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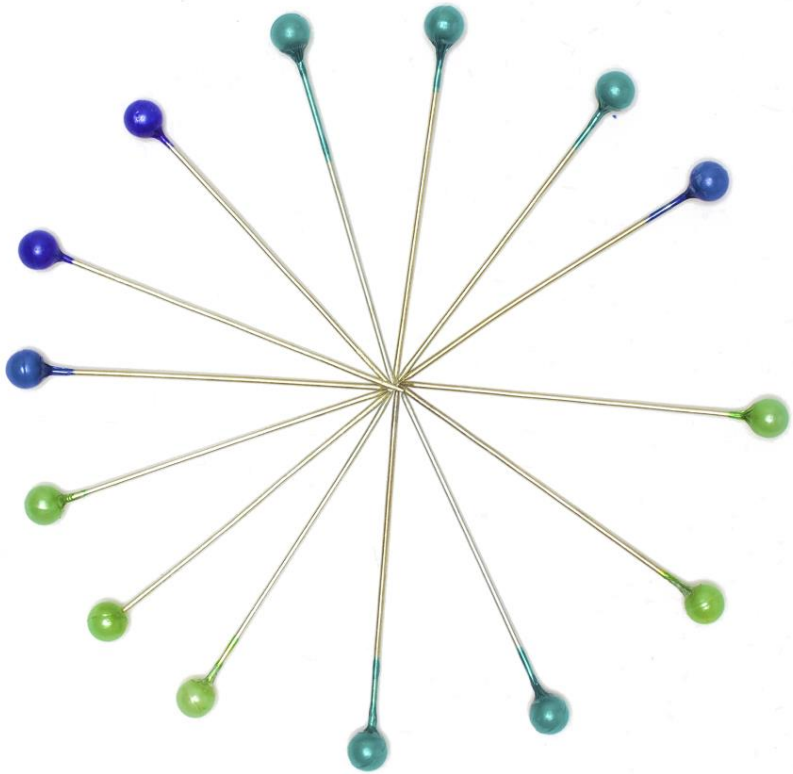

New Zealand Disability Support Network

Funding and Financial Analysis: New Zealand Disability Support Providers

23 November 2018

Contents

Important Notice

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23 November 2018

Dear Garth

Funding and financial analysis: New Zealand Disability Support providers

We are pleased to enclose our report for the New Zealand Disability Support Network (**NZDSN**) on the funding and financial analysis of New Zealand's disability support providers. Our report comprises two parts. Part A covers a broader overview of revenue and cost pressures impacting your members. Part B covers a more in-depth anlaysis of the proposed Residential Pricing Model (**RPM**) and an overview of workforce issues derived from provider interviews, supplemented with a literature review.

Our report includes conclusions from our anlaysis and makes suggestions as to further actions.

We draw your attention to appendices titled "Scope and Basis of Work", in which we refer to the scope of our work and sources of information.

Yours sincerely

Linda Meade
Partner
For Deloitte Limited (as trustee for the Deloitte Trading Trust)

Executive Summary

Executive Summary | Key findings

Background and introduction

- The disability sector has undergone a number of funding and regulatory changes since the de-institutionalisation process began in New Zealand in the 1970s. These include the introduction of new policies such as in-between travel time agreements; and health and safety, vulnerable children, pay equity legislation, Holidays Act changes and KiwiSaver increases.
- The sector is about to experience another significant change with System Transformation (**ST**) being prototyped in the Mid-Central District Health Board region from 1 October 2018, giving disabled people and their families greater choice over the support they receive so they can plan for the lives they want. ST will mean changes in how disability support is funded, with greater budget-holding responsibilities devolved to individuals. The Ministry of Health (**MoH**) is developing a funding tool for residential providers, and an NZDSN working group has contributed to and reviewed it. However, NZDSN has some reservations around the assumptions and transparency of the model.
- In this context, the New Zealand Disability Support Network (**NZDSN**) asked Deloitte to undertake a piece of work broken into three parts. The first is a high-level view of historical funding streams, analysis on the impact of changes to minimum wage and pay equity and a breakdown of provider margins, while the second looks at the Residential Pricing Model. The third part provides commentary on the legacy effects of de-institutionalisation on providers, as well as potential impacts and opportunities from the pay equity settlement and ST.
- To support our analysis we surveyed a mix of 14 providers chosen by NZDSN; all 14 providers were interviewed for qualitative perspectives. 13 agreed to provide financial data and eight completed the data template to a meaningful degree. In order to develop a picture of cost pressures and margins for 13 providers we analysed publicly available financial statements.

Part A: Funding and cost pressures

- With the exception of CPI which was below some contract price movements in 2014 and 2015, contract price increases have been below movements in CPI, minimum wage, housing inflation, electricity inflation and petrol inflation. We compared contract price increases for community residential, day programmes, supported living and community participation against market data such as CPI, minimum wage, housing inflation, electricity inflation and petrol inflation over the period of 2014 to 2018.
- From the contract price movement information provided to us by NZDSN over the period 2013 – 2018 it appears the funding received by providers has not kept up with cost pressures.
- If the gap between the cost of providing services and contracted funding grows sustaining quality, safety and innovation will be an increasing challenge.
- Funding from MoH and the Ministry of Social Development (**MSD**) has increased over the past 10 years, driven by a greater number of people becoming eligible for funding but it has not kept up to date with a number of cost of living indicators.
- MSD funded community participation services have received nil cost of living increases for the period surveyed which may impact quality and availability.
- Providers are investing in client relationship management (**CRM**) systems, rostering tools and staff training from their reserves to gear up for the anticipated changes of ST.
- Many providers expressed concerns about the changes ST would bring to their business models, as individuals seek to purchase their own services. Providers are concerned that, as demand for some services decline, the cost to deliver them will increase, leading to individuals not being able to purchase the services they can today under the current funding model.

Executive Summary | Key findings

Part A: Funding and cost pressures (continued)

- A number of providers noted their net surplus had declined in FY18 as a result of the relativities associated with pay equity. Many believe it will continue to be an issue going forward as ST is rolled out across the country, and if an averaging approach continues to be used across pay equity levels. This impact will increase with each additional year covered by the pay equity legislation, if an averaging approach continues to be used across pay equity levels.
- Using data extracted from providers' annual reports we analysed the net surplus (deficit) margin between 2013 and 2017. 2018 was excluded as not all providers had 2018 financial statements available.
- Overall, the analysis shows the gap between the minimum and maximum margin has been narrowing between 2013 and 2017 from 18.5% to a gap today of 12.0%.
- We also analysed the net surplus (deficit) margin for property owning and non-property owning providers, as we understand some organisations formed out of the de-institutionalisation process inherited large amounts of property. This has allowed those providers who inherited property to accumulate additional wealth over time, and supplement their Government funding.
- The 2017 pay equity settlement resulted in 55,000 care and support workers moving to a four-level system based on an individual's qualification or length of service.
- Although the pay equity settlement provided better recognition for support workers, it also increased pay relativity issues for those outside the scope of the settlement, such as team leaders or managers who supervise support workers. Providers have funded additional pay increases for these workers in order to maintain pay relativities, putting financial strain on their organisations.
- Under the Government's proposal to increase the minimum wage to $20 by April 2021, any pay differential between the minimum wage and workers on pay equity settlement level 1 will have bottomed out, which may make attracting workers to the sector difficult.

Part B: Residential pricing model (continued)

- We reviewed the RPM to test the model logic and assumptions and noted several errors, which have been referred to NZDSN to discuss with the model developer.
- In order to test the reasonableness of some key assumptions we compared the food, household supplies, telecommunication costs, medical supplies and energy cost assumptions currently in the RPM against the FY18 cost providers are currently incurring.
- In all instances, the average cost per day providers are currently incurring is higher than the assumption included in the model. We understand this is because the main data source is the 2013 Household Economic Survey (HES), which is a general population survey as opposed to using a data source that specifically relates to those in the disability sector.

Part C: Qualitative perspective and literature review

- We interviewed providers on workforce issues pertaining to compensation; education and training; recruitment; and working conditions, and conducted a literature review to supplement findings from providers. Feedback and key themes from providers are summarised below, and compared to literature in other jurisdictions undergoing ST to patient-centred and directed care, as well as New Zealand literature.

Compensation

Providers' views

- The pay equity settlement has not only caused pay relativity issues between in-scope pay equity staff and those out of scope; it has also resulted in perverse outcomes such as difficulty finding the right level of staff for certain roles and reluctance to hire or train staff at the more highly paid levels. Maintaining relativities between their management staff, and similar roles in the wider health sector, was difficult and inhibited the ability to source the right senior people.

Executive Summary | Key findings

Compensation (continued)

Literature review

- The quality of remuneration is a consistent theme in the literature, with issues including low wages, and lack of parity with counterparts in institutional settings. While the pay equity settlement may have alleviated some of these issues, the literature showed other forms of compensation could be examined, including parental leave over and above legal obligations, and use of a company car. Casualisation is also linked to compensation, as the absence of guaranteed hours can force workers to seek a second job to achieve an adequate income.

Education and training

Providers' views

- Many providers thought the qualifications and training on offer from Careerforce were not suitable for ST, and were self-funding bespoke courses for their staff. They also felt there was an absence of training specific to managing and de-escalating complex behaviour. Providers were investing in technology for their business operations, and also for staff training, with online learning and e-learning modules common.
- One provider, which specialised in kaupapa Maori services to a largely Maori and Pasifika client base, felt there was a cultural barrier to implementing ST: "We have a high number of Maori and Pasifika staff. The more Western way of looking at the world is that people and systems are egalitarian. But we are hierarchical and whanau-based, not egalitarian and individual. A Maori staff member might be more inclined to take the advice of a kaumatua than their boss. The Ministry needs to acknowledge these cultural differences as part of the implementation of Enabling Good Lives."
- The provider felt, more generally, that kaupapa Maori would be lost in ST. With many clients and staff related, and some relationships stretching back decades, the possible weakening of strong whanau-based loyalty was a concern.

Education and training (continued)

Literature review

- In some jurisdictions implementing transformation, there was an emphasis on both integrating how disability workers and other health professionals worked together, and up-skilling workers for client-directed care. The literature from several Australian states shows investment in online learning and tools for aligning training for new skills to service delivery requirements. In the states of Victoria and Tasmania, centres of excellence for research and education are being established, in order to promote best-practice, and to moderate and validate courses.

Recruitment

Providers' views

- Going hand-in-hand with education, providers felt more needed to be done to 'professionalise' the sector, and promote the skills they felt were needed – like critical thinking, problem-solving and negotiation – rather than 'traditional caring' skills. They were also trying to diversify their workforce to better match staff to people. Providers felt ease of recruitment varied, with external factors such as the cost of housing and transport, and availability of other good jobs, affecting rural and metropolitan providers to varying degrees.

Literature review

- The literature recommends a broad range of recruitment tools, including fostering closer, more formal ties between training establishments and providers, using word-of-mouth networks to attract staff, and targeting people outside the 'traditional' workforce. These include students, 'grey nomads', parents wanting to work school hours, and indigenous staff.

Executive Summary | Key findings

Working conditions

Providers' views

- Providers were divided on whether or not casualisation of the workforce would occur under ST and, if it did, to the extent that it has grown in Australia. There were some concerns among providers around how any casualisation would impact on collective agreements, under which many employees were covered. The wider potential impacts of ST were unclear to providers, who were concerned about competing for clients and the cost of service provision under individualised funding, and how these factors would affect working conditions and business models.

Literature review

- Increased casualisation of the workforce is the dominant theme in the literature – and there are two sides to the coin. On one is the uncertainty, stress and under-employment for workers, and on the other is the flexibility it gives to recruit 'non-traditional' workers. In Australia, particularly, financial viability and covering the costs of services borne of uncertainty around a 'new way of working' appears to be the top of mind issue for providers.

Regional differences and the impact of de-institutionalisation (DI)

- Providers we spoke to felt the lingering impacts of DI to different degrees, depending on where in the country they offered their services, how and when their own organisation was established, and the types of services they offered.
- The impacts of DI are linked to some extent to regional differences. Historical funding for people moved from institutions into community settings was raised as an issue, with providers saying former residents in the North Island were funded differently to those in the South Island. Additionally, areas like Nelson/Marlborough and the Horowhenua, where institutions had once existed and where a high proportion of disabled people resided, received what were perceived to be as 'higher' or 'better' funding arrangements than areas not historically associated with institutions.

