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Annual Minimum Wage Review 2011- Submitters' Questionnaire

Name of organisation:	New Zealand Nurses Organisation

Issues for submitters to address:

If you need more space to respond to the following issues please attached additional paper to the questionnaire. You may also send your response in letter format if you prefer.

1	**Which industry/groups do you represent?**
	Health Sector - nurses, midwives, kaimahi hauora, health care assistants, students, allied health workers 45,000 members
2	**Of the people you represent, what proportion are directly affected by the minimum wage?**
	6-8 percent
3	**What impacts have you observed as a result of changes to the minimum wage?** *(You may wish to discuss the April 2011 increase, and/or increases over the past 5 years, please define the period you are discussing).*
	The minimum wage has not been set at a level that enables meeting normal cost of living expenses - housing, food etc. What we have observed is increased poverty as the cost of living has risen exponentially in comparison to the tiny incremental increases in the minimum wage. The 2011 increase of 25 cents was derisory. As the minimum wage drops relative to other wages it make it more attractive for employers to substitute qualified workers with minimum wage earners where possible, and this has certainly happened in the health sector where health care assistants are substituting for registered and enrolled nurses in an ever widening range of settings.
4	**What are the gains or positive impacts likely to be from a moderate increase in the minimum wage rates for the people you represent?** *(The 2011 increase was 25 cents.)*
	Raising the minimum wage has significant, quantifiable benefits in health care assistants (HCAs) being able to adequately feed and clothe their families, keep them warm and dry and provide for extra-curricular sport and cultural activities which are currently beyond their means. The economic benefits are self evident and sustained - a healthier more productive workforce and reduced future demands on health, housing and other social support services. NZNO knows that in workplaces where there is no collective bargaining, the majority of workers are paid the minimum wage and the only pay increases they receive are the result

of the government increasing the minimum wage. The vast majority of those employed in aged care and Māori and iwi health care providers are in this category. Those populations identified as having poorer access to healthcare and poorer outcomes – that is Māori, Pacific and migrant communities, are overly represented.

Elsewhere, particularly in rural and socio-economically disadvantaged communities, lack of access to primary health care[1] is a major driver of health disparities which, in turn, drive up the costs of care with increased medications, hospitalisations, emergency treatments etc.

Raising the minimum wage would give people the means to see a doctor when the cost of intervention is least, (though we also suggest that access to would be hugely improved if there were alternative pathways to primary care, other than private GP practice - the potential of primary health care nursing in Aotearoa New Zealand this regard has long been established, if not acted upon[2]). A higher minimum wage has a direct effect on nurses workload by reducing the number and acuity of patients.

5 **What are the costs or negative impacts likely to be from a moderate increase in the minimum wage rates for the people you represent?** *(The 2011 increase was 25 cents.)*

There are no costs of negative consequences for our members. First we would have to ensure that they received it. There is little evidence that minimum wages are monitored and/or enforced. Indeed there is little information about anything to do with the people who live on the minimum wage - how many there are, where they live, what they eat, how they get to work and, most importantly, how many jobs they have to do to make a bare living on the minimum wage. Lack of accurate, timely and comprehensive workforce and immigration information which can be cross-referenced ensures the continuation of this situation which is of benefit to no-one. In this context NZNO notes the dual importance of having sound employment data, that is knowing how many people are employed, in what capacity and at what rates; and enforcement of employment law, including payment of the minimum wage.

Most of our members on the minimum wage are in the aged care sector. These are people working with vulnerable older adults who need continuity of care. Instead, they often get a succession of workers as not only are the wages inadequate but also they are often not given enough hours to earn a living wage.

The Department of Labour is complicit in this having, without any mandate or consultation that we are aware of, unilaterally decreed that that 30 hours work constitutes full time work! The implications of this are enormous - for ACC victims, for minimum wage earners, for assessing the outcomes of programmes trying to get people into full time work etc. The effects are, as yet, not fully indentified, since this has been decided 'under the radar'. Refer to NZNO manifesto for further discussion.

