

**IN THE EMPLOYMENT RELATIONS AUTHORITY  
WELLINGTON**

[2011] NZERA Wellington 86  
5325091

BETWEEN NEW ZEALAND DISTRICT  
HEALTH BOARDS (LISTED  
IN SCHEDULE 1)  
Applicants

AND ASSOCIATION OF  
PROFESSIONAL AND  
EXECUTIVE EMPLOYEES  
INCORPORATED  
Respondent

Member of Authority: G J Wood

Representatives: Peter Chemis, for the Applicant  
Bill Manning for the Respondent

Investigation Meeting: 16 March 2011 at Wellington

Submissions Received: 16 March 2011

Determination: 20 May 2011

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**DETERMINATION OF THE AUTHORITY**

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**Employment relationship problem**

[1] When unions in the public health sector such as the respondent (APEX) take industrial action, under the Code of Good Faith for Public Health Sector employers such as the applicants (the DHBs) are required to ensure the provision of life preserving services. If union members' assistance is required this must be arranged by negotiation, or by binding decision of an independent clinical expert or adjudicator. The DHBs claim that two issues (known as the *gatekeeper* and *conduit* issues) that have been subject to decisions of a clinical expert/adjudicator under the code are outside the parties' and therefore the clinical expert/adjudicator's jurisdiction. The DHBs also claim that the adjudicator has no jurisdiction to set the

pay to be paid, if any, to striking employees who are required to be on call to provide life preserving services.

[2] It is APEX's view that the code requires not only the negotiation of the matters explicitly set out in the Code, but also any other matter that is reasonably ancillary to any one of those three prescribed matters.

### **Factual and legal discussion**

[3] Schedule 1B to the Employment Relations Act 2000 provides for a Code of Good Faith for the Public Health Sector. The purposes of the code are to promote productive employment relationships in the public health sector, to require the parties to commit to engaging constructively and participating fully and effectively in all aspects of their employment relationships, and to recognise the importance of the role of unions in the public health sector, amongst other things.

[4] Clauses 11-13 deal with patient safety. Clause 11 makes it clear that during industrial action employers must provide for patient safety by ensuring that life preserving services are available to prevent serious threat to life or permanent disability. Pursuant to clause 12, an employer is required to develop contingency plans for such industrial action. If during industrial action life preserving services can not be arranged or delivered without the assistance of members of the union, an employer must make a request to the union seeking agreement to maintain or to assist in maintaining such life preserving services. Subclause 3 provides:

*The request must include specific details about –*

- (a) *the life preserving service the employer seeks assistance to maintain; and*
- (b) *the employer's contingency plan relating to that life preserving service; and*
- (c) *the support it requires from union members.*

[5] Pursuant to subclause 5, the parties must then:

*...meet and negotiate in good faith and make every reasonable effort to agree on –*

- (a) *the extent of the life preserving service necessary to provide for patient safety during the industrial action; and*

- (b) *the number of staff necessary to enable the employer to provide that life preserving service; and*
- (c) *a protocol for the management of emergencies which require additional life preserving services.*

[6] Clause 13 provides that if agreement *under clause 12.5* can not be reached, then it must be adjudicated on by an agreed clinical expert or other adjudicator. The adjudicator must attempt to resolve any differences between the parties to enable them to reach agreement and, if that is not possible, make a determination binding on the parties. I note that only those matters under clause 5 may be determined by the adjudicator.

[7] I accept that patient safety must be the key focus for this part of the code. The way that is achieved is by ensuring that life preserving services are made available. It is the employer's responsibility to ensure it can provide life preserving services during industrial action. If members of the union are required to provide such services, the employer must request the union's agreement to maintain or assist in maintaining the services. The formal request must *include* specific details about the three points in clause 12.3(a)-(c), which clearly means that other issues may be part of the request. The parties must then meet and attempt to agree on to those items set out in clause 12.5(a)-(c), which are not identical to those issues set out in clause 12.3, and are constrained in the sense that there is no reference either to the word *include*.

