

Current Financial Pressures for NGOs

An Overview from the Health and Disability Sector NGO Working Group

1 Introduction

Over the last few months, as part of its Ministry of Health contractual obligations, the Working Group has been identifying issues affecting NGOs through a number of strategies. Many of the issues relate to increasing financial pressures on NGOs, which have implications for their financial viability, the quality of service delivery and the health and wellbeing of their communities.

This paper outlines a number of these issues identified and suggests some possible ways forward.

2 Pay Parity and Related Issues

2.1

NGOs have a history of commitment to achieving social justice and equity and, therefore, support the principle of pay equity.

2.2

Nurses' MECA:

NGOs recognise that the recently negotiated 20% increase will not apply to all DHB nurses and the size of the increase will be dependent on specific roles, etc. There are major implications for NGOs. Unlike PHOs, many NGOs do not receive Cost of Living increases or Future Funding Track provisions and therefore struggle to pay current annual increases of 1.5%-2% to nurses.

We understand that the NZNO intends to negotiate the next MECA on behalf of practice nurses and will then seek to negotiate one involving NGOs.

Unless funding levels for NGOs are urgently addressed, a MECA that seeks even a 5% increase would be impossible for NGOs to absorb.

2.3

Already the DHB NZ MECA is impacting on the recruitment and retention of nurses in NGOs, particularly in Auckland. The Family Planning Association currently has seven vacancies and its National Nursing Adviser has just resigned to work in a DHB in Sexual Health. Several prospective applicants, who made enquires about vacancies last year, have withdrawn their applications.

2.4

The issues for Royal NZ Plunket Society are similar; Plunket is seeing an increase in staff turnover, and expectations of significant salary increases as part of the upcoming negotiations.

2.5

The impact is also being felt in the mental health sector, with Challenge Trust reporting it is unable to fill posts for registered nurses, an employment category required by their contract. The MECA will exacerbate an already difficult situation in the NGO mental health sector which currently experiences a lower payment per clinical FTE than is paid to the public health providers.

2.6

If the MECA results from the intention to provide pay equity, NGOs are unable to understand why only some nurses are seen to be entitled to equity, while those outside of the DHB system are not.

From a professional point of view, this does little to recognise the valuable work of nurses in the NGO sector in comparison to their professional peers. Already, they are often disadvantaged by fewer opportunities for professional development and feel that they, and their employing organisations, are increasingly marginalised. This is particularly obvious when there is a clear parallel between their work and that of colleagues in DHBs, e.g. between an Advanced Level nurse in FPA working under delegated authority/standing orders and a nurse in Sexual Health both providing contraception and Sexually Transmitted Infection consultations.

2.7

A number of NGOs already provide very comprehensive training in a specific scope of practice, e.g. well child, family planning or mental health. This requires considerable investment by the NGO and the existing problem of staff retention, following the completion of six months of training, is now exacerbated by the MECA.

2.8

The provision of the MECA to DHB nurses reinforces the notion among some health professionals, and the public, that ‘hospital’ health care is the priority and worthy of greater investment. This reinforcement sits uncomfortably with a Primary Care Strategy which aims to promote the importance of good preventative primary care, rather than advance the more traditional ‘medicalised’ model. If NGOs are unable to afford to employ nurses, an unintended potential consequence is the lack of “recovery focused” mental health environments, in which new mental health nurses can work.

2.9

Doctors’ Pay Agreement

We are aware that the Association of Salaried Medical Specialists has made real progress in moving towards a similar agreement in relation to DHB Medical Officers. Although fewer NGOs employ doctors, those that do already have lower pay scales than colleagues with similar qualifications, despite often being involved in similar work.

The implications of this are of concern for similar reasons as the Nurses’ MECA.

2.10

Support Workers' Pay Scales

Many organisations within the health and disability NGO sector rely on a large workforce of relatively low paid support/health workers, some earning below the median income. Without increased funding, NGO employers, that do not receive the new primary care funding, cannot raise these pay levels. Consequently, they are contributing to the continuation of low income levels which add to the factors causing child poverty and inequalities in health.

2.11

The Impact of Pay Issues in Summary – Resource Shifting and Quality

In order to maintain their ability to recruit and retain nursing staff with the advent of the DHBNZ MECA, NGOs are likely to increasingly re-allocate more of their scarce resources to nurses' salaries, and subsequently doctors'.

This in turn will further disadvantage the health/support workers and impact on the organisations' overall quality of service delivery, and, therefore, on the community's health.

2.12

Morale and Possible Disruption of Services

While it is true that nurses, like other staff, work for NGOs because they believe in the cause (the so called 'love factor'), this can only stretch so far. From July this year a nurse in an NGO, such as Plunket, earning \$45,000 will see his/her peer earning \$51,000 for very similar work.

NGOs should not continue to be expected to pay their staff less than their professional counterparts simply because they work in the voluntary/community sector which has traditionally been largely staffed by women. Therefore, for two reasons they have been traditionally funded at a lower level.

If NGOs are not funded to provide at least some degree of parity, morale will continue to deteriorate, and the NZNO will, understandably, encourage industrial action to achieve parity. The same will happen with the PSA and the FSWU in relation to support/health workers. This will inevitably result in disruption of services and impact negatively on individual and community health and wellbeing.

2.13

The Principle

The MECA has been signed in recognition of the need for pay equity. The principle of pay equity must apply to all nurses in the health sector, wherever they carry out their profession, not just those working for DHBs.

