Canterbury
District Health Board
Te Poari Hauora ō Waitaha

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12 September 2007

Mr Stephen McKernan
Director General of Health
Ministry of Health
P O Box 5013
**Wellington**

Dear Mr McKernan

**Nurses and Midwives MECA Settlement**

The purpose of this letter has changed due to a set of decisions that were taken subsequent to last Friday's Board meeting where the Board decided to vote against the proposed NZNO MECA settlement seeking further work to be done. It is important though that the intent and the reasons for the Board's decision last Friday are set out as the sector will now need to urgently understand the terms of the proposal in order to ensure the many problems that will arise from the proposed settlement are mitigated and treated. This is vital in order that the sector continues to deliver its expected operational services and within its broad fiscal parameters. It is worth describing DHBs' practical working environment, obviously it is well known to you, but it paints the environment of decision making clearly.

The Canterbury DHB's original position communicated last Friday, on the proposed NZNO settlement was reached only after very careful consideration. The seriousness of this decision was as much about concern for meeting current service demand, patient responsiveness and the maintenance of hospital services as well as the affordability consequences.

With DHBs having a capped budget they are allocated a fixed sum by Government each year to carry out their Statutory functions. This means that when unexpected decisions are made beyond their budgets, without governance approval, in this case to nurses' salaries and conditions, it comes at an expense - eg: delay or containment of other services planned, or in the worst case, existing services are managed down to create the savings to pay for an unbudgeted event.

Thus, if more than a "fair share" of dollars is granted to nurses and midwives it is then not available for the planned level of other services or indeed to other employee claims from other staff groups. If too much is given the Board will most likely have to reduce other services to avoid overspending, but that has practical problems in the short run that need to be coped with within the constraints of legislation and policy.

As you know, at a more micro level, the decisions that are made at patient level mirror this decision. Where very high cost patients present to DHBs, the resources required for their care (ie the money, bed and staffing) are recovered by deferring or delaying treatment to other patients. This is the hard reality of a capped budget (finite resource). It is exactly like the theory of relativity, a force that pushes large expenditure in one direction, creates a need to create (downward) pressure elsewhere in order to live within budget. Money spent on wages and conditions of employment is no longer available to be spent on treatment supplies.

These are trade-offs that DHBs always have to make as they try to balance the relative priorities for the needs of staff, additional services or new technology. The size of this NZNO MECA's unexpected cost and its service consequences will need significant collective action due to its sheer scale and the risk involved.

None of this dilemma is eased because clearly nurses and midwives as a group are valued and are a vital part of continuing existing services. It is also clear that their industrial round is influenced by an environment where the gains of an earlier pay jolt to redress wage issues was sought by the NZNO to be maintained and not eroded. The teachers' pay claims clearly created an environment where nurses and midwives feared that teachers would again move ahead on salaries. The NZNO seems not to understand pay equity is a Government issue for resolving.

The cost of the settlement is high which creates an enormous problem. As important to our Board, is the fact that new conditions of employment also reduce the clinical hours of each nurse. This means that the current nurse shortage will actually be worsened. We are currently recruiting overseas for about 50 nurses. This settlement's reduced clinical hours will cause close to another 40 nurses being needed to maintain existing services. That impact will mean unless we can attract that increased number of nurses, the shortages will affect both nurses and patients.

The NZNO will argue that the settlement itself may improve our ability to recruit. It is almost impossible to reach a clear decision in terms of relative value between these two tensions. Curiously from the pay jolt we noted that the improvement of pay conditions actually caused an increase in part time work as nurses reduced their full time hours and retained a similar income. If this recurs it may exacerbate the situation.

On Friday, the Board and Managers wrestled with this dilemma. The only specific framework they felt they could apply was the duty of Boards to act on major decisions in terms of the legislation. Briefly stated they must:

- Deliver on current District Annual Plan
- Ensure the DHB does not overspend
- Otherwise act with probity.

The conclusion of the analysis of the options led the Board to believe that the proposed settlement would imperil the Board's ability to comply with its duties under the legislation (which is detailed later).

In the joint Chair, Chief Executive email of Friday, 7 September, we said that the Canterbury District Health Board cannot agree to the proposed NZNO MECA settlement. In stating that, the Canterbury District Health Board would have been prepared to accept an amended settlement with the suggested framework set out below. Some of this framework is not now able to be applied. However, the underlying principles around the framework are still applicable and could be useful means of making collective progress.

1. The tripartite parties (or their agents) analyse the fiscal, interpretation and staffing risks and set up a mechanism to regularly report progress on the mitigation, treatment and resolution of the risks identified by DHBs, Government and Unions in proceeding with this proposed settlement.

2. The tripartite parties should work on all the elements of risk and report to Government and to the Boards of DHBs to assist them in monitoring their risks and carrying out actions that reduce the fiscal and staffing impact of the settlement and its effect on patient care. The Ministry, DHBs and CTU would carry out the detail of this work, but Ministers would be appraised and provide feedback as well as responses as necessary.

3. All DHBs should be requested to mitigate the proposed settlement's flow-on effects by setting goals for 'savings' in each DHB, and reducing provider arm and NGO flow on effects by staging or savings goals to minimise the flow on effects.

4. Defer approval of the leave (5 week annual leave, sick leave and long service leave) to work through its full effects as a clause in the partnership agreement to achieve a decision that fully considers flow on effects, costs, staffing problems and all other consequential factors. This activity should report to the tripartite group as it should effectively work out the principal standard condition clauses for all collective employment contracts issued by DHBs. (This probably is too late for the NZNO collective but it would be a sensible approach to follow to shape future collectives.)

