Briefing

Addressing the impacts of pay disparity in the health funded sector

Date due to MO:	13 October 2022	**Action required by:**	17 October 2022
Security level:	IN CONFIDENCE	**Health Report number:**	20221373
To:	Hon Andrew Little, Minister of Health Hon Grant Robertson, Minister of Finance		

Contact for telephone discussion

Name	Position	Telephone
Allison Bennett	Group Manager, Health System Settings	s 9(2)(a)
Maree Roberts	Deputy Director-General, Strategy, Policy and Legislation	s 9(2)(a)

Minister's office to complete:

☐ Approved ☐ Decline ☐ Noted

☐ Needs change ☐ Seen ☐ Overtaken by events

☐ See Minister's Notes ☐ Withdrawn

Comment:

Released under the Official Information Act 1982

Addressing the impacts of pay disparity in the health funded sector

Security level:	IN CONFIDENCE	**Date:**	13 October 2022
To:	Hon Andrew Little, Minister of Health Hon Grant Robertson, Minister of Finance		

Purpose of report

1. This report responds to Ministers' request for advice on the extent of pay disparity in the health funded sector and provides options to address the impacts of pay disparity between Government-employed and Government-funded nursing and related roles, what these options will deliver and associated costs and risks.

Summary

2. The nursing and care workforce in New Zealand is under growing pressure. Net movement of nurses and related workers out of the New Zealand health sector is further complicated by impactful net movement within the sector. For instance, serious shortages of nurses and healthcare assistants in aged residential care (ARC) are not only lowering aged care provision but also increasing demands on Te Whatu Ora hospitals.

3. Pay differentials between workers in different parts of the sector exacerbate pressure on the nursing workforce, especially in this time of heightened cost-of-living pressures. Current pay relativities favour Te Whatu Ora-employed workers and hospital work over a number of community settings (not including general practice primary care). They tend to incentivise against work in some of the care settings (such as Māori and Pacific health) that most need growth if we are to improve equity and health outcomes and manage health in the long term. They are seen as unfair and inequitable.

4. This report proposes options to improve pay relativities between nurses working in different parts of the sector and to improve pay and career development for kaiāwhina or healthcare assistant roles. Recognising the urgency of action to bolster the nursing workforce, options focus on early actions that can be announced once decisions have been made and will be implemented from early in 2023. Interfaces with future-focused work on health system funding, commissioning and models of care are outlined to highlight contribution to managing New Zealanders' health in the long term.

5. The options achieve funding uplifts that would allow pay increases for workers in the first half of 2023. The options build in scale, providing funding calculated at levels that are designed to improve relativities towards or to parity with the Te Whatu Ora hospital rates of pay; and in scope, providing funding targeted to a widening group of workers.

6. The options do not guarantee the funding will be fully used for pay increases, nor that all workers will end up with the same relativities. They cannot achieve pay parity in a workforce market where workers are employed by many different providers who have

Released Under the Official Information Act 1982

their own circumstances and goals. The options will improve relativities and assist in improving the confidence of nurses in the New Zealand health system as a fair and rewarding place to work.

Recommendations

We recommend you:

a) **Note** that serious shortages of nurses and healthcare assistants in the health funded sector are lowering care provision in the community (especially in aged residential care and homecare) and increasing demands on Te Whatu Ora hospitals

b) **Note** that pay relativities and disparities exacerbate other drivers of workforce shortages

c) **Agree** to take a phased approach to address service impacts by lifting service funding to support improved pay relativities in the funded sector **Yes/No**

d) **Indicate** which options you support to improve pay relativities:

i) Option 1: improve pay relativities for over 10,000 registered and enrolled nurses across all service settings, starting with high service impact settings – estimate s 9(2)(j) total cost over two years 22/23 and 23/24 **Yes/No**

and / or

ii) Option 2: improve pay relativities for over 32,000 workers across nursing and related healthcare roles, starting with high service impact settings – estimate s 9(2)(j) total cost over two years 22/23 and 23/24 **Yes/No**

and / or

iii) Option 3: achieve movement towards relativity across some 45,000 health funded sector roles within the funding envelope (estimate s 9(2)(j) total cost over two years), building evidence to best achieve this over time **Yes/No**

and / or **Yes/No**

iv) Other – please indicate

e) **Note** that in the funded sector there is no direct relationship between service funding and employment, nor a guarantee that service price increases will result in better pay and conditions for staff

f) **Note** that linking service price increases to contractual requirements for employment conditions can mitigate the risk that pay relativities will not improve, and that negotiations for such contractual requirements take time

g) **Indicate** your preference for either:

v) Endeavouring to achieve service price increases that support nursing pay relativities in the highest service impact settings before the end of 2022 **Yes/No**