Far from a minimum wage artificially fixing low wages as has been suggested, it is a benchmark which ensures our economic and ethical credibility. The reality is that removing the minimum wage would remove the safety net which aligns us with other socially responsible nations and tip the balance of migration leading to a lower waged economy.

[1] Carter, K., Blakely, T. & Soeberg, M. 2010 Trends in survival and life expectancy by ethnicity, income and smoking in New Zealand: 19802 -20000s. *New Zealand Medical Journa*,l 123 (1320).

[2] Ministry of Health. 1998. *Report of the Ministerial Taskforce on Nursing: releasing the potential of nursing.* Wellington: Ministry of Health.

Expert Advisory Group on Primary Health Care Nursing. 2003. *Investing in Health: a framework for activating primary health* Ministerial Taskforce on Nursing. Wellington: Ministry of health

Ministerial Nurse Practitioner Employment and Development Working Party. 2006. *Flexible Funding Options for Nurse Practitioner Employment.* Wellington: Ministry of Health

	Conversely, raising the minimum wage would have a 'trampoline' effect. By addressing poverty, the root cause of ill health, we would reduce demands on health services, reduce high staff turnover and increase the sustainability of our workforce.
6	**In April 2008 the youth minimum wage ceased to apply and the new entrants minimum wage came into effect. What impacts have you observed as a result of this change?**
	NZNO does not support the new entrants' minimum wage as it is unfair and discriminatory to pay lower wages to a worker performing the same work as another worker on the basis of age. It is also contrary to the principle of non-discrimination in employment. ILO Convention No. 111 Discrimination (Employment and Occupation) 1958, is one of the core ILO conventions and outlaws unequal payment for work of equal value. There is no evidence to support the position that the work carried out by younger and new workers is inherently of a lesser value than the work done by older workers, nor to support the theory that a youth minimum wage will increase the employment of 16 and 17 year olds NZNO agrees that Aotearoa New Zealand has a youth employment crisis and that there is an urgent need to reduce youth unemployment. But neither youth rates nor a new entrant rate are solutions to this complex problem. NZNO supports the recommendations of the New Zealand Institute[3] for better transitions of young people between education and employment and more investment in education and training. NZNO notes that a study by Hyslop and Stillman's show that the rise in youth unemployment over the last three years cannot be attributed to removal youth rates[4]. In addition, their study "found that the introduction of the New Entrants minimum wage was largely ignored by businesses and that most 16 and 17 year old workers were moved on to the adult minimum wage". The fact that employers are not using it is a further reason for removing it. NZNO shares the long standing concern of the CTU regarding the absence of a minimum wage for those aged under 16 years of age. Workers under 16 years of age can be paid wage rates lower than those received by other workers, and there is no redress or any protections limiting how low these rates can fall. Research by Caritas in 2003[5] and 2006 [6]found that that there is inadequate attention given to the working experiences of New Zealand children. They showed that children working in delivery work are exposed to significant health and safety hazards and experience injuries as a result. It was a revelation to many Parliamentarians at the time of the Abolition of the Age Discrimination Bill that there is no minimum wage level or employment protection for young people under the age of 16 years. This is in breach one of the four international labour standards - ILO Convention No. 138 Minimum Age Convention 1973. NZNO submits that there should be an approach to the ILO that would assist us review our labour and education laws and policy to provide a threshold for the entry of young people into work, and that must include the setting of minimum wage levels for young people under 16

[3] Bowen, R. Harland,C., and Grace, L. *More ladders, Fewer snakes: Two Proposals to reduce youth disadvantage* , The New Zealand Institute, July 2011.

[4] Hyslop, D. Stillman, S. *The impact of the 2008 youth minimum wage reform*, August 2011 New Zealand: Wellington

[5] Caritas Aotearoa New Zealand *Protecting Children at Work: Children's Work Survey.* 2003. Wellington: Caritas

[6] Caritas Aotearoa New Zealand *Delivering the Goods, A survey of Child Delivery Workers.* 2006.Wellington: Caritas

years old.