Regional differences and the impact of de-institutionalisation (DI) (continued)

- There are similarities between the changes DI brought, and the expected changes of ST, particularly around service provision for individuals and the skills required from staff. The changes the sector are going through are not new, but ST is arguably a far more complex undertaking requiring at least a similar level of investment to achieve intended outcomes.

Conclusions

- The disability sector has experienced the effects of a range of policy and legislative changes since the last institution closed in 2006. While providers are excited about the benefits of ST, there appears to be noticeable cost pressures on providers, with margins closing as they invest to upgrade their operations and upskill their staff. The pay equity settlement is impacting providers and, despite the uplift in wages providers are experiencing difficulty retaining and recruiting staff, and finding the 'right' staff for the people they support.

Background and Approach

Background and Approach | Introduction

Background

- Since de-institutionalisation (**DI**) began in New Zealand in the 1970s, the disability sector has undergone a number of changes affecting its service provision and business model. These include the sleep-over settlements of 2011, to in-between travel time agreements, changes to health and safety legislation, working with vulnerable children and ongoing changes to employment relations legislation.
- Disability service providers also saw their support staff included in the 2017 pay equity settlement, which not only boosted wages and created a progressive pay structure linked to qualifications for direct support workers, but also placed pressure on providers to maintain earnings relativity between in-scope staff and those outside the settlement.
- The compliance costs on providers have not been trivial. Many spoke of having to be smarter about their service provision, and finding efficiencies within their businesses to keep costs down, particularly as compliance with successive regulatory or policy changes drive up costs.
- The sector is now on the cusp of further significant change, with System Transformation (**ST**) being prototyped in the Mid-Central region from 1 October 2018. ST is about bringing the principles of Enabling Good Lives (**EGL**) to life: it means giving disabled people and their families greater control and choice over the support they receive, so they can plan for the lives they want.
- ST will likely mean more disabled people holding individual budgets and choosing their own services, and will likely change how service providers configure their business, employ their staff, and interact with the people they support.
- The Ministry of Health (**MoH**) has recently developed the Residential Pricing Model (**RPM**) to determine the funding for various costs residential providers incur, including food, utilities and transport. It is yet to be rolled out across the sector. We understand this will now not occur until at least July 2019.

Background (continued)

- In light of these changes, the NZDSN asked Deloitte to undertake a piece of work broken into three parts. The first is a high-level view of historical funding for the sector. For this, two sources of funding were examined: Disability Support Services (**DSS**) funding from the MoH, and National Contract funding from the Ministry of Social Development (**MSD**). Other sources, including Accident Compensation Corporation (**ACC**) and District Health Board (**DHB**) funding, were included in our analysis, but not examined in detail. We also looked at the impact of changes to the minimum wage and pay equity and a breakdown of provider margins.
- The second part looks at the RPM logic and assumptions, while the third provides commentary on the legacy effects of DI on providers, as well as the potential impacts and opportunities of the pay equity settlement, workforce issues and ST.
- To supplement both parts, we surveyed a mix of 14 service providers chosen by the New Zealand Disability Support Network (**NZDSN**). The providers are located throughout the country, and are funded for a range of services. The service providers supplied us with information on their costs and funding through a standardised data collection template, and were also interviewed by Deloitte staff. The interviews gathered providers' thoughts on policy issues, business model changes, and the preparation they were undertaking in advance of ST. 14 providers were interviewed for qualitative perspectives. 13 agreed to provide financial data (around 43% of the total proportion of providers based on revenue) and eight completed the data template to a meaningful degree. In order to develop a picture of cost pressures and margins for 13 providers we analysed publicly available financial statements.

Acknowledgements

- Deloitte would like to thank the disability support service providers who gave their time to participate in our survey, and the Ministry of Health and Ministry of Social Development staff who assisted with interpreting and understanding funding sources.

Background and Approach | Funding Streams

Funding categories

- The two main sources of funding are MoH and the National Contract funding from the MSD, however funding is also provided through other agencies such as ACC, local councils, DHBs, Work and Income (**W&I**), Oranga Tamariki (**OT**), Ongoing Resourcing Scheme (**ORS**) funding etc.

Ministry of Health Disability Support Services funding streams

- MoH DSS funding is split into:
  - **Residential care:** Clients with a significant disability who require 24 hour care
  - **Funded family care:** Clients who employ their parents or family members over 18 (who they live with) to provide them with personal care and/or household management support
  - **Community care:** Clients who are able to live in a family home but require care services
  - **High and complex**: Clients who are either covered under one of two steams. Those who require secure monitored and are covered under a high and complex framework and individuals who have high and complex needs such as autism
  - **Other individualised funding** which is provided to some individuals directly. Under ST this funding stream is expected to increase further

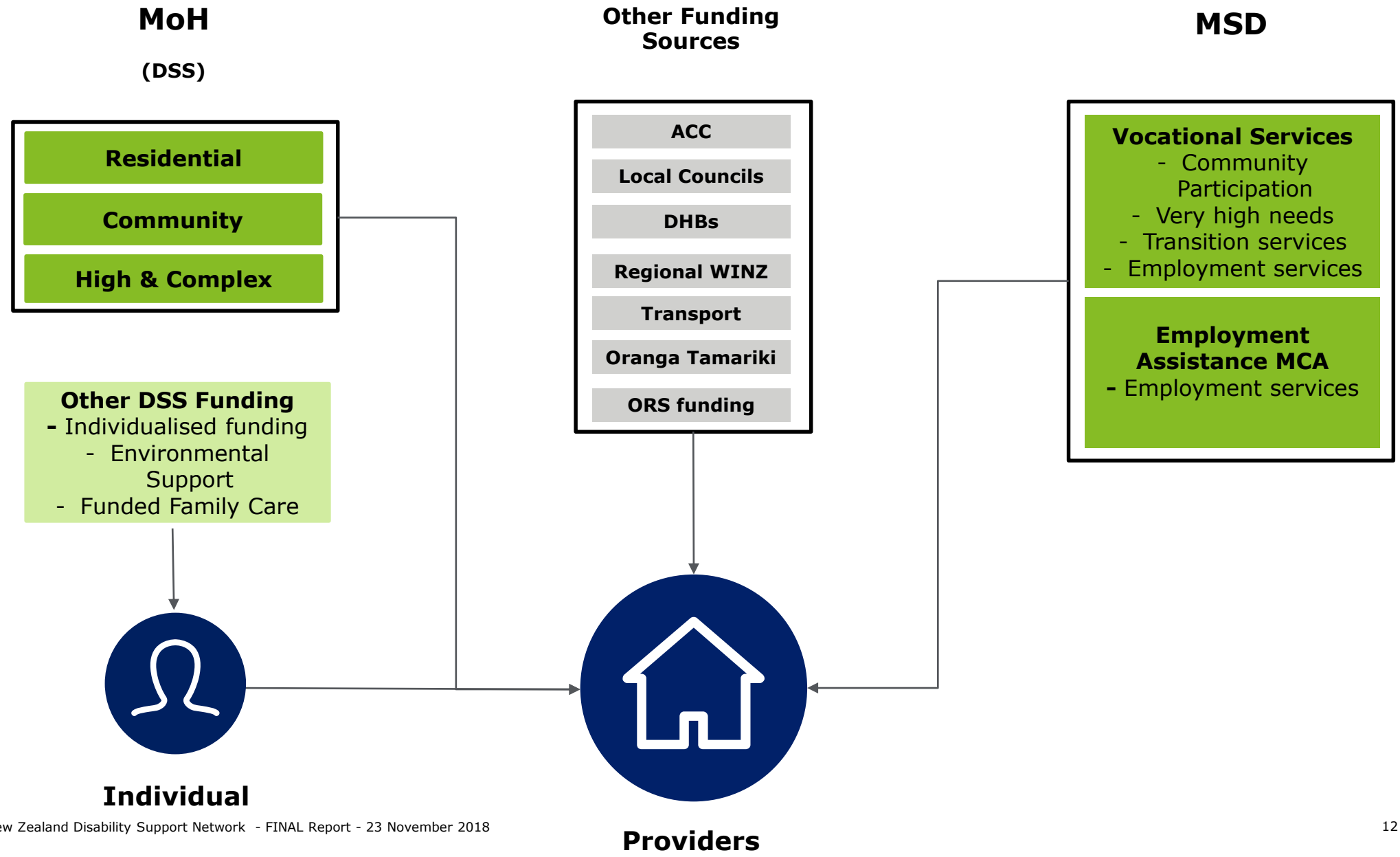
Ministry of Social Development funding streams

- MSD national contract funding is split into:
  - Employment services funding is from two appropriations **– Vocational Services** and the **Employment Assistance MCA**. Clients with long-term severe disabilities are eligible for Vocational Services and clients who are registered job-seekers with a disability receive funding through the MCA appropriation. Employment services funding is outcome-based, meaning providers receive more or less funding depending on outcomes achieved.
  - Community participation / day programmes funding is appropriated through **Vocational Services**. The majority of funding will be on a contract basis for providers. A small portion of the funding will go to clients with **very high needs** and will be funded on an individualised basis.
  - Transition services are also funded through **Vocational Services**

Other funding streams

- Although MoH and MSD are the largest funding stream, funding is also provided via ACC, local councils, DHBs, W&I, OT and through ORS.
- The diagram on page 12 outlines the different funding streams within DSS from MoH, MSD and other providers.

Background and Approach | Funding Streams



Part A: Revenue and Cost Pressures

Part A: Revenue and Cost Pressures | Timeline

KiwiSaver
The minimum employer contribution has gradually increased since the introduction of the KiwiSaver Act in 2006 – from 1% of gross salary in 2007 to 2% in 2009 and again to 3% in 2013.

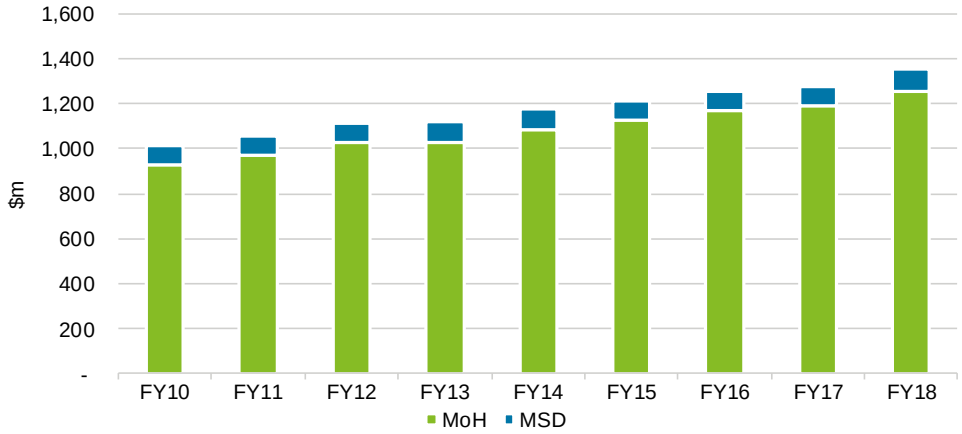
Pay Equity
The pay equity pay rates will gradually increase the minimum pay for support workers over a five-year period from 2017 to 2021. Current rates range from $19.80 for level 1 workers to $24.50 for level 4 workers.