Released under the Official Information Act 1982

or

vi) Achieving service price increases tied to contractual requirements around pay from early in 2023 for the highest service impact settings **Yes/No**

h) **Agree** that agencies should engage with other public service funders of nursing services including the Accident Compensation Corporation and Whaikaha **Yes/No**

i) **Agree** to forward this briefing to the Prime Minister and MOGSSER Ministers **Yes/No**

j) **Agree** that agencies should engage with providers and unions to gain greater understanding of pay relativities in the funded sector **Yes/No**

Hon Grant Robinson
Minister of Finance
Date:

Hon Andrew Little,
Minister of Health
Date:

John Whaanga
Acting Director-General of Health
Date: 13/10/2022

Released under the Official Information Act 1982

Addressing the impacts of pay disparity in the health funded sector

Context

7. You have recently considered two August 2022 reports:

   a. a Treasury report, *Addressing urgent workforce supply issues due to pay disparities in the health system*

   b. a report from the NZ Nurses Association, *Non HNZ (DHB) Nursing Disparity Issues*.

8. Taken together, these reports:

   a. provide evidence of growing nursing turnover and vacancy rates in aged residential care (ARC) settings, and increasing pressure on other community nursing positions

   b. comment on the impacts of this turnover and pressure, both in the settings with resulting vacancies and in the Te Whatu Ora hospital system

   c. suggest making early efforts to improve pay relativities for aged residential care (ARC) services staff to improve recruitment and retention as well as taking steps to address other nursing shortage impacts.

9. In response, you indicated your agreement to address pay disparity in the funded sector with a pragmatic and affordable approach and with pace. You wished to see a discernible benefit to nursing workforces in early 2023 as the initial priority and have indicated that a funding envelope of s 9(2)(f)(iv) could be available, based on initial estimates of pay differentials.

10. This report:

    a. presents new, updated information showing pay differentials that are lower and affect fewer workers than earlier estimates

    b. responds to your request for implementation options to address pay disparity in the health funded sector.

Terminology - what is pay disparity?

11. *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. *Pay disparity* is where there are pay differences between roles that do not correspond to differences in the work.

12. For any employee, there are many factors in choice of work roles over and above pay and conditions (such as location, flexibility, fit with lifestyle and responsibilities, personal satisfaction, social attitudes). Their importance varies between people and with changes

Released under the Official Information Act 1982

to wider economic and social conditions. Over large groups of employees, pay differentials and relativities can have large effects on staff movement.

13. These effects include movement out of health roles to better-rewarded 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.

14. Throughout this report, the term *kaiāwhina* is used to cover a wide range of non-regulated care roles. 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.

What we know about the size of the problem

New Zealand is experiencing significant workforce pressure

15. New Zealand is experiencing growing and significant health workforce pressure that has been exacerbated by low unemployment, emigration, and increased demand for services. Enduring high demands on the health sector over the course of the pandemic and changing public confidence in health services continue to affect health worker morale.

16. 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 quality of patient care).

17. Employee vacancies are 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)[1]. Median replacement time for registered nurses had increased to four months. Other estimates of staffing retention also show that ARC nurse retention is falling and the rate of this fall increased between 2020 and 2021.[2]

18. ARC facilities are now required to report to HealthCERT on shortages of registered nurses to cover shifts, with reasons and management steps. These shortages increased dramatically over winter with sickness being a significant but minor cause and vacancies or recruitment difficulties the dominant causes.[3]

Workforce pressure is compounded by competition for workers between health services

19. We are seeing a net flow of nurses out of ARC and into Te Whatu Ora hospitals. There are signs this is also impacting home and community support services. One cause of this

1 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.

[2] Ministry of Health, unpublished data 2022.

[3] HealthCERT. Registered Nurse Shortage Section 31 Notifications in Aged Residential Care Facilities: 4-week rolling total report between 04 April 2022 to 28 August 2022.

Released under the Official Information Act 1982

net flow, especially with inflationary pressures on household budgets, is better pay and conditions for nurses and related workers in Te Whatu Ora hospitals.

20. Nurses and care workers can experience better pay and conditions in Te Whatu Ora and overseas, and this contributes towards Non-Government Organisation (NGO) providers' challenges in recruiting and retaining staff.