5. A Working Paper on a sector wide sustainable solution for future settlements is prepared and submitted to the Minister for consideration. That paper might best be commissioned by the Tripartite Committee in order that the widest scope and effort can be applied. A suggested approach has been developed which might be a start for discussions on purpose and objectives and is attached to this letter (**Appendix 3**).

We have outlined in this letter the major concerns the Canterbury District Health Board had with the settlement because these form the background to the very specific suggestions we convey above. It is clear from the tenor of the replies DHBNZ received from DHBs that this situation remains critical and if repositioning of the proposal is not possible, it is vital we apply stricter disciplines for the future and mitigate the effect of flow ons.

Our principal concerns related to the NZNO proposed settlement were:

**Process**
Somehow the Union went to ratification on a proposed settlement that was high risk and beyond the previously approved DHB Boards of Governance parameters. This should never have happened and steps need to be introduced to prevent that occurring again. An examination of the process used could lead to clear processes that are determined for future settlements. The Board will have to review the extent to which it permits DHBNZ to speak and act on its behalf and has a low level of confidence in this entity.

**Available Nurse Clinical Hours**
In a general sense, whenever salaries and wages exceed the Labour Cost Index, Consumer Price Index, or our Health Future Funding Track, we lose ground against other indicators that measure relative cost/benefit. This settlement above CPI salaries input, even if nurse clinical hours remained the same, would mean labour input costs to our hospital outputs will grow.

Worse than this though, the various conditions will mean paid leave of various types will increase. This means that nurse clinical hours available for patient care decrease as a result – labour costs to outputs increase.

Put in another way, the extra pay each full time employee earns will compromise a higher % cost in each output, but also each FTE will work less hours requiring more people (nurses) also at higher pay rates to be employed, so compounding the effect of the settlement.

We have modelled the problem using Canterbury's workforce. The key trend is:

| **Year** | **Clinical Hours** |
|---|---|
| Pre 05/06 FTE | 1745 productive hours |
| 06/07 FTE | 1705 productive hours |
| 07/08 FTE | 1696 productive hours |
| MECA proposal | 1649 productive hours (best case) |
| MECA proposal | 1574 productive hours (worst case) |

(This is built on assumptions of discretionary leave and the full detail is in **Appendix 1**)
Note: the additional nursing staff to cover the MECA effect is 39 for the Canterbury DHB provider arm or 326 for full flow on nationally. Nationally it is possible 1700+ will be required in an extreme worst case scenario. These estimates are modelling and have risk of error – it does highlight the risk more clearly than not undertaking this approach to size the problem.

The financials are our current financials given to model the new FTEs required. The financials in **Appendix 1** are relevant only as the source drawn to derive the model additional FTEs. These are expressed as the modelled best/worst case employee number increases. The smaller FTE increase on both the best and worst cases is Canterbury's provider arm. The DHB sector is the provider arm nationwide – taking Canterbury as 12% (in number) of the sector (it is not the sector including NGOs).

**Impact on Services**
The lead time to gain additional nurses required as a result of the MECA will need to be taken into account, as it is also a real risk. Once the MECA is approved it will require planning to start to acquire the additional staff required as assessed by each DHB.

In our case, without the estimated nurses, somewhere near 40 (best case), we will struggle at heavy demand times. Some will be made up (Bureau or overtime) but these measures add to fiscal pressure as they are both more costly than staffed nurse hours.

On the wards, one nurse to say five beds on morning shift means if we are down, significant beds are lost – sufficient shortages lead to likely gridlock in Christchurch Hospital. If we borrow staff from other hospitals at Canterbury DHB, we experience some clinical risks but also deplete other wards causing the discharges from those facilities to slow, that also can exacerbate gridlock at Christchurch Hospital/Christchurch Womens.

Clearly in summer this problem is reduced but in winter serious worries will exist, and it will be very difficult to do electives.

**Flow On**
Unlike the pay jolt, additional funding will not be available and pressures will be raised as NGO/Primary Nurses may be attracted to main provider arm services. This too will affect services negatively - NGOs, etc will tend to lose nurses to public but they are already tight for trained staff, so service consequences will almost certainly occur in NGOs. They are likely to cope but with difficulty.

Inevitably pressure will be applied to gain similar pay and conditions in NGO situations that will eventually need funding.

These costs are not costed into the settlement but will be fought for in contract rounds to redress the difficulty NGOs are likely to experience. Nor are they modelled for possible additional employees if the conditions of employment are changed. We haven't got the detail of the breakdown to do that but assume a 1.4% to 5.9% increase in nursing staff may be needed for that sector.