Part A: Revenue and Cost Pressures | Historical Funding

Historical Disability Support Services funding overview

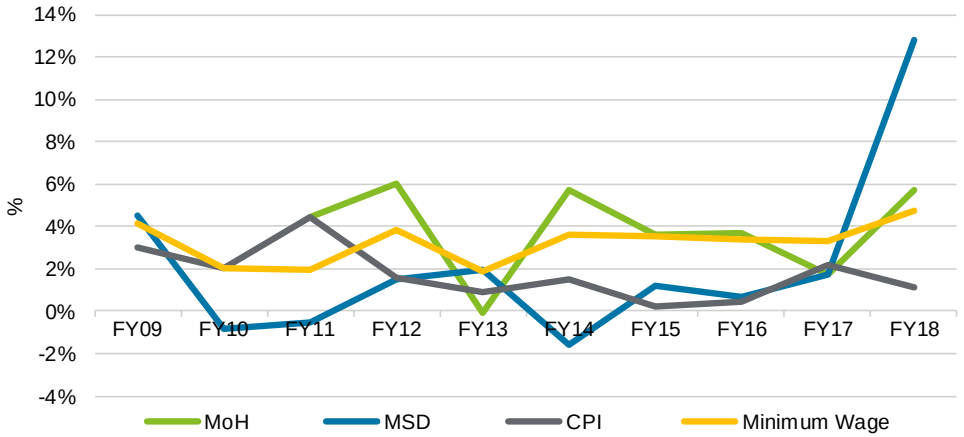
- The chart opposite (top) presents MoH and MSD funding for DSS services over the past 10 years. Overall total funding has increased over the past 10 years from both Ministries, with funding totalling $1.35b in FY18 (split between $1.25b from MoH and $100m from MSD).
- In FY12 the increase in MoH funding was due to the introduction of the Sleepover Settlement, which meant sleepover staff who were rostered on went from being paid a $30 per night allowance to an hourly rate based on the minimum wage. As part of the settlement, MoH was required to make back payments to sleepover staff in the prior two years at 50% and 75% of the minimum wage respectively.
- In FY13, Autism Spectrum Disorder (**ASD**) was introduced as a DSS-funded service, which providers said has led to a higher number of high and complex clients.
- In FY14 MoH provided $23m for funded family care, however, only $4m was used, with $19m returned back to MoH. In the same year there was a funding increase due to the introduction of heath and safety legislation.
- In FY18, MoH funding increased as result of the implementation of the pay equity settlement, along with the associated wash-up payments. We understand this additional funding only was to met the cost of new support worker wages under the pay equity settlement. It did not include cost of living adjustments or the flow on cost implications of the settlement.
- Total MSD funding has been relatively consistent over the past 10 years, with the majority of the changes due to the timing of top-ups and contract adjustments. In FY18 there was a funding increase as a result of the pay equity settlement and a funding increase for Support Funds and Employment Services.
- The chart opposite (bottom) presents the movements in MoH and MSD funding against movements in both the Consumer Price Index (**CPI**) and minimum wage. Overall, both MoH and MSD funding changes broadly aligns with movements in CPI, increases in people requiring services (approximately 1% p.a.) and regulatory changes that have an effect on costs. However, the total funding is also affected by the number of clients funded within the scheme and the number of services funded, which can vary year to year.
- We have also looked at the impact KiwiSaver and Mondayising public holidays had. Their impact is minimal on the funding from MoH and MSD.

MoH & MSD Funding



Source: MoH & MSD data

Funding vs CPI growth



Source: MoH, MSD & StatsNZ

Part A: Revenue and Cost Pressures | Historical Contract Prices

Introduction

- The charts on pages 17 and 18 illustrate the contract pricing movements - supplied by NZDSN (and verified by MoH and MSD) between 2014 and 2018 against CPI, wage cost escalation, housing inflation, electricity inflation and petrol inflation over the same period. The inflation data has been taken from Statistics New Zealand's website and the percentage movements are based on the Q1 movements each year. The wage cost inflation represents the movements in minimum wage over the same period. We have also included a table showing the contract price movements and inflation data on page 18

Contract pricing movements vs CPI

- The chart on page 17 illustrates the contract pricing movements against CPI between 2014 and 2018.
- The trend illustrates the following:
  - Community residential and supported living contract price increases were greater than CPI in 2014 and 2015 but below CPI in the three years following.
  - Day programme contract prices were only higher than CPI movements in 2015. In all other years the price increases were below CPI.
  - Community participation contract price increases were nil in all years
- Overall the contract price increases appear to largely move in the same direction as CPI. However, CPI was below contract price movements in 2014 and 2015, and above contract price increases in 2015 – 2018.

Contract pricing movements vs Minimum Wage

- The chart on page 17 illustrates the contract price movements against changes in minimum wage cost inflation between 2014 and 2018.
- The trend illustrates the following:
  - Minimum wage movements have been well above all four contract price movements between 2014 – 2018.
  - In 2018, minimum wage costs appear to be increasing further while contract prices decline generating an even larger gap between contract pricing and wage cost escalation.

Contract pricing movements vs Housing Inflation

- The chart on page 17 illustrates the contract price movements against housing inflation between 2014 and 2018.
- The trend illustrates the following:
  - With the exception for 2014, where housing inflation was the same as contract price increases for community residential and supporting living, housing inflation was above contract pricing increases in 2015 – 2018.
- Housing is a key cost for residential providers as they either have to source any accommodation from Housing New Zealand or the market.

Contract pricing movements vs Electricity Inflation

- The chart on page 18 illustrates the contract price movements against electricity inflation between 2014 and 2018.
- The trend illustrates the following:
  - Despite a large dip in electricity inflation in 2016, electricity inflation was above all four contract price increases between 2014 and 2018.
- Electricity is a fundamental costs set by the external market outside of providers' control, which impacts their day-to-day running costs. Electricity forms an even larger part of residential providers cost base.

Contract pricing movements vs Petrol Inflation

- The chart on page 18 illustrates the contract pricing movements against petrol inflation between 2014 and 2018.
- The trend illustrates the following:
  - Petrol inflation dropped significantly between 2014 and 2016 as crude oil prices declined globally from over $US100 a barrel to below $US35 a barrel. This has since increased in line with rising oil prices and the falling New Zealand dollar. Petrol inflation is now on an upward trend and is well above the contract pricing movements in 2018.

Part A: Revenue and Cost Pressures | Historical Contract Prices

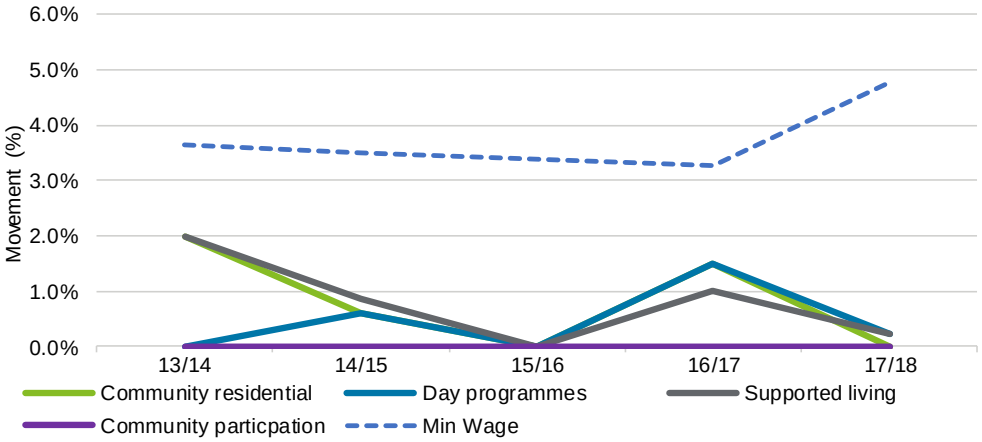
Contract pricing movements vs Petrol Inflation (continued)

- Petrol is another key input cost for providers, which is again set by the external market through crude oil prices and the New Zealand exchange rate outside of providers' control.
- Residential providers are further affected by petrol costs due to the additional vehicles they own/lease.

Summary

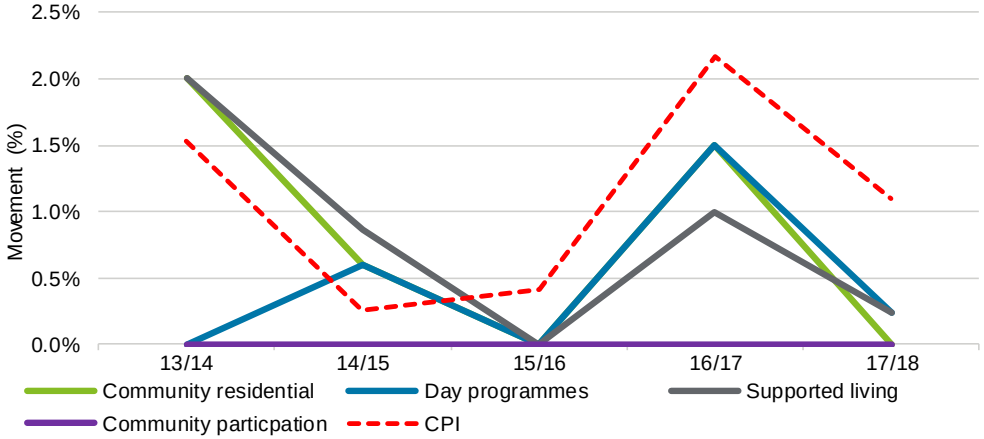
- Overall the above analysis illustrates, with the exception of CPI which was below some contract movements in 2014 and 2015, contract price increases have been below movements in CPI, minimum wage, housing inflation, electricity inflation and petrol inflation.
- As a number of the indices measured such minimum wage, housing, electricity and petrol are outside the control of providers, NZDSN and the Ministries may wish to work together to investigate how such changes could be factored in to contract pricing or similar going forward.

Contract pricing vs Minimum Wage



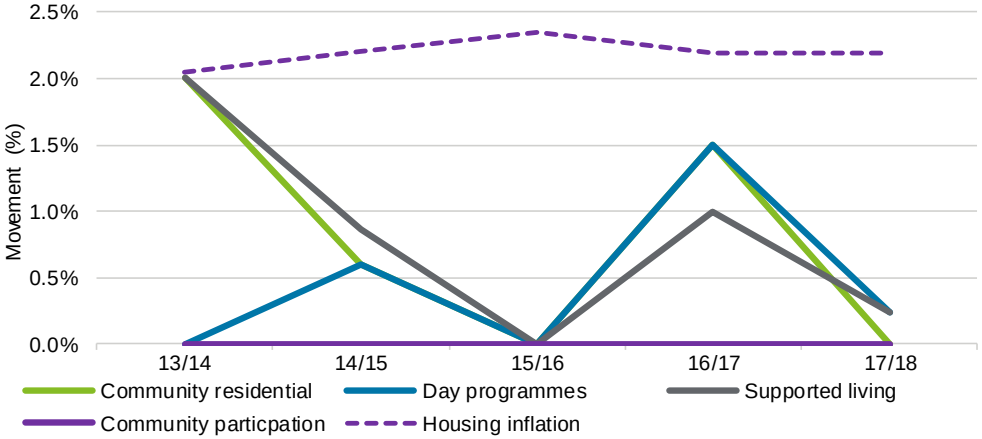
Source: Management information, Statistics NZ

Contract pricing vs CPI



Source: Management information, Statistics NZ

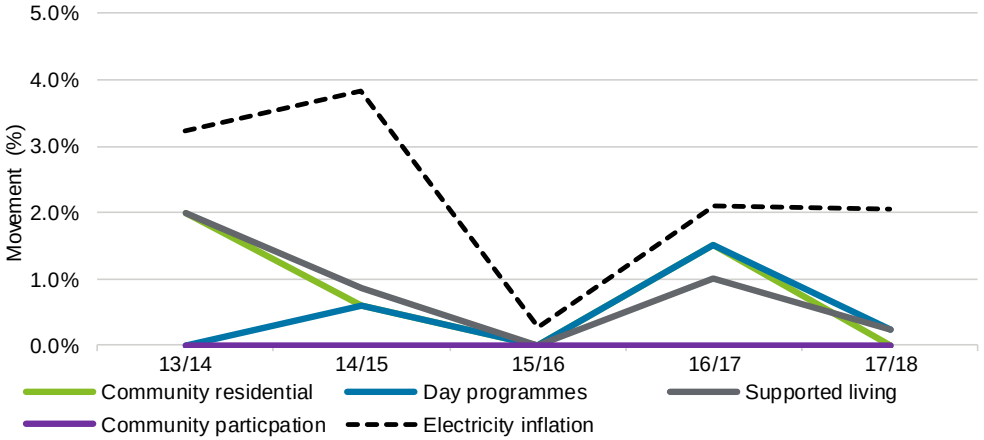
Contract pricing vs Housing Inflation



Source: Management information, Statistics NZ

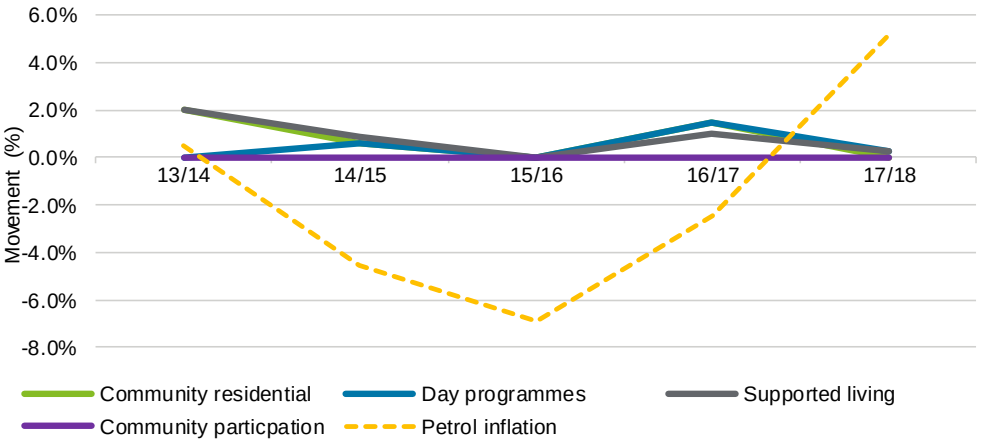
Part A: Revenue and Cost Pressures | Historical Contract Prices