21. Perversely, workforce flows into Te Whatu Ora hospitals can result in lower access to hospital care if up- and down-stream services are affected. Where community residential care beds are in lower supply, hospital beds may be used long-term for people whose needs would otherwise be met elsewhere. Likewise, lower access to primary and community care can delay and exacerbate healthcare need, especially in high need communities.

Pay differentials have a significant impact on health service operations

22. There is no established mechanism to recognise the impacts of salary increases for Te Whatu Ora-employed workforces on funding for wider health services. At present, those on different employment agreements may have significant pay differentials, impacting on recruitment and retention and compounding service and workforce pressures.

23. Differentials between pay rates across employers in the Government-employed and Government-funded sectors have always existed. In some cases employers in the funded sector have paid higher rates (eg, telehealth) and in other cases Government employers have paid higher rates historically. In some service settings, regular price adjustments are built into funder-provider agreements and these adjustments may maintain pay relativities, as has occurred for general practice primary care nurses this year. This approach softens relativity gaps, yet absolute (rather than percentage) and actual (pay to employees) relativities may worsen over time.

24. In the district health boards and New Zealand Nurses Organisation (NZNO) multi-employer collective agreement (MECA) settlement of September 2021, a pay equity in advance base salary adjustment of up to $4,000 was agreed in addition to the agreed MECA salary adjustment. This payment has put Te Whatu Ora rates of pay further ahead, disrupting the historical relativities.

25. These disparities are a problem because of their labour market impact, which in turn limits service delivery in primary and community settings and flows through to backlogs in hospital and specialist settings. In some settings (such as ARC and homecare), relatively small disparities can result in significant service disruption, while larger gaps in other sectors may have less acute impacts on services.

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. Numbers of providers have reduced the scope of services in lieu of receiving additional funding.

Released under the Official Information Act 1982

27. Impacts already being seen include "bed blockages" in Te Whatu Ora hospitals where ARC beds are unavailable as providers cannot fill staff vacancies. ARC reports to HealthCERT identify admissions being stopped in 15% of shifts with registered nurse shortages[3]. Other flow-on effects include increasing needs complexity and staff ratios in homecare services, reducing access for people with lower (but possibly escalating) needs and increasing hospital admission risks.

28. At present, these gaps are moderate in size for many settings. When the pay equity claim for Te Whatu Ora nurses is eventually settled, the gaps will increase significantly and put further strain on the system over what is currently being experienced. s 9(2)(f)(iv) [redacted]

29. Addressing pay differentials for nurses before pay equity for nurses is resolved will signal an intention to recognise like-for-like work and delay or decrease movement of nurses out of non-Government employment roles.

Other drivers of workforce pressure are important

30. While pay differentials exacerbate workforce issues, there are other factors at play such as legislative and regulatory environments (ie, immigration settings and pathways to registration), training and education, service commissioning, models of care, working conditions, and funding which are being addressed in the upcoming workforce strategy.

31. Fewer migrant workers are available to fill health workforce gaps in some settings such as ARC, as opportunities for better pay and/or working conditions exist in hospital settings which are now more accessible to migrant workers due to acute workforce shortages.

32. We also know that our existing service models do not fully utilise the capability and capacity of the nursing workforce and that flexibility and career development opportunities vary across settings.

33. There is a fairness dimension to pay parity, it is important to recognise the value of similar work regardless of setting as it relates to how motivated and empowered workers feel to deliver quality care.

Pay differentials in the funded sector

34. The Ministry of Health (the Ministry) and Te Whatu Ora have collated staffing figures from multiple sources[4] and time periods and included some projections based on workforce growth trends to indicate which settings and roles are experiencing the greatest wage gaps. This information is more readily available for nurses and kaiāwhina/healthcare assistants working in ARC and for nurses working in parts of the

[4] **Nursing Council, Aged Care Association, and Stats NZ**

Released under the Official Information Act 1982

primary care system. For other workers and roles, the available data is less complete, and good, rather than robust, estimates have been used.

35. Table 1 below identifies numbers of workers in non-Crown employment nursing and related roles and settings. It estimates the size of pay differentials currently.

