

District health board engagement with the living wage movement: evidence from official information requests

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ABSTRACT

From a public health perspective, there is strong evidence that income is a major modifiable determinant of health. District health boards (DHBs), who were responsible for providing and/or funding regional health services across Aotearoa, are major employers. International literature suggests implementing a living wage strategy can improve health outcomes, contribute until July 2022 to the reduction of ethnic health inequities, and is ethical and socially responsible business practice.

In February 2021, official information requests were sent to all DHBs to determine engagement with the living wage movement. This was augmented through a content analysis of publicly available collective employment contracts to benchmark practice.

The review found no DHBs were registered living wage employers, nor is it a requirement of those whom they sub-contract. Two out of twenty DHBs are planning to become living wage employers, and several confirmed they were working collectively to improve working conditions of lower paid workers.

This paper makes a scholarly argument for DHBs to commit to becoming living wage employers. As significant regional employers this is an opportunity for DHBs to positively contribute to the alleviation of entrenched poverty a modifiable determinant of ethnic health inequities.

Living Wage Aotearoa (LWA) is part of the global living wage movement, ensuring workers can afford the necessities of life and can actively participate in communities.¹ LWA was launched in 2012 by 200 unions and community groups working across a bipartisan coalition.² They advocated for a living wage that covers food, shelter, utilities, transport, health-care, childcare, and a small buffer for unforeseen events. The calculation assumes two adults working for 60 hours per week in total, with two children. The living wage is calculated each year by the New Zealand Family Centre Social Policy Unit, and the living wage hourly rate for 2021/22 is \$23.65.² The median hourly rate in 2020 for all full-time employees was \$27.00, but Māori and Pacific median rates were significantly lower at \$24.98 and \$24.00, respectively.³

LWA initially prioritised campaigning for the living wage within the local government sector. They argued that public money should not be used to entrench hardship and inequity in society.⁴ Campaigns have been run in Britain where procurement, tendering practices for catering and cleaning jobs, and collective bargaining within

public institutions have resulted in the successful introduction of a living wage to low paid public sector workers.⁵

Employers can obtain formal accreditation with LWA if they meet criteria focused on the terms and conditions of directly and indirectly employed workers. Within Aotearoa, more than a hundred private and public employers have committed to the programme (LWA, 2020). District health boards (DHBs) are of strategic importance in terms of the living wage movement, as they were major regional employers and they, often through their sheer size and the unionisation of their workforce, set the standard in regional employment conditions. Uptake by major health employers could encourage other employers to match this minimum benchmark.

The international literature provides a range of evidence to support employers becoming living wage employers. Much of the living wage work is voluntarily led by union activists, and so remains largely unevaluated with gaps in the evidence base. Research shows that health gain is likely from lifting household income, and that paying a living wage could contribute to reduced

ethnic inequities. Likewise, engagement with the living wage movement is a practical organisational demonstration of a commitment to ethical and socially responsible business practices. These are explored below.

Income is a key modifiable determinant of health⁶ which is a universal right.⁷ A World Health Organization survey found people in the poorest socio-economic status quintile were twice as likely to experience poor health than those in the wealthiest.⁸ Eliminating poverty, by implementing a living wage policy alongside other system-wide initiatives, remains an important public health strategy to address health inequities.⁹

Some studies have captured specific health gains from the introduction of living wage initiatives. For example, Landefeld, Burmaster et al¹⁰ found improvements in social status and self-rated health with particular improvements for women.

Decades of inaction on health equity in Aotearoa have meant limited improvement in Māori health outcomes despite targeted yet ultimately ineffective legislative and policy imperatives.¹¹ Systemic policy and practice failure¹² have heightened persistent ethnic socio-economic disparities.¹³ Since Māori are over-represented in the lowest wage brackets, a living wage initiative could contribute to lifting Māori households out of poverty within the context of wider concerted action around addressing other critical determinants of health and the enduring legacies of colonisation.

Littman¹⁴ has demonstrated that living wage-based procurement policies can impact positively for some of the lowest paid workers. Uptake across the public sector, could therefore make a significant long-term contribution to addressing health inequities. As DHBs are major regional employers, this is likely to provide concrete local benefits within their respective districts. This would also, in the long term, reduce demand on public health services as disease and consequences of poverty are reduced.