Contract pricing vs Electricity Inflation



Source: Management information, Statistics NZ

Contract pricing vs Petrol Inflation



Source: Management information, Statistics NZ

Contract Pricing vs Market Data

	13/14	14/15	15/16	16/17	17/18
Contract pricing increases					
Community residential	2.0%	0.6%	0.0%	1.5%	0.0%
Day programmes	0.0%	0.6%	0.0%	1.5%	0.2%
Supported living	2.0%	0.9%	0.0%	1.0%	0.2%
Community particpation	0.0%	0.0%	0.0%	0.0%	0.0%
Market data					
CPI	1.5%	0.3%	0.4%	2.2%	1.1%
Minimum wage	3.6%	3.5%	3.4%	3.3%	4.8%
Housing inflation	2.1%	2.2%	2.3%	2.2%	2.2%
Electricity inflation	3.2%	3.8%	0.3%	2.1%	2.0%
Petrol inflation	0.5%	-4.5%	-6.9%	-2.4%	5.1%
Cummulative pricing increases					
Community residential		2.6%	2.6%	4.1%	4.1%
Day programmes		0.6%	0.6%	2.1%	2.3%
Supported living		2.9%	2.9%	3.9%	4.1%
Community particpation		0.0%	0.0%	0.0%	0.0%
Cummulative market data					
CPI		1.8%	2.2%	4.4%	5.5%
Minimum wage		7.1%	10.5%	13.8%	18.6%
Housing inflation		4.3%	6.6%	8.8%	11.0%
Electricity inflation		7.0%	7.3%	9.4%	11.5%
Petrol inflation		-4.0%	-10.9%	-13.3%	-8.2%

Soure: Contract rates from NZDSN, Statistics NZ

Part A: Revenue and Cost Pressures | Services Funded

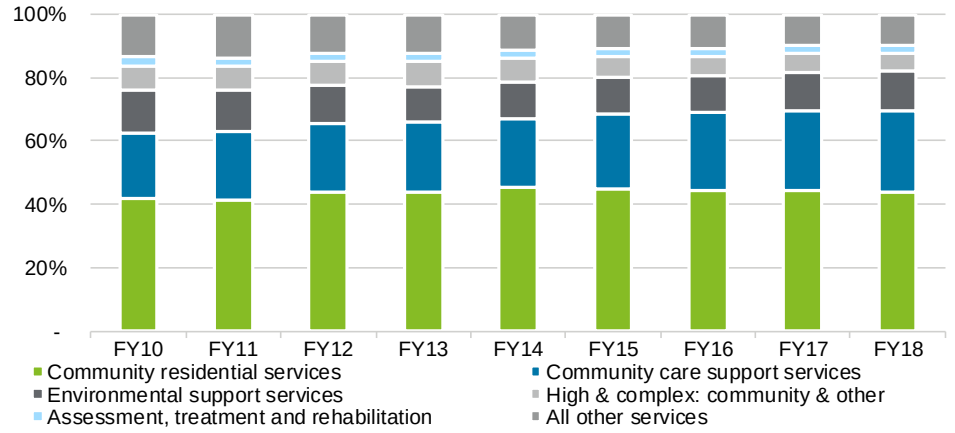
Ministry of Health funding

- The chart opposite (top) presents a breakdown of MoH funding over the past 10 years, split into the five largest categories (with the remainder included within "other").
- Community Residential Services is the largest category which received year-on-year funding increases, and comprised c.44% of MoH funding in FY18. Despite the year-on-year increases in funding, providers have noted this will be a declining funding stream going forward, as younger clients are becoming more independent and have their own accommodation instead of wanting to live in group homes. Providers also believe demand for residential services will slow under EGL-led ST.
- Community Care Support services have received the largest funding increases of between 2%-10% pa, driven by the inclusion of Family Funded Care but this largely goes to individuals.
- High and complex funding is split into two streams: those who require secure monitoring and are covered under a high and complex framework, and all other high and complex cases, such as individuals with ASD and require one-to-one monitoring. The funding presented in the chart is for high and complex individuals under the framework, with other high and complex clients spread across all of the funding streams. Providers have expressed concerns with high and complex funding, as demand has been increasing while funding has been relatively flat. Providers have noted high and complex cases increasing since ASD was included as a DSS-funded disability service in 2013.

Ministry of Social Development funding

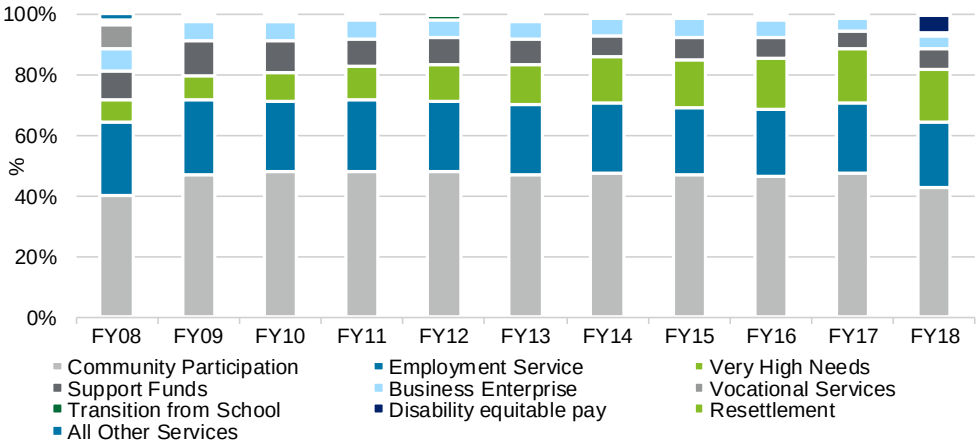
- The chart opposite (bottom) presents a breakdown of MSD funding over the past 10 years, split into the nine largest categories (with the remainder included within "other").
- The largest category is Community Participation, which had year-on-year funding increases in response to demand and comprised 48% of total MSD funding in FY18.
- Many providers have indicated they are finding it increasingly difficult to place disabled clients in work, while others have said they like the milestone payment system as it pays based on performance. However, all of the employment service providers indicated there is a lack of funding for behavioural support, despite increasing costs to deliver services.

MoH funding by service



Source: MoH data

Services as a percentage of total MSD funding



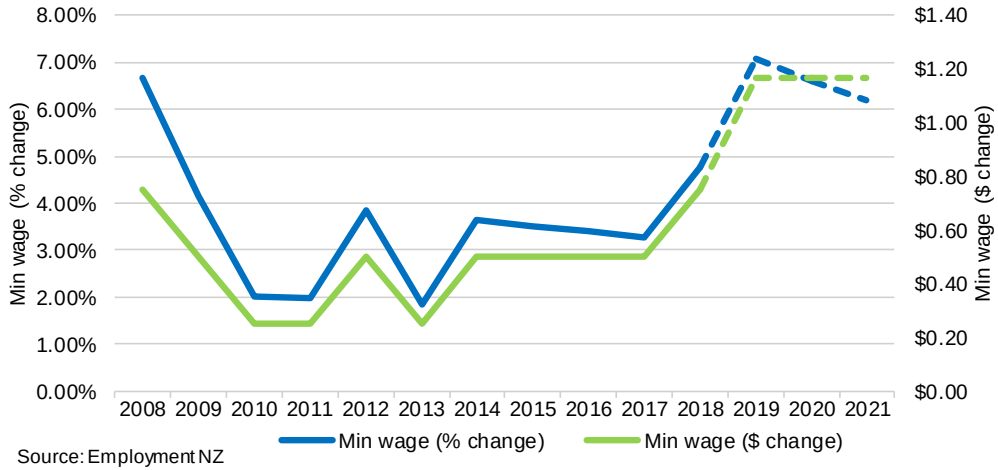
Source: MSD data

Part A: Revenue and Cost Pressures | Minimum Wage Trends

Minimum wage changes

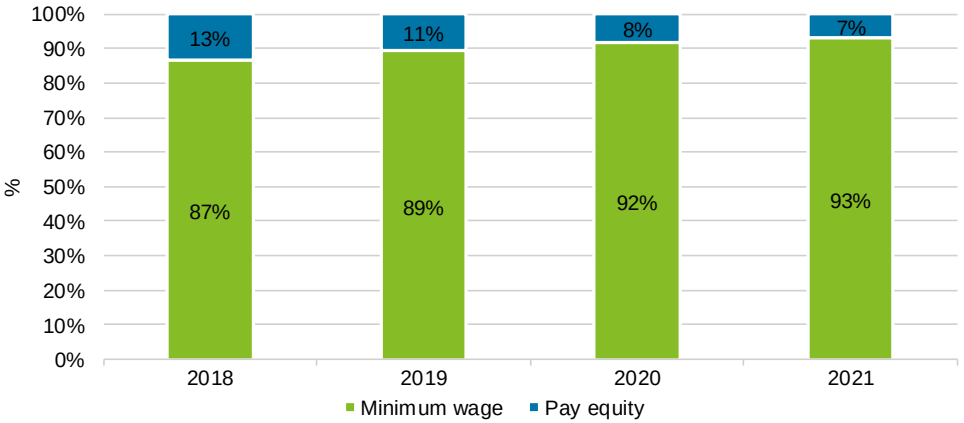
- The chart opposite (top) illustrates the dollar and percentage changes to the minimum wage since 2008. We have also included a forecast minimum wage based on the Coalition Government's proposal to increase the minimum wage to $20 an hour by April 2021.
- Since 2008, the minimum hourly wage rate has increased by 25 cents, 50 cents or 75 cents. Over time, as the minimum wage has increased, the percentage impact of a given increase has lessened. For example, the 75 cent increase to the $12.00 minimum hourly rate in 2008 had a circa 6.7% impact, whereas the same increase 10 years later in 2018 only had a 4.8% impact.
- While the percentage impact is decreasing, the real impact to businesses of having to fund these changes is another matter. The Government proposes to increase the minimum wage by another $3.50 over time to $20.00 by April 2021 (as no information has been released on how large the movements will be each year, we have assumed it will occur in three even instalments). Survey respondents noted significant cost pressures at current levels.
- The chart opposite (below) illustrates the impact of the forecast minimum wage on the level 1 pay equity band. We note the legislation includes a clause that states if the compound annual growth rate for the labour cost index (**LCI**) between 1 July 2017 and 1 July 2021 is more than 1.7% the pay equity rate for 2021 will also increase by the same amount. As we do not know what the forecast LCI will be in 1 July 2021, we have assumed the LCI will be lower than 1.7% and the pay equity rate unchanged from the legislation in 2021 and compared this to the forecast minimum wage.
- As the minimum wage continues to rise, the pay gap between workers on a minimum wage and level 1 support workers will be eroded. Currently the minimum wage makes up 87% of the level 1 pay equity rate. This proportion will increase year-on-year, reaching 93% of the level 1 pay equity rate in 2021, reducing the advantage the pay equity settlement gave to support workers in the form of an uplift in margin to make it more attractive to work in the disability sector. Without this wage differential, it may be difficult to attract workers in to the disability sector as they could obtain a similar wage working in another industry.