Table 1: Estimates of pay differentials with Te Whatu Ora MECA [5]

Service setting	**Number of employees (FTE) and average pay differential (% below DHB MECA)**								
	Registered Nurses		**Senior Nurses**		**Enrolled Nurses**		**Kaiāwhina**		**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**
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	3,836		268		65		13,325		**17,495**
Other Residential	454						2,755		**3,209**
Total workers (FTE)	**12,795**		**1,038**		**818**		**36,447**		**51,099**

36. The information available indicates the following:

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

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

c. There are large differentials in the 'other' categories which include Mental Health and Addiction, Other Community (eg, Plunket, Family Planning) and other Residential (eg, Disability), and other providers who are cross sectorial or not easily categorised.

37. Figure 1 shows the average variation from MECA rates currently and as anticipated in future if the current pay equity offer is accepted. Senior nurses are not included as identifying accurate pay differentials will require further work on role requirements across settings.

[5] **Percentage differentials are estimated based on provider survey returns of 2022 wage rates, and can be regarded as a lower estimate that is probably more reflective of actual pay differentials but may contain bias if higher-paying providers were more likely to be survey respondents.**

Released under the Official Information Act 1982

Figure 1: Summary of average base salaries by sector, compared with Te Whatu Ora MECAs current and anticipated

s 9(2)(j)

Variation within roles and between employers

38. It is important to note that the estimates use average wage and salary costs as well as a standard "oncost" percentage across all roles to cover statutory employment costs (Kiwisaver, ACC), leave and training time and in some settings overtime and other forms of penal payment. It provides a standardised view, whereas actual pay and conditions may vary widely across providers in some service settings.

39. It is also important to acknowledge differences in the nature of nursing and kaiāwhina roles (such as in ARC and primary care compared with hospital nurses), and how these are changing over time. For example, kaiāwhina in ARC and homecare settings may perform a number of clinical care roles that are not undertaken by kaiāwhina in Te Whatu Ora hospital settings. As ARC services adjust to deliver care while carrying nurse vacancies, the responsibilities of remaining nurses, such as for leadership and supervision of higher ratios of healthcare assistants, may be greater. This could lead to changes in scope of roles and required experience and credentials.

40. Figure 2 demonstrates current variation in pay rates across providers in one sector, ARC. s 9(2)(ba)(i), s 9(2)(b)(ii) in very few cases are nursing rates at or above the Te Whatu Ora MECA rates (s 9(2)(ba) . Kaiāwhina have similar variation though pay rates are higher in relation to current Te Whatu Ora MECA rates.

Released under the Official Information Act 1982

Figure 2: Distribution of base hourly rates in Aged Residential Care

s 9(2)(ba)(i), s 9(2)(b)(ii), s 9(2)(j)

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

41. Outside directly nursing related roles, others are also affected by historic service funding approaches. These include allied health roles such as for psychologists, social workers, youth 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.

42. Medical practitioners may also be affected, such as with employed general practitioners (half of all general practitioners working in primary care are now employees).

Addressing impacts of pay differentials in the funded sector

43. In a pure market situation, employers adjust pay and pay differentials as well as other aspects of their businesses in order to achieve their business goals (which may be profits and may include growth, stability, sustainability, community esteem and other goals).

44. In the funded health sector, there is a dominant (sometimes single) payer, and service contracts may have a large (though not sole) impact on employer offerings to staff. Adjusting service contracts may be the single biggest lever to affect employee pay and conditions and improve pay relativities so as to reduce adverse impacts of competition between employed and funded sectors.

Released under the Official Information Act 1982

45. Such adjustments remain at a remove from employment contracts, leaving employers flexibility to optimise impacts on their goals, including by paying over or under comparator rates.

Mechanisms to improve pay relativities

46. Service agreements are between the funder (eg, Te Whatu Ora, Te Aka Whai Ora, Whaikaha or ACC) and the employer; collective agreements are between the employer and the unions; and in some service settings individual employment agreements are common. It is difficult for the health agencies to influence pay rates directly, being focused on commissioning service delivery.

47. Mechanisms that have some indirect influence on pay and conditions through service commissioning include transparent pricing methodologies linked to staffing costs, credentials and/or workloads. Such mechanisms may build in alternative service models or arrangements and/or reference periodically updated employment terms and conditions such as in MECAs.

Improving relativities in settings with standard pricing review processes

48. For some service settings an overall arrangement is in place for consistent commissioning across funders and providers, and a standard and regular process for updating payment terms and conditions. General practice primary care is an example with pricing referenced to collective employment agreements and minimal current pay disparities.

49. ARC also has a standard process for pricing, making a setting-wide approach to improve employee pay relativity feasible. A setting-wide funding or fee uplift along with contractual provisions relating to employment standards could be relatively straight-forward to administer. However, even in such settings, wide business differences between providers may prolong negotiations and complicate implementation. 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.