It appears that private hospitals may well be able to match the DHB MECA through raising fees, but this is not an option for NGOs. Even those which charge fees for non-subsidised clients generally charge considerably less than local GPs, including many which are PHO members. For example, in order to ensure accessibility, FPA will charge \$38-45 for a contraceptive consultation, compared with \$61 at some PHO

GPs. It is clear that at least one DHB receiving funding to implement the MECA is not using this to increase funding for an NGO that delivers DHB services.

2.14

Suggestions

It is unclear whether the implications of the MECA for the Primary Health sector, and NGOs in particular, were overlooked but it is essential that work begins to develop a MECA for nurses in primary care, and that NGOs be funded accordingly.

This will be tangible proof of the respect for the Primary Care sector which is the foundation of the Health Sector reforms, and ensure the minimum impact on quality of service delivery.

In order to do this, some thorough analysis is needed to quantify the problem, involving:

- job sizing
- relativity to other professions (e.g. teachers and police)
- the number of FTEs and actual staff employed, and
- the impact on staff turnover.

3 Health Practitioners Competency Assurance Act

As a result of this legislation, all organisations that employ nurses, occupational therapists, physiotherapists and psychologists will face additional compliance costs. Most of the professional associations have not yet thought about the implications for the NGO sector. In mental health and intellectual disability we do not know how many of the workforce this will impact on. We do know that some organisations have a contractual requirement to employ registered health professionals. Ironically, the results may be diminished quality, as resources are diverted away from services to clients into the compliance costs which result from additional administration processes.

4 Other Compliance Costs

The implications of the Holidays Act are the same for NGOs as for DHBs but there is no indication that funding is to be provided to compensate for this.

Likewise the Charities Commission Act and, eventually, the Review of the Financial Reporting Act have further financial implications.

5 Transaction Costs and collaboration with PHOs

Under the Primary Care Strategy, NGOs are rightly expected to collaborate with PHOs. There are, however, considerable unrecognised transaction costs in building relationships with DHBs and PHOs which hamper such developments.

While NGOs recognise the role of PHOs and are keen to collaborate, it is not a 'level playing field' when one prospective partner receives annual cost of living increases of 4%, as well as management and administration funding.

6 Reduction of inequalities

Many NGOs focus on delivery in rural areas and the reduction of inequalities, but this often involves more costly outreach activities. They generally receive no funding to recognise rurality or the reduction of inequalities.

7 New Zealand Health Information Strategy

We are pleased to have a Working Group representative on the NZHIS Steering Group. We understand that a number of NGOs are to be involved in consultation. This will hopefully reduce the chance of the NGO sector being overlooked, which seems to have been the case with the MECA.

To avoid further unexpected and unsustainable compliance costs, we are anxious that consideration be given to how compliance costs will be met with the implementation of the NZHIS Strategy.

While NGOs are generally very supportive of the work of the smaller PHOs, and welcome the recent announcement of an additional \$3million to assist them to develop their management infrastructure, NGOs feel that there is a need for similar funding for NGOs. Professional development, administration, data collection, IT, etc, are currently generally funded out of their contract price per FTE, or funding formula per visit.

8 Regional difference

There is considerable concern at the inequity in the level of DHB funding for similar programmes across the country, resulting in increasing inconsistencies in service delivery. Whereas a contract from the HFA to a Maori NGO once had consistent funding across regions, it is now a contract with six DHBs, all of whom now fund variable service specifications and prices.

There continues to be significant differences in funding for mental health services between the North Island and the South Island although service delivery expectations are the same. This is being compounded by differing funding levels within DHBs as well.

In mental health, the price paid per FTE trained support worker varies by \$25k per year between the North and South Island, yet a national qualification exists.

There is a concern that funding disparities could impact further on the quality of service delivery to clients and communities, even though as there are national expectations of quality described in legislation, such as the Health and Disability Sector Safety Standards.

9 Costs of professional development

Increasingly, opportunities for professional development, health sector updates or training, at which Ministry of Health officials are key speakers, are offered through conference organisers, at a prohibitive registration fee of some \$1,700 for two days. This is well beyond the level affordable to NGOs.

There is, therefore, a risk that NGOs can lack the information that is necessary for them to participate fully in the health sector, keep abreast of changes in legislation, policy and good practice.

We would like consideration to be given to facilitating greater NGO participation in such processes.

10 Conclusion

The Working Group believes that there are a number of financial pressures currently impacting on NGOs in the health and disability sector, with the likelihood of even greater impact in the near future, which compromises the financial viability and long term sustainability of many agencies.

We are concerned at the consequent impact on the morale of staff, as well as on recruitment and retention, and believe there is considerable potential for industrial disruption this year, as evidenced last year with NGO nurses in a Christchurch NGO. This in turn has the potential to impact on the implementation of the Primary Care Strategy and on clients and communities.

It is important to note that as NGOs have traditionally been committed to the reduction of inequalities, their clients are often those who most need to receive the benefits of additional primary care funding. These clients would be most affected by the closure of NGOs.

There is some suggestion that the lack of consideration of the financial implications of policy changes on NGOs has not been an oversight, but a deliberate strategy to reduce the number of NGOs working in the sector.

We believe that this is not Government policy, nor the Ministry's intention. We do, therefore, recommend that we are at a point where this needs to be openly discussed and a plan developed in order to address this misconception.

We believe that NGOs are committed to ensuring any funding increases they receive are used on client services staff salaries, thereby ensuring improved health outcomes.

NGOs would be very willing to participate in a working group with Ministry and DHB representatives to consider the range of issues presented in this paper, especially those most urgent priorities, which affect clients and staff so significantly.