Minimum wage changes



Source: Employment NZ

Minimum wage changes & pay equity (hourly rate)



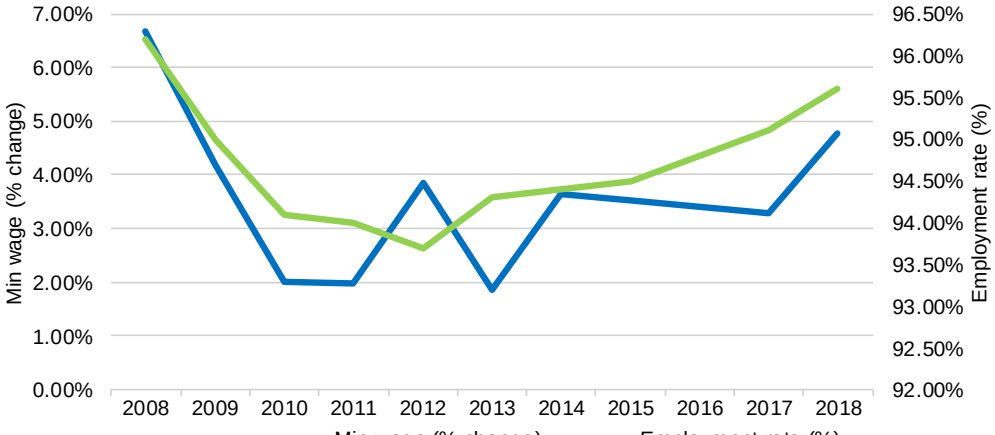
Source: Employment NZ, MoH website

Part A: Revenue and Cost Pressures | Minimum Wage Trends

Historical minimum wage relationship

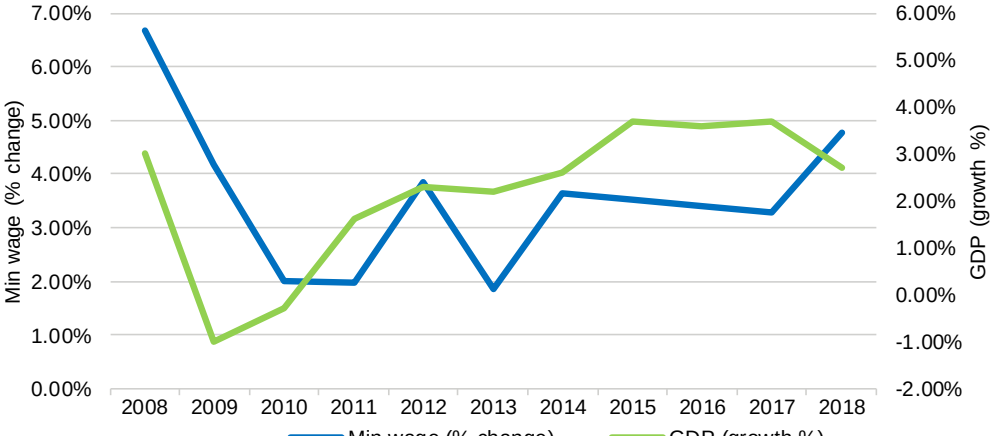
- The chart opposite (top) illustrates the positive relationship between the New Zealand employment rate and the percentage change in the minimum wage. The bottom chart illustrates a positive relationship between New Zealand gross domestic product (**GDP**) and the latter.
- The Ministry of Business, Innovation and Employment (**MBIE**), formerly the Department of Labour, noted in a working paper that it considers the following factors when assessing changes to the minimum wage level:
  - the inflation rate, using the CPI as the indicator;
  - wage growth, using the median wage as the indicator;
  - any restraints on employment; and
  - any other relevant factors, such as impact on industry, impact on the state sector and interface with other government policies. Currently, this includes analysis of the impact of minimum wage increases on contracts funded by MoH and MSD.
- This somewhat explains the positive relationships shown in the charts.
- In particular, higher unemployment and / or lower GDP have typically been followed by lower increases to the minimum wage than when the indicators have been more favourable.

Minimum wage changes & employment rate



Source: Employment NZ & Statistics NZ

Minimum wage changes & GDP



Source: Employment NZ & Statisitics NZ

Part A: Revenue and Cost Pressures | Pay Equity

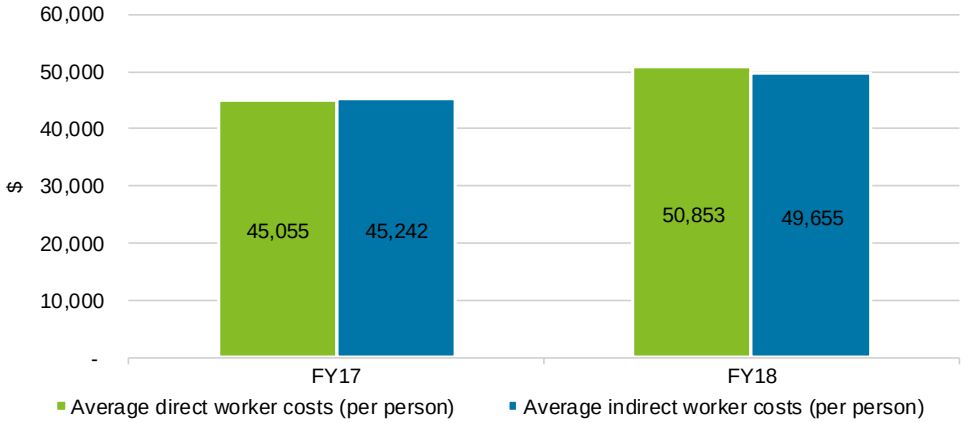
Pay equity overview

- The introduction of the pay equity settlement was one of the biggest changes to affect the sector in recent years, with the majority of providers surveyed noting it as being a significant change to their business and staff.
- Pay equity was introduced on 1 July 2017 and resulted in over 55,000 care and support workers moving to a four-level system, based on an individual's qualification or length of service. For those who were on the minimum wage it meant they received a pay rise to $19 an hour for level 1 with the ability to earn up to $23.50 for level 4 staff.
- While pay equity provided better recognition for support workers, it also created material pay relativity issues for those who were outside of the scope of the pay equity settlement, such as team leaders or managers who supervised support workers. Pay equity meant the wage differential between team leaders/managers and support workers was minimal or eroded.
- One provider said many of their management vacancies were previously filled internally due to competition from support staff and the comparatively lucrative salaries. However, they are now having to look to the external market to fill such positions as pay equity has eroded away any pay differential between the roles.

Impact of pay equity on employee cost and numbers

- The chart opposite presents a comparison of the average direct (support worker) and indirect (all other) worker costs between FY17 an FY18 to illustrate the impact of pay equity. The data is based on 7 respondents to our survey.
- The average cost of both direct and indirect workers increased in FY18 due to the impact of pay equity. Although pay equity only affects direct support staff, many organisations chose to maintain the pay relativities for their other staff and increase indirect worker wages in line with increases to pay equity.

Pay equity impacts



Source: Provider responses

Part A: Revenue and Cost Pressures | Pay Equity

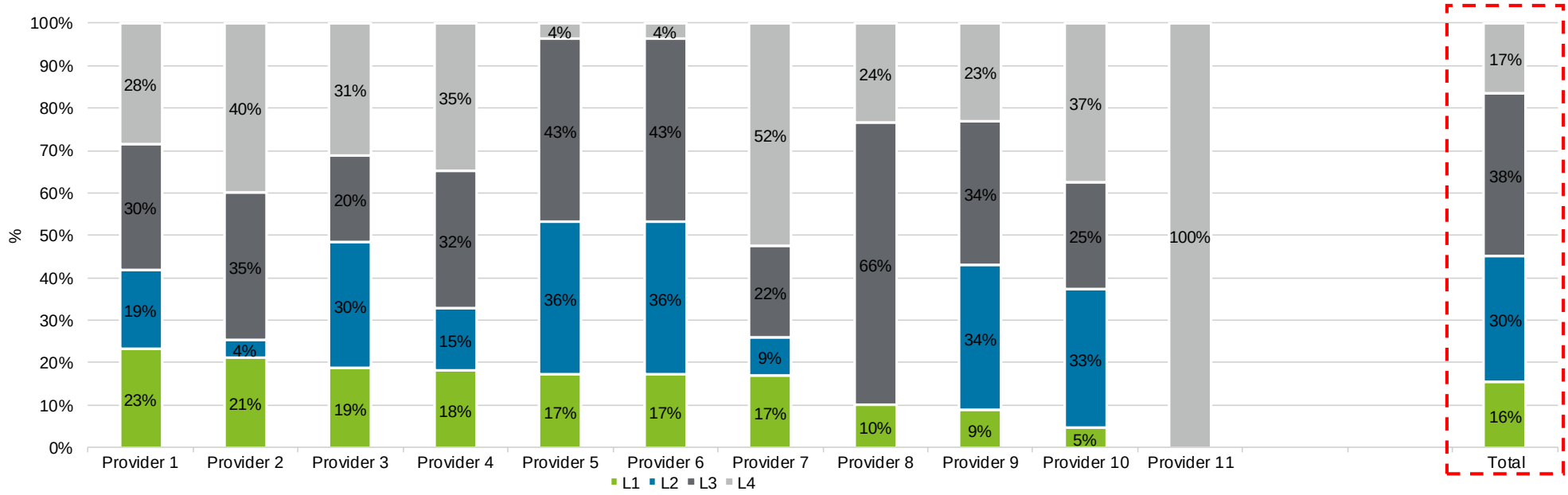
Pay equity levels

- The chart below presents the various level of workers based on the four-level pay equity scheme using the data received from 11 providers. We have also included a total across the providers.
- Many providers noted the averaging approach for pay equity as a concern. Under this approach, MoH funds all providers based on the average pay equity hourly wage across all levels, meaning providers with a highly qualified workforce need to fund any shortfall themselves. Those providers who have a less qualified workforce generate a greater margin on their staff, which flows towards their overall surplus.

Pay equity levels (continued)

- The averaging approach discourages providers from employing a highly qualified workforce, and does not incentivise them to train their staff to attain higher levels.
- Many providers noted there was a compliance cost burden due to the wash-up process of pay equity, which calculates the actual cost of implementing the pay equity rates by collecting retrospective data for a time period. However providers tell us this is a non-funded compliance cost.

FY18 Provider employee FTE qualification breakdown



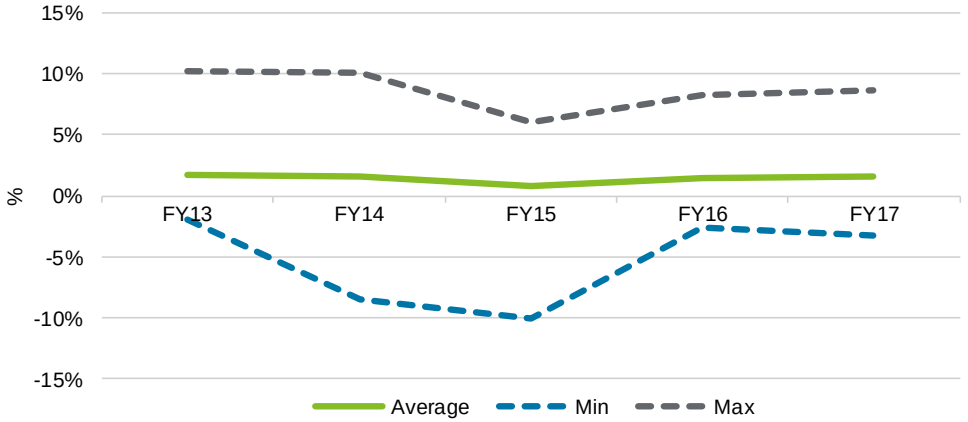
Source: Provider responses

Part A: Revenue and Cost Pressures | Financial Analysis

Provider net surplus margins

- The chart opposite presents the average, minimum and maximum net surplus / (deficit) margin for 13 providers, based on the financial statements and annual reports for FY13 – FY17 to give an indication of the range of nets surpluses of providers. Many of the providers are finalising their FY18 accounts and were not able to provide draft financial statements. In order to keep the data and providers consistent across all years, we have excluded FY18 from our anlaysis.
- During our discussions with providers many were concerned about the slim margins, which has impacted their ability to invest in their businesses IT infrastructure, systems, processes and people. Many providers noted they have made significant investments in technology such as Customer Relationship Management (**CRM**) systems, online rostering and IT infrastructure over the past few years in anticipation of ST. However, many providers were concerned they would not be able to continue to make such investments in the future as they were unsure of the impact ST would have on their business.
- In order to fund investments in technology, many providers indicated they tried to cut costs through reducing overheads, including administration and management staff.
- A number of providers noted their net surplus had declined in FY18 (not shown in the chart), as a result of the relativities associated with pay equity, as discussed earlier. They expect this will continue to be a material issue going forward as ST is rolled out across the country, and if an averaging approach continues to be used across the pay equity levels.
- Providers believe they have been squeezed further in recent years as the number of high and complex clients continue to increase, particularly since ASD was entered into the DSS system in FY13. This has meant many providers have support workers providing more tailored one-to-one services, which is not adequately funded.

