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We support sustainability and pay parity. But maybe not for you..

In 2018, the secondary care nurses' pay negotiations resulted in a well-deserved double-digit increase. Whilst good news for DHB employed nurses, this created a significant pay gap between secondary care nurses and their counterparts working in primary and community care.

Since then, many in the primary care sector have been understandably arguing that this disparity is harmful to stability in the sector and contrary to the much-repeated mantra that primary and community care is the key to improving health outcomes. There have been many calls for this issue, referred to as "pay parity", to be addressed by the Ministry and DHBs as Crown funding agents.

But if general practices are private businesses (albeit providing an essential public health service to the people of New Zealand), why is it that pay awards for their staff should be a matter for Crown funding agents at all?

The answer is quite simply that unlike any other private business, the two main sources of general practice income are both either prescribed or regulated by the Government. As explained below, general practice capitation funding is prescribed by DHBs with no provision for negotiation by general practices. At the same time, general practices' other main source of income - patient fees – are either capped or prohibited altogether (with many consultations, such as those for all under 13 year-olds, now provided free of charge). General practices have very little or no ability to cover cost increases through raising their fees and have lost that key sustainability mechanism that all other private businesses take for granted.

<u>The 2020/21 Primary Health Care MECA settlement</u>

In April this year (2021), the Minister of Health (who represents neither the employers nor employees who are party to the primary health care multi-employer collective agreement – the MECA) intervened in the MECA process in the midst of industrial action organised by the employees' agent, the New Zealand Nurses Organisation (NZNO). Putting the party and union firmly in the centre of decision making, he offered additional temporary one-off funding to cover the pay gap between primary and secondary care nurses – but only for unionised members of general practices which were party to the MECA; approximately half of New Zealand's essential general practice nursing workforce.

Whilst the temporary funding covered only the period which ends on 30 June 2021, in a separate letter to PHO chief executives from the Ministry of Health and DHBs jointly, a commitment was given that "Future annual adjustments of capitation funding are expected to accommodate this cost (pay parity) going forward".

The temporary funding combined with the reliance upon future capitation increases was enough for the parties to the MECA negotiation to recommend that their employer and employee members accept the deal being offered. It was subsequently ratified by both sides.

Future capitation increases

But what reliance should we place on these future annual adjustments to capitation funding? History tells us that we should be cautious, particularly when annual adjustments to capitation funding have failed to address the pay parity issue up until this point, have failed to address the long-running under-funding of primary care and, have also failed to fund the rising costs of a sector being expected to undertake more work on behalf of secondary care and more work to support non-clinical compliance and administration.

Is there anything in the PHO services agreement, or the general practice back-to-back contract, or the contract negotiation protocol (PSAAP) that in some way lays down a pathway to "accommodate" this cost? The short answer is no.

Adjustments to capitation are entirely at the whim of DHBs. There is no process to compel DHBs to increase funding for capitation. Whilst there is a process for DHBs to "consult" regarding the proposed annual capitation/funding increase, if primary care representatives don't agree, as is increasingly the case in recent years, the DHBs simply impose the change through a compulsory variation to the contracts. There is, in effect, no negotiation whatsoever.

There should however be two other processes arising from the PSAAP protocol that have some influence.

Firstly, there's an interesting clause in the PHO services agreement. Clause F.21 (2) states:

> *We acknowledge that it is the government's intention to:*
> *a) regularly adjust.... to maintain the value of those payments; and*
> *b) work with the sector the ensure the sustainability of general practice.*

These are of course fine words. But in practice they are utterly un-enforceable and, by-and-large are ignored by the contracting process and those representatives involved. As explained above however, general practice is totally reliant upon the Government to ensure it remains sustainable.

That is why the second PSAAP process matters so much. This is what's known as the "ASFRI" - the annual statement of reasonable fees increase. This process is the mechanism which calculates by how much general practices can increase their fees each year. This is designed to allow general practices to increase their patient fees to cover those legitimate costs which have not otherwise been covered by the DHBs increase to capitation funding.

It is customary for the independently calculated figure (currently undertaken by SAPERE) in the ASFRI process to also guide DHBs as to by how much they might increase capitation funding. But what does the ASFRI figure actually represent and how is it calculated?

