing their relevance through clauses requiring them to be offered to new employees, guaranteeing the right to research and publication in the competitive environment, establishing the right to participate in public debate and dialogue, increasing reimbursement of education leave expenses, as-of-right access to mediation in the event of an impasse in future negotiations, and (in some CHEs) enhancing involvement in managerial decision-making.

Conclusion

In the on-going disputes over the applicability of collective bargaining and collective contracts for salaried senior doctors, each of the three chronologial phases produced different outcomes.

The first phase, 1989-1991, was a period when the State Services Commission possessed considerable power under the Area Health Boards Act but conversely senior doctors, through the ASMS, also had significant protections and rights under the Labour Relations Act. This was a period when the commitment of the Commission, and many area health board managers, to individual contracts was at its strongest and most devout. The origins

were in the 1988 state sector restructuring and were consistent with the ideology of "managerialism" that has been discussed elsewhere.[11]

As was to be expected a compromise outcome was achieved. Senior doctors retained their national award which included enhancements. The Statement of the Parties (Memorandum) addressed individual contracts by underpinning them with the award. While senior doctors were able to accept individual contracts in such a way as to preserve their position over the national award, the Commission was still left with the opportunity that, over time, award conditions might become superfluous.

The second phase, the 12 months following the expiry of the award on 30 June 1992, was a period of significant change in power relationships. While the Commission's statutory powers remained unchanged, despite the cosmetic loss of its designation as an "employer party", under the Employment Contracts Act the senior doctors' union was in a weaker position. From a situation where 100 percent of its membership were covered by a collective contract, 12 months later this had fallen to a little over 50 percent with only five of the 14 employers agreeing to collective negotiations.

It was also a period when, for the first time, health employers were able to offer, as an alternative to the award, individual contracts to senior doctors, especially new appointees. Invariably, to one degree or another, those that took advantage of this new situation promoted contracts that involved reduced conditions and rights.

The third period, from 1 July 1993, yet again involved a change in power relationships. Although the Employment Contracts Act still applied, the Commission's role and infrastructure were radically reduced under the Health and Disabilities Services Act. Senior doctors found themselves with an increased number of employers (from 14 to 23), many of whom employed managerial personnel from outside the Commission's tutelage. Rather than a centralised authority the ASMS found itself dealing with 23 separate fragmented entities. The ASMS itself, however, owing to the comparatively small size of the senior medical workforce (when contrasted, for example, with the nursing workforce), was able to remain centralised using the same advocate for all negotiations. The bargaining position of senior doctors thereby improved as they retained their centralised organisation and network.

In fact, the Commission appeared to have reduced its drive for individual contracts, at least as an industrial relations priority, although its formal position remained unchanged. In its draft report on the 1992-1993 round the Commission merely summarised the outcome of senior doctor CEC negotiations in the five affected area health boards and passed no judgement over these outcomes or the wider question of collective bargaining.[12]

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11 Walsh, Pat (1991), Industrial Relations and Personnel Policies under the State Sector Act. In Boston, Pallot and Walsh (eds), *Reshaping the State: New Zealand's Bureaucratic Revolution, 1984-1990*, Auckland, Oxford University Press.

12 State Services Commission, *Draft Report on 1992-1993 Health Service Wage Round.*

Senior doctors during this period saw a revival of collective bargaining which successfully procured many significant enhancements, including major remuneration increases. At the same time as they were receiving salary advancements of around 8-10 percent, nurses were achieving outcomes of only around 2-3 percent, even after, in some instances, taking industrial action.

Inadvertently the Employment Contracts Act helped, although not initially, alter the bargaining position of senior doctors. The Act, to be effective in reducing wage bills, was dependent on the existence of a reserve army of unemployed as an alternative source of labour. In the state sector effective central constraint powers were also necessary. However, the first factor was never applicable while the second disappeared with the Health and Disabilities Services Act.

The introduction of the internal market, with all its associated complexities, also led to reduced managerial enthusiasm for senior doctor individual contracts. In addition to the preoccupation of coping with the implementation of the "health reforms", there are three other possible reasons for this - the discrediting of individual contracts by those area health boards who had attempted to use them to reduce conditions and rights of employment, the demise of the State Services Commission, and an influx of new managers not inculcated to the same extent by the Commission in the ideology of individual employment contracts.

Even those managers previously involved in area health boards who had refused to collectively bargain with the ASMS had to re-think their position. Crown health enterprises, such as Northland, Waikato, Eastbay and Taranaki, whose managers came largely from those former boards which had previously refused to negotiate collectively with the ASMS changed their position.

Arguably, given the particular labour market circumstances of senior doctors and the trend under the Employment Contracts Act for greater pay movements for highly skilled, high demand occupations, they may have achieved these results regardless of collective bargaining. However, the fragmented nature of individual bargaining, the lack of a managerial infrastructure to cope, the drive of the health restructuring to reduce publicly provided services, and the differing recruitment and retention situation of separate specialty groups repudiates this view.

Senior doctors now find themselves in an unexpected position. Instead of battling to retain collective conditions and feeling vulnerable to the Commission's drive for individual contracts, they are in a new environment of negotiating (or have negotiated) collectively for considerable collective gains in at least 22 of the 23 CHEs, albeit amicably in some and acrimoniously in others.