Average net surplus margin for providers



Source: Provider annual reports/financial statements

Provider net surplus margin (continued)

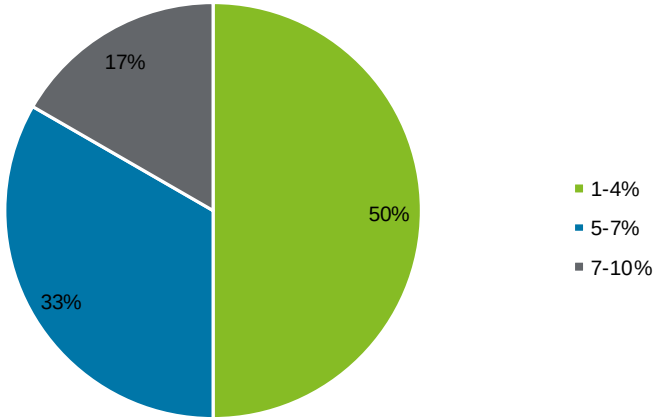
- Every provider noted the new health and safety legislation as having a significant impact on their business in the past decade. The new legislation has created a number of additional compliance costs for businesses, which has only been funded to an extent by MoH.
- Overall, providers have noted a number of factors causing their net surplus to vary over the past five years, however the analysis illustrates the gap between the minimum and maximum margin has been narrowing between 2013 and 2017 from 18.5% to a gap today of 12.0%. We also note the number of providers with a negative margin ranged from three to six providers and those with a margin of less than 3% range from eight to twelve providers between 2013 and 2017.
- Many providers have expressed concerns with their future viability as they are unsure of the impact ST will have on their organisation, and the wider sector in general.

Part A: Revenue and Cost Pressures | Financial Analysis

Reasonable margins

- During the qualitative part of our survey, we canvassed providers' thoughts on a reasonable operating margin, in order to invest in technology and resources. The chart opposite summarises the responses from the providers.
- As described on page 24 above, the majority of providers are operating at very slim margins (less than 1%) and, based on our survey, half believe operating at a 1%-4% margin would help them invest in technology or resources. 33% believe a 5% to 7% margin would be required, and only 17% thought a margin greater than 8% was required. This shows that while providers currently operate on very low margins, if they were able to operate on a 1-4% margin, it would allow them to invest in the future sustainability of their business.
- Providers expressed concerns about the future of their business due to the impact of ST and resultant individualised funding model. Several providers indicated that, as individuals became more selective about their purchases, some services may see a reduction in demand and therefore an increase in costs, as providers lose economies of scale. This could mean the services individuals may be able to purchase with their funding today may end up costing more under ST.
- Looking forward, many providers were concerned about the sustainability of their business as their cost to deliver certain services rose and demand for others fell. Providers believed their residential services (which is the bulk of funding for some) would decline in the future as their clients' preferences change and the traditional residential population 'ages out'.
- Some providers indicated they may look to diversify their funding streams to help focus on services with the greatest demand and, therefore, which are the most attractive to deliver. However, some providers also believed this could result in a loss of certain services in some areas, especially rural and remote regions.

Reasonable margin to operate - provider feedback



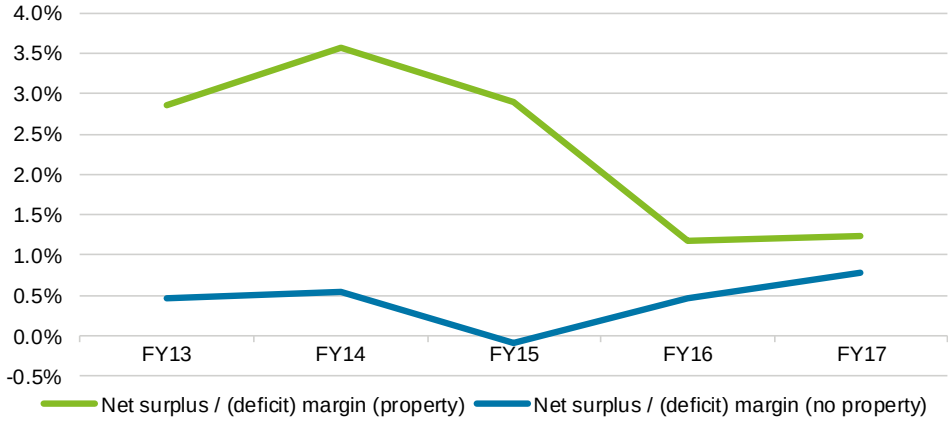
Source: Provider responses

Part A: Revenue and Cost Pressures | Financial Analysis

Property vs non-property owning providers

- The chart opposite presents the average net surplus / (deficit) margin for the 11 residential providers surveyed, split between providers that own property, and those that do not. The data was extracted from the providers' annual reports for FY13 – FY17. As described above, many providers are finalising their FY18 accounts and were not able to provide their financial statements for that year.
- Overall, property-owning providers have been able to generate a higher net surplus margin than providers not holding property. This is because property-owning providers either generate additional revenue from their properties, or do not need to rent residential properties from Housing New Zealand or the private market.
- We understand some of the organisations formed out of DI inherited large amounts of property compared to other providers who started without any. This has allowed property-inheriting providers to accumulate additional wealth over time (in the form of additional revenue through rental income or greater surpluses through a reduction in rental costs), which has been used to supplement their Government funding.

Net surplus / (deficit) margin property vs no property



Source: Provider annual reports/financial statements

Part B: RPM

Part B: RPM | Overview of RPM

Overview and approach

- We have reviewed the RPM to test the model logic, and provide an independent perspective on the model assumptions and approach.
- As part our testing, we have used specialist model review software, "Spreadsheet Detective", which has assisted with identifying where unique formulae are and where inconsistencies may lie.
- To further test the model logic, we have developed a logic flow diagram (as provided on page 31) to illustrate how the model works. We have tested this with two separate providers.
- We have developed a more detailed logic flow diagram, describing the calculations, and have included an assumption book, summarising the key assumptions within the model and their source, in Appendix 4.

Key observations

- Based on our review of the model's key assumptions and discussions with two providers we note the following:
- Although all assumptions have been indexed to 2017 values we found the model uses out-of-date data sources for a number of key assumptions. The 2013 Household Economic Survey (**HES**) was used for the majority of key assumptions, but we also found some older sources going back to 2003 for household maintenance costs and specialist services therapy.
- Support staff costs which comprise c.60-70% of the total RPM costs do not take into account the new pay equity levels. Only one hourly rate at $17.97 (before loadings) has been used in the calculation of support worker costs. Given the introduction of four pay equity rates and the level 1 rate being $19.00 (increasing up to $23.50 for a level 4 worker) as at 1 July 2017, the support worker rate loaded in the model is significantly underfunded.
- The model has a limited training allowance, with only two days of training leave included for support workers each year.

Key observations (continued)

- The model is based on a standard five-person household. From discussions with providers many of the houses have four people or fewer. Many providers have noted the households are also not "standard households", with the needs of their clients being greater as they use wheelchairs or require other specialist equipment which creates additional wear and tear on furniture and fittings. A few providers noted some of their houses have 24/7 operations where their clients spend the majority of their time based in the houses.
- The model assumes one motor vehicle will be used across three houses, and the type of vehicle used is a medium-sized car. Many providers have noted the majority of their fleet are not standard medium-sized vehicles, but specialist vans with hoists, costing more to purchase / lease and have higher running costs.
- Food costs do not take into account staff who eat meals with their clients. Providers have noted there can be up to three staff members eating with their clients in certain houses. Providers have commented they are often criticised about the quality of food purchased when they are audited, and they are unable to purchase better-quality food with the funding available.
- The needs for telecommunications have changed dramatically over the past three to five years, with technology such as wifi and fibre becoming standard in households. The costs included in the model are based on the 2013 HES, which do not represent the costs of telecommunication services today.
- The RPM doesn't take into account funding for IT infrastructure which can be significant in residential houses to ensure they are equipped with technology such as wifi, cameras and computers.

Part B: RPM | Overview of RPM

Key observations (continued)

- The overheads calculation of the RPM comprise two components, (1) overheads which are non-people based costs such as stationery, office rental, postage etc. and (2) management costs which are people based costs and assumes management spends 1 hour per week with each resident and administration/accounting staff spend 0.5 hour per week with each resident. The model applies a standard effort factor based on the complexity of the resident to the overhead costs but does not apply any factor to management costs, meaning a complex resident will get a higher share of overheads which are non-people resources while people-based resources (through the management costs) remain unchanged based on complexity.
- The standard effort factor used also has quite large bands ranging from 50% to 500% creating some large step increases based on the complexity of the resident and could potentially disadvantage residents which sit just below each band. NZDSN has noted there is potential to re-examine how standard effort is calculated, and this could be investigated with the Ministry of Health.
- The people-based costs (through the management costs) only include an allowance for 1 management FTE and 1 administration/accounting FTE and do not include HR, L&D, clinical and other shared overhead staff that sit within a finance team. The model also does not include any allowance for a governance function. As we noted in our analysis, there may be scope for other overhead inputs to be included in the RPM, in order to better reflect the operations of present-day residential services providers.
- We understand NZDSN and its members have discussed splitting the overheads component of the RPM into three categories, (1) operational management, (2) shared services and (3) sustainability margin which will allow a more rational consideration of each. In our experience improved transparency leads to better outcomes.

Key observations (continued)

- The allowance included for medical supplies appears to be low, as providers have mentioned their clients have specific needs, such as gastro feeding tubes, which they currently pay for as the allowance does not cover specific items.

Minor errors noted

- As part of our review we have noted the following errors in the model:
  1. The food cost line that feeds through to the model excludes the restaurant and ready-to-eat meals line, which means food costs are underfunded.
  2. No costs have been provided for telecommunications equipment for one and five people even though costs are provided for two, three and four people.
  3. The input assumption for the house contents value is fixed and does not change based on the number of clients in the house, meaning the same cost is applied regardless of the number of occupants.
  4. On the "Core Staff" sheet some of the formulae link to a value that appears to have been deleted and will therefore only be able to return a certain value regardless of the scenario.
  5. The car insurance data is based on 2016 data which has not been indexed to 2017 values.

Corrections of errors

- We have discussed these errors with NZDSN, who has referred them onto the model developer to be corrected.

Part B: RPM | Overview of RPM

Recommendations

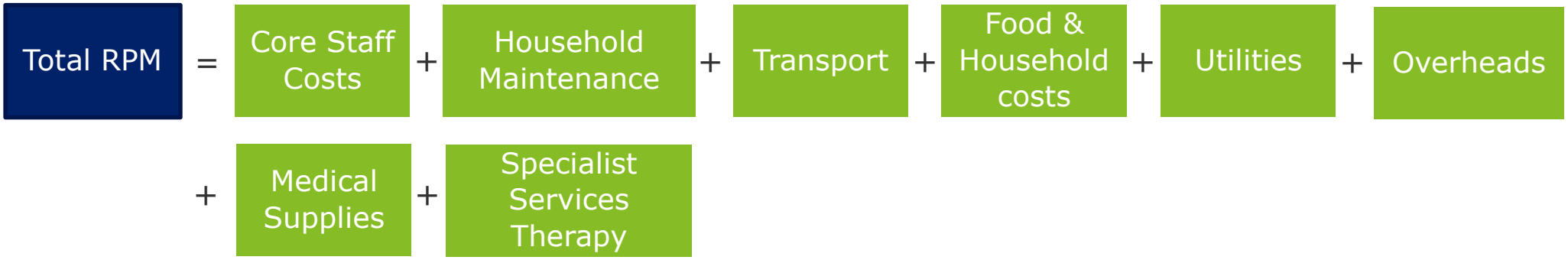
- Based on our review of the model and the underlying assumptions, we suggest investigating the following to see if:

1. The input assumptions could be based on 2018 data sources, instead of older data being indexed to 2018.
2. The model could be updated to incorporate the different levels of pay equity for support workers.
3. The model could include an adjustment to take into account whether a house is rented from Housing New Zealand or the private rental market
4. The maintenance costs included in the model could be revised to take into account the specific needs of clients, such as wheelchairs, which will result in additional wear and tear. The model could also take into account those houses which are run on a 24/7 basis.
5. As support workers eat meals with their clients, the model could take into account the additional food costs associated with staff members eating with the people they support.
6. The model could include a number of different vehicle types instead of a standard medium-sized vehicle, as many providers use vans, or vans with hoists.
7. The model could include an allowance for IT infrastructure to allow houses to incorporate new technology such as wifi and fibre.
8. The model could include an adjustment factor to take into account houses in urban vs rural areas.
9. The model could be re-run whenever clients move houses instead of being run on an "unders and overs" basis until the yearly review of the client's needs.
10. A full review could be undertaken to calculate the amount of time management and administration staff spend with each client (every week) to justify the 1.0 and 0.5 hour input assumptions.

Part B: RPM | Logic Flow

RPM logic flow

- The diagram below provides an illustration of the calculations included within the RPM. A detailed breakdown of the individual components, along with an assumptions book, is included within Appendix 4.