Assuming that Nursing comprise 40% of DHBs Provider Arm personnel cost and the DHB Provider arm comprise 50% of the total vote health funding, the fiscal flow on impact of this settlement could appear as follows:

| | CDHB<br>$'M | Sector<br>$'M |
|---|---|---|
| Gap between Funding and Nurses Settlement | 22.7 | 126.0 |
| Flow on to Other DHB Staff (excl SMO/RMO) | 17.0 | 94.5 |
| Flow on to Wider Sector Staff | 26.5 | 220.5 |
| Total | 66.2 | 441.0 |

**Fiscal**
The initial parameters for bargaining reflected a lower level of sustainable funding given as FFT by Government, as against the high expectations of the health sector unions, for salary settlements. These expectations were fuelled by the nurses pay jolt (an external factor for Government not DHBs), some high increases overseas, teachers' claims in NZ and the police settlement.

| | **2006/07** | **2007/08** | **2008/09** | **2009/10** |
|---|---|---|---|---|
| The original financial bargaining parameters approved were | 2.93% | 2.1% | 2.1% | 2.1% |

The above bargaining parameters were subsequently revised up to:

| | **2006/07** | **2007/08** | **2008/09** | **2009/10** |
|---|---|---|---|---|
| Revised Approved Parameters | 2.93% | 2.6% | 4.0% | 4.0% |

The Canterbury DHB estimates the settlement parameters as follows:

| | **2006/07** | **2007/08** | **2008/09** | **2009/10** |
|---|---|---|---|---|
| Estimated Settlement Parameters (excluding Step Progression impact) | 2.3% | 5.2% | 4.8% | 4.7% |

It was also expected that conditions of employment were to be capped or reduced, not increased, as part of those approved parameters.

Based on Canterbury DHB's provider nursing expenditure for this MECA of $160.220M, over the 39 month period, the original parameters would have cost $26.838M. The revised bargaining parameters would cost the DHB $37.054M, ie an increase of $10.216M (these parameters had received Board approval). These were intended to be the maximum applied at the time of that approval.

Nurses received 23% plus in the last settlement (colloquially known as the pay jolt). Either of the parameters previously agreed could, in the Board's view, be seen to be reasonable in the current environment for nurses.

***Cost of Proposal Based on Interest Based Bargaining***

The cost of the proposal based on interest based bargaining for the whole sector, I am advised, has been calculated by DHBNZ to be $62.939M higher than the revised bargaining parameters indicated above. The CFO group reviewing the costing indicated that conservatively, a further $20M could be added to that gap for the cost of recruiting and training of additional nurses required as a result of increased leave entitlements and the flow on impact of the cost for the last three months in the 2009/10 financial year.

This means conservatively, we can expect a funding gap of around $82.939M over and above the effect of the revised parameters above. On a pro rata basis Canterbury DHB's share of the "extra" funding gap is around $12.441M.

***Funding/Cost Savings Proposals Analysed as Part of Interest Based Bargaining Approach***

The combined increased funding above FFT and the funding gap amount means that Canterbury DHB has to find a total of $22.657M (i.e. $10.216m plus $12.441m) over the next three years. The Negotiators have indicated that potential areas where additional funding/cost savings are as follows:

*Cost Savings Proposals*

The proposal is alleged to result in improved staff retention and recruitment as evidenced by the improved retention after the pay-jolt. The improved retention could reduce recruiting cost, retraining, orientation, improve rostering productivity, reduce support services (HR) and reduced reliance on casuals (backfill). The cost savings assumed by DHBNZ were estimated at $9.556M which means Canterbury DHB's share is $1.433M. However, the pay jolt saw well over 100 nurses reduce their FTE input by 0.1. If this occurs again, it will shift some nurses in the full-time workforce into part-time work creating a higher head count and more recruitment costs.

*Partnership Agreement with Union*

Working together in partnership with the union, DHBs will be able to better match service requirements with staff rostering improving productivity and avoiding reliance on external agency nursing for roster flexibility. The partnership agreement will deliver some savings to DHBs but these are unquantified and will depend on other dynamics. The timing of the savings follow a process that will have low urgency, while the cost of the settlement will occur once signed and is backdated.

*Ministers Proposal*

If the above savings and other savings are achieved, a scheme offered by the Minister for 2008/09 will yield $43M of which our relative PBFF share could be $4.7M. This will be built into base funding which will mean a similar amount will be available in 2009/10 giving a total for the MECA period of $86M (Canterbury DHB's share $9.4M). It should however be noted that this scheme was intended to cover all MECA and not just this nurses MECA under discussion (eg SMO, MRT, RMO, etc).

*FFT in the Future*

We can expect some likely movement upwards in the 2008/09 and 2009/10 FFT allocation from Government which would help to reduce the gap. Assuming that FFT is based on estimates of CPI and the labour cost index, the future FFT rate could be closer to 3%. Should this happen, the funding could increase from the current $26.838M to $30.578M, an increase of $3.740M but this has already been claimed as

part of the base proposal and cannot be used twice. It is also a future assumed, not yet delivered.

**Risks of Interest Based Bargaining Proposal**
Overview of the risks associated with this proposal are:

- The risk of FFT staying low or an incoming Government in 2008 not keeping the tripartite, funding arrangements, etc in place.
- The sector has to achieve savings of $43M to receive the Minister's savings contribution in less than 10 months – a difficult goal on past experience.
- This nurses' MECA represents about 40% of the DHB's total employment cost, the risks are high and all these measures may be required to fund this settlement, leaving less money available for other employee groups' MECA or other health initiatives.
- Flow-on effect to other MECA and IEAs in the Provider arm and rest of NGO sector are almost certain and will add to the financial risks.
- As noted separately, if insufficient staff can be recruited to cover, service delivery will be affected.

**Health Services**
On fiscal risk, the Canterbury District Health Board is seriously concerned this settlement is unaffordable and will threaten or consume funds for direct health services and funds set aside for other planned purposes (eg key strategies on 24/7 GP care, acute demand projects and the Chronic Care/Long Term Services community funding). At worst, it could lead to a financial deficit occurring for the Canterbury District Health Board.