NZNO notes that Council of Trade unions (NZCTU) has given partial support to a trainee rate but our experience and the potential risks to public safety, are such that NZNO would not support this in the health sector.

7	**How do you see the minimum wage working with other employment and income-related government interventions? (For example the tax system and social assistance)**

Unfortunately there is not much evidence that government policies, programmes or interventions are integrated. We note, for instance, that Housing NZ which would be expected to be responsive to income effects such as the minimum wage has indicated its Statement of Intent (June 2011) that it "...will be doing things differently. We will stop activities that are better aligned with the responsibilities of other agencies and other providers in the social housing sector. The result will be a more efficient state housing..."

NZNO recommends to your attention to the Report of the World Health Organisation Commission on Social Determinants of Health *Closing the Gap in a generation: health equity through action on the social determinants of health* (2008)[7] which explains the pivotal role of health equity in sustaining economic development and social cohesion. Raising the minimum wage addresses all three of the Commission's overarching recommendations:

- Improve Daily Living Conditions;
- Tackle the Unequal Distribution of Power, Money and Resources; and
- Measure and understand the Problem and Assess the impact of Action

8	**What sector or industry-specific issues related to changes in the minimum wage are you aware of? In what circumstances or types of work?**

The increasing use of minimum wage health care assistants replacing registered nurses in from aged care and hospitals, private GP practice, outpatients, mental health etc. is evidence that that the "knowledge economy" is being dumbed down. What enables this is a very low minimum wage which is a strong incentive to replace nurses, particularly where there are no mandatory staffing standards as in aged care. Indeed NZNO has been asked by one Age Care Chain "How many HCAs does it take to replace a nurse?"

The implications for the health workforce and public safety are significant as the UK has discovered. Instead of having a highly skilled and flexible workforce able to be deployed where needed (and health challenges can be sudden and unanticipated eg Aids, SARS,the Christchurch Earthquakes), we have a small number of overworked and stressed nurses trying to supervise a large number of untrained HCAs - it is not uncommon for one nurse to supervise 60 patients and a number of HCAs in aged care. The long term result is a deskilled workforce and less safe health care.

Poor wages, heavy workloads and no mandatory levels of staffing[8], make it difficult for aged care providers to recruit New Zealand staff, who under the Health Practitioners Competence Assurance Act (2003), are legally responsible for care. Many nurses choose not to put their professional careers at risk in aged care facilities which lack even the minimum, let alone optimum staff number and skillmix. Consequently overseas trained nurses (OTNs), often from developing countries, are recruited, but many end up working as minimally paid HCAs, with no security of employment or residence, though they may have entered the country on skilled migrant visas as nursing is listed as a the long term list of skills shortages.

[7] World Health Organisation.(2008). Commission on the Social Determinants of Health *Closing the Gap in a generation: health equity through action on the social determinants of health. Final report of the commission on Social determinants of health.* Geneva: World Health Organisation. (2008).

[8] The sector determined, voluntary *Minimum Standard for Safe Aged Care and Dementia Care for NZ Consumers,* Standards NZ, are consistenly ignored with impunity.