Improving relativities in other settings

50. For other service settings, a direct link between service provision and employment standards is not readily available. Standard contracting approaches may not apply; contracts may need to be negotiated with individual providers; multiple contracts and/or funders may be involved; and/or broader funding revision may be required. Many issues could create feasibility challenges as well as information accuracy challenges as this work proceeds.

Longer-term approaches

51. 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, responsive to desired service and model of care changes. Work on drivers of

Released under the Official Information Act 1982

health expenditure (including workforce costs) and how they interface with the system shifts that we expect to see as a result of the reforms will inform the multi-year funding arrangement for health that has been agreed by Cabinet as part of the reforms. s 9(2)(f)(iv) s 9(2)(f)(iv) [redacted]

52. In the long-term, a sustainable approach to ensuring potential pay disparities are managed 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.

Kaiāwhina roles

53. Kaiāwhina is the over-arching term to describe non-regulated care and support roles in the health and disability sectors. This group includes a wide range of roles (for example, nine different role groups in Te Whatu Ora hospitals) and pay differentials may or may not impact movement between roles. Evidence of market pressures and their impacts exists for ARC healthcare assistants (included within the kaiāwhina category for this report). Evidence is less clear elsewhere.

54. Te Whatu Ora advises that investing proportionally and fairly across this workforce would be very challenging and that a future pay lift linked to career development would be more effective. A career development approach would provide clear, staircased pathways to credential growing skills and capabilities as kaiāwhina progress through their careers. A workforce development investment could be higher impact and less distortionary, and lead to better addressing pay relativities over time and with increasing skill recognition. In addition, non-nursing home care and support roles are subject to a pay equity process currently.

55. Nevertheless, given the low pay rates for this workforce, together with higher numbers of Māori and Pacific staff, not providing any relief when lifting nurse rates is likely to be inequitable. Providing some pay relief as well as investing in workforce development is likely to attract more people from communities with high health needs into health career paths. Such pay relief could, for example, be based on keeping pace with the minimum wage increases (possibly together with other cost increases such as fuel for mobile services or household living costs for residential care) that have occurred over the last year.

56. Te Aka Whai Ora advises that the staircased pathways solution is an option that will be taken up by those who want to progress in their careers. They note a significant proportion of this workforce are happy to be in kaiāwhina roles and bring much experience but will continue to be financially disadvantaged if staircased pathways is the only pay parity solution for this group.

57. Improving pay relativities for kaiāwhina through service pricing will be time-consuming and may take longer than anticipated; and may have low impact and/or raise wider expectations. However, equity impacts are expected to be positive.

Released under the Official Information Act 1982

We recommend a phased approach to improve pay relativities in the funded sector

58. The Ministry, Te Aka Whai Ora, and Te Whatu Ora recommend taking a phased approach to improve pay relativities in the funded sector. A phased approach will:

    a. provide relief for the most affected workforces and service settings in the short term

    b. build out the evidence base over time to provide a robust basis for changes in some service settings

    c. build towards later work on longer-term mechanisms to adjust service funding so that changes in pay relativities do not disrupt service provision

    d. signal to providers that Ministers are acting now to forestall any worsening, and to health workers that their important work is recognised.

59. We note Ministers' preference for early action that would result in a pay uplift before Christmas. However, Te Whatu Ora advises that, even were this achievable on which confidence is low, there would be a number of negative impacts. These include:

    a. Urgent processing of service price increases before Christmas would delay other uplifts being processed, including ARC uplifts already in the pipeline.

    b. Only blanket uplifts with no equity weightings could be processed in that time, even with delays to other pricing adjustments.

    c. It is not possible to negotiate and process uplifts for all service settings at once. Highest service impact settings like ARC and Home Care will need to be started first, with other settings to follow.

    d. Some settings, including Māori and Pacific providers, will involve a very high level of work because of the huge numbers of contracts and providers involved, and cannot be rushed.

    e. To maximise the level at which price increases flow through to workforces, reciprocal contractual provisions will be required. Any blanket funding pass-through approaches carry high risks of the funding being used for other purposes than staff pay and conditions.

60. We advise that, while announcements can be made in late 2022, actual price uplifts will only be feasible from 2023. Progressive implementation starting early in 2023 will mean many settings will see price uplifts in the 2nd quarter of 2023 as attempting to move faster carries many risks.

