Addressing the impacts of pay disparities in the health funded sector

Proposal

1 This paper seeks agreement to establish a tagged contingency of $40 million in 2022/23 and up to $200 million from 2023/24 that will increase pay rates for over 15,000 nursing and 5,000 healthcare workers in the health funded sector to rates similar to those paid to Te Whatu Ora | Health New Zealand-employed staff.

Relation to government priorities

2 The Government is committed to managing New Zealander's health for the long-term and maintaining progress towards a fully equitable, sustainable, and quality health system for the future.

3 One of the greatest assets to achieve these priorities is the health workforce. Ensuring the supply, skills, and competencies of the health workforce that supports each part of the health system will be integral.

Executive Summary

4 The nursing and care workforce in New Zealand is under growing pressure. Pay differentials between workers in different parts of the sector exacerbate the impacts of workforce shortages, especially in this time of heightened cost-of-living pressures. Current pay relativities favour Te Whatu Ora-employed workers and hospital work over most community settings.

5 As a result, service supply issues are being seen in many parts of the sector with increasing employee vacancy rates and providers unable to deliver full services (eg, closing beds and lowering staff time available to patients).

6 I propose improving pay relativities in the health funded sector (to close to or at parity) with Te Whatu Ora-employed staff. This would provide relief for the most affected workforces and service settings in the near term, with average pay increases for nurses, for example, of up to s [redacted] in aged residential care (ARC) and up to s [redacted] in Māori health. It would signal to providers that the government is acting now to forestall any worsening service supply issues, and to health workers that their important work is recognised. Please note: Redacted information in paragraph 6 is withheld under section 9(2)(j) of the Act.

7 This proposal is an early action to bolster the workforce in the health funded sector while health agencies undertake work to address these issues for the long-term, including the development of:

7.1 strategies mandated under the Pae Ora (Healthy Futures) Act 2022;

7.2 a health workforce strategy; and

7.3 a long-term funding approach for Budget 2024 and beyond.

8 I recommend that a funding envelope of $40 million in the 2022/23 financial year and $200 million ongoing from 2023/24 onwards is made available in a tagged contingency to support improved pay relativities across over 15,000 nursing and 5,000 care roles in the funded sector over the coming 18 months. This would support pay uplift for nurses of between s 9(2)(j) and for other healthcare workers of between s 9(2)(j) across service areas.

9 Providing these funds through a tagged contingency will allow flexibility to respond to changing service pressures and more exact workforce information during implementation. It will also mean that other Government funders such as Whaikaha can draw on the contingency where they fund related services employing the same health workforces.

10 Following Cabinet decisions, I propose announcements are made before the end of 2022, with commitment to delivery in the first quarter of 2023 for the services at greatest risk. ARC and homecare services (with the greatest current service impacts) and Māori and Pacific health providers (with the greatest pay disparities and equity challenges) will receive initial priority, followed by mental health & addictions, other residential, hospice and Whaikaha disability care settings within the first six months of 2023. This progressive phasing is due to the complexities in some parts of the funded sector. There will be further rollout to wider groups during the 2023/24 financial year.

11 Implementation will involve, for each service setting, obtaining and updating information, consulting providers, negotiating contract changes where required under service agreements, quantifying required funds, agreeing draw-down on the contingency, making and ratifying offers that include pass through of price increases to employees, and effecting the changes to service prices and employee pay.

Addressing workforce pressures is a priority for this Government

12 Long-standing health workforce pressures have been exacerbated by low unemployment, emigration, and increased demand for services. The COVID-19 pandemic and increased levels of winter illness has compounded these pressures. As a result, service supply issues are being seen in many parts of the sector with increasing employee vacancy rates and providers unable to deliver full services (eg, closing beds, deferring non-urgent care and lowering staff time available to patients).

13 We are building an approach to assure a health workforce that can effectively manage New Zealanders' health over and for the long-term. I expect to bring a progress update to Cabinet in early 2023 on delivering a health workforce strategy. s 9(2)(f)(iv)

14 While this work is underway, the persisting and urgent nature of the workforce challenges have required immediate action. From 1 July 2022, with the passage of the Support Workers (Pay Equity) Settlements Amendment Act 2022, an interim 3% wage increase has been funded for care and support workers while a pay equity process is underway.

15 In early August 2022, I announced a suite of initiatives that aim to alleviate some of the immediate workforce pressure through training more health workers domestically and bringing more doctors and nurses into the country. This was a necessary action given the funding parameters could not provide for the level of cost pressures experienced in the health sector.