	There is no incentive whatever for wages or conditions to be improved to the standard set elsewhere, if OTNs working for less can be recruited for nursing positions, or to work as HCAs on the minimum wage. In this way, the wages and conditions of New Zealand workers are driven downwards, stimulating the emigration of our own health practitioners to other countries. We also note our reliance on overseas trained health practitioners - the majority of specialists, half the doctors and one third of nurses are overseas trained[9] - to meet our health needs.
9	**Do you think there are any additional issues relating to minimum wage rates that are relevant to specific groups you represent?** *(eg: Women, Māori, Pacific Island groups, people with disabilities, migrants, temporary workers, SME's or employers?)*
	The minimum wage has a significant impact on the health workforce where the increasing replacement of registered nursing staff with unregulated HCAs with little or no training has eroded the ability of New Zealand to maintain a skilled, high waged economy and quality health system commensurate with those of other developed countries. Māori and pacific and migrant and refugee workers are disproportionately represented amongst those on the minimum wage. Māori and iwi health workers, earn between 15 and 25 percent *less* than their District Health Boards (DHB) counterparts. In a discussion document the Human Rights Commission (HRC) is preparing for its report on structural discrimination in Aotearoa New Zealand in accordance with Article 14 of the *Convention on the Elimination of All Forms of Racial Discrimination (CERD),* the issue of pay disparity between Māori and Iwi health workers in primary health care services and health care workers in DHBs is identified as "Another manifestation of structural discrimination and a barrier to health equality[10]". The government's failure to act on the unanimous finding of the Health Select Committee in response to *Te Rau Kokiri* (TRK)campaign, there is a substantial equity issue regarding pay rates for Māori and Iwi health service workers and that provision should be made for the parties involved to come together to work out a solution, is shameful. We strongly suggest that the much-vaunted "whānau ora" initiatives will have little chance of success if the workforce supporting it continues to be under and poorly paid.
10	**In the workplaces of the people you represent, how long do people tend to remain on the minimum wage? What factors affect the length of time someone is paid the minimum wage?**
	There tends to be very high turnover. In one aged care chain turnover was reported (21 October 2011) to have had a 33% since June this year.
11	**In the workplaces of the people you represent, are the wages of people earning above the minimum wage increased as a result of minimum wage increases? Please describe.**
	No Indeed there has been pressure for nurses to hold back on wage claims in order to accommodate low paid HCAs.

[9] Dumonte, Jean-Christophe, Zurn, Pascal 2007 *Health Workforce And International Migration: Can New Zealand Compete?* OECD, DELSA/ELSA/WP2/HEA(2007)3

[10] Human Rights Commission *A fair go for all: Do systems perpetuate inequality? A discussion paper* Human Rights Commission, October 2011.

12	**Do the workplaces of the people you represent make any changes to improve productivity in adjusting for the cost of a minimum wage increase? Please describe.**
	No.
13	**Are you aware of some employees being paid below the minimum wage? What is the extent of this and why does it occur?**
	Not our members, but we are aware of illegal practices such as holding passports, withholding legitimated pay claims, hourly rates reduced by up to $2.00 when people move from individual agreements to a collective agreement, so it would not be surprising if below minimum wage rates were paid.
14	**What would you consider an appropriate setting for the 2012 adult minimum wage? Why?**
	$ $17.66 (per hour) A minimum wage of $15.00 per hour could be considered as an interim step towards the adoption of the International Labour Organisation's recommendation that the minimum wage should be set at two-thirds of the average wage, that is $17.66[11] per hour from 2013;
15	**Are there any other issues you would like to raise in relation to changes to minimum wage rates?** (For example should the minimum wage level be assessed in a different way than it currently is?)
	NZNO supports indexing the minimum wage to the average wage. Good health, which determines the quality, productivity, and length of life, is fundamental to economic development. Addressing the systemic factors implicated in poor health, such as low income, is therefore most effective route to economic advancement. Raising the minimum wage is one of the most important tools the government has at its disposal to do that. NZNO **recommends** that you: **Note** our support for the NZCTU's submission on the Minimum Wage Review; **Agree** that a minimum wage is essential**;** **Agree** that the minimum wage should be two thirds of the average wage; **Agree** to raise the minimum wage to $17.66; and **Agree** that there is an urgent need to improve the collection of accurate workforce data, increase monitoring of workplaces and to enforce employment law.

[11] Based on 66% of the estimated average ordinary time hourly rate at 31 March 2012. The average ordinary time wage as at June 2011 in the Quarterly Employment Survey was $26.21 an hour and Treasury forecasts a 2.1% increase to take it to the end of March 2012.