In recent years, businesses have become increasingly interested in ethical business practices and corporate social responsibility.¹⁵ Becoming a living wage employer is one tangible way to demonstrate this social commitment. Proven benefits from such moves include reduced staff turnover and absenteeism, alongside productivity improvements, strengthened recruitment and organisational reputation.^{4,16} Haar¹⁵ found that organisational trust improved even if individual

worker's salaries were not raised, and also that employees' attitudes and behaviours improved.

Accredited living wage employers are required to allow unionisation and collective processes, which further develop social integration and citizenship. These actions and consequences can deliver improved economic outcomes for the organisation offsetting the upfront wage cost.¹⁷ However, it is also noted that human resource practices, including wage-setting, are often applied differentially. This results in some groups receiving socially responsible human resource management, while others experience socially irresponsible approaches, resulting in entrenched inequalities and the creation of deliberate in-work poverty.¹⁸

The health sector is currently being restructured and reimagined.¹⁹ DHBs were dis-established and then recreated with the bulk of their funding and health delivery functions fulfilled by new entities. The Waitangi Tribunal¹² WAI 2575 health sector report directed the Crown and the health sector to urgently address systemic ethnic health inequities. The adoption of the living wage as a minimum requirement in any new entities could be an effective contribution to alleviating these inequities.

This paper makes the case for major health employers to become living wage employers. It then presents primary data examining to what extent DHBs engaged with the living wage campaign.

Method

Data for this article were collected through a narrative review of academic and grey literature, official information requests to DHBs and a content analysis of publicly available collective employment agreements. No organisational ethics approval was required for this study.

The Māori and Pākehā authors have all been union members and/or union delegates, with three having a professional background in public health and one in management studies.

At the time of writing there were twenty DHBs providing health services to their respective populations. We sent official information requests to DHB chief executives in February 2021, asking:

Ultimately, we got a 100% response rate from the DHBs but had to lodge a complaint with the ombudsman for initial non-compliance with one request. The content analysis of DHB collective employment contracts was to review the contracts' alignment with living wage salary benchmarks.

1. Is your DHB currently a registered living wage employer?
If yes, what factors influenced that decision?
2. Are your contractors/sub-contractors currently living wage employers?
Do you require them to be?
3. Does your DHB currently have plans to become a living wage employer?
If so, can you describe how far you have progressed?
4. What do you see as the obstacles to becoming a living wage employer?

Findings

We undertook content analysis of the collective agreements between the DHBs and the Public Service Association (PSA) and E Tū, as major health sector unions covering lower-paid workers. The current multi-employer collective agreements covering clerical and administrative jobs (covered by the PSA) all had pay scales which were above the living wage. However, the collective agreements struck between E Tū and the DHBs continue to have pay scales below the living wage. The nature of the jobs at such levels includes orderlies, attendants, cleaners, laundry, kitchen hands, carpenters, painters, gardeners, stores and drivers, trade assistants and driving services. It is unclear how many workers are paid on the scales below the living wage.

Of the 20 DHBs, none were accredited living wage employers, and none required their contractors and sub-contractors to pay the living wage. Several noted they required procurement contracts to comply with current legislation which references the Minimum Wage Act 1983. One noted that staff of large on-site contracts are paid the living wage or better.

Seventeen of the DHBs had no plans to become living wage employers. One DHB reported that only 1.93% of their workforce were earning below the living wage in their base salaries, prior to allowances and penal rates which were routinely paid. Others noted that one group of employees had been moved to the living wage, and they were awaiting the outcome of a national pay equity claim, focused on historically underpaid workers from female-dominated professions, before taking further action. One shared they were supporting their workers to attain qualifications that would enable progression to higher levels of remuneration.

In response to questions about obstacles to become a living wage employer, most DHBs noted they were working with multi-employer and single employer collective employment agreements which were subject to robust collective bargaining processes. Many DHBs repeated the statement that *“any discussions about the living wage would progress in line with government expectations and through national discussion with health sector unions”*.

Some noted that once 2021 negotiations were completed, they expected minimum rates in most collectives to be close to or above the living wage. This was part of a commitment by all DHBs to improve the low wage conditions of their employees, which for most didn't require naming it as a living wage.

There were three DHBs that were moving toward becoming living wage employers. One had made the commitment as part of a strategy to reduce the gap between the lowest and highest incomes. By the end of 2021 they expect to have fewer than 2% of staff being paid under the living wage. The other had formally endorsed movement to the living wage for all current staff through collective agreements as part of a wider equity framework and state sector pay expectations.

Another DHB stated they were undertaking further analysis before deciding whether to proceed with the living wage.