16 In addition to the immediate actions that I announced in early August and the development of a health workforce strategy, there is an urgent need to address the impacts of pay disparities[1] between the government-employed and government-funded sectors.

17 Over large groups of employees, pay differentials and relativities can have large effects on staff movement. These effects include movement out of health roles to better-paid roles in other sectors as well as movement between health sector settings. Such movement is more likely in tougher economic times and where pay relativities are perceived to be worsening or likely to worsen.

18 Employee vacancies are now acute in the ARC setting. Annual turnover of registered nurses is reported to have increased to 48% (a 15% increase) in the two years 2019-21 and clinical nurse manager turnover up to 33% (a 33% increase)[2]. Median replacement time for registered nurses is reported as four months with some providers unable to recruit new staff at all.

19 Primary care practices are also experiencing recruitment difficulty, despite paying newly recruited nurses at rates above those in applicable employment agreements. Current industrial action highlights support across a number of nursing groups for pay parity across service settings.

Pay differentials are impacting service delivery

Workforce pressures are compounded by competition for workers between health services

20 The government provides funding to a broad range of providers of health and disability support services in the Non-Government Organisation (NGO) and private sectors. This includes providers of primary health care, ARC, as well as home and community, disability, and mental health and addiction support services.

[1] *Pay disparity* exists where there are pay differences between roles that do not correspond to differences in the work. *Pay differences* are the differences in pay and conditions between roles and pay differentials the sizes of those differences. *Pay relativities* describe pay differentials in terms of the differences between roles. *Pay parity* is where like-for-like roles have the same or equivalent pay and conditions.

[2] New Zealand Aged Care Association (NZACA) and BERL: Aged Residential Care Industry Profile 2021-22. Scaled, based on survey responses covering 71% of the ARC bed supply.

21 We are seeing a net flow of nurses out of ARC settings and into Te Whatu Ora hospitals. There are signs this is also impacting home and community support services. One cause of this net flow, especially with inflationary pressures on household budgets, is better pay and conditions for nurses and related workers in Te Whatu Ora hospitals.

Pay differentials have a significant impact on health service operations

22 Through the district health boards and New Zealand Nurses Organisation (NZNO) multi-employer collective agreement (MECA[3]) settlement of September 2021, an advance base salary adjustment of up to $4,000 was agreed in addition to the agreed MECA salary adjustment. This adjustment recognises a pay equity claim in progress with an offer under consideration.

23 The adjustment has put Te Whatu Ora rates of pay further ahead than they have been historically, amplifying the pay differentials between these sectors.

24 When the pay equity claim is eventually settled, the gaps will increase significantly and put further strain on the system over what is currently being experienced. s s 9(2)(f)(iv) Alongside this, if the Public Service Pay Adjustment is implemented in the public health system, then the wage gap will widen further.

25 These disparities are a problem because of their labour market impact, which in turn limits service delivery in primary and community settings, contributing to backlogs in hospital and specialist settings.

26 Providers have responded in a range of ways – some have sustained lower wages and are facing staffing pressures as a result, whereas others have raised pay rates to match Te Whatu Ora rates – in some cases at the cost of financial sustainability.

Other healthcare roles in the funded sector are also subject to pay differentials

27 Kaiāwhina[4] is a broad term encompassing a range of healthcare assistant roles. Some of these roles have had pay increases this year under the Support Workers (Pay Equity) Settlements Amendment Act 2022; further pay adjustments are not included in this proposal. However, other roles, especially those in Māori and Pacific health and primary and community health, were not included in that process and pay disparities with Te Whatu Ora-employed healthcare assistants are material.

28 Other funders across the social sector also fund services that rely on health workforces. For example, nurses are employed in a range of assessment, healthcare, rehabilitation, respite, behavioural support and other services funded by Whaikaha; in

[3] The district health boards and New Zealand Nurses Organisation (NZNO) multi-employer collective agreement is referred to as the Te Whatu Ora MECA throughout this report

[4] Throughout this report, the term kaiāwhina is used to cover a wide range of healthcare roles not regulated under the Health Practitioners Competence Assurance Act (2003). These roles include healthcare assistants and community support and homecare workers, all of whom are providing a level of personal health care to individuals and whānau.

a range of school health, family and sexual health, violence prevention and rehabilitation services funded variously by single or joint social sector funders. Such workforces are included in this proposal. Numbers of employees in these varied services are small in relation to the numbers in health funded sector roles.