Prioritising settings to improve pay relativities in the first instance

61. In developing this phased approach, we have looked at different service settings, roles and impacts of current pay differentials to identify priorities for early action. We have prioritised setting based on impact measures and equity and principled factors, such as:

Released under the Official Information Act 1982

a. impact on workforce supply within NGO providers and flow-on impact on service supply within the sector

b. impact of service supply on access to care and health outcomes for communities - including intersectional consideration of equity for historically underserved communities

c. feasibility of investment within proposed timeframes, that is, technical complexity of delivery

d. scale of the wage gap between Te Whatu Ora employed workforce and the NGO workforce

e. alignment to te Tiriti o Waitangi principles and system expectations, including consideration of rangatiratanga, options, equity, active protection and partnership.

62. You have a range of options representing:

a. Increasing scale - from targeting acute problems to forestalling future impacts

b. Increasing scope - between addressing pay relativities for registered and enrolled nurses only, or for other health care roles as well

c. Increasing levels of commitment to pay parity over and above dealing with established service impacts and risks.

Options to improve pay relativities in the funded sector

63. Four options are presented for feedback, building in scale and scope. The options are described briefly below, with expected impacts and costs and key risks and benefits.

64. All options deliver positive benefits for staff and providers in high service impact settings, and for whom pay relativities are currently poor. Further detail on the options is provided in Appendix 1.

Option 1. Improve relativities for registered and enrolled nurses			
Timeframe	Settings	Number of FTE	Cost ($m)
2022/23 (half year)	ARC, homecare, Māori and Pacific health, mental health & addictions, other residential	6,379	s 9(2)(j)
2023/24	Full funded sector	10,280	

Released under the Official Information Act 1982

Key risks and benefits

- This option has the biggest early impact for nurses, makes no commitments to other healthcare roles but does build towards fully addressing current pay relativity gaps for nurses over 18 months.
- Even though it does not explicitly seek pay parity, this option is likely to raise parity expectations for nurses into the future.
- The option may raise expectations for other healthcare practitioner groups.
- The option may be seen to favour nursing roles over other healthcare roles (such as psychologists or healthcare assistants) and to support continued health inequities for communities with lower representation in the nursing workforce.

Option 2. Improve relativities across nursing and kaiāwhina roles, starting with high service impact settings

Timeframe	Settings	Number of FTE	Cost ($m)
2022/23 (half year)	ARC, homecare, Māori and Pacific health, mental, mental health & addictions, other residential	12,411	s 9(2)(j) [redacted]
2023/24	Full funded sector	29,638	[redacted]

Key risks and benefits

- This option expands to include kaiāwhina as well as nursing roles, in the same high impact service settings.
- It does not commit to fully addressing pay differentials everywhere, s 9(2)(f)(iv) [redacted]
- The option may raise expectations for other healthcare practitioner groups.
- s 9(2)(j), s 9(2)(f)(iv) [redacted]
- It includes a focus on career development with future pay incentives linked to gaining credentials, starting with kaiāwhina.
- s 9(2)(j) [redacted]

Released under the Official Information Act 1982

Option 3. Move towards relativity across all healthcare roles in the funded sector within a funding envelope, building evidence to best achieve this within the funding envelope over time.

Timeframe	Settings	Number of FTE	Cost ($m)
2022/23 (half year)	ARC, homecare, Māori and Pacific health, mental, mental health & addictions, other residential, starting with nursing and kaiāwhina roles	12,411	s 9(2)(j) [redacted]
2023/24	Full funded sector including other roles outside nurses and kaiāwhina	45,000	

Key risks and benefits

- This option keeps early impacts focused on nursing and kaiāwhina roles in high impact service settings.
- The option provides greater flexibility for service funders to consider relativities for a wider range of roles (eg, psychologists) working closely with nurses in some settings.
- In diffusing across a wider range of roles it puts the emphasis on the services needing maintenance or growth rather than on one practitioner group.
- It does not commit to fully addressing pay differentials everywhere, s 9(2)(f)(iv) [redacted]
- s 9(2)(j), s 9(2)(f)(iv) [redacted]
- It includes a focus on career development with future pay incentives linked to gaining credentials, starting with healthcare assistants.
- s 9(2)(j) [redacted]

65. The options and their impacts are detailed in Appendix 1. Impacts highlighted include the number of FTE workers affected in each phase of the work, and costs in 2022/23 and in 2023/24. Any increases beyond 23/24 would be subject to future consideration.