**Deficit Risk**
Knowing this possibility and yet agreeing to it, potentially places the DHB in breach of at least most of the following:

> NZ Public Health and Disability Act, 2000 sections 22 and 23 failing to deliver planned services indicated in the District Annual Plan. Sections 27, 39, 41 (see also Crown Entities Act 2004 section 51). Schedule 3 clause 44(2). This duty seems to be being discharged by DHBNZ currently. There could be questions if this is appropriate but if so, it is clear from the last portion of the Director General of Health's letter that the fiscal risks were not made plain. The scale of this settlement does have a high potential risk of taking (or worsening) most DHBs into deficits, it may also affect the Canterbury DHB.
>
> Crown Entities Act 2004. Ss 49-56. Increased discretionary expenditure that could threaten DAP objectives and basic probity could be breached by this decision.

**Procurement Risks**
The driver for these savings is strong and the dollar for dollar additive is present. There will be some easy wins; but lining up the whole sector to agreed clinical change to common products is difficult for one DHB let alone the nation. DHBNZ is unlikely to be able to deliver on this matter at the level expected. It is not likely to be enough to help offset the scale of this problem. It is suggested many small to medium savings in departments' operating costs etc, will be necessary.

The timing is close - Canterbury DHB is facilitating South Island procurement for Cytotoxics. We have been working hard on this for several months. Tenders closed last Wednesday. We estimate a supplier will not be determined until after 23 October. This gives an idea of the logistics of organising a big deal.

It is important we advance the work quickly and diversify the effort; given the likely flow ons to other organisations and other staff groups.

**Conclusion**
It seems that the NZNO MECA will settle as it stands. Urgent action is needed to mitigate the factors in this paper. It will need a national approach and has to involve Government due to the high risks involved.

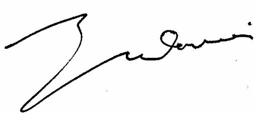
The scale of the effects and flow ons are large and containment strategies are needed. An orderly containment of the problems outlined above needs to be negotiated and the range of devices that exist and some others will need to be employed.

A possible way of approaching that larger task (earlier referred to) is attached as **Appendix 3.** Some of the items that might have been dealt with in negotiation are listed in **Appendix 2**.

Attached (**Appendix 4**) is a slide produced to show some past effects – costs/caseweights. The trend gap will be worsened by this MECA decision.

We will need to map how we can cope with the other staff groups requesting similar settlements and achieve some mitigation of the large risks involved in this nearly settlement. We urge that this activity starts immediately.