29 Outside directly nursing related roles, others are also affected by historic service funding approaches. These include allied health roles such as psychologists, social workers, and counsellors. In some cases, workers in these roles provide care that may be similar to that provided by nurses, such as where multidisciplinary teams share caseloads.

Evidence showing pay differentials in the funded sector

30 Manatū Hauora | the Ministry of Health and Te Whatu Ora have collated staffing figures from multiple sources[5] and time periods. This includes projections based on workforce growth trends to indicate which settings and roles are experiencing the greatest wage gaps.

31 Table 1 below identifies numbers of workers in non-government-employed nursing and related roles in health settings. It estimates the size of pay differentials based on provider survey returns of 2022 wage rates, and may contain bias if higher-paying providers were more likely to be survey respondents. The costs shown are conservative estimates of the costs to employers of lifting pay rates that are currently below those in the Te Whatu Ora MECA to the MECA rates.

32 The information available indicates the following:

32.1 Nurses working in Māori providers (and, anecdotally, Pacific providers) have the greatest wage gap across the board.

32.2 Kaiāwhina[6] or healthcare assistant wage rates vary widely, with some above current Te Whatu Ora hospital rates and others significantly below.

32.3 There are large differentials in the ‘other’ categories which include mental health and addictions, community (eg, Plunket, Family Planning), residential, hospices, rural hospitals and providers who are cross sectorial or not easily categorised.

32.4 Nurses working in General Practice have base wage rates that are relatively close to the wage rates in hospital care, and current funding rounds for primary care capitation take explicit account of relativities with the Te Whatu Ora MECA.

[5] Nursing Council, Aged Care Association, Home and Community Health Association, many employers and Stats NZ

[6] Kaiāwhina numbers include care and support worker groups who, with passage of the Support Workers (Pay Equity) Settlements Amendment Act 2022, received a 3% pay increase from 1 July 2022 while a pay equity claim is being progressed. The proposal in this paper excludes these workers but includes kaiāwhina who were not covered including employees of Māori and Pacific providers, hospices, rural hospitals and primary care practices.

Table 1: Estimates of pay differentials with Te Whatu Ora MECA

Service setting	Number of positions (FTE) and average pay differential (% above [+][7] or below [-] Te Whatu Ora MECA)										Estimated annual cost[8] ($ million)
	Registered Nurses		Senior Nurses[9]		Enrolled Nurses		Kaiāwhina[10]		Total		
Aged Residential Care	4,396	s 9(2)(ba)(i), s 9(2)(j)	770	s 9(2)(ba)(i), s 9(2)(j)	550	s 9(2)(ba)(i), s 9(2)(j)	16,190	s 9(2)(ba)(i), s 9(2)(j)	**21,905**		s 9(2)(ba)(i), s 9(2)(j)
General Practice Primary Care	3,333				170		900		**4,403**		
Māori Health Providers	522				27		1,151		**1,700**		
Mental Health & Addiction	254				7		2,126		**2,386**		
Other Community[11]	3,836		268		65		13,325		**17,495**		
Other Residential	454						2,755		**3,209**		
Total positions (FTE)	**12,795**		**1,038**		**818**		**36,447**		**51,099**		
Estimated annual cost[8] ($ million)	s 9(2)(ba)(i), s 9(2)(j)										

33 Figure 1 below shows the average variation from MECA rates currently and as anticipated in future if the current pay equity offer is accepted.

[7] Positive differentials reflect higher pay rates than those under the Te Whatu Ora MECA

[8] Estimated cost is to bring negative pay differentials up to zero so as to increase pay up to parity with the Te Whatu Ora MECA

[9] Senior nurses include clinical leadership and management roles that are similar to senior nurse roles in hospital settings. Not all service settings have similar roles. Nurse practitioners are not included in this category.

[10] Kaiāwhina include all non-regulated care and health assistant roles working in health settings, including those who are covered by the Support Workers (Pay Equity) Settlements Amendment Act 2022

[11] Other community includes homecare, hospices, rural hospitals, well child tamariki ora, telehealth and a range of other health-funded settings. It does not include non-health-funded settings including disability assessment, rehabilitation and care.

Figure 1: Summary of average base salaries by sector, compared with Te Whatu Ora MECAs current (September 2021) and anticipated (if pay equity offer is agreed)

s 9(2)(j)

[redacted]

Mechanisms for addressing pay relativities

34 In a pure market situation, employers adjust pay and pay differentials to achieve their business goals. Yet in the funded health sector, there is a dominant (sometimes single) funder, and service contracts may have a large (though not sole) impact on employer offerings to staff.