Discussion

Neoliberalism, as embraced by political leaders in Aotearoa in 1980s and 1990s, is based on the notion that the market is the most efficient mechanism for determining the worth of something or someone.^{20,21} This entails belief that society is a meritocracy, where character and tenacity combined with hard work brings success. It includes the assumption that society is a level playing field with everyone having fair chances to thrive.²² Giroux²³ argues this phenomenon is a kind of collective denial of history and structural discrimination.

The passing of the Employment Contracts Act 1991 saw the transformation of employment relations. This legislation undermined collective bargaining, resulting in fewer multi-employer collective agreements, lowered union membership and reduced penal rates²⁴ meaning real reductions in earnings.

Seeing the rapid increase in inequities across New Zealand society, current political leaders have distanced themselves from these policies,²⁵

but the legacy of decades of unrelenting hardship and massive wealth inequities remains. DHBs were imagined at the height of neoliberalism as a mechanism to contain health spending and with an imperative to run as effective businesses.²⁶ Presumably these imperatives made it difficult to prioritise ethnic pay parity. Research shows that the ethnic pay disparities remain entrenched²⁷ with fewer than 2.7% of Māori staff earning salaries over \$100,000.

A living wage raises workers out of in-work poverty, enhances individual dignity and may avoid reliance on charity. Increased household income lifts all its members to a better standard of living, reducing poverty-related health issues, improving educational achievement, reducing deprivation, and enabling inclusion and citizenship.²⁸

The living wage requires employers to pay an evidence-based fair wage rather than the lowest legal possibility, and the current minimum wage does not support human flourishing. The purpose of the minimum wage was not to reduce poverty on its own²⁸ relying instead on other government transfers (i.e., accommodation, health, and education) to support low-income families. Given the antipathy of sections of society fuelled by the media towards government top-ups and low-wage workers the minimum wage contravenes notions of decent work and a just society.²⁹

Most of the DHBs in their responses are reluctant to take any initiative on their own sites and are followers of “government expectations”. This passive position by most DHBs appears to contradict their own Employment Relations Strategy 2019–2024 document which states the DHBs are committed to “lifting the pay of the low-paid workforce” and importantly, “reducing poverty and inequalities by leveraging our employment footprint”.³⁰ The DHBs’ reference to collective agreements suggests they are unable to change the wage structures. The two main unions on sites at DHBs for non-medical employees, E Tū and the Public Service Association, both have a position on always

presenting a living wage claim in bargaining.

Employers retain control over what step new employees begin on and could appoint above or at the living wage and in effect make lower rates functionally obsolete. While data on the actual number of employees on wages lower than the living wage were not collected, even small percentages represent individuals and families impacted by low incomes and too often in-work poverty. In a large workforce this can be a lot of employees.

Conclusion

The literature is very clear that the benefits of paying adequate wages to lift workers and their families out of poverty results in improvements for organisations through stronger commitment, self-esteem, productivity, and a reduction in absenteeism. As publicly funded health institutions DHBs are obliged to concern themselves with health outcomes within their region. Article three of Te Tiriti o Waitangi further emphasises the importance of equity.

Uptake of living wage accreditation within the health sector remains low behind other sectors within Aotearoa. If all major health employers paid living wages and became accredited living wage employers, they could be positive role models for other health sector employers and clearly demonstrate their commitment to best business practice. This accreditation would also provide security for employees, since their wages would be protected, and ongoing union involvement guaranteed.

The pending restructuring of the health sector signals an opportunity for the lowest wages in the sector to be reviewed. The variation across health providers may be moderated to contribute to the goal of reducing poverty and inequality to be realised. This is an opportunity for significant change in the thinking and practices of our health institutions, both in health delivery and in addressing the underlying issue that poor pay is inextricably linked with negative health outcomes.

COMPETING INTERESTS

Nil.