Yours sincerely

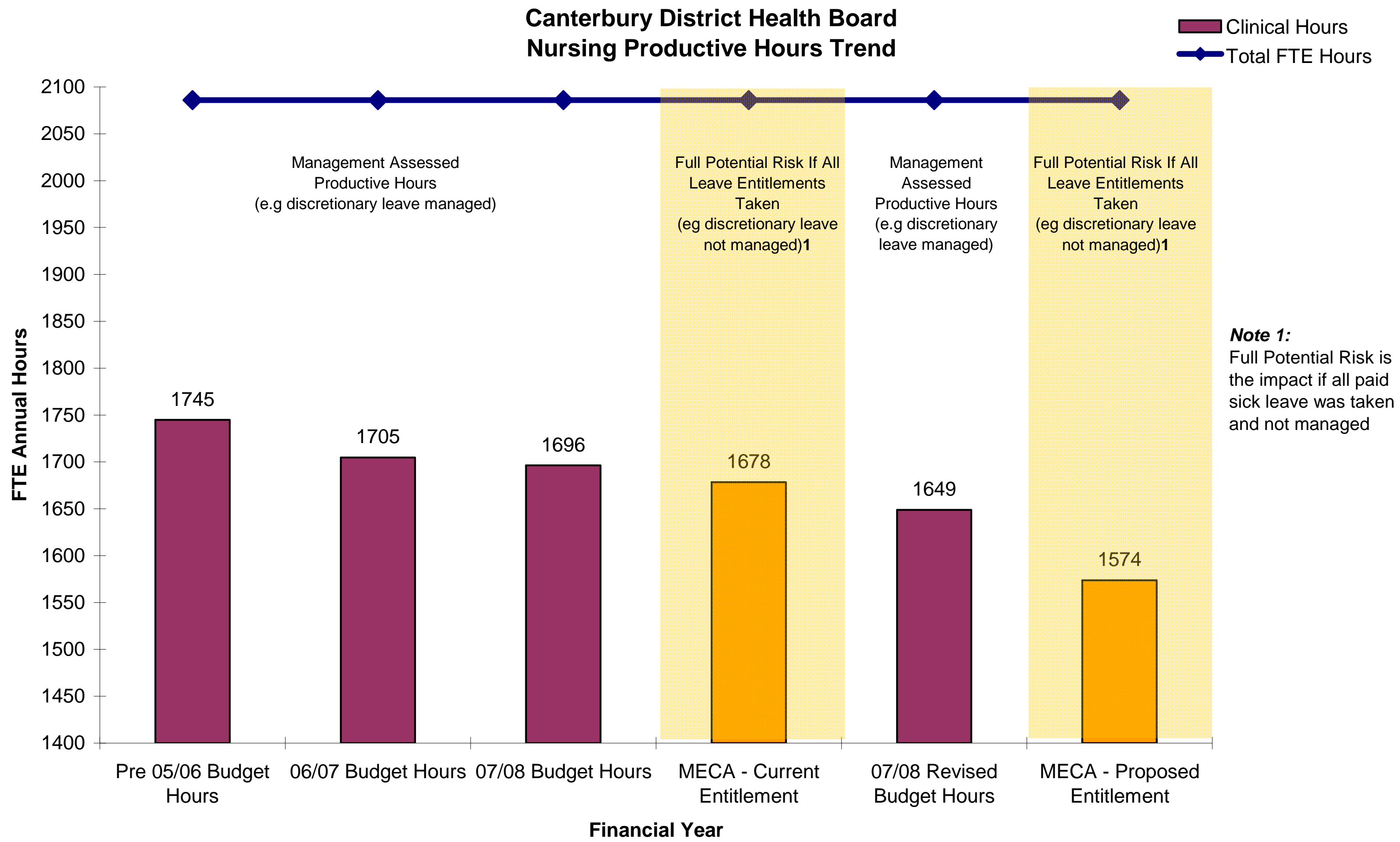


**Gordon Davies**
**Chief Executive**

**Syd Bradley**
**Chair**

**Copy to:** CDHB Board Members
Julian Inch, CEO, DHBNZ
All DHB Chief Executives
Minister of Health's Office
Executive Management Team, CDHB
GM Group, CDHB

**APPENDIX 1**




***Note 1:***
Full Potential Risk is the impact if all paid sick leave was taken and not managed

**APPENDIX 1**

## Canterbury District Health Board

10-Sep-07

*Productive Hours Impact Assessment Of NZNO MECA* ***(Measured Against All Nursing Staff Regardless Of Union)*** *- FTE required to maintain productive hours*

| | Base | | Best Case Impact | | | | | Worst Case Impact | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Jul-07 | | 07/08 Revised Budget Assumptions | | | DHB Sector Impact Of MECA | | Proposed MECA Full Entitlement | | | DHB Sector Impact Of MECA | |
| | FTE | Productive Hours | FTE | Productive Hours | Increase on 07 FTE | Sector FTE Increase | $$ On Increased FTE | FTE | Productive Hours | Increase on 07 FTE | Sector FTE Increase | $$ On Increased FTE |
| *Nursing* | 2,356 | 3,940,757 | 2,390 | 3,940,757 | 34 | 283 | $ 17,850,678 | 2,504 | 3,940,757 | 148 | 1,235 | $ 77,811,385 |
| *Nursing Support* | 351 | 587,099 | 356 | 587,099 | 5 | 42 | $ 1,688,479 | 373 | 587,099 | 22 | 184 | $ 7,360,240 |
| ***Total*** | ***2,707*** | ***4,527,856*** | ***2,746*** | ***4,527,856*** | ***39*** | **326** | **$ 19,539,157** | ***2,877*** | ***4,527,856*** | ***170*** | **1,419** | **$ 85,171,624** |

### *Assumptions Impacting Productive Hours*

| FTE Annual Entitlement | Jul-07 | | 07/08 Revised Budget Assumptions | | Proposed MECA Full Entitlement | |
|---|---|---|---|---|---|---|
| | Days | Hours | Days | Hours | Days | Hours |
| *AL* | 21 | 168 | 23 | 184 | 23 | 184 |
| *Long Service Leave* | 0.67 | 5 | 0.92 | 7 | 0.92 | 7 |
| *Public holidays* | 5 | 40 | 5 | 40 | 5 | 40 |
| *Lieu days* | 6 | 48 | 6 | 48 | 6 | 48 |
| *Sick* | 8 | 64 | 10.6 | 85 | 20 | 160 |
| *Shift* | 5 | 40 | 5 | 40 | 5 | 40 |
| *Prof development leave* | 3 | 24 | 4 | 32 | 4 | 32 |
| **Clinical Hours Per FTE:** | | ***1696*** | | ***1649*** | | ***1574*** |
| **Non Clinical Hours:** | | 390 | | 437 | | 512 |
| ***Total FTE Hours (Per Annum):*** | | **2086** | | **2086** | | **2086** |

### *Additional Notes*

1. Recruitment & training costs not factored in
2. This analysis covers productive hours impact only - not the salary increase component
3. This deal covers 45% of DHB staff - significant impact on remaining 55%
4. Nursing Directors now paid less than Nurse Managers
5. No assessment of impact on Community/Primary Care Sector Nursing
6. If FTE not increased, leave liability will grow - resulting in buyout at higher salary rates several years down track.
7. Currently CDHB has 2.6 days per nursing FTE in unpaid sick leave which will now become paid sick leave - hence 8 days to 10.6 days. (The wording of the agreement for this clause has yet to be finalised, but there is a risk around the interpretation of this clause)
8. In addition to the above 'ongoing' productive hours impact there is a one-off impact on Long Service Leave for staff who could potentially immediately get five days on ratifying the MECA. This equates to 7083 days which will immediately hit the books at over $1.7m.
9. "Best Case" is based on sick leave risk being managed - "Worst Case" is the full liability risk based on sick leave days going to 20 days.
10. This assessment does not cater for patient growth - it assumes status quo
11. The costings are based on the average FTE salary rate of $63,000 per annum (from CDHB 05/06 FY), not the proposed MECA rates

**Appendix 2**

## NZNO Proposed Collective Agreement – CDHB Issues Pre-Ratification

## NOTE: SOME OF THESE ARE URGENT ACTIONS THAT CAN STILL BE ACTIONED

## List of 'problems' in addition to patient/service impact (covered in main CEO briefing paper) that could be resolved separately: or could be 'removed' if we were quicker on our feet.