Contractual mechanisms

35 Contracts between funders and providers provide the most direct ways to acknowledge service-related conditions and standards. Intended outcomes may not always be achieved and conditions may not be enforceable. Goodwill, shared intent and industry-wide approaches may have strong influence when it is uncertain or difficult to enforce a contractual requirement to pay rates that are not built into that industry's collective employment agreements.

36 For some service settings, an overall arrangement is in place for consistent commissioning across funders and providers, and a standard and regular process for negotiating updated payment terms and conditions. General practice primary care is an example with pricing referenced to collective employment agreements and minimal current pay disparities. (Differentials above MECA rates are, though, offered increasingly to fill vacant positions.)

37 ARC also has a standard process for pricing that creates a setting-wide approach to improve employee pay relativity. s 9(2)(j) [redacted] s 9(2)(j) [redacted] Some

providers may not be able to meet new employment conditions without a more significant funding uplift because of business size, stage, model or costs.

38 For other service settings, industry-wide arrangements may be lacking and negotiation with hundreds of providers over thousands of contracts is time consuming and likely to delay outcomes for employees. Further work is to be completed by health agencies to determine how adjustments to service contracts may be implemented going forward and the first stage will inform implementation of the proposal in this paper.

Indexed and other enduring mechanisms

39 Over time, it is desirable that service price adjustments are funded in line with salary uplifts to Te Whatu Ora's workforce, to ensure a functioning market for health workforces that is responsive to desired service and model of care changes. A sustainable approach to ensuring potential pay disparities is managed will support this long-term vision. It can be built on the foundation of Fair Pay Agreements, which offer a more coherent, strategic way to ensure common terms, conditions and minimum rates across Te Whatu Ora and funded sector employers. The NZNO has signalled their intention to promote parity across the sector.

Mechanisms that grow capability and career mobility

40 Greater opportunities for skill acquisition and use, capability growth and career flexibility and progression are needed for an adaptable health workforce fit for the future. The health workforce strategy now in development will promote such adaptive and flexible approaches.

41 Accelerating career development for kaiāwhina is one priority in the developing workforce strategy. It would provide clear, staircased pathways to credential growing skills and capabilities as kaiāwhina and other healthcare workers progress through their careers. It would be likely to attract more people from communities with high health needs into these career paths, increase representativeness of the workforce and promote more equitable health outcomes for workers and the communities they serve.

Options to address the health service and outcome impacts of pay disparities

42 Health agencies have worked with the Treasury to identify options to address the service impacts of pay disparities for the nursing and related workforce. A number of options were considered, as outlined in table 2. Because available information is incomplete and regarded as conservative, cost ranges are provided.

Table 2. Options considered with numbers of positions affected and costs

Beneficiary group	Estimated beneficiaries (FTE) and costs ($ million) in 2022/23	Estimated benefiaries (FTE) and costs ($ million) in 2023/24 and outyears
Registered and enrolled nurses in highest service risk settings	s 9(2)(j)	
All nurses in highest service risk settings		
All nurses and certain kaiāwhina[12] in health-funded settings		
All nurses and certain kaiāwhina in government-funded settings		
All nurses, certain kaiāwhina and related health workers in government-funded settings[14] **(recommended)**		
All nurses, all kaiāwhina and related health workers in government-funded settings		

[12] Certain kaiāwhina excludes those covered by the Support Workers (Pay Equity) Settlements Amendment Act 2022

[13] Given the expected timeframes for implementation across the indicated groups, the funding envelope is likely to cover uplifts executed during the first half of 2023.

[14] Government-funded settings include social sector funders such as Whaikaha, but not ACC. Beneficiaries and costs are rough estimates as further work is required to identify numbers of positions involved.

43 A narrow scope of work would be likely to shift the impacts rather than help solve them. For example:

43.1 addressing the issue only for highly affected service settings such as ARC would be likely to cause flow-on shortages in other service areas, most obviously homecare and also over time across many residential and community services;

43.2 addressing the issue for nurses only, even across all service settings, would be likely to continue inequitable outcomes for Māori and Pacific peoples by limiting the workforce available to Māori and Pacific providers. These providers have a greater reliance on kaiāwhina workforce who would continue to be disadvantaged. Kaiāwhina not covered by the Support Workers (Pay Equity) Settlement Amendment Act 2022 and paid at rates a margin above minimum wage have not received pay increases when minimum wage rates were lifted;

43.3 addressing the issue for nurses only would also be likely to promote a cascading set of pay parity and pay equity claims across other workforces (health and wider);

43.4 addressing the issue for services funded only by health agencies would be likely to continue inequitable outcomes for people with disabilities, children in State care and communities with multiple deprivation, for whom social services are particularly important. With smaller scope and scale, it is likely that the options would not achieve significant progress towards improving pay relativities in the health funded sector. In making no commitment to other healthcare roles and settings, these options would likely enhance existing inequities within the funded sector and between Māori and Pacific and other providers.