Part B: RPM | Comparison of Key Assumptions

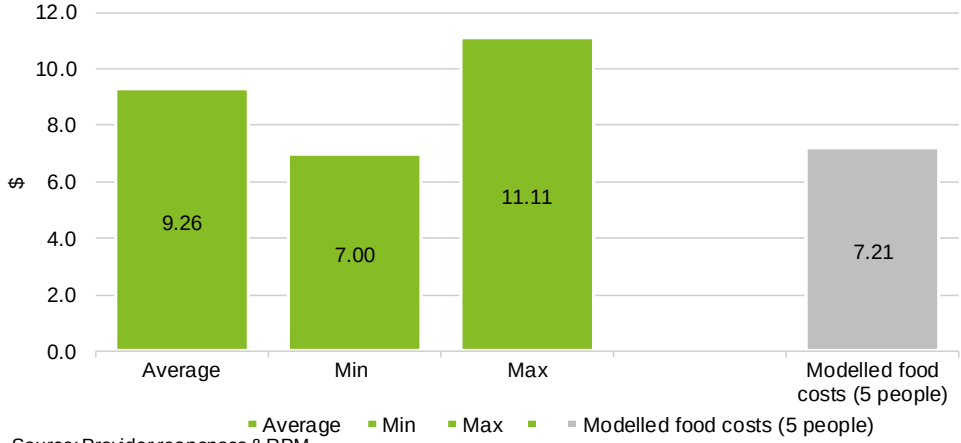
Overview

- As illustrated in the logic flow diagram on page 31, the RPM calculation comprises a number of components, each based on its own input assumption from third-party data.
- In order to test some of the key assumptions used in the model, we have used the input assumption for food costs, household supplies, medical supplies, telecommunications and energy costs per person from the model, based on a five person household. We tested these against the 2018 data we collected from providers to see whether the assumptions used in the model are reasonable on a per person basis. In order to make a fair comparison, we have indexed the input assumptions from the model to 2018 values by using CPI data for the 12 months to 31 March 2018.

Food costs

- The table opposite (top) presents the modelled costs for food of $7.21 per person per day against the average, minimum and maximum providers spent on food per person each day in 2018 (our sample included nine different provider responses).
- Overall, the assumption used within the model is $2.05 or 22% lower than the average daily cost of food but $0.21 or 3% higher than the minimum. A key reason for this variance is because the model does not take into account the support workers who do not have a meal break and eat with their clients. Furthermore, the assumption has been taken from the 2013 HES, which is out of date in terms of the basket of goods included for food. The data is also based on an average household of five residents, though the needs of the clients in many houses is much greater than an average five person household due to specific dietary requirements of their clients.

FY18 Average daily food cost



Source: Provider responses & RPM

Part B: RPM | Comparison of Key Assumptions

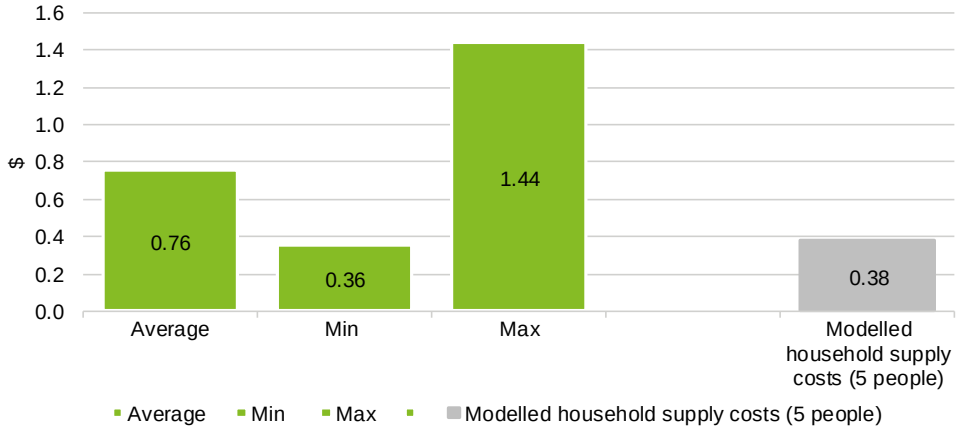
Household supplies

- The table opposite (top) presents the modelled costs for household supplies of $0.38 per person per day against the average, minimum and maximum providers spent on household supplies per person each day in 2018. Our sample included seven different provider responses. Household supplies include items such as cleaning agents, toilet paper and disposable items.
- Overall, the assumption used within the model is $0.38 or 50% lower than the average daily cost of household supplies but $0.02 or 6% higher than the minimum. A key reason for this variance is because the 2013 HES data is based on the household supplies required for a standard household. Providers say specialist cleaning equipment is required for many clients in relation to hygiene (for example bed changes and infection control). Also as some of the houses are occupied for all hours of the day (as they do not go out for day programmes) they use more household supplies than a standard household would.

Telecommunication costs

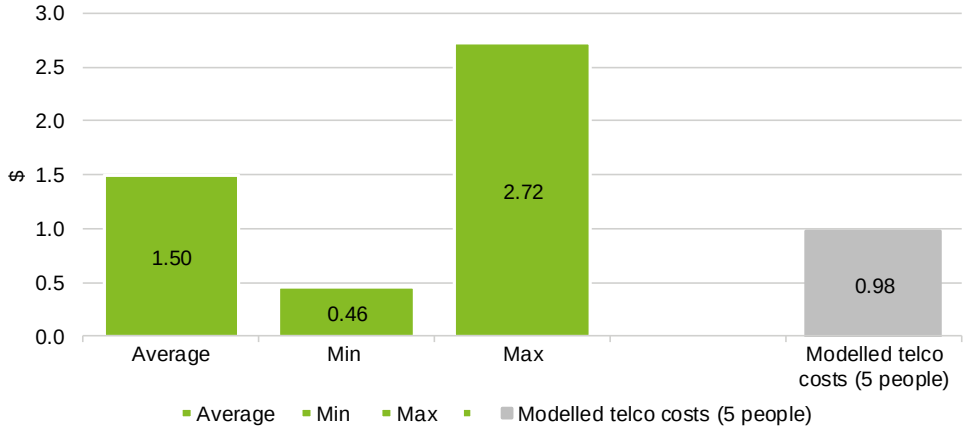
- The table opposite (bottom) presents the modelled costs for telecommunication services and equipment of $0.98 per person per day against the average, minimum and maximum providers spent on telecommunications services and equipment per person each day in 2018. Our sample included seven different provider responses.
- Overall, the assumption used within the model is $0.52 or 35% lower than the average daily cost of telecommunication services and equipment but $0.52 or 113% higher than the minimum.
- Telecommunications have changed dramatically over the past five years, with technology such as fibre and wifi becoming standard in most households. This should be incorporated within the assumption for telecommunication costs.

FY18 Average cost of household supplies



Source: Provider responses & RPM

FY18 Average telecommunications cost



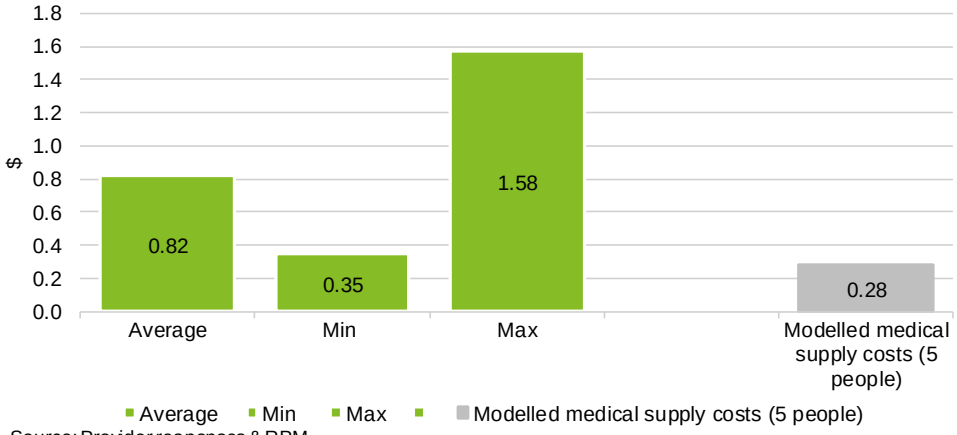
Source: Provider responses & RPM

Part B: RPM | Comparison of Key Assumptions

Medical supplies

- The table opposite (top) presents the modelled costs for medical supplies of $0.28 per person per day against the average, minimum and maximum providers spent on medical supplies per person each day in 2018. Our sample included six different provider responses.
- The assumption used in the model is $0.54 or 66% lower than the average daily cost of medical supplies and $0.07 or 20% lower than the minimum. A key reason for this variance is because the 2013 HES data is based on the medical supplies required for a standard household but, from discussions with providers, some supplies like gastro feeding tubes are generally paid for by them.
- As the DI population ages, many residents have a greater need for medical supplies and specialist equipment.
- Providers have also noted clients are required to fund their own doctors' visits and prescriptions. In many cases this falls on the provider when the client cannot afford to pay for them.

FY18 Average cost of medical supplies



Source: Provider responses & RPM

Part B: RPM | Comparison of Key Assumptions

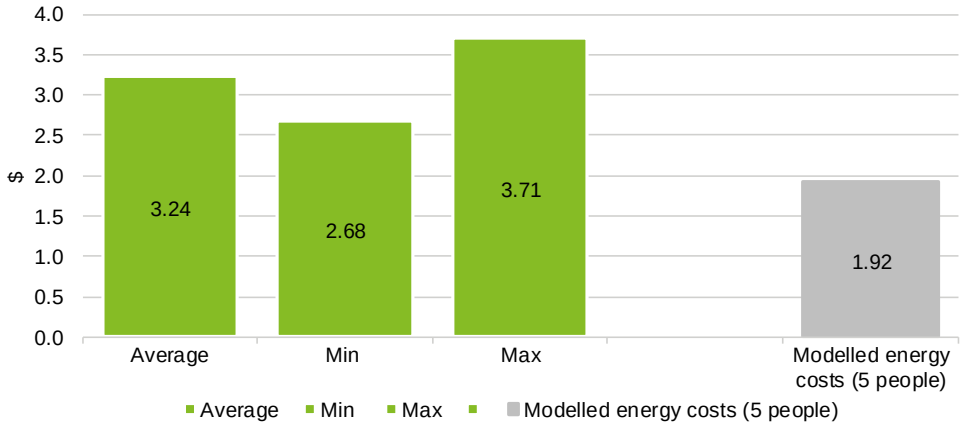
Energy costs

- The table opposite (top) presents the modelled costs for energy cost of $1.92 per person per day against the average, minimum and maximum providers spent on energy costs per person each day in 2018. Our sample included seven different provider responses.
- Overall, the assumption used within the model is $1.32 or 41% lower than the average daily cost and $0.76 or 28% lower than the minimum.
- As many provider households are 24/7 and include specialist equipment which needs to be run at all times, residents are consuming energy at a much higher rate than a standard five-person house. As energy consumption will depend on the requirements of the clients living in the house, the model should take into account the complexity of the support required.
- Finally, the modelled assumption does not take into account water tax which needs to be paid for in Auckland, Tauranga and other regions.

Summary

- Based on our anlaysis of five assumptions included in the RPM, all of them were well below the average responses from our survey and two out of five were below the lowest cost.
- The assumptions used are based on a general population survey. As the needs of clients are much greater than a standard household the assumptions could better reflect the costs providers are currently incurring.

FY18 Average energy cost



Source: Provider responses & RPM

Part C: Qualitative Perspectives and Literature Review

Part C: Qualitative Perspectives and Literature Review | Literature Review

Overview

- The 2017 pay equity settlement for care and support workers brought unprecedented opportunities for the disability sector. Aside from often giving workers a substantial pay rise, it also meant a career in disability support should – in theory – be more attractive than it has been previously.
- This is an opportunity not to be squandered. Growing the sector means increasing capacity to support the country's disabled population, as well as strengthening capability, particularly as ST will mean news ways of working for disability support staff and other health professionals.
- As part of our interviews with providers, we covered four areas pertaining to workforce issues: compensation; education and training; recruitment; and working conditions.
- Feedback and key themes were summarised and compared to literature in other jurisdictions undergoing ST to patient-centred and directed care, as well as New Zealand literature.
- A review of the international literature shows while there is documentation on health workforce planning in general, there is a limited amount specific to disability carers. Literature on the broader home and community care sector also exists.
- Because of the broad similarities between the disability and home and community care sectors and their workforces, literature on both sectors has been included for review.