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REFERENCES

1. Living Wage Aotearoa. Living wage 2020 [Available from: <https://www.livingwage.org.nz/>]
2. Living Wage.(n.d) About. <https://www.livingwage.org.nz/about>
3. Statistics New Zealand. Earnings from wage and salary jobs by sex, age groups, ethnic groups, and full-time and part-time status 2021 [Available from: <https://www.stats.govt.nz/information-releases/labour-market-statistics-income-june-2020-quarter>]
4. Luce S. Living wages: A US perspective. *Employee Relations*. 2017;39(6):863-74.
5. Hirsch D. The 'living wage' and low income: Can adequate pay contribute to adequate family living standards? *Critical Social Policy*. 2018;38(2):367-86.
6. Lynch J, Smith G, Harper S, Hillemeir M, Ross N, Kaplan G, et al. Is Income inequality a determinant of population health? Part 1. A systematic review. *The Milbank Quarterly*. 2004;82(1):5-99.
7. United Nations. Universal Declaration of Human Rights. Geneva, Switzerland: Author; 1948 10 December.
8. Hosseinpoor AR, Stewart Williams, J.A., Itani, L., Chatterji, S. Socioeconomic inequality in domains of health: Results from the world health surveys. *BMC Public Health*. 2012;12(198).
9. Wilkinson R. Income distribution and life expectancy. *British Medical Journal*. 1996;304(6820):165-8.
10. Landefeld JC, Burmaster KB, Rehkopf DH, Syme SL, Lahiff M, Adler-Milstein S, et al. The association between a living wage and subjective social status and self-rated health: A quasi-experimental study in the Dominican Republic. *Social Science & Medicine*. 2014;121:91-7.
11. Came H, McCreanor T, Manson L, Nuku K. Upholding Te Tiriti: Ending institutional racism and Crown inaction on health equity. *New Zealand Medical Journal*. 2019;132(1492):62-6.
12. Waitangi Tribunal. Hauora report on stage one of the health services and outcomes inquiry: WAI 2575 Wellington, New Zealand: Author; 2019.
13. Ministry of Business Innovation and Employment. Māori in the labour market: June 2020 quarter (unadjusted) Wellington, New Zealand: Ministry of Business Innovation and Employment; 2020.
14. Littman D. The living wage: An idea whose time has come. *New Zealand Journal of Employment Relations*. 2014;151(3):70-7.
15. Haar J. Living wage employer status and job attitudes and behaviours. *New Zealand Journal of Employment Relations*. 2019;44(3):45-57.
16. Coulson A, Bonner J. Living wage employers: Evidence of UK business cases. London, England: Living Wage Foundation; 2015.
17. Maloney T, Gilbertson A. A literature review on the effects of living wage policies. Auckland: Auckland Council; 2013.
18. Richards J, Sang K. Socially irresponsible human resource management? Conceptualising HRM practice and philosophy in relation to in-work poverty in the UK. *International Journal of Human Resource Management*. 2021;32(10):2185-212.
19. Health and Disability System Review. Health and disability system review – Final report – Pūrongo Whakamutunga. Wellington, New Zealand: Author; 2020.
20. Kelsey, J. (1996). Life in the economic test-tube: New Zealand "experiment" a colossal failure. *Radical Journal of Organization Theory*, 2(1), 1-5.
21. Labonté, R., & Stuckler, D. (2016). The rise of neoliberalism: how bad economics imperils health and what to do about it. *J Epidemiol Community Health*, 70(3), 312-318. doi:10.1136/jech-2015-206295
22. McCreanor T. Challenging and countering anti-Maori discourse: Practices for decolonisation. New Zealand Psychological Society Conference; August;

- Palmerston North, New Zealand 2009.
23. Giroux H. Spectacles of race and pedagogies of denial: Anti-black racist pedagogy under the reign of neoliberalism. *Communication Education*. 2003;52(3/4):191-211.
 24. Rasmussen EJ. *Employment relations in New Zealand*. Auckland, New Zealand: Pearson; 2009.
 25. Cooke H. Jacinda Arden says neoliberalism has failed. *Radio New Zealand*. Wellington, New Zealand, 12 Sept 2017.
 26. Skegg, D. *The health of the people*. Wellington, New Zealand: Bridget Williams Books. 2019.
 27. Came, H, Badu, E., Ioane, J, Manson, L, & McCreanor, T. (2020). Ethnic pay (dis)parities in the public sector leadership from 2001-2016 in Aotearoa New Zealand. *International Journal of Critical Indigenous Studies*, 13(1), 70-85.
 28. Newman A. Precarious work and a living wage in our communities. *New Zealand Journal of Employment Relations*. 2014;38(2):64-9.
 29. New Zealand Treasury. Living wage information release: New Zealand Government; 2013.
 30. Edmonds, S. (2022). 'Kick in the guts for businesses': Minimum wage to rise to \$21.20 <https://www.stuff.co.nz/business/300515349/kick-in-the-guts-for-businesses-minimum-wage-to-rise-to-2120>
 31. Central Region Technical Advisory Services Limited. 20 DHB employment relations strategy 2019-2024 Wellington, New Zealand 2019.