Proposal to improve pay relativities, starting with service settings that will see the greatest gain through immediate investment

44 I seek Cabinet agreement to urgently address pay disparities for nurses and kaiāwhina working in service settings that are experiencing high turnover and service reductions (including ARC and homecare) and the greatest pay disparities and equity challenges (including Māori and Pacific health providers) as soon as practicable in early 2023. These settings will receive initial priority, followed by mental health & addictions, other residential and Whaikaha disability care settings within the first six months of 2023.

45 I further propose that relativities be progressively addressed for a wider range of nursing and healthcare roles in the funded sector over the 18 months to the end of June 2024.

46 The approach will provide flexibility for service funders to consider relativities for a wide range of roles (e.g., psychologists) that work closely with nurses in some

settings. In doing so, services will become less reliant on one sole practitioner group, such as nurses, and adopt models of care that support a multidisciplinary approach to healthcare.

47 The price increases that are incorporated into this funding envelope will recognise growth in minimum wage and cost of living, which will most impact lower-paid kaiāwhina roles. The proposal to address pay relativities focuses for kaiāwhina on those who work in roles similar to hospital "healthcare assistants", including kaiāwhina working for Māori and Pacific providers, hospices, rural hospitals and primary care practices. In particular, it does not consider 'support workers', whose terms and conditions have already been addressed by the Support Workers (Pay Equity) Settlements Amendment Act 2022.

48 Further workforce development is needed to attract, retain and grow capabilities of kaiāwhina, especially from the communities who most need care and support to achieve equitable health outcomes. One aspect of pay differentials for this workforce is the lack of qualifications and career progression that would support workers to progress in their careers and receive remuneration commensurate with higher quality care.

Funding to improve pay relativities

49 To allow a response starting as soon as practical in early 2023, I seek agreement to set aside funds in a tagged contingency, as outlined below, with drawdown to be approved by the Minister of Health and Minister of Finance, jointly, subject to their satisfaction with an implementation plan, including the percentage uplift for each group of providers, the contractual mechanisms to support higher pay rates and the expected salary increases and pay differentials accommodated as a result:

	$million – increase				
	2022/23	**2023/24**	**2024/25**	**2025/26**	**2026/27 & outyears**
Improving pay relativities for funded sector health workers - Tagged operating contingency	40.000	200.000	200.000	200.000	200.000

50 The funding amounts recommended are based on an upper range of average pay rate estimates across service settings and on current position numbers including positions that are currently vacant. Information including costs and position numbers will be updated during preparation to implement the proposal.

51 Nevertheless, limitations in data available at this time could result in the funding being insufficient to address pay gaps fully. Giving Te Whatu Ora, Te Aka Whai Ora | the Māori Health Authority and other funders the goal to 'improve pay relativities', rather than 'achieve pay parity' will promote fiscal management. s 9(2)(g)(i), s 9(2)(f)

s 9(2)(f)(iv), s 9(2)(g)(i)

52 The tagged contingency will be the upper limit on funding available to address pay disparities. If the estimated cost of addressing pay disparities increases through further work on design and implementation, funders will manage within the ceiling created by the contingency to prioritise funding increases. Such prioritisation will involve collective funders including Te Whatu Ora, Te Aka Whai Ora and Whaikaha.

Implementation

53 Health funders will prepare to make the initial service funding uplift/s as soon as possible after Cabinet decisions. This preparation requires a number of steps, including, for each service setting, obtaining and updating information, discussions with other public funders around impacts and how to deal with costs that may be divided among funders, consulting providers, negotiating contract changes where required under service agreements, quantifying required funds, agreeing draw-down on the contingency, making and ratifying offers that include pass through of price increases to employees, and effecting the changes to service prices and employee pay.

54 I propose announcements are made before the end of 2022, with commitment to delivery in the first quarter of 2023 for the services at greatest risk (especially ARC and homecare). Due to the complexity in some parts of the sector, delivery will be progressive over the first six months of 2023.