1. The settlement and commencement of liabilities and performance risk is backdated from 1 January 2007 – by the time it comes into effect 9 months of leave liabilities will have accrued that must be eliminated within the reduced productive hours available but already conceded. The wording in the agreement for sick leave, long service leave and annual leave needs further work to ensure the words reflect the intent agreed during negotiation. The final wording of the agreement needs to be completed without resulting in additional cost. In future the wording needs to be agreed before the costing/proposal is submitted to CEOs for approval.

2. The costing model needs to consider full years expenditure and all relevant costs and be peer reviewed to ensure accuracy. In addition, the operational implications will need to be considered and identified eg loss of clinical hours reducing service capacity, gridlock, etc.

3. The financial parameters for settlement of monies provided by the government for the 07/08 financial year was 2.1% - the settlement is now estimated to exceed well in excess of this. This growth is on top of the base set by the nurses pay jolt. The loss of productivity hours becomes a double penalty!

4. No 'hard' productive/performance gains were made to offset the additional leave of various sorts. Some provision can be made in the partnership agreement.

5. The deal covers only 40% of DHB staff – significant impact and forward risk to the remaining 60% as their unions claim restoration of relativities in both salary and conditions of employment.

6. Nursing Directors are now being paid less than Nurse Managers with the resultant tensions that can only rectified by DHBs in adding cost to restore the gap – not considered or factored into the settlement.

7. No assessment of impact was made on Community/Primary/Private Sector Nursing which is of a similar size to the DHBs Provider Arm – based on estimate of DHBs Provider arm accounting for $5 billion of the total Vote Health of $10 billion.

8. If FTE are not able to be increased, leave liability will grow – this will force buyout at higher costs several years down the track – and significant dollar pay outs when nurses resign.

9. The urgent need to recruit and train new nurses to close the loss of productive hours gap – no lead time by the DHBNZ negotiated proposal was placed on the table to phase in the loss of productive hours to match the ability to recruit.

10. The previous pay-jolt resulted in large number of staff moving from full-time to part-time. This proposal could further increase the movement of staff to part-time employment requiring recruitment of even more nurses. This impact has not been factored into the cost of settlement.

11. The Canterbury DHB has 2.6 days per nursing FTE in unpaid sick leave from special leave without pay. With sick leave entitlements being doubled this will now become paid sick leave with no direct benefits achieved for our patients and the government (the government leading the market on conditions of employment and the resultant political consequences and dialogue of non-productivity). Hence 8 days sick leave on present data and trends will go to 10.6 days. Nationally, around 11 DHBs have no limits currently and how the opening sick leave balances for staff in these DHBs will be set has not been adequately covered in the draft agreement.

12. In addition to the above "ongoing' productive hours impact, there is potential for a one-off impact on ratifying the MECA - Long Service Leave for staff who will get 5 days leave and staff qualifying 5 weeks annual leave. This equates to 7,083 hours (for the Canterbury DHB alone) which will immediately hit the Canterbury DHB bottom line at over $1.7M – an estimated sector impact of approximately $20M.

13. In terms of sick leave – 'best case' is based on sick leave risk being well managed – 'Worst Case' is the full new liability risk based on sick leave trending upwards to 20 days. Including setting the precedent and risk of this significant increase of a condition of employment being spread to the rest of our workforce, that will be impossible to resist – both in Secondary Primary and Private providers. The State will also be seen to be leading the way and will become a political issue. Some offset was obtained in carry forward but no techniques for management of inappropriate use included in the MECA.

14. Step movement cost impact was not included in financial analysis.

**APPENDIX 3**
**WORKING DRAFT – 06/09/07**

# INDUSTRIAL: POLITICAL SOLUTION TO UNAFFORDABLE INDUSTRIAL SETTLEMENTS

These fall into three categories to achieve better systematic approaches, more national cohesion, improved control of the largest and growing cost in the health service – salaries and wages and conditions of employment.

**Simple Problem Statement**

The Employment Relations Act offers options and places value on Multi Employer contracts. Ministers of Health have encouraged their adoption for fairness purposes and pre 1988 many such arrangements were nationally standard. Current behaviours in some DHBs mirror those of the more competitive period in health post 1993 where markets and incentives to attract and retain staff were made. If we are to have national systems such behaviour is no longer appropriate and directions should be given to DHB Chief Executives that this will not be tolerated.

Many DHBs are at different stages of population based funding and they have different levels of ability to pay settlements proposed such as the NZNO MECA, which adds cost but does not reduce existing health needs. This is exacerbated by some DHBs being in different financial positions due to failure to perform, local difficulties, size, growth, etc. These DHBs are all in very different situations as to the affordability test expected in S41 New Zealand Health & Disability Act 2000 (NZHDA) and S51 Crown Entities Act 2004. The obligation laid on Chief Executives in Clause 44 Schedule 3 of the NZHDA indicates clearly that this activity would be monitored carefully. Clause 42(2) requires prior consultation with the Director-General in the terms and conditions of Collective Agreement. This must have been intended to check financial probity and 'fit'. More agreement on the nature of this consultation should be expected from the parties and the Ministers of Health and Finance.

