AN ALLIED SCIENTIFIC AND TECHNICAL JOURNAL

EVOLUTION OR REVOLUTION

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CONTENT

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EVOLUTION / REVOLUTION

"We have two pathways for change, evolution or revolution. These guys can't wait for evolution, so revolution it is." These words were said too me three years ago when I became involved in my first APEX strike campaign. In the context of health, this statement could not be more accurate.

With the introduction of new technology, new techniques and of course, new illnesses, the way in which we provide care is constantly evolving, yet the attitudes of some employers remain in the past. Despite growing populations and increasingly complex patients, the NZ Health Sector proliferates outdated attitudes towards health & safety, collectivisation, and the needs of their employees. "One of your colleagues is sick? You can cover their workload as well as yours, right Jenna?", "You want to go part-time to become the primary caregiver for your child David? Best I can do is 0.9FTE plus full participation in the shift roster".

These are issues we hear about again and again, and with each issue comes the repetitive process of raising it with the employer, arguing over contractual

interpretation and usually, resolving the issue. Unfortunately, this resolution may not stick, and we then move on to addressing the same or similar issue a month or so later. Overall this is not necessarily a bad thing and can be seen as part of our collectives' evolutionary process, as with each issue we raise and resolve, our collective's become more resolute and powerful.

So is evolution better? Often yes, but it does need to happen and not take an ice age to achieve. Resolution of many of our issues away from the bargaining table, before they become a point of frustration and resentment for members, would be ideal and would also de-escalate bargaining however getting to that utopia has proven to be difficult. For whatever reasons, once bargaining is over, employers move to the next priority which is usually not resolving the issues we need to ahead of the next round. And this does not just affect us as the NZNO situation, where the promises of the employers over CCDM have not materialised over a period of some years – and that's before we get to the vexatious issue of pay equity!

Sometimes we simply cannot wait for a slow, evolutionary change and a strategic decision is made to take issues to bargaining where our members can exercise their "revolutionary" powers. Strike action is not a decision taken lightly.

However, in some instances, it cannot be avoided. An example where a revolutionary approach may be taken is in matters relating to health & safety. In recent years, with the increase in populations and health needs of our patients, the way in which we provide some services has become outdated, such as night time on-call rosters. Moving from an on-call roster to a night shift roster when the number of call-backs

has become inherently unsafe, is a massive change in service which requires an additional FTE of up to 20%. You can imagine the additional cost of these employees is seen unfavourably by the employers and often requires more than polite discussion to acheive.

This is merely one example where "revolution" may be required to create change, and despite some feeling powerless against the power of the employer, it does work. The MITs fatigue matrix, the Psychologists salary scale reformation and the Sonographer's recruitment and retention increases were all achieved because of strike action. Unfortunately, as health workers it is etched into us that by striking, we are putting our patients at risk. Nothing could be further from the truth as without a strong united workforce with conditions of employment that attract future workers, our workforces will eventually crumble. Sometimes we simply have to stand up for what is right.

APEX is constantly looking at our collective agreements and asking questions around how we can improve them. It is fair to say that many of our claims in collective bargaining are a result of employers attempting to fix service-related issues or shortages at the expense of good rostering or employees existing terms and conditions of employment. Many more are because of employers failing to address key issues outside of bargaining. Unfortunately, with the latter, whilst we agree many issues should not be the subject of bargaining, if the employer delays or frustrates resolution, where else can we turn? This is exactly what we are seeing in the current workforce crisis with expansions of roles without appropriate financial recognition, frustration over merit progression, increasing workload and the introduction of new shifts without the impact and needs of the employees being considered.

It is very clear that some of our members are entering bargaining with specific expectations that they are rightly, unwilling to have ignored. In combination with the Governments current pay freeze, the rate of inflation and Te Whatu Ora's inconsistent approach to bargaining, it is little surprise that our members are angry and can turn to "revolution" to acheive what they are owed.

EVOLUTION / REVOLUTION

HEALTH NZ – THE POTENTIAL OF NATIONAL SERVICES

The reorganisation of the public health service into a nationally governed Health NZ will open the door for regional specialist services to become co-ordinated national services.

The first two candidates for re-organisation on a national level are our laboratory and radiation oncology networks. Each in their own way demonstrates how the creation of national specialist services can improve health outcomes.

Radiation Oncology – The Postcode Lottery

In radiation oncology, radiation therapists and medical physics, alongside medical, nursing, clerical, and other clinicians, such as psychologists, provide the foundation of one of New Zealand's main treatment responses to cancer. But the much discussed "postcode lottery" of the DHB-led system, meant the ability to access radiation oncology was unequal. And despite cancer being New Zealand's single biggest cause of

death and 25,000 New Zealanders getting a cancer diagnosis each year, the system struggles with a serious lack of focus and co-ordination.

Linear accelerators, the machines used to provide radiation oncology are static and expensive machines. The workforces required to operate them are small and require careful protection and investment. Small changes in available workforce can have a dramatic impact on the ability to provide cancer care in a region. Because of this, radiation oncology services can become strained when the provincial DHB leadership is unaware the investment in the specialist service is inadequate to meet local treatment requirements.