What the options will and won't deliver

66. The options are not intended to achieve pay parity. While they are costed at average role parity, this is approximate only as there are many reasons that staff may not have average experience, skills or other attributes, and role requirements will vary. The options cannot guarantee the costs will be fully passed on in pay and conditions to staff.

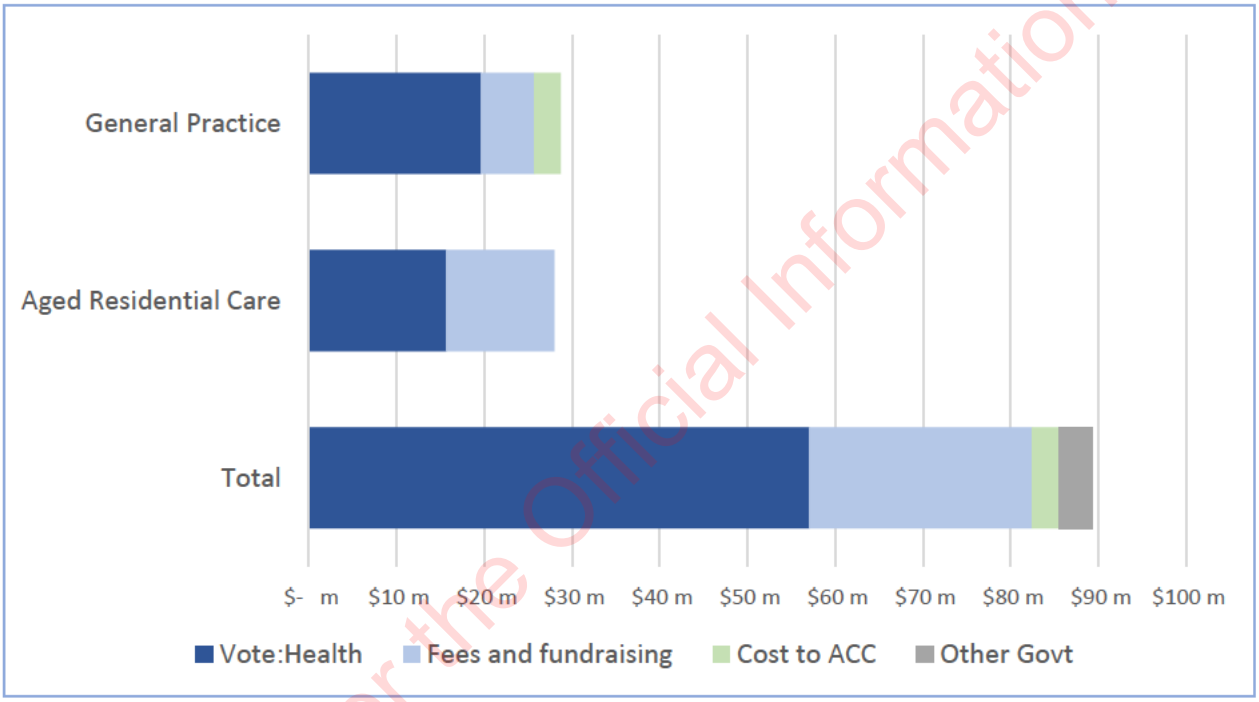
Released under the Official Information Act 1982

67. Costings are based on total costs to employers of paying at parity, however funds may be passed to all employers as average price increases, meaning that, across a setting, some employers will receive insufficient funds to pay staff at the envisaged rates. To balance this effect, costings have not been adjusted to take account of different payers.

s 9(2)(j) [redacted]

68. Other public funders as well as private payers are involved in this sector, as shown in figure 3.

Figure 2: Provider income by source, 2021/22[6]



Risks and Mitigations

Effectiveness

69. It is important to note that there is a significant risk that funding uplifts to NGO providers may not be passed onto staff. We are mitigating this by, where possible, linking increased funding to a requirement to amend employment agreement requirements. Contractual changes are the most feasible means of influencing pay and conditions and are likely to be easier with sectors such as aged residential care where a single overall approach to service pricing is in effect.

70. What this requirement looks like may need to look different for different sectors. For ARC, differential rates of pay mean we are likely to attempt to use agreed minimum

[6] **Income sources based on information from a variety of sources, covering patient fees and charges, ACC funding, other government funding (such as Education) and fundraising and grant income.**

Released under the Official Information Act 1982

s 9(2)(j) [redacted]

71. Some providers, because of other business pressures, may be unable to pass on all of the increase to staff. For others, price increases may be insufficient to bring staff to pay parity even if fully passed on.