Part C: Qualitative Perspectives and Literature Review | Literature Review

Compensation: Providers' view

- While providers welcomed the support workers' uplift in wages through the 2017 pay equity settlement, it had created compensation issues for the wider workforce. In order to maintain relativities between support workers and supervisory and management staff, providers have had to self-fund pay rises for staff not covered by the settlement. Universally, providers raised this as a concern, particularly as they felt they had no choice in the matter if they were to retain staff and maintain staff harmony.
- While some had seen support staff turnover decline with the advent of pay equity, others viewed the effect as fleeting, and believed turnover had returned to pre-settlement levels after a short time.
- While specific incentives for support workers – over and above pay – were not specifically mentioned, a number of providers had equipped their staff with smartphones and laptops or tablets to help them work flexibly and remotely. Some had installed computers in residential homes to help both clients and staff.
- Some, but not all, providers felt pay equity had contributed to making disability support a more attractive career. However, while some disability sector jobs and similar roles in DHBs were paid commensurately, others felt the gap was glaring and meant the sector was still not viewed desirably.
- The broader issue of compensation to the providers themselves was without exception raised as an issue, with the 'averaging' approach to pay leaving those who employed highly qualified staff disadvantaged. Providers across the board wanted actual compensation for their staff, and felt they would be more inclined to take on Level 3 and Level 4 staff if actual wage rates were paid.
- The second aspect of this was the cumulative effects of policies, including the sleepover settlement, the Vulnerable Children's Act, and health and safety. Providers felt these brought significant compliance costs which were not recognised by funding agencies.

Compensation: Literature review

- The quality of remuneration is a consistent theme in the literature. Compensation issues include low wages, lack of wage parity with counterparts in institutional settings, and/or workers in other jurisdictions (Home Care Sector Study Corporation, as cited in Keefe, Knight, Martin-Matthews and Legare, 2011). The issue of parity was also raised by NZDSN and the Public Service Association (**PSA**) in 2012. While to an extent the issue of mandated better pay for support workers may have been alleviated in New Zealand, other forms of compensation could be examined. Providing formal recognition and additional incentives, including parental leave over and above legal obligations, use of a company car, awards for good performance and formal feedback were identified as incentives specific to disability service providers, according to Laragy et al (2013).
- The 2017 pay equity settlement in New Zealand may mask the issue of casualisation of the workforce. According to Nugent (2007), without regular or guaranteed hours, a second job is often necessary to achieve an adequate income (as cited in Keefe et al, 2011). Casual workers can be distressed by irregular working hours and often wish for more job security – and the disability sector cannot complete for recruits with similar fields if most of the work was casualised and workers had no career prospects (Laragy et al, 2013).

Part C: Qualitative Perspectives and Literature Review | Literature Review

Education and training: Providers' views

- It is clear from the literature that availability of training is one thing, and the quality of training is quite another. Most providers invest heavily in inducting and training staff, and many were doing so from the perspective of being ready for the demands of ST, including developing negotiation skills, critical thinking and problem-solving. Several providers were bringing in experts from other jurisdictions to help upskill staff, often at considerable cost to themselves. Broadly speaking, there were several reasons for this investment:
  - Providers did not often consider the offerings from Careerforce appropriate for developing the type of support worker who could cope with the requirements of ST. As one provider said, "we don't need carers, we need professionals."
  - Providers felt there was a noticeable gap in training specific to de-escalating and managing complex behaviour.
  - Providers were self-funding as the training grants provided by Te Pou had shrunk in recent years.
- Providers often relied on technology to deliver training, including using e-learning and online training modules.
- Interestingly, a number of providers felt the qualifications pathway formalised under the pay equity settlement was not a great inducement for staff, many of whom were not motivated to gain further qualifications and increase their wage packet.
- One provider, which specialised in kaupapa Maori services to a largely Maori and Pasifika client base, felt there was a cultural barrier to implementing ST: "We have a high number of Maori and Pasifika staff. The more Western way of looking at the world is that people and systems are egalitarian. But we are hierarchical and whanau-based, not egalitarian and individual. A Maori staff member might be more inclined to take the advice of a kaumatua than their boss. The Ministry needs to acknowledge these cultural differences as part of the implementation of Enabling Good Lives."
- The provider felt, more generally, that kaupapa Maori would be lost in ST. With many clients and staff related, and some relationships stretching back decades, the possible weakening of strong whanau-based loyalty was a concern.

Education and training: Literature review

- For the purposes of this literature review, education will focus on formal qualifications, while training dwells on the ongoing training support providers can offer workers.
- In health systems undergoing transformation, the way health professionals work together is an important part of training and learning. Lavis, Moat & Waddell (2016) note the traditional hospital-led or physician-led approaches do not take into account more integrated, multi-disciplinary teams and new models of care. Training, too, is not always aligned with the scope of practice – defining how health workers perform their tasks alongside other professionals.
- The state of Victoria's Workforce Plan (2016) approaches this by testing collaborations between the National Disability Insurance Scheme (**NDIS**) and services, such as justice and health, to support disabled people.
- Laragy et al (2013) note many workers are facing a role change in Australia, with the emphasis on "high-quality and innovative support that enable people with disability to maximise independent lifestyles and full inclusion in the mainstream community" expanding their roles and demanding new skills.
- The state of Victoria's Workforce plan for the NDIS offers practical solutions for this transition, including:
  - A self-assessment tool to help the workforce identify new skills and appropriate development opportunities
  - A multi-stream training approach for new skills and capabilities that align with service delivery requirements
  - A workforce-readiness portal with relevant tools, learning resources and practical support for the workforce
- This last point is interesting, as it indicates the need for a more deliberate use of technology to help disability workers stay engaged with each other, and with training opportunities.

Part C: Qualitative Perspectives and Literature Review | Literature Review

Education and training: Literature review (continued)

- Laragy et al agree, recommending Skype and Facebook be used for staying in touch and networking – which is especially useful for workers in rural and remote areas. Interestingly, telehealth and other technologies to assist the person/support relationship are not discussed in the literature, perhaps because it would not suit all patients.
- The need to educate support staff with skills to work in a transformed environment is also important (Laragy et al, 2013), with skills including communication, creativity and self-discipline called out, among others.
- The emphasis for education is on quality. The Victoria Workforce Plan outlines the needs for high-quality work placements, and a review of relevant disability qualifications to identify and respond to any gaps. Leragy et al also advocate for IT learning platforms.
- Greater uptake of IT across all aspects of the business is seen as crucial in the Tasmanian Disability Workforce Strategy and Action Plan (National Disability Services, 2016). It points to innovative IT solutions to support reporting and supervision efficiencies, and 'train the trainer' programmes to train workers internally for IT systems use. The Plan also points to initiatives to professionalise the workforce, including a leadership training programme, and training on leading a diverse workforce. In terms of service delivery, the plan points to workplace literacy, preparing people for person-centred service delivery, and strengthening staff to support people with behaviours of concern.
- Going a step further, the Victoria Workforce Plan has a focus on excellence in research and education, and the Future Social Services Institute will develop training, education and research in the disability sector. Similarly, the Tasmanian Workforce Plan set out plans to develop a Training Quality Network to validate and moderate courses, and to complete teaching and learning resource development.
- The plan will also promote social care and support as a valuable career. This is an important point, as disability support can be seen as 'women's work' (Stace, 2013) and perhaps not accorded the level of respect it ought to be.

Recruitment: Provider feedback

- Some providers had experienced perverse outcomes from the settlement. While some had experienced an immediate improvement in hiring after the pay equity settlement came into effect, this didn't linger. Many providers spoke of difficulty in recruiting for management or supervisory roles, because the relativity gap was now so slim.
- Some providers whose point of difference had been their high wages now saw that eroded, and recruitment was now consequently more difficult.
- The ability to recruit also varied depending on location, with some providers in the regions saying they found it easy to recruit skilled people given the absence of other employment opportunities – while others in the same position found it tough, citing quality rental accommodation and transport as issues. City-based providers found they had different pools of talent to draw from, particularly students – but also faced competition from a range of other industries.
- Overall, most providers felt they, and the sector, could do more to attract a range of people, 'sell' the industry as a career, and bring on board the right people to work in a transformed system.

Recruitment: Literature review

- Deinstitutionalisation has been cited (New Zealand PSA and New Zealand Disability Support Network, 2012) as a cause of the 'feminisation' of the disability workforce. In Australia, where the workforce predominantly comprises women aged in their 40s-50s, efforts are underway to attract a range of people to the sector. Both Laragy et al (2013) and the Victoria Workforce plan note the need to recruit both indigenous and linguistically diverse staff.
- Laragy et al (2013 specify using word-of-mouth networks for workforce recruitment, specifically for rural and remote, and indigenous, staff. They also advocate for more tailored recruiting, matching people with disabilities to staff who have certain skills or areas of interest.

Part C: Qualitative Perspectives and Literature Review | Literature Review

Recruitment: Literature review (continued)

- Keefe et al (2011) note some similar, and some different tactics, including having a single point of contact for recruitment and allowing staff to 'try out' the job. They agreed targeting recruitment campaigns can also help attract the workers the sector wants. Yamada (2002) found younger workers were attracted to opportunities for career advancement (as cited in Keefe et al, 2011)).
- The Victoria Workforce Plan is taking a deliberate approach to bridging the gap between training and recruitment. It will facilitate partnerships between disability service providers and education and training establishments, and trial collaborative workplace models.
- Interestingly, the literature shows little other evidence of such formal arrangements between training institutions and the sector to help bridge the gap between training and employment.
- Perhaps undermining the concerns around casualisation, Laragy et al also recommended targeting workers including university students, parents who want to work school hours, 'grey nomads' who work part of the year, or migrant workers on temporary visas.
- This seems to be at odds with the desire for both patients and workers to form long-term, meaningful relationships in a transformed environment.
- Perhaps the overall point is that people from a range of backgrounds need to be recruited, and the profession needs to be elevated with specialised, robust courses.
- Laragy et al recommend expanding disability workers' roles into formal planning to show their knowledge and judgement is appreciated. Providers can also develop formal induction, mentoring and performance review processes, ensuring workers understand health and safety, and disability, rights. Such formal processes may assist in 'professionalising' the sector and foster a sense of 'team.' This is important as, in New Zealand, one of the effects of deinstitutionalisation is greater autonomy and a lessening of peer support for disability workers no longer based in hospital-like settings (NZDSN and PSA, 2012).

Recruitment: Literature review (continued)

- Access to a coordinator or supervisor can build confidence and skills, and supports including an Employee Assistance Programme (**EAP**) line can be useful (Laragy et al).

Working conditions: Provider feedback

- In New Zealand, 10% of the disability support workforce was casual in 2015 (Te Pou o te Whakaaro Nui & NZDSN, 2015), while casualisation of the Australian disability workforce is rising, up from 40% in September 2015 to 46% in March 2018 (Alcorso & Lui, 2018).
- Providers were divided on whether or not large-scale casualisation of the workforce would come to fruition with ST. Some believed the matching of staff to people would mean becoming creative with contracts, in order to ensure there was a degree of guaranteed work. Others felt there was little chance of casualisation increasing, given the difficulty it would present with the current collective agreement.
- The majority of providers agreed ST would change how they operated their business, particularly as they would be competing for clients, dealing with clients individually (rather than being funded centrally) and competing for the best staff. A number were already working on branding and marketing issues in anticipation of a new way of working.
- All were concerned the 'true cost' of service provision was not well understand by funders, and felt ST would be difficult for a number of providers and the people they provided services to.
- Australia's State of the Disability Sector report (National Disability Services, 2017) notes 'most disability service providers support the direction of change, but they feel under immense pressure. The NDIS demands huge growth and change at the same time'.
- The casualisation of the workforce has positive and negative elements. Laragy et al (2016) noted casual work suited those who preferred flexibility, whereas others, echoing Cortis' (2017) findings, were distressed by their insecure positions and irregular working hours. Guaranteeing minimum hours, matching the person to the worker, flexible working arrangements for work/life balance were suggested as ways to improve working conditions.

Part C: Qualitative Perspectives and Literature Review | Literature Review

Working conditions: Literature review

- The report notes services providers are concerned about low NDIS prices, the costs of change, and uncertainty about their financial sustainability. And these can flow into working conditions, with the cost of transport, the difficulty of providing services in rural and remote areas, and narrow margins reducing the ability to invest in the workforce cited by providers as impacting working conditions. Around 60 per cent of providers were finding it difficult to recruit disability support workers. While under-employment is already high in Australia's broader