Submission on

Next Steps Towards Pay Equity

The New Zealand Nurses' Organisation

December 2002

1.0 Introduction

The New Zealand Nurses Organisation (NZNO) welcomes the 'Next Steps' towards pay equity and is keen to work in partnership with government, employers and other unions to achieve a socially-just pay system in New Zealand for all workers and especially women.

The NZNO represents 33,000 nurses and health workers. With over 85% of female membership, NZNO is the single largest representative organisation of women workers in New Zealand. Pay equity is a fundamentally important issue for NZNO.

When the Employment Equity Act was passed in 1990, nurses were first in line for a job evaluation process that promised to lead to pay equity. The repeal of that legislation within a few months, the introduction of the Employment Contracts Act and the market-driven health sector imposed a cruel 'divide and underpay' regime on the nursing workforce in the 1990s.

We now look with optimism and hope towards this current exercise to provide the legislative, administrative and industrial structures necessary to end the economic disadvantage of women in this country and in particular of nurses.

The urgent need is to agree that occupational segregation contributes significantly to the gender pay gap and that mechanisms must be put in place to overcome that effect. Women and men should not have to do men's work to get men's pay. Women and men should not have to compromise their parenting or caregiving tasks to receive incomes commensurate with their training, skill and responsibility.

It has often been lamented that the fragmentation of wage bargaining makes it difficult to develop an effective pay equity mechanism. There are two important responses to this from our members.

Firstly, they are almost all employed in the state sector, and most of those that are not are employed by private providers funded by Vote:Health. The government as employer or funder could thus directly address gender pay inequality through mechanisms already available to it, including contract compliance, the size and structure of the vote, and ministerial direction.

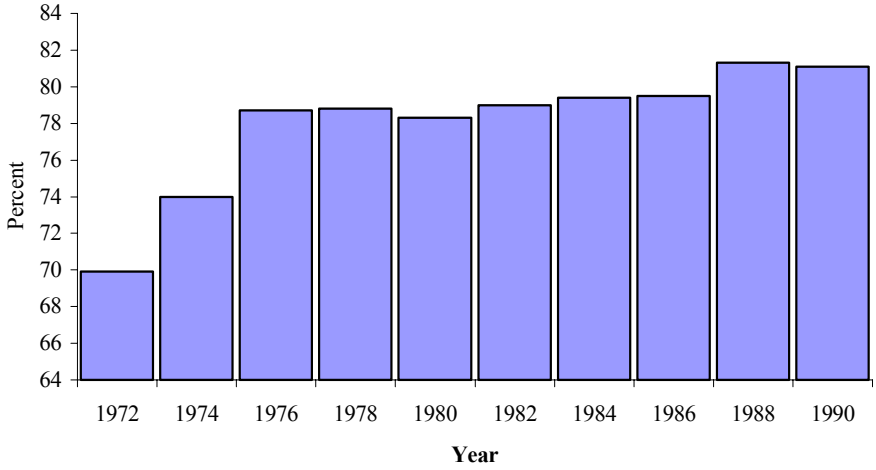
Secondly, where fragmentation of bargaining restricts the implementation of equal pay for work of equal value it needs to be challenged. The alternative is to tolerate a pay fixing system with the knowledge that its outcomes are discriminatory.

2.0 Background

Nurses' pay is bound up with a decades-long struggle for equal pay for women in the workforce, both in New Zealand and internationally. It is over 40 years since equal pay was formally introduced into the public sector workforce, and 30 years since the Equal Pay Act (1972) outlawed pay discrimination on the basis of gender.

By the middle of the 1980s it became clear that further legislative provisions were needed in order to bring about equal pay for women. The Equal Pay Act did narrow the gender pay gap, but only by a finite amount. That legislation, by focussing only on equal pay for identical work, failed to address the pay deficit in, for example, women-dominated industries. As a result, between 1978 and 1990 the gender pay gap remained relatively unchanged with women earning around 80 percent of average male hourly earnings.

Figure 1: Female hourly earnings as a percentage of male, 1972 -1990



The 1990 Pay Equity Act aimed to move beyond the 1972 legislation, in particular introducing "the premise that women who participated in the labour force were disadvantaged both in *equality of opportunity* and *equality of outcome*" (Fargher and Maani 1992 p.2). The New Zealand Nurses Union moved quickly to request pay equity assessments for nurses, making submissions to the Employment Equity Commission as early as October 1990. However, as Fargher and Maani put it:

> Soon after a change of government in November of the same year, the Act, still in its infancy, was repealed, but the differential in male and female earnings, together with significant industrial and occupational segregation or 'gender gap', remains (1992 p. 2).

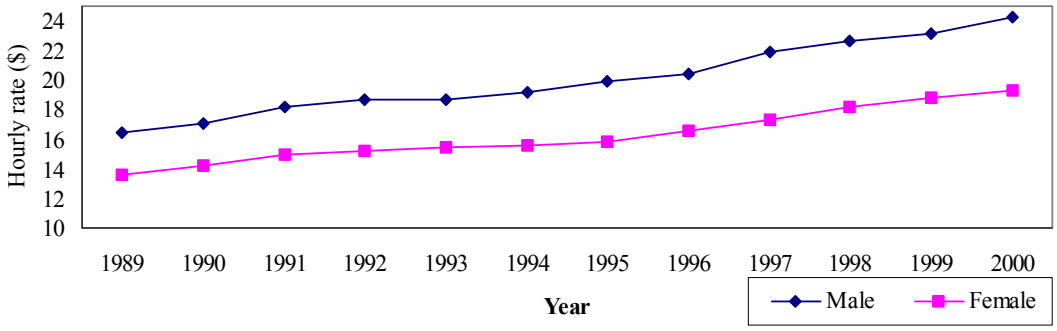
These writers conclude that factors such as occupational segregation, with women 'crowding' into certain professions (especially nursing) at least partially explains the continuation of the gender pay gap. The inequality is 'structural', they conclude, and raises 'significant policy concerns':

> .. the gender gap is far from being removed and the concerns for women in the labour force raised by the 1988 Working Group are still relevant in terms of disadvantage both in equality of outcome and equality of opportunity (1992, 18).

The repeal of the Pay Equity Act was followed quickly by the introduction of the Employment Contracts Act. For nurses, who in 1988 had effectively been shut out of State Sector pay mechanisms through the abolition of the Health Services Personnel Commission, this was a triple blow.

Women workers have not fared well since 1990, with the gender pay gap stagnant or, at times, tending to increase further. In the public sector, where most nurses work, there has been a slight but sustained opening of the pay gap in dollar terms.

Figure 2. Hourly pay rates by gender, public sector 1989-2000 (INFOS time series)



Gordon and Morton analysed the public sector gender pay gap in 2000, and pointed in particular to the surprising relationship between women's relative pay in the state sector and tertiary qualifications. The point these authors make is that educational outcomes for women have changed dramatically over the past fifteen years, with women now making up two-thirds of graduates with a Bachelor's degree, but women's pay has hardly improved at all, relative to men's.

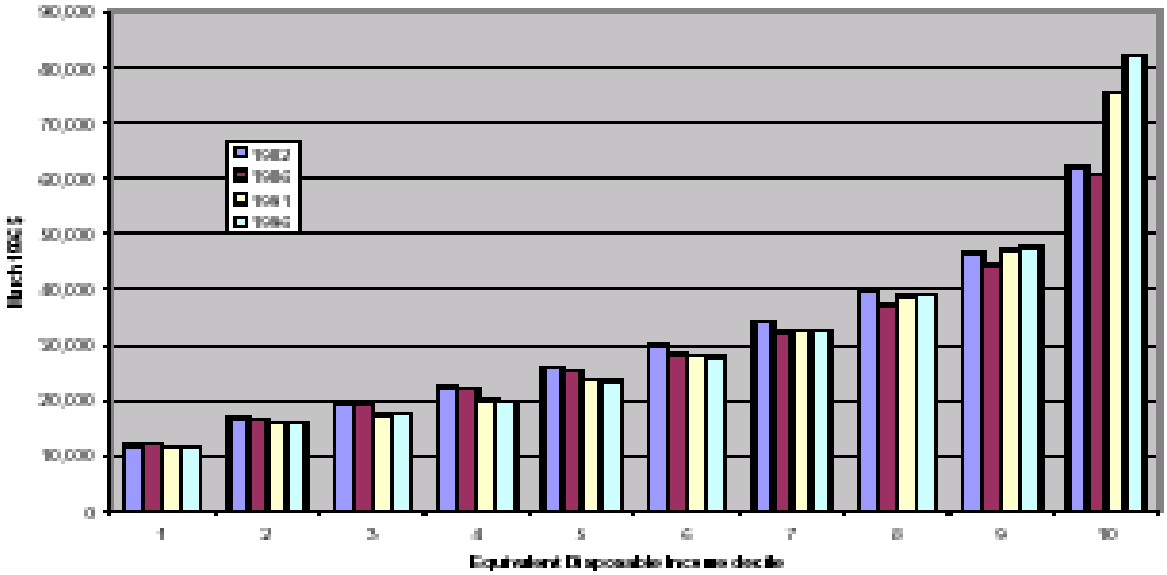
In her (October 2002) speech to the PSA pay equity seminar, Margaret Wilson notes that the relationship between education and the gender pay gap *is* breaking down. As women get higher and higher qualifications, it is having little or no effect on their pay levels overall. Not surprisingly, Sholeh Maani's (1999) study showed that women's rate of return from their 'investment' in education is falling. To put this another way, those who have said for years that if only women were better educated the pay gap would disappear have been proved clearly wrong by the relationship between qualifications and wage movements in New Zealand over the past decade.

Nurses have been severely hit by the trends noted here. They are clearly one of the groups whose better education has not led to better pay. The continued gender pay gap, the shift to fragmented bargaining processes and market principles, the segmentation of

the labour market and the loss of pay equity legislation have all conspired to worsen the relative position of the nursing workforce.

All of this would be enough to argue for a new approach, but yet another factor must be added. For more than 20 years New Zealand has experienced growing income inequality, with middle-income earners apparently hardest hit by falling wages. This income deficit reflects in part the relative fall in nurses' incomes. The following table in reproduced from O'Dea (1999) and demonstrates the growing gaps clearly.

Fig 3. Average household disposable income by decile, 1981-1996.
(Source, Statistics New Zealand, 1999)



Nurses rates of pay (and there are a number of nurse pay scales in existence) have been influenced by many factors negative to the nursing profession, such as the destructive market bargaining of the 1990s, the failure of pay equity legislation, increasing inequalities and the fragmentation of state structures of bargaining. Moreover, as the American Nurses' Association (1986) makes clear, existing rates:

> perpetuate existing societal discrimination against women in women's jobs…. (they should be) compensated on the basis of the inherent value or worth of the work they perform, rather than on the basis of historically depressed pay levels or other discriminatory factors.

It is therefore necessary to consider carefully both the causes of depressed pay levels and effective forms of overcoming these and moving towards equal pay.

3.0 The causes of the gender pay gap for nurses

We endorse the analysis of the causes of the gender pay gap outlined in 'Next Steps'. The NZNO believes that nurse pay discrimination is caused by a range of factors, but it is the fact that it is a 90% women-dominated industry, associated in the past with women's caring work, that provides the engine of pay inequalities with similar industries. Other related factors include: no national strategy to improve nurses pay, especially in the public sector; a failure to recognise nurses' improved qualifications and the costs of education under the student loan scheme; the 'customary' health gender gap whereby the traditionally male occupations are valued more than women's, despite interdependence; and finally a decade of market health reforms which often forced the reduction of working conditions for nurses.

3.1 Occupational segregation

We agree with the finding of 'Next Steps' that occupational segregation constitutes the most important single factor in maintaining the gender pay gap. Nursing is segregated both by its workforce, which is 90 percent female, and by the gendered assumptions of 'caring service' that underpin it.

The 1993 Department of Statistics publication 'All about Women in New Zealand' included a very interesting table, showing the top ten occupations for women (which in 1991 constituted 38% of the female workforce) and associated median pay rates. This table was not reproduced in subsequent census documents so no later figures are available.

Table 1. Top ten full time occupations of women and median incomes, 1991

Sales Assistant	$14,947
General Clerk	21,359
Secretary	20,737
Accounts Clerk	22,642
Primary School Teacher	31,030
Registered Nurse	27,669
Bank Officer	22,679
Information Clerk/Receptionist	20,031
Retail manager	18,603
Sewing Machinist	14,102

The table reveals that teaching and nursing are still by far the main degree-level professions taken up by women, but that these two most popular professions, while paying significantly better than all the other top ten women's jobs, are far behind male incomes. As the report's text notes:

> "While some of men's common occupations are low-paying, all except one exceed $20,000 and two exceed $40,000. By contrast, three of the top ten occupations for women have median incomes below $20,000 and only one, primary school teaching, exceeds $30,000" (Dept of Statistics, 1993 p. 114).

In New Zealand occupational segregation by gender is characterised by low pay for women. Segregation would not matter if women and men were equally remunerated on the basis of the work that they do, rather than on the basis of gender-based valuations.

However, a gender-based valuation system runs deep in our society. While other forms of discrimination against women, such as educational equality and barriers to the ability to live autonomous lives have been overcome, little has changed in regards to pay and conditions in segregated jobs. The slogan of the twentieth century might as well have been' Think women: think low pay".

Because this thinking runs deep, a systematic method of undertaking neutral job evaluations is crucial to overcoming occupational segregation. In researching this submission, the NZNO has examined the 1991 job evaluation kit put out by government departments to underpin the employment equity legislation of 1990, although the kit was never used for that purpose. The NZNO believes that this kit should be revised and updated as part of a comprehensive plan to overcome gender pay gaps.

3.2 Undervalued education and the student loan scheme

Up until about 40 years ago, nursing was generally considered to be a 'vocation', or an individual calling, rather than a profession. Training stressed individual conduct (on and off the job) rather than high-level skill. Due to a number of remarkable changes in medical practice, educational methods and views about the role of women, nursing is now very much a profession, characterised by a degree-level benchmark qualification and continued professional development. It is now not unusual for nurses to hold a Masters qualification, which provides a route into management or to a more autonomous clinical practice.

The degree benchmark has only developed over the past decade. Prior to that, since around 1970, three-year programmes in the polytechnic sector led to a Diploma qualification. Nurses are required to hold an annual practicing certificate, and will soon, like Medical Practitioners are, be subject to professional competency requirements.

The changes to the training regime have underpinned and paralleled an unmeasured increase in skill levels and productivity among nurses. However, unlike similar professions, an improvement in qualifications has not been reflected in better pay. Not

only has there been no general measured improvement in pay since 1990, but also there is no space within existing pay scales for recognition of higher qualifications.

The shift to higher qualifications within the nursing profession has been matched by increased specialisation in some areas. From the Nurse Practitioner to the Maori Disease State Management Nurses, there is now great scope for the development of specialist practice.

There is for nurses what Sholeh Maani has termed a 'falling rate of return' from education for all women workers. In the nursing context, it is easy to see how that has taken place. A marked improvement in qualifications plus incomes that are static or falling in real terms indicates a clear loss for nurses, especially since the profession still resides under the handicap of a gender pay gap.

3.3 Student debt

The cost of education and training courses in New Zealand has soared in recent years. Before 1990, the average student undertaking a three year degree or diploma programme paid a total of less than $400 in fees covering the whole period. Now, the cost to individual students of a degree in fees alone is in excess of $10,000.

At the same time, access to a universal student allowance has been increasingly restricted via age and parental income limits. Most students now borrow around $7,000 per year each to fund their tertiary education costs. The average nurse will complete her qualification with a debt of around $20,000, which will have to be repaid, with interest, out of her pay packet for a number of years.

The salary of nurses is high enough that they are, if working full-time, subjected to the maximum interest rates (currently 7%) on student loans, but is too low to repay much principle. The average nurse owing $20,000 on graduation will still have a debt of around $17,500 after five years, having paid nearly $10,000 towards her student loan (see appendix 1).

Compared to the police, where qualification costs are met by the organisation and recruits are paid a salary to train (and there is not yet any degree requirement), nurses are significantly affected by the costs of training. Even if we ignore the opportunity costs of training to be a nurse (the loss of potential income over three years), there is a direct cost of, after tax, around $2000 per year on nurses paid from an income which is, in terms of other professions, not high.

3.4 A women's labour market

Nursing shows all the key features of women's labour market participation. The 'Next Steps' report notes that, along with segregation, it is differences in experience and qualifications that together constitute the main cause of the gender pay gap. Women tend to be less qualified and have been in the workforce less long.

With a degree as the benchmark qualification, the pay gap in nursing cannot be explained by qualification differences. However, a recent study has shown that over 30% of nurses who have annual practicing certificates are not in nursing practice at any one time. Research undertaken by the Nursing Council to find out the reasons why nurses were not choosing to work in clinical practice were stated as child care and parental responsibilities, unattractive hours and poor salary (NZHIS, 2000). While lower pay may be an effect of being out of the work force for intervals, it might also be a cause.

Nurse researchers found that the career plans of nurses aged 31- 40 years are influenced by family and income responsibilities and that they requires more flexible work/shift hours and access to child care to remain in nursing (Cobden-Grainge and Walker, 2002).

Another labour market feature of the 1990s, which has particularly affected nurses, has been the growth in the use of casual labour. While nurses value flexibility in employment conditions, the use of casual nursing staff has been dramatic, and cannot be explained by a change in nurses' employment preferences. Prior to 1990 private hospitals and public hospitals rarely used nursing bureau and casual nursing staff. The use of casual nurses, though somewhat reduced since the mid 1990s, still remains unacceptably high.

The caregiver workforce comprises about 30,000 people, mostly women, and many of whom are employed in the home care sector. Data about pay rates and employment conditions for caregivers is incomplete. The introduction of the Employment Contracts Act resulted in the cessation of the one national training programme. Training programmes are sporadic and many caregivers are expected to fund themselves through them. Average wages for caregivers are between $11 & $12 an hour.

3.5 The 'customary' health sector pay gap

The question of principle regarding the relative pay of nurses and doctors in a modern hospital system rests on the inter-relationship between their work. It is at least complementary and often overlapping, as the following quote from the United Kingdom shows:

> "an equality-proofed pay structure would put an end once and for all to a system 'where some professionals are by some automatic right paid more than others'….
>
> If a patient needs an aortic valve replacing, for instance, they require a skilled surgeon to perform the operation, but they also need intensive care nursing pre-operatively. Without that care the operation could not take place. Yet while the surgeon would probably be earning well over £60,000, the intensive care nurse would be lucky to get £20,000" (Cole, 1998 p.15).

Moves towards clinical grading in the United Kingdom have not increased nurse pay as much as was expected. Many charge nurses, for example, are now being paid at a lower

grade than a decade ago. The Royal College of Nurses' current submission to the British nurses' pay review board makes the following point:

> "...a culture of underpayment was allowed to develop in the wake of clinical grading; a structure which properly valued nursing was simply too much to bear for a health service too used to valuing traditional male roles more highly than traditional female roles." (RCN 2002)

Nevertheless, the RCN recommends a continuation of the current policy of pay improvement for nurses in the UK, albeit at a substantially increased rate. The announcement of a process for overall pay rises plus a schedule for implementation of pay equity through job evaluation, announced at the end of November 2002 as part of the 'Agenda for Change', has confirmed this approach.

The NZNO expects that the inevitable anomalies and problems thrown up in pursuit of pay equity will be satisfactorily addressed only if there is clear agreement that occupational segregation contributes hugely to the gender pay gap and that it should be removed as a factor in arriving at pay outcomes.

This is important for all our members. They share a common experience of being employed in predominantly female occupations with ensuing relatively low pay.

However some groups of women within the health service are further disadvantaged by the relatively greater availability of their skill and experience and their resulting reduced bargaining power. Health care assistants share many of the characteristics of the home care workers that the Ministry of Women's Affairs has previously championed in this regard.

This makes it clear that addressing pay equity for health workers will not only have a dramatic impact on the gender pay gap but would also contribute to combating income inequality in New Zealand.

4.0 A Principled Way Forward

The single greatest obstacle to achieving pay equity will be an unwillingness to intervene in the labour market, and yet that is exactly what will be required.

There is thus an urgent need to agree as matter of government policy that occupational segregation contributes significantly to the gender pay gap and that mechanisms must be put in place to overcome that effect.

To do otherwise is to accept a level of gender discrimination that runs counter to the Government's commitment to human rights and gender equality.

There are a number of steps that could be taken by Government as an employer and/or funder that would narrow the gender pay gap for health workers, and thus have a wider

impact. Historical bargaining arrangements need not be an obstacle to this. A willing Government has all the tools it needs, without legislation, to make this change.

We would like to see the Government endorsing the following as a result of its consideration of MWA's discussion document:

- The gender pay gap will not be closed without mechanisms designed to overcome the historic disadvantage resulting from gender based occupational segregation.

- Government policy and existing powers should be used to overcome the unequal pay resulting from gender based occupational segregation within the health sector. Formal tripartite structures may provide a vehicle to implement pay equity determinations.

- Separate funding should be allocated to meet pay equity claims. It is unacceptable for nurses and women's workers to be in a position where they are competing for public service funds.

- If the development of mechanisms presents difficulties in a relatively fragmented bargaining environment, then there must be a willingness to make the environment less fragmented. In this context specific pay equity legislation will be required.

- The initial focus should be on the 10 most common occupations where women are employed including recognition of the employment areas where Maori and Pacific Island women are concentrated.

- Increased unionisation will assist and collective bargaining will contribute to a narrowing of the pay gap but will be not replace the need for regulatory support for equal pay for work of equal value.

- The development of skills and opportunities for Maori and Pacific Island women, who are the most adversely affected by the gender pay gap, is a priority. Nursing is not one of the 10 most common occupations where Maori women are employed demonstrating an inequality in educational and training opportunities for Maori and Pacific women.

While also important, the development of equal opportunities and greater opportunities for women workers is not a substitute for the implementation of a framework for equal pay for work of equal value.

With these things in mind we urge the Government to commit itself to a timetable for closing the gender pay gap in the public sector and to taking the steps required in the private sector to close the gaps there, within a decade.

Whatever mechanisms are in the end agreed to, job evaluation will need to be undertaken and work could begin now on the tools for this. We suggest that the July 1991 SSC and Labour Department job evaluation kit 'Equity at Work' be revised according to international best practice and made available as a tool for achieving gender pay equity.

The EEO Commissioner has a role in advancing pay equity. To demonstrate a shared commitment to this role we suggest that the government (as employer or funder) and an appropriate union could work with the Commissioner to define an occupational group whose pay could be the subject of an investigation by the Commission, with an agreement to advance her recommendations.

Pay audits within the public sector should be undertaken without further delay. These will be a driver for ongoing work in the achievement of pay equity, both through collective bargaining and regulation.

We would welcome the opportunity to contribute to a more detailed discussion of a legislative framework for making pay equity determinations and implementing them. We believe that it will be in implementing, rather than reaching, such determinations that the real challenge will lie. Such mechanisms will have to:

- Be based on collective and not only individual claims
- Allow claims to be made across a whole occupational group
- Result in determinations that are capable of being extended to all those employed in the occupational group
- Be based on an implementation principle that results in acceptable internal relativities within the organisations affected.

This requirement would allow the implementation of a determination to vary from organisation to organisation within an overall framework of equal pay for work of equal value and would overcome the difficulty posed by the lack of occupational agreements. If every organisation closed its own gender pay gap then of course the gap would close overall. It would also clarify that this policy is about closing the gender pay gap, rather than addressing sector or regional pay differences.

References

American Nurses Association (1986) Pay Equity: what it means and how it affects nurses. AMA, Missouri.

Cobden-Grainge, Fay and Walker, Jackie (2002) New Zealand Nurses' Career Plans. Report, CPIT Publishing Unit, Christchurch, New Zealand.

Cole, Andrew (1998) Ups and downs of equal pay. Nursing Times, vol 94 no 37 pp. 14-15.

Fargher, Scott and Maani, Sholeh (1992) The gender pay gap in New Zealand: evidence of income differentials and occupational segregation. Working Paper no. 109, Department of Economics, University of Auckland.

Gordon, Liz and Morton, Missy (2000) Women – well educated and poorly paid: gender pay discrimination in the public service. Proceedings of Women's Studies Association Conference, July.

Maani, Sholeh (1999) Private and public returns to investments in secondary and higher education in New Zealand over time (Wellington, Treasury working paper 99/2).

Ministry of Women's Affairs (2002) Next Steps Towards Pay Equity. Wellington: MWA.

New Zealand Health Information Service (2000) Non Practising Nurses and Midwives Report.

Royal College of Nurses (2002) Evidence in submission to the Review Body of nurses' pay (on RCN website).

Scott, Graham (1995) Comparable pay, unequal earnings. Nursing Standard vol 9 no. 52 pp 23-25.

State Services Commission and Department of Labour (1991) Equity at Work: an approach to gender neutral job evaluation (SSC/DOL, New Zealand)

Weiner, Nan (2002) Effective redress of pay inequities. Canadian Public Policy, Vol XXVII, special edition.

Wilson, Margaret (2002) Address to PSA Pay Equity Seminar. New Zealand Government.

Appendix 1

Notional repayment of student loan debt for a Registered Nurse

	$
Year 1 Debt:	*20,000*
Interest:	1400
Repayment (salary 30,000)	1500
Owes	19900
Year 2 Debt:	*19900*
Interest:	1393
Repayment (salary 32,000)	1700
Owes	19593
Year 3 Debt:	*19593*
Interest:	1372
Repayment (salary 34,000)	1900
Owes	19065
Year 4 Debt:	*19065*
Interest:	1335
Repayment (salary 36,000)	2100
Owes	18300
Year 5 Debt:	*18300*
Interest:	1281
Repayment (salary 38,000)	2300
Owes	17281

Owing after five years: *$17281*