Take for example Southern DHB, where cancer care waiting lists became a national focus after dying Southland man Blair Vinning, took on the Government. A report by consultancy firm Ernst Young for Southern DHB has just confirmed what many clinicians have been saying for some time that behind the DHB's long wait lists is significant understaffing compared to other centres.

	Auckland DHB	Waikato DHB	MidCentral DHB	Capital and Coast // Hutt DHBs	Canterbury DHB	Southern DHB
Catchment population	1,894,580	860,905	603,555	477,430	832,155	344,000
Radiation Oncology courses	3,221	1,651	1,559	1,717	2,034	1,198
LINACs	6	4	4	3	4	3
Registrar FTE	8.00	5.00	4.48	7.14	7.00	2.00
Registrar FTE per LINAC	1.33	1.25	1.12	2.38	1.75	0.67
RT FTE	74.8	41.0	37.1	35.6	40.8	28.6
Radiation Oncology courses per RT FTE	43.1	40.3	42.1	48.2	49.9	41.9
RT FTE per LINAC	12.47	10.25	9.26	11.87	10.19	9.54
MP FTE	19.88	11	11.71	9.1	11.6	7.05
MP FTE per LINAC	3.31	2.75	2.93	3.03	2.90	2.35

Responding to the report in the Otago Daily Times, the widow of Blair, Melissa Vining said, "it was sad more public money had been spent by the SDHB on an external report which had found what wait lists and its own medical professionals could have already told it."

But the problems in Southern DHB demonstrate just how bad the cancer system has broken down. DHBs not listening to patients and staff. The Ministry of Health not listening to DHBs. And the report shows what most APEX members will be aware of, that behind the postcode

lottery of patient access are extreme differences in staffing numbers – where Southern DHB has just 76% of the radiation therapists per linac and 70% of the medical physicists per linac that Auckland DHB has (and to be clear, we are not saying ADHB has too many!).

Creating a radiation oncology national service would allow some centralisation of data, and co-ordination of investment. It would allow those who govern the service to view local problems against a national context. Better data and a broader overview should allow planners, funders, and service managers to recognise the sequelae of short staffing within a local service. We could even hope that through national co-ordination, the amalgamation of public health systems leadership and expertise in radiation oncology will lead to a more proactive approach to training, ongoing education, hiring additional staff and installing new linacs to meet the increasing demands of a growing and aging population.

KIWILAB – FLYING BLIND IN A PANDEMIC

The delays in March 2022 as labs become overwhelmed by the sheer volume of Covid test results they were required to process and risks of staffing absences from sick or isolating staff across New Zealand's medical laboratory network, highlighted the urgent need for a national medical laboratory service.

Information flow between the Ministry of Health and the dozens of both public and private laboratories which serve our communities clearly broke down. The Ministry misunderstood or did not realise that pooling of Covid tests, which had been done extensively, would become unviable with higher positivity rates. That demonstrated the need for closer integration and better communication between those who make the health system run and those who run the health system.

A national medical laboratory service – or "Kiwilab" would bring together all laboratory professionals and the service they provide under one umbrella. This would make the co-ordination of our laboratory workforce with overall public health responses or goals simpler.

The Health and Disability System Review's Final Report, completed in March 2020, which paved the way for Health NZ made several observations about laboratories including:

- To grow workforces at the pace required and better reflect the community will require new training pathways and suggests a future,

"Health NZ may have the scale and resources to provide in-house training and development for relevant roles (eg, laboratory assistants and technicians)."

- The system needs better integration of screening services into the hospital network and notes, "Technological advances will present options for new and existing population screening programmes. Genomic testing, for example, may provide greater insight into identifying high-risk groups for screening in the future."

The Final Report is very clear that we need to stronger public health infrastructure with reduced fragmentation, which has caused confused roles, weakened accountabilities, and a depletion of population health expertise. The Report states the country must do better at public health surveillance:

A strong infrastructure for health protection requires comprehensive population health surveillance systems in place for both communicable and non-communicable diseases. This involves the ongoing systematic collection, analysis, interpretation, and dissemination of data to assess heath trends, threats, risk factors and influences.

Currently, New Zealand's public health surveillance services are distributed across several providers under contract to the Ministry of Health, including the Institute for Environmental Science and Research Ltd (ESR), Massey University and the University of Otago and private laboratories. There are also numerous other information and surveillance systems that inform the health system.

Now and into the future it would be increasingly important to ensure our surveillance systems are sufficiently robust and well-integrated and that there is capability in the system to interpret and respond to this information in a timely way.

The best way to ensure our laboratory network receives the focus and investment it needs is to bring the regional labs under one national service to ensure the capacity and collaboration required to respond to current and future disease responses.

Conclusion

The laboratory and radiation oncology sectors of the health system share a few things in common. Both rely on small and highly skilled workforces, require expensive and complex machinery, and have and will continue to be under growing pressure to deliver more services to more patients in the future. To meet these challenges there are significant advantages for these services operating nationally and APEX will continue to lobby and push for both sets of services to become national services as we move beyond the beginning of Health NZ.