Wider sector impacts

72. Increasing pay for nurses outside Te Whatu Ora hospitals may shift the concentration of the overall nursing supply shortage towards the hospital sector. This may be mitigated by increasing numbers of migrant nurses now that cross border movement is freed up. Other mitigations will be provided with the health workforce strategy under development (eg, increasing pathways into nursing).

73. Addressing pay relativities for some parts of the sector now may impact on incentives for longer term service model changes. These impacts may be positive (such as in increasing nurse-led Māori and Pacific services) or negative (such as in lowering incentives to address outdated models of care).

Financial

74. The funding amounts recommended are based on average pay rates across service settings and on workforce numbers that are adjusted for, rather than including, vacancies. We have adjusted the funding quantum by 15%, the nursing vacancy rate reported by the Nursing Council across the sector pre-COVID-19.

75. These limitations could result in the funding being insufficient to address pay gaps fully. Giving Te Whatu Ora and Te Aka Whai Ora the goal to "improve pay relativities", rather than "achieve pay parity" will promote fiscal management. s 9(2)(f)(iv) [redacted]

Perceptions

76. Standard price increases for service settings will result in provider "overs and unders". Some providers are already paying at parity and price increases could be perceived as "waste" or as subsidising services for people affluent enough to pay.

77. If nurses in roles and settings that are not at risk receive pay increases while kaiāwhina in fragile services do not, this is likely to reinforce perceptions of a fundamentally inequitable sector driven by a professional elite, provider capture and systemic racism.

Delivery

78. Te Whatu Ora advises that the initial uplift to priority workforces is unlikely to be delivered before Christmas, even for the parts of the sector where uplift is expected to be more straight-forward (such as ARC). After Cabinet decisions and announcements, insufficient time will remain for the negotiations anticipated to be required with amendments to service contracts.

Released under the Official Information Act 1982

79. Announcements can be made before Christmas, with commitment to delivery in the first quarter of 2023 for the services at greatest risk (especially ARC and homecare). While Te Whatu Ora and Te Aka Whai Ora would seek to progress uplifts as soon as possible, the complexity in some parts of the sector mean that delivery for the initial tranche will be progressive over the first six months of 2023.

Equity

80. Narrowing pay disparity between Te Whatu Ora employees and employees of other providers may improve both the outcomes for our 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. 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.

Next steps

81. We suggest you forward this report to:

    a. the Prime Minister and the Minister for the Public Service, to seek their input

    b. members of the Ministerial Oversight Group on State Sector Employment Relations (MOGSSER), to raise awareness of the potential implications for other public service employers and funders.

82. The Ministry will prepare a Cabinet paper on your behalf on to seek approval to address the impacts of pay differentials in the funded sector, for consideration by SWC in November.

83. The Ministry, Te Whatu Ora, and Te Aka Whai Ora will work together to prepare to make the initial service funding uplift/s as soon as possible after Cabinet decisions. Depending on which option is agreed, this work will include:

    a. Updating and obtaining further information on workforce estimates (a survey of Māori and Pacific providers is underway, for example)

    b. Discussions with other public funders around impacts and how to deal with costs that may be divided among funders.

ENDS

Released under the Official Information Act 1982

Appendix 1. Options for approach to be announced in Q2 2022/23 and for delivery (funding to providers) to start in Q3 2022/23

Stated purpose	Context description with key benefits and risks	Phase 1 actions (Q3-4 2022/23)	Phase 2 actions (2023/24)	Phase 3 actions (2024/25 and out)	Impacts (estimated)
Option 1: **Improve relativities for registered and enrolled nurses**	s 9(2)(j), s 9(2)(f)(iv) [redacted]				
Option 2: **Improve relativities across nursing and related healthcare roles, starting with high service impact settings**					

s 9(2)(j), s 9(2)(f)(iv) [redacted]

Released under the Official Information Act 1982

Stated purpose	Context description with key benefits and risks	Phase 1 actions (Q3-4 2022/23)	Phase 2 actions (2023/24)	Phase 3 actions (2024/25 and out)	Impacts (estimated)
Option 3: **Move towards relativity across all healthcare roles in the funded sector within a funding envelope**, building evidence to best achieve this within the funding envelope over time.	s 9(2)(j), s 9(2)(f)(iv)				

Released under the Official Information Act 1982