The backdrop to these local problems is the fact that few countries have sufficient health workforces and intense competition exists internationally as the current workforces in most countries age and needs replacement. Almost all countries see a large gap looming between the projected needed workforce and that available locally as the demographic shape of the general population changes compared to the working life projections of the current workforce.

No planning on this looming threat occurred from 1993 to 2001; preoccupation with deficits in 2000-2003 and the sector work since has not really achieved any effective traction to cover this problem to date. Health as a workforce relies on overseas trained staffing (often while we lose whole intakes of new graduates to other countries as they actively mount campaigns in NZ). In many countries another dynamic is creating further pressure on the need for larger numbers of staff to do the same work. Limits on safe hours and standardisation of EEC working practice (working hours) has driven the need for more staff to cover the hours lost through more holidays, overtime limits, etc. This latter problem has occurred here with RMOs, SMOs (6 weeks holiday plus guaranteed medical education each year). Parental leave and other such benefits also have had an effect. Many nurses after the pay jolt elected to reduce hours: seeing that as more benefit than more money. None of these are necessarily bad: but they reduce the productivity of the workforce and force the need for more staff to cover the same workload: at a time when this is a resource under both international and local pressure.

The worst estimate of the effect of the conditions at one large DHB is that productive nurse hours will drop by 7%. This will lead to the need to employ some 170 extra nurses. Extrapolating nationally that would be approx 1,419 nurses.

## Other Countries Approaches

Most countries have approved larger salaries than NZ can afford. Government assisted greatly with the most significant change in NZ – the pay jolt for nurses. It is likely that nurses are better positioned as a result than some other groups. Australia has paid different rates in different states, had flirtations with minimum rosters, etc. UK has a whole project on aligning to European hours and conditions. All have international poaching and increased local programmes (pay, conditions, and training initiatives) to achieve the workforce they need.

Some (Scotland and England) are altering the scope of locally provided services to concentrate their most needed sub specialists in larger centres and providing a more primary and lower scale service in areas that have less population. Full Emergency Department numbers reduced: but basic clinics in smaller towns. So a two pronged approach – services replanned and workforce pay, conditions and training numbers have been employed.

NZ needs to do the base work on this matter and the planning needed for the future. A distributed group of 21 DHBs can never achieve this and do their current workload. It requires national planning (with sector input). The changes in the Ministry role and function positions it well to do this work.

Similarly, 21 DHBs driving selectively IR/ER work with a competitive Union structure is paralysing. It seems only weeks ago that the junior medical staff collective was settled and we are already into the next round. There is a serious and growing need to also centralise the IR/ER function and align it closer to Government. The importance of the size of this workforce, its need in a vital service makes it too important to leave uncoordinated and remote from Government direct influence and input. Corrections, CYPS, Teachers, Police, Fire all have central features. The Health workforce needs similar fairly direct oversight.

## Fiscal Risk

DHBs and Government have poured huge amounts of money into this problem and considerable energy. They are doing that from their health allocated funds and it is difficult to prioritise future workforce against current service expectations. How can that be done adequately at local level? Any settlement has more affordability in some DHBs than in others. Those that are unable to afford it are disproportionately punished and have less chance to keep services adequately resourced. It is only by Ministry smoothing of PBF and allocation that services can be protected from inappropriate calculation of their funding for IR/ER in medium to smaller DHBs, eg a Board in deficit gets no FFT on that portion of their expenditure and will need full funding and no demographic funding.

The pattern of sustainable money being paid to DHBs over the period 2000-2008 was variable. Government must allocate a sustainable level to DHBs and avoid the lower than projected CPI/LCI scenario that currently exists. Vote Health has been well provisioned but the out years of DHB funding given the current rate of settlements (outside health) are not able to be afforded on the current profile.

Here too national co-ordination would benefit the process as sector pressures would be more directly known by the Ministry/Government.

## Productivity

The Government and opposition parties have been concerned that relative productivity has dropped in the health sector. That perception is not entirely correct and relates to the fact that many services are not counted because Information Technology has been poorly used in the sector. Nearly half of all expenditure is on NGOs, GPs, Pharmaceuticals, Lab tests, etc. No volume information is readily available (except totals on pharmaceuticals (expenditure) and Labs (tests and expenditure)).

In hospitals, outpatients have only recently been featured and some innovations mean that less work is measured (Community focused programmes in lieu of outpatients).

Nevertheless, it is undeniable that conditions of employment in many groups has reduced time at work and, therefore, productivity. The Holidays Act as well as six weeks annual leave for Senior and Resident Medical Officers and an increased entitlement to continuing medical education, contribute to the reduced time at work. Such things as training days, longer leave have benefits (recruitment, retention, etc) but cost in terms of dollars and absence from work (and, therefore, productivity).

The calculation of the national effect of the proposed Nurses MECA is outlined in Appendix1.

**Current Situation**

The sector is poised to face unaffordable increases in several areas. In each case productivity will be lost. More workforce will be needed and it is not readily available. Unless rates of Future Funding Track (FFT) higher than the advised 2.1% in each of 2008/09 and 2009/10, large deficits are inevitable. They will threaten the DHB model which is the best NZ has had and is envied in many countries.