### **Determination**

[8] The issues for determination are whether the clause 12.5 items are the only items that can be negotiated and determined, and if not to what extent other matters may be so negotiated and determined.

[9] The key to the DHBs' case is that they do not believe that they have to agree with the union on whether a patient's clinical condition and clinical needs mean that life preserving services are necessary, or agree on which person should make the decision (i.e. a *gatekeeper*), or which person (i.e. a *conduit*) should communicate the decision that is ultimately made to the striking employee. It is said that the *gatekeeper* and *conduit* issues relate to how the parties interact during industrial action, rather than being covered by the provisions of clause 12.5.

[10] APEX's view is that taking such a prescriptive approach is inappropriate, as it is contrary to the general duties of good faith and the deliberate lack of prescription in the code generally, as well as the Act itself.

[11] I do not accept APEX's view that because clause 12.5 does not align with clause 12.3 then the matters prescribed by clause 12.5 were not intended to be exhaustive, as clause 12.5 negotiations are a continuation of the process initiated by a clause 12.3 request. This is because of clause 13. I find that clause 13 thus provides for jurisdiction where the parties cannot reach agreement *under* clause 12.5, not *in relation to* the preceding negotiations, which may have been much wider. The term *under* is significant and implies that clause 12.5 was intended to be exhaustive for the purposes of adjudication. Similarly, clause 12.5 sets out what the parties are to negotiate on.

[12] Contrary to APEX's submissions, I conclude that the words *must meet and negotiate ... on* clauses 12.5(a)-(c) are restrictive. In a voluntary bargaining environment, parties may agree on, especially under the mutual duty of good faith, any matters that they believe will advance issues, but this is an environment where adjudication is provided for and therefore the adjudicator's jurisdiction is to be limited. It is part of the principles of the Act that third party intervention be minimised and thus the DHBs' interpretation is more consistent with that than APEX's. Thus an adjudicator's job, a difficult one at best, is in fact made easier by narrowing the issues that can be adjudicated on.

[13] I therefore conclude that the first obligation on the parties is to negotiate and that they may negotiate on a broad range of issues, but those matters that are to be dealt with by adjudication can only be those matters provided for under clause 12.5. This is both because of the prescriptive nature of the language used, and the fact that third party adjudication is provided for, which is most unusual under the Act and only applies in relation to these sorts of provisions in the public health and police sectors, or potentially in facilitation.

[14] I reach this conclusion with regret because otherwise such issues can and have ended up before the Authority. As I found in *APEX v. Capital & Coast DHB* (WA98/07, 17 July 2007) the Authority is probably not the best place to determine disputes about the use of life preserving services. Instead, such matters would probably be better determined by an independent medical specialist acting in an

advisory and/or decision-making role. This is in fact what the union has requested and the parties and/or the adjudicator have subsequently found by providing for the *gatekeeper* and *conduit persons*. In any event, APEX's concerns over the kind of staff necessary, and which staff will be made available, can still be provided for by agreement, particularly as they relate to processes to ensure and monitor the effectiveness of how the DHBs implement the life preserving services agreement. Unlike the DHBs, I can see benefits in the use of medical experts to give practical effect to life preserving services agreements. Indeed I acknowledge the initiatives of the union to promote such systems. However the DHBs are fully aware of the potential for further disputes in the Authority over the implementation of such issues, should there be no *gatekeeper* or *conduit persons* involved.

[15] The same concerns do not, however, apply to adjudicators determining the pay for union members required to be on call under life preserving services agreements. That is a matter for the parties, not the adjudicator.

[16] I therefore find for the applicants and determine that issues relating to *gatekeepers* and *conduit persons* are not matters over which a clinical expert/adjudicator has any jurisdiction. I also determine that a clinical expert/adjudicator has no jurisdiction to determine pay or allowance issues between the parties.

### **Costs**

[17] Costs are reserved.

**G J Wood**  
**Member of the Employment Relations Authority**