When you are an APEX member covered by a collective agreement you are entitled to take sick leave when you or someone who is dependent on you is sick. We encourage you to keep that simple right in mind when you need to take sick leave. How much sick leave you are entitled to, and how and whether you will be paid for it, will vary however depending on your collective agreement. Please read your own collective agreement to verify the general entitlement and contact your delegate or advocate if you are unsure of your own personal entitlement.

In recent years some of our collective agreements have secured improved sick leave entitlement in areas such as accumulation, application to dependents, requirement for medical certificates, and ability to take part-days for medical appointments; again, check your collective agreement to know what applies for you.

On the legislative front the government legislated a major change to the Holidays Act in July 2021 to increase the entitlement under law from 5 days to 10 days per annum. At the time many employees gave that little thought as most collective agreements already provided for 10 days sick leave. But!.., and it is a big but, many of our collective agreements provided for sick leave to paid at ordinary pay for the days not covered by the law. In other words, the first five days of sick leave would be paid at relevant daily pay as required by law (the total that you would have earned on the day but for you being sick), but after the first five days only ordinary pay applied. ***The law now requires that all ten days be paid at relevant daily pay (RDP).*** For most Workers RDP is often a higher amount. And, bluntly, what you actually get paid frequently comes down to how up-to-date your own employers' payroll system is. Check your payslips when you take sick leave. If you think you are not being paid according to current legislation, then challenge it.

A final point on sick leave. If you have bad luck with health – you or your family - it may be the case that you use up all your paid sick leave entitlement. When that happens, you are entitled to take unpaid sick leave, or be granted additional paid sick leave by your employer. Sometimes, for financial reasons, you may choose to use up some of your accumulated annual leave. 'Choose', is the operative word here! Being sick is not a holiday. Annual leave is meant for rest and recreation, not recovering from illness. Whilst it may be necessary for you, ***at your own choice*** to use annual leave to cover for sickness to keep body-and-soul together, you cannot be required by your employer to use annual leave for sickness. The clues are in the words; annual leave (i.e. holidays; rest

and recreation) and sick leave (i.e. illness of you or a dependent). We have also seen a disturbing trend in recent years for employers to try and reduce annual leave balances by cajoling / encouraging / requiring employees to use annual leave when they have run out of sick leave.

It is not legal for them to assume that you move onto annual leave if you run out of paid sick leave.

Let your delegate or advocate know if you come under pressure to use annual leave to cover for sick leave; employers need to be stopped from doing it … it is against the law.

SICK LEAVE

FAIR PAY AGREEMENTS

The Labour Government is implementing a Fair Pay Agreement (FPA) system, like the Australian Awards system which seeks to regulate working conditions and pay for employees across a given sector or industry.

Fair Pay Agreements will involve employers, and unions advocating for employees, to set a minimum standard for all employees within that industry by 'bargaining' for minimum pay and employment terms.

Some businesses and sectors have been competing for contracts and market share by decreasing costs/ prices, via a business model dependent on low wages and employment conditions can be in a "race to the bottom". In Health, we have seen this over the years, especially in cleaning and catering contracts where one DHB cleaning contract comes up for tender and a competitor company says they can do it at less cost than the incumbent. A union might have spent several years bargaining and increasing wages for the incumbent group, gains that are lost overnight as a new non-union company takes over the service contract with the workers on lesser pay and conditions.

FPAs instead aim to create an environment where businesses compete on the quality of products and services, rather than on price and by driving down wages/ conditions. It is hoped that businesses will be incentivized to invest in productivity, education, training, and innovation.

According to Workplace Relations and Safety Minister, Michael Wood, FPAs are targeted toward Kiwis who are working in critical roles, who previously lacked the power to advocate for improved pay and conditions:

"Fair Pay Agreements (FPAs) have long been one part of our wider work programme focused on lifting the wages of those on low to medium incomes."

What's the proposed system?

Under the Agreements, employees will be able to initiate negotiations with employers if at least 10% of their workforce, or 1000 staff, agree to it. The Agreements are aimed at providing minimum fair pay standards for employees.

All FPAs must include certain topics, such as:

- Base wage rates; and
- Ordinary hours; and
- Overtime; and
- Penalty rates.

Other topics can also be discussed though not necessarily agreed, such as:

- Redundancy; and
- Leave; and
- Health and safety.

The government will provide funding of up to $50,000 to support bargaining sides (unions who will represent employees, and employers who will choose representatives). An FPA will be vetted and agreed upon by the Employment Relations Authority and - if successful - brought into force by MBIE. This secondary legislation will apply to all employees within that industry.

So, when will it happen?

The Fair Pay Agreements Bill was introduced in parliament in March 2022 and is expected to be passed at the end of 2022, with the FPA system commencing shortly after. It is envisioned that about two FPAs will be bargained each year.

The focus will initially be on sectors or industries, where wage rates and conditions are low, and unionization could also be quite low; remember in the private sector only 10% of workers are in unions.

Sectors that could be first in line for an FPA are supermarkets/retail, bus companies, logistics, cleaning companies, security, fast food, aged care, and early childhood centers.