**Suggestions**

1. Work is undertaken immediately to revise the FFT. It needs to be developed to offer a sustainable level of funding to DHBs. It is inappropriate to have a technology adjuster of 0.5% and then have it offset immediately by a 0.5% efficiency adjuster. FFT is calculated from estimated CPI and LCI (Labour Cost Index) that already has embedded the same efficiencies as applies to the rest of the economy. NSW uses CPI and 2%. A suggestion is CPI plus at least 1%. However, the LCI

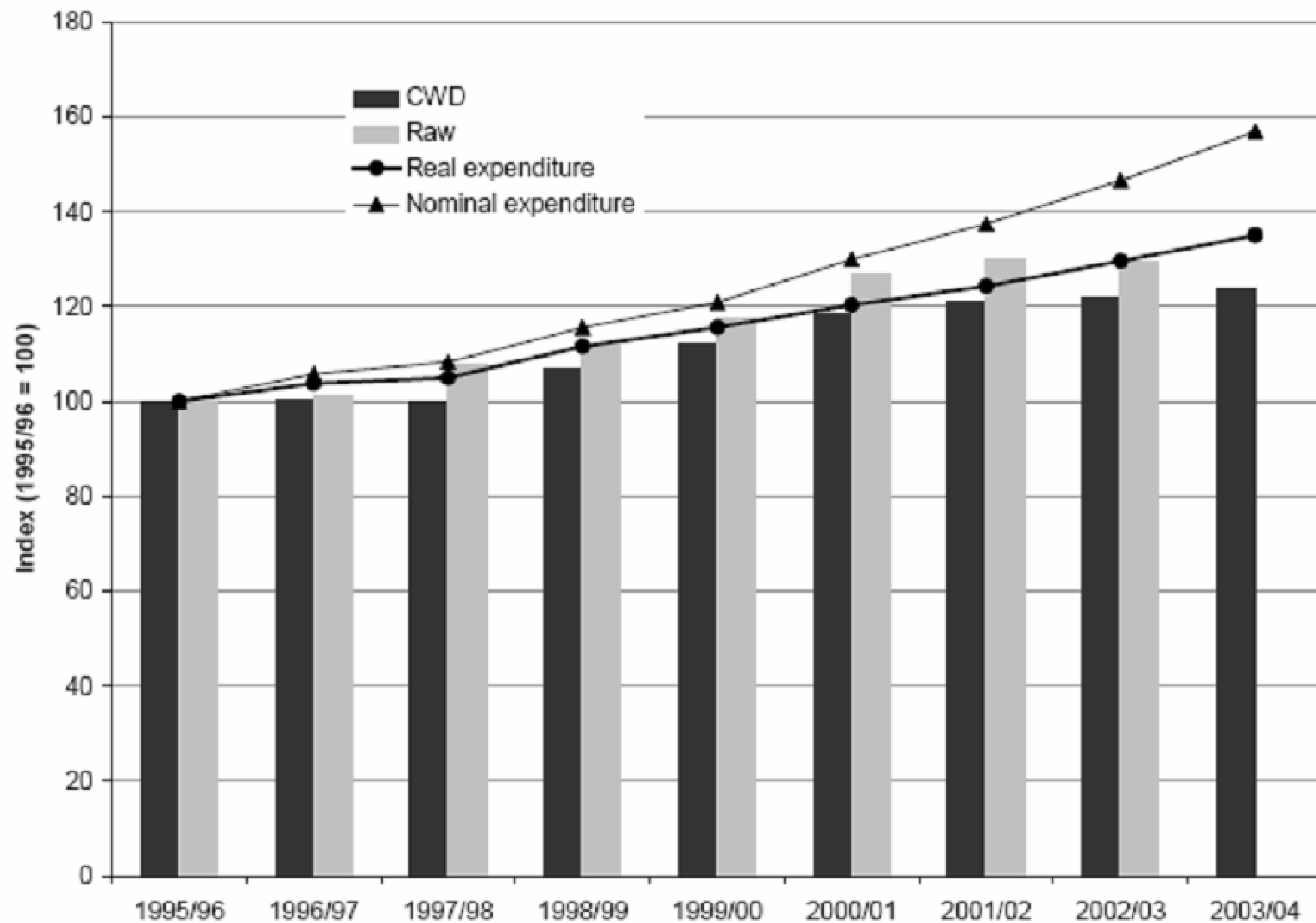
looks as if it may be higher than CPI over the short term, so a mix may be best.

2. IR/ER Workforce should become a function overseen closer to Government and aligned with its health/economic/workforce objectives based on long terms goals – not short term FFT calculation for DHBs. It would be more efficient than 21 operational units doing it part-time and trying to cope with 21 unique fiscal and service settings. Several models have existed previously: several exist in other countries.

3. The Nurses settlement since it is interest based be accepted as the final move in their pay equity claim and be partly supported by Government (the portion above FFT).

4. For this year 2007/08 all ER/IR settlements be under the aegis of direct Ministry input and the financial effects provisioned for the out years. Treasury should also be involved to advise and influence the particular parameters. The arrangement could be put in place via the Tripartite Agreement and agreed in that forum. The objective should be to match all future and past settlements to FFT and apply a much stronger discipline over current and future negotiations.

5. Consider a joint national committee – government, DHBs, Ministry under an independent Chair to undertake a national review of pay, conditions benefits and the relative productivity impact on an essential 24/7 Health Service. This could chart a way forward that establishes industrial policy norms and a real focus on improving the performance of the health system.


Hospital expenditure and output by year
Index (1995/96 = 100)
180
160
140
120
100
80
60
40
20
0
CWD
Raw
Real expenditure
Nominal expenditure
1995/96
1996/97
1997/98
1998/99
1999/00
2000/01
2001/02
2002/03
2003/04