55 s 9(2)(f)(iv)

Financial Implications

56 The funding amounts recommended are based on average pay rates across service settings and on workforce numbers that assume 15% vacancies, the rate reported by the Nursing Council across the sector pre-COVID-19. These limitations could result in the funding being insufficient to address pay differentials fully. If this is the case, funders will collectively prioritise use of the funds remaining in contingency.

57 The proposal has implications for ACC and for funders outside government including private payers. For example, in ARC 41% of residents have income or assets above a threshold and fund a proportion of their care costs. A s increase in ARC nurse wages, costing Te Whatu Ora s 9(2)(j) and Whaikaha s 9(2)(j) per year, would cost these residents, collectively, s 9(2)(j) per year. Increased primary care practice costs may have implications for patients paying full costs of care and for ACC.

58 The proposal encompasses addressing pay relativities for the nursing, kaiāwhina and related health workforces employed by providers in the wider funded social sector. It does not address pay relativities of non-health workforces. There may be potential

impacts on pay expectations or pay equity claims by other government-funded workforces.

59 The tagged contingency will be charged outside of any Budget allowances and therefore draw-down of the tagged contingency will represent a decrease in the Crown operating balance before gains and losses (OBEGAL) and an increase in net debt.

Legislative Implications

60 There are no legislative implications for the government from the proposals in this paper.

Climate Implications of Policy Assessment

61 There are no climate implications arising from this paper.

Population Implications

62 Narrowing pay disparity between Te Whatu Ora employees and employees of other providers may improve both the outcomes for the health workforce and for populations who experience poorer health outcomes, especially Māori, Pacific peoples, disabled people, rural communities and people with lower socio-economic status.

63 These are the population groups for whom community-based services have the biggest potential to improve health outcomes. They are also the population groups most likely to be impacted by barriers to hospital services that occur because of lower levels of community-based services.

Human Rights

64 The proposals in this paper are consistent with the New Zealand Bill of Rights Act 1990 and the Human Rights Act 1993.

Consultation

65 I am advised that Manatū Hauora has consulted with Te Whatu Ora, Te Aka Whai Ora, Treasury, the Department of Prime Minister and Cabinet, the Public Service Commission, ACC, Whaikaha, the Ministry for Social Development, the Department of Corrections, and the Ministry of Education in the development of this paper.

Communications

66 I propose to announce this proposal prior to the end of 2022.

Proactive Release

67 This paper will be proactively released after decisions have been announced, according to standard processes under Cabinet Office circular CO (18) 4, subject to redactions as appropriate under the Official Information Act 1982.

Recommendations

The Minister of Health recommends that the Committee:

1. **note** that the nursing and care workforce is under considerable pressure with increasing vacancies and turnover rates in the funded sector, exacerbated by current pay relativities that favour Te Whatu Ora-employed workers and hospital work over most community settings;

2. **note** that the net flow of workers from the funded sector into Te Whatu Ora hospitals is impacting service delivery in primary and community settings (e.g., closing beds, and lowering quality of patient care) which flows through to backlogs in hospital and specialist settings;

3. **agree** to improving pay relativities for health workers in the funded sector subject to further work on finalising operational arrangements including contractual mechanisms to support higher pay rates and stakeholder consultation;

4. **note** this proposal is not intended to achieve pay parity but to reduce the gap in pay relativities for health workers between the government-employed and government-funded sectors;

5. **note** that with up to $40 million in 2022/23 and $200 million per annum from 2023/24, health funding agencies expect to be able to improve pay relativities for over 20,000 health workers across the government-funded sector;

6. s 9(2)(f)(iv) [redacted]

7. **agree** to establish a tagged operating contingency associated with the Health portfolio of up to the following amounts to provide for improving pay relativities in the funded sector:

	$million – increase				
	2022/23	**2023/24**	**2024/25**	**2025/26**	**2026/27 & outyears**
Improving pay relativities for funded sector health workers - Tagged operating contingency	40.000	200.000	200.000	200.000	200.000

8. **authorise** the Minister of Health and the Minister of Finance jointly to draw down the tagged operating contingency funding in recommendation 7 above (establishing any new appropriations as necessary), subject to their satisfaction with the outcome of the further work described in recommendation 3 above;

9. **agree** that the expiry date for the tagged operating contingencies in recommendation 7 above will be 1 February 2024;

10. **note** that the tagged operating contingency in recommendation 7 above is not charged against any allowances but instead has a direct impact on OBEGAL and net debt.

Authorised for lodgement

Hon Andrew Little

Minister of Health