Our union is unlikely to be initially impacted– though opportunities for an FPA agreement might exist in a sector such as private laboratories, which has a business model that could become dependent on low wages and worker exploitation. To date this has not happened by the presence of a union that represents all laboratory workers public or private and therefore the ability to if not ratchet, have sufficient knowledge of the going rates to maintain employee's terms and conditions through a degree of industry competition for workers. Should the supply of workers exceed demand across both sectors however, the potential to lose conditions does still exist.

PAY SPINE

A pay spine is defined as a "tiered range of salaries for different jobs or roles or for those who have been in a job for differing amounts of time". Most current APEX contracts could be defined as being pay spines that have a tiered range of salaries that are determined either by how long the member has been in the job (automatic salary progression) or who have demonstrated advanced skills (merit progression).

This article is going to discuss the former part of the definition where the salaries are tiered based on different jobs. In essence

a pay spine under this definition is a pay structure starting with the lowest salary going to the top and each individual workgroup is placed somewhere within the scale of lowest to highest. There could be overlapping within the spine so for example pharmacists could range from $80,000 to $100,000 and psychologists from $90,000 to $110,000 and still be on the same pay spine.

Pay spine warrants consideration at this time given the declared principle of having all employees doing the same job on the same terms and conditions. As stated in the Government Workforce Policy on employment relations May 2021:

"Using any opportunities in bargaining to modernise terms and conditions of employment and to enhance consistency and commonality across the Public Service."

There is nothing wrong with the premise that the same workers, doing the same job, should have the same salary scales when working for the same employer or across a sector, and regardless of union (ignoring for a moment that the members of one union may take a different approach to setting those salaries from time to time). But when the determination of a profession's salary scale is tied to a whole range of other but different professions salary scales, that is where things become tricky. Easier for payrolls of course, but the added benefit to the employees less easy to identify.

Benefits of a pay spine

As you will see from the next section, many of the perceived benefits of a pay spine can equally present an issue.

A pay spine can be a simple transparent system where it is clear to see where a work force currently sits and as a result when any percentage increase is achieved through bargaining, relativities must be maintained. Any employee (including students who may be deciding on which career lath to follow) can refer to the spine and see not only the salary they are and can expect to be paid but also others in the workplace. This can be a benefit in that workers have a greater understanding of pay across all employees on the spine.

This pay structure can mean simpler bargaining as presumably to avoid the issues of relativity, a percentage increase would (or should) be applied to the spine in its entirety. In other words, if a single group must be paid more due to issues such as recruitment and retention, then other groups could benefit from such an increase when the same issue may not be a factor for them. However, given the standard affordability argument from employers this may be difficult to achieve in bargaining and the reverse apply i.e. a movement on the basis of recruitment and retention declined because of the additional cost of applying that to all.

The spine could also be used when negotiating if one group with similar level of experience, responsibility and workload is paid higher it could be claimed that another group needs to move higher on the pay spine if they have the same role. Pay equity may be a pay spine determinant!

The downside of a pay spine

Establishing the structure

of a pay spine in the first instance would be challenging. While qualifications or job sizing can be taken into consideration when determining placement these are not exact sciences. Ask any member of ASMS they will tell you how job sizing is problematic at best.

Under the current APEX structure with varying pay scales applying to different groups it could be a considerable task to turn this into a single spine without any group being disadvantaged. And how would this translate across different parts of the public sector let alone private sector. If private sector moves scales in recognition of recruitment and retention, but public gets stuck within a relativity argument, what of our workforces?

Once a pay spine is in place it could be difficult to get movement on the scale. The spine is an inflexible model; to "play around" with the spine would risk upsetting the relativity between groups. And like successful pay equity claims, internal relativity is impacted when the implementation of changes to salaries for external reasons (unrelated to the negotiated contract) only impact on limited subgroups on the spine. The Oranga Tamariki social work pay equity settlement is a case in point which was applied to those "in the field" and not those in office-based functions, just as critical to the overall performance of the business. Workforce migration to the higher paid positions is inevitable leaving an additional workforce challenge.

A pay spine would seem to be at odds with the APEX structure. One of the reasons members join APEX is the individual "boutique" way in which we bargain. We listen to members and then taken the issues, such as recruitment and retention, confronting the relevant group to the negotiating table.

We do cover the same workers in different sectors and with a widening range of employers resulting in positive pay pressures arising out of divergence and ratchet of rates. However this is usually a time limited mechanism; another more enduring means to advance a single profession is to amalgamate all the agreements in the single sector (see psychologists' article elsewhere in this journal). In this manner the only relevant issues relate to the one profession and labour market/workforce objective relevant to that group.

Planning ahead

APEX is protected against the down sides of a pay spine through the contracts currently covering individuals within the same profession. However there may be a move to a pay spine that sits outside of our contracts (and potentially within the realm of the PSA for example) which could cause some tension as we try to bargain to meet our member's needs, whilst the public sector employers potentially trying to hold us to another (pay spine) means to determine salaries.

This matter will be discussed at our upcoming National Divisional Council meeting and undoubtedly at membership meetings thereafter. In the interim we suggest members watch for signs of a move to a pay spine and think carefully to identify the added value (or not) this structure might provide to your profession.

DELEGATE TRAINING

Delegates are a union's most important assets. In a way they are the face of the union that members are most like to know. They are also the union's people on the ground not just assisting the members at the coal face but also representing those members with the bosses, the media and the public where necessary. This is a hugely important role not just for APEX head office, but for all members who can access quick and valuable support from their local delegate who knows the workplace and the workforce. Considering this role, it is important to ensure that we have well-trained delegates to take on this role. The delegates are essential to union work which is why each year, we hold a two-day delegates training session in Auckland.

For these two days our delegates participate in training sessions which involve improving knowledge of employment relations, industrial trends, contract interpretation and general supporting of members. They learn how to work with members, escalate issues to human resources and know when to call upon a union advocate should this be necessary.

With the introduction of Te Whatu Ora, this role will be more important than ever for those of you in the public sector. Under a single employer, the importance of communication between localities outside of your district will only heighten. With its ethos on the employees' rights and commitment to training, what we do not want to see is consistency down to the lowest common denominator, rather than pulling everyone up to the best terms of conditions of employment for each profession. This is not limited to those delegates employed in the public sector. While those of you who are not employed by Te Whatu Ora, will see little change on the ground the same advantages and risks of only looking locally apply. Delegates need to be networking with colleagues no matter who the employer is in order to advance the goals common to the workforce. Getting in touch with other delegates should not be limited to the annual APEX conference but should be done in both a scheduled manner and on an as needs be basis.

Communicating with your delegate colleagues across the health sector will become a necessity in order to grasp the opportunities that come our way in order to change our workforces for the better. Advanced scope of practice, change management processes, community-based care are all opportunities that can and should be advanced for all APEX members. With well-trained delegates in our workplaces, who understand how to engage and utilise these opportunities to our advantage, we can be extremely successful in improving the conditions of our members, rather than having these things thrust upon us in formats which are only beneficial to the employer and at the expense of the employees.

So what can you do? Take part in the training, reach out to your colleagues, set up meetings (both in person or virtual) with delegates in other locations, talk about the future – what it should look like and what the risks are on the horizon, encourage others to become delegates so you are not taking on tasks alone and also have a succession plan.

SUPERANNUATION

Extension of Superannuation contributions by HNZ to all Healthcare Workers

APEX recently attended facilitation on behalf of our Auckland perfusionist members. Whilst that dispute remains unresolved, one of the issues on the table, and indeed in claims for many of our members in bargaining currently, is for an improvement to superannuation.

We have been seeking:

1. An increase to 6% employer contributions.
2. Extension of superannuation to non-residents of NZ (as KiwiSaver is not available to them).
3. Continuation of contributions for those working past 65 years of age.

In our perfusionists facilitated settlement, the Employment Relations Authority (ERA) recommended that:

"Despite being persuaded by ADHB's position in this instance I must also suggest the arguments being proffered by Perfusionists in support of the claim are, if not compelling, strongly persuasive. They have proffered six arguments emphasising wide economic and social benefits which, I note, even ADHB concedes the merits of - its issue is, … affordability and precedent.

When I add this to APEX's intentions regarding the pursuit of similar claims for others and ADHB's comment this requires a "national policy" I recommend the parties (and here I mean TAS on behalf of all DHB's) commence discussion about the future of this initiative forthwith and that if APEX does not agree to the involvement of other health sector workforces represented by the PSA and NZNO, that the DHB's approach them as well.

In making the last recommendation I note the government's bargaining parameters are due to be reviewed late 2022. This would suggest the recommended discussions be commenced with some alacrity so as to possibly inform the parameters reconsideration."

APEX had no objection to expanding the issue to include all health unions. Whilst acknowledging doctors already have 6% superannuation the reasons to extend this provision to all Healthcare Workers, especially at times of pay restraint, are both many and well grounded.

Six Reasons to Extend Superannuation Contributions to 6%

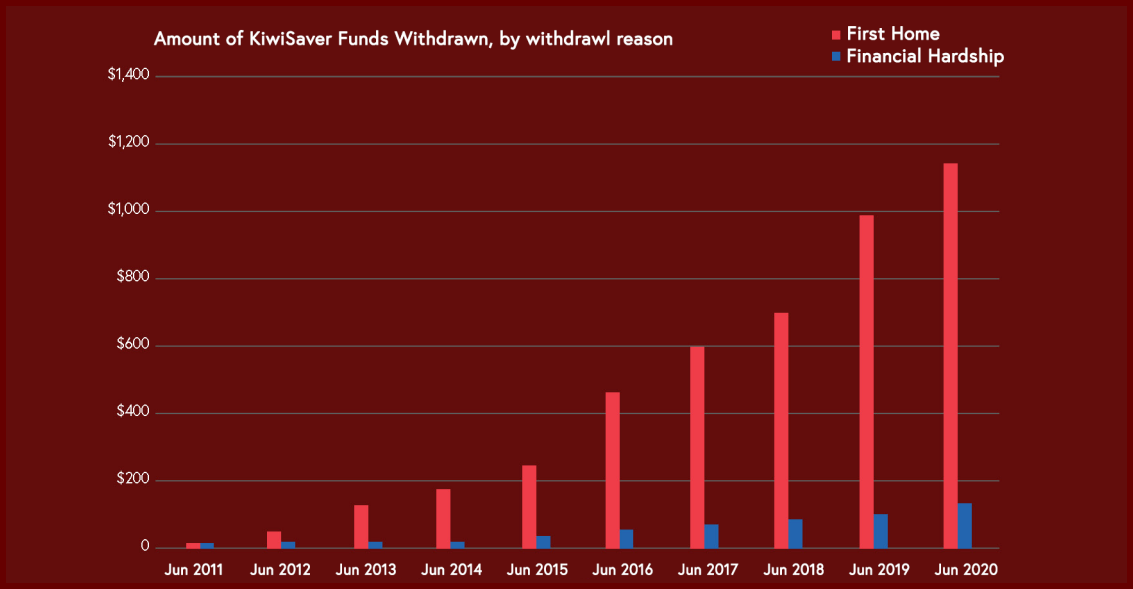
1. New Zealanders are Living Longer

The retirees of 2022 will be those born in 1955 when the life expectancy for males was 68, and for females 73. Life expectancy is now 80 for males, and 83.5 for females – we are living 13-15% longer, with men having 12 more years of retirement, and

women having 10 more years of retirement they need to plan and save for.

2. KiwiSaver is Increasingly Important for First Home Buyers

KiwiSaver is a one of the main safeguards for first home buyers being able to compete with the equity of owners of multiple properties. There is a need to keep KiwiSaver contributions increasing alongside house prices, especially as the annual increase in Auckland house prices to November 2021 was 27.9%.
Over a billion dollars was drawn out in the year to June 2020 to support first home buyers. Increasing KiwiSaver contributions increases the ability of employees to purchase their first home.



3. The Cost of Retirement is Growing

Most New Zealanders want a better standard of living in retirement than NZ Superannuation can achieve. For two person households they need to save a lump sum of $809,000 to have a retirement with 'choices' in a metropolitan area. A one-person household wanting a 'no frills' lifestyle in a metro area needs to save at least $293,000 before retirement. The No Frills guidelines reflect a basic standard of living that includes few, if any, luxuries. The Choices guidelines represent a more comfortable standard of living, which includes some luxuries or treats.

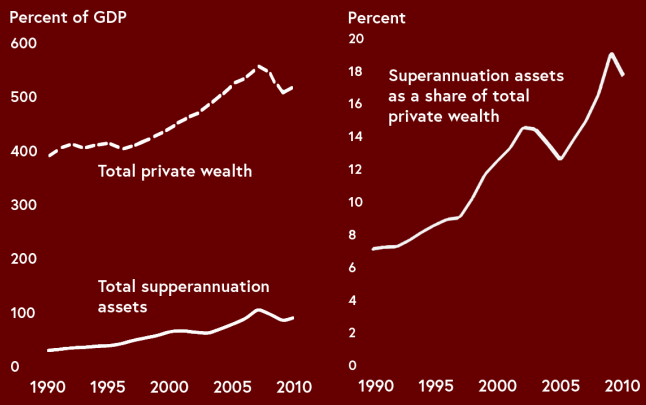
NEW ZEALAND RETIREMENT EXPENDITURE GUIDELINES AS AT 30TH JUNE 2021

	ONE-PERSON HOUSEHOLDS		TWO-PERSON HOUSEHOLDS	
WEEKLY NZ SUPER RATES After tax	$436.94		$672.22	
Total Weekly Expenditure	**Metro**	**Provincial**	**Metro**	**Provincial**
No Frills budget	$726.19	$604.92	$864.94	$746.81
Choices budget	$1,028.89	$1,116.23	$1,470.26	$1,176.14

4. Boosting Superannuation Reduces Wealth Inequality

52% of New Zealanders have a superannuation asset but superannuation assets make up only 5% of the value of all assets. By contrast in Australia, since the introduction of compulsory employment based superannuation the share of total wealth held as a superannuation asset went from 7.3% in 1990 to 17.4% in 2010. Superannuation is seen as one of the key reasons for Australia's relatively even wealth distribution.

Total Private Wealth and Total Superannuation Assets, Australia, 1990-2010



5. Investing in Superannuation/ KiwiSaver helps address Gender Equality

Investing in KiwiSaver/ Superannuation for the health workforce has potentially far-reaching benefits in addressing pay equity issues and the growing disparity of savings between men and women when they reach retirement age. As Radio NZ has reported, women's KiwiSaver balances for those aged 55-64 are already almost a quarter lower than men's and New Zealand's rate of gendered income inequality for over 65s is high. The health workforce is a key area where higher retirement savings will particularly benefit women as of the 81,940 DHB employees in September 2021, 77% of them are women.

Women suffer more from a lack of retirement savings than men due to their earnings over a lifetime being lower than men. This is due to overall lower pay, breaks from work when superannuation contributions are halted (such as for parental leave or time taken caring for children). Women also live longer so the amount available at retirement must go further for women than men.

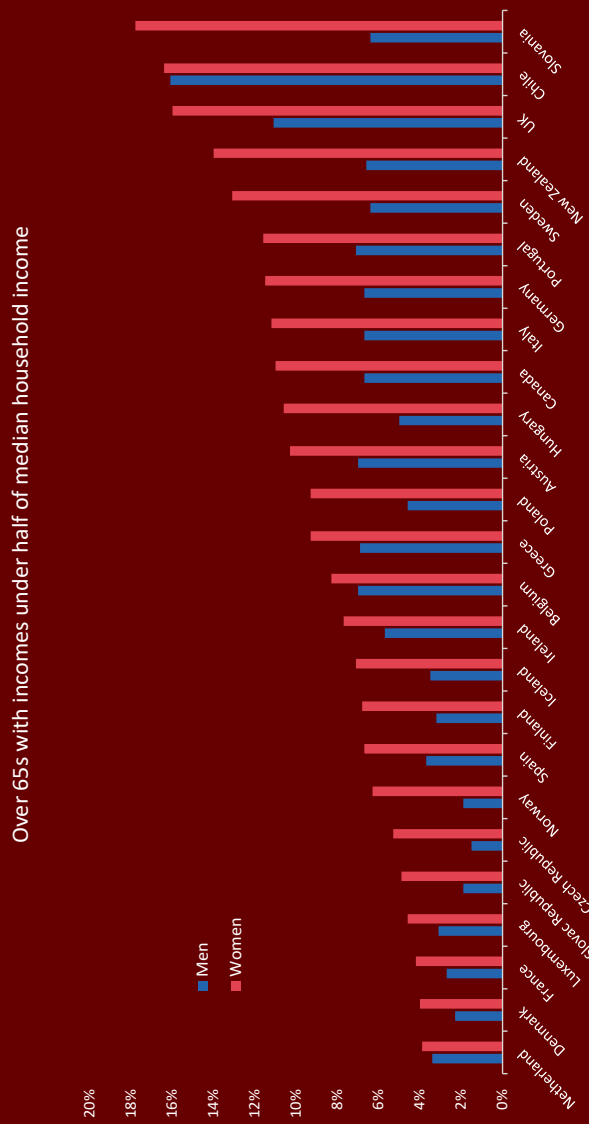
It is also documented that male dominated groups of workers have traditionally achieved higher superannuation contributions. In NZ, the police as an example have a 15% contribution. Doctors also have a higher superannuation contribution which was agreed at a time when this was also a male dominated profession.

6. KiwiSaver and Superannuation Builds Economic Resilience

Every dollar invested in KiwiSaver has been described as "probably more valuable than any other" because it is NZ's largest pool of domestic

savings, and Australia's $3 trillion in savings has "shielded it from recession for the past 26 years". The money is available to invest in infrastructure and because the money is locked up for a long term, fund managers can use it for venture capital and private equity, start-up funding. As CEO of Simplicity Sam Stubbs says, "KiwiSaver money is special. It will slowly transform New Zealand from a capital-poor to a capital-rich economy, just as it has in Australia, Europe and America. It will be invested for a long time, and it will be our money. It will fund many start up and SME companies, directly or indirectly, with low interest rates accelerating this. It won't happen quickly, but it will happen, transforming our economy long term, helping save it in the short term".

In response to the facilitators decision, APEX took this issue to the National Bipartite Action Group (NBAG) at our February meeting. The initiative was positively received by all and has now been progressed up the food chain (so to speak). We await further feedback and hopefully action on this front soon.



CHANGE MANAGEMENT

An often-used expression, change management can mean different things to different people and can also take a myriad of forms.

Probably the reason for so many definitions of change management is that it is a term used to describe:

1. The task of managing change;
2. An area of professional practice;
3. A body of knowledge (consisting of models, methods, techniques, and other tools); and
4. A control mechanism (consisting of requirements, standards, processes, and procedures).

Avoiding process-based definitions, a more helpful description may include:

- The coordination of a structured period of transition from situation A to situation B to achieve lasting change within an organisation.
- A structured approach to transitioning individuals, teams, and organizations from a current state to a desired future state.

Several pitfalls held within these definitions include the view that:

- The change is restricted to a period of change indicating that it is an episodic or punctuated period during which change occurs.
- There is a predetermined end state that is understood or accepted (at least by some).

We suggest that a better overview of change management is that which is derived from "a style of management aimed at encouraging organisations and individuals to deal effectively with the changes and potential changes

taking place in their work." This reflects an ongoing or evolutionary style of change occurring, through positive means as the focus. Those changes may be desired by the parties or not, required due to external factors such as technological advances, or sought by any party to improve the workplace as they perceive improvement to be.

Our current systems use a very punctuated and adversarial process often premised on an assumption that staff surplus (redundancy) may eventuate. It also usually sees a draft document being circulated by management with a 2-week consultation timeframe for feedback before they give what often feels like perfunctory consideration to any feedback, before a final decision document is released and then HR just get on with it.

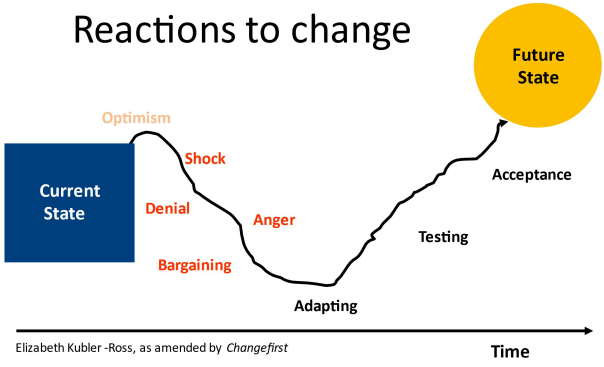
Given the potential for staff surplus, unions, where the change affects members, tend to go on the offensive, defending the employee's current position or continued employment. And not surprisingly research tells us that 70 – 75% of major organisational change efforts fail to meet the expectations of key stakeholders.

But change is a normal part of life, probable more so in a technologically evolving environment and where we are blessed with large numbers of well-informed experts in their fields. And it happens around us all the time as we introduce new machines or methods and as research gives us insight into better practice etc. This change does affect us, it does require us to change, so why is this change effectively BAU whereas change involving us but driven from our organisation's anything but?

To understand this further we need to look at the human psychology of change (as it affects us personally). Change fails at least in part because we focus on process and structure not on the people. Where the people are integral to successful business outcomes, the impact of being human is even more imperative. From this perspective change fails because we:

- Underestimate how challenging the change will be for people; and
- Have poor leadership; and
- Possess the inability to deal with resistance; and
- Misalign the change with behavioural norms; and
- Ask for too much change for people to absorb too quickly.

The psychology of change follows quite closely the human reaction to grief as first described by Kubler-Ross. In the case of change, it is the loss of control (perceived or otherwise) including that derived from disruption to how we think, feel or behave, that drives the emotional reaction:



And we also know that whilst some of us welcome change (the early adopters) others simply won't change. Most of us (~70%) however fall in between, either "want to but can't" (these people need education and training if they are to accept change) or "can, but won't". The latter group will follow the early adopters and if educated, the "want to but can't" group as they make the shift.

The first thing we fail to do is undertake unfettered issue identification at the start:

- What is the problem we are trying to solve? or
- What is the opportunity we believe we can secure?

This failure gives no room for the parties to start considering all the possible options, to see the need for change and therefore achieve buy in. We are more likely to react defensively and see predetermination in what is being proposed, generating in turn anger, resistance, and resentment. Hardly the stuff of constructive engagement or as all too often is suggested as meritorious, "taking people on the journey".

To make any change happen people need awareness of the need to change; identifying the issue we are trying to address is critical. People are often aware of a problem, sometimes of an opportunity, but if we can collectively capture "what it is we want to do something about" awareness comes to exists. Hopefully this can be followed by desire to do something about the current situation and with that knowledge about the issue and options plus the ability to put that knowledge to real purpose. Even then when change is afoot, reinforcement of the implementation and embedding of change will be required.

It also requires the commitment of the organisation to the process; cherry picking an outcome for instance will result in feelings of anger and betrayal by staff; trust will be hard to re-establish if it can be at all and staff will remember.

And all this will take time because it takes time for human beings to adapt to change, and must include support for us as human beings; for those challenged by or resistant to change, and provide good leadership throughout.

In our view, change needs to put the human elements first, and should be a process of constant evolution rather than the punctuated, time restrained and potentially threatening processes we all too often see. Genuine constructive engagement from the get-go, joint issue identification, transparent and honest options exploration and importantly the time to adapt will see more change occur and endure than the abysmal failure rate we see currently.

PSYCHOLOGISTS THINKING DIFFERENTLY ABOUT CONTRACTS

Psychologist members of APEX are currently discussing and considering options for progressing their professional issues through a co-ordinated to bargaining approach across multiple agencies including Health NZ, the Ministry of Education and Oranga Tamariki.

APEX has been progressing improved working conditions for psychologists by raising wages, improving professional development and supervision, and trying to get employers to focus on workforce development.

Psychologists are a relatively small workforce within the public sector and there is a critical need for the government to resource the internship pipeline and retain psychologists in the public sector to meet the mental health, child development and wellbeing needs of the community. Despite this, government workforce initiatives so far have been lacklustre and uninspiring.

With all this in mind, APEX has proposed uniting all psychologists within a single cross-public sector collective agreement to push forward with pay parity, the need for professional leadership structures including a chief psychologist, and an investment in the future of the workforce, from internship programmes to ensuring enough psychologists are available in our public health, education and welfare services.

APEX members will be meeting to discuss the proposal during the month of September before voting on the proposal in November.

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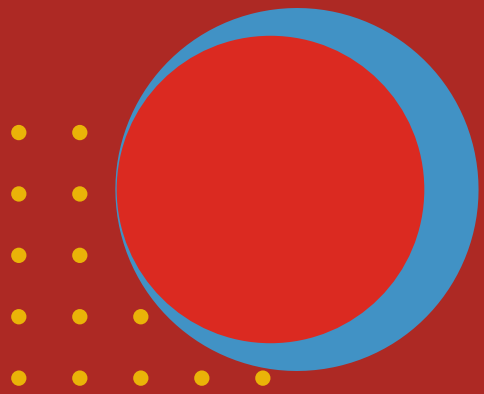

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