The ASFRI calculates the pressure on general practice costs for the upcoming year, using the previous year's data. The data used includes:

- The Labour Cost Index (health) - wages
- The Producer Price Index (health) - the goods and services we need to run our practices
- The Capital Goods Price Index (balance sheet and assets stuff).

Thus, the capitation increase and any allowed patient fees increase are expected to cover those myriad of cost increases that general practice experiences every year (including the salaries of doctors and nurses; the salaries of managers, administrators and receptionists, nurses; rent; insurance; telecoms; power; medical supplies; accountants; lawyers; IT costs etc etc – the list, as any general practice business owner will probably tell you, is seemingly endless).

However, the calculation takes no account of other exceptional costs affecting the sustainability of general practice – this includes exceptional salary/wage rises, and also increasingly includes new enrolment systems (e.g. NES), costs of managing COVID, increased compliance costs (e.g. Foundation Standards), statutory police checking (vulnerable children) and firearms obligations to name but a few.

Additionally, the non-negotiated yet biggest cost of all doesn't get a look in – that is the constant transfer of services from DHBs to general practice. This includes unprecedented levels of referrals being refused by secondary care and bounced back for those patients to be managed by general practice. It includes increasing requests by secondary care for general practice to follow-up diagnostic results, arrange scans, or to co-ordinate on-going care for a patient after a same-day discharge.

<u>Funding lag</u>

As mentioned above, the ASFRI calculation is retrospective and based on the previous 12 months data. Therefore, with costs continuously rising, there is by definition a delay between the date when a general practice becomes liable for increased costs and the effective date of any associated capitation funding increase. For example, a MECA pay award for nurses which might be payable by their general practice employer in February 2021, will only have a 2-3 month impact at best in an ASFRI calculation undertaken in (let's say) April 2021 for implementation from 1 July 2021. This means in any normal year there might be a potential 17 month un-funded lag between general practices paying their nurses the increased salary in February 2021 and the associated full-year impact being included in the ASFRI calculation implemented from, in this case, July 2022.

For general practices which employ nurses who are not members of the union or for general practices who were not party to the latest MECA, the prospective nature of the ASFRI calculation means they will require separate recompense for the one-off temporary funding which the Minister only awarded to unionised MECA practices for the period to 30 June 2021. Those non-MECA practices will have still likely paid their nurses at the equivalent higher rate – not least because of the highly competitive demand-driven workforce market which exists with the nationwide shortage of skilled healthcare professionals. To not pay at the market rate invariably results in disillusioned staff voting with their feet and moving to one of the many employers who will.

There is a PSAAP negotiation coming up for the adjustment of capitation funding rates with effect from 1 July 2021. Through this PSAAP process the ASFRI calculation is being relied upon to make good the funding required to support last year's MECA settlement. But remember, neither the ASFRI nor the capitation increases are negotiable, nor is ASFRI inclusive of many associated cost pressures, nor is it reflective of the real date of general practices' increased financial liabilities.

The sector, through PHOs, was given an assurance that "Future annual adjustments of capitation funding are expected to accommodate this cost" [the recent MECA award]. For that to be the case, the usual ASFRI process and its calculation will need to be expanded to at least include the full-year impact of the previous 12 months cost increases and, a one-off adjustment to make good the temporary funding shortfall for non-MECA practices.

Prospective increases

Moving forward we need to correct the fundamental flaws of the ASFRI calculation. For example, the majority of our primary care nursing workforce are already paid at the top of the pay band 6 and should move to band 7 during 2021/22 as is proposed to secure parity with secondary care DHB employed nurses. A retrospectively calculated formula does not include such prospective increases.

Similarly, on behalf of secondary care nurses, the NZNO are now negotiating for a new 17% pay increase. Part of the rationale for that increase is the workload and responsibilities which were, and continue to be, undertaken in response to the COVID 19 pandemic. It should go without saying that primary care nurses, along with all other general practice staff, were no less a part of this country's defence and response to the pandemic. Many might say they were more so and will be even more so in the future. That will require at least equal recognition following the current secondary care nurses pay bargaining.

GenPro is keen to support our sector colleagues to ensure the right outcome is secured from the forthcoming PSAAP negotiation process on behalf of general practice and primary care. An outcome which requires a re-focus of attention on the lost Clause F.21 (2) – a clause which should be used to hold the Government to account for its stated intention of ensuring the sustainability of general practice. Saying that we support the principles of both sustainable general practice and pay parity should also mean that we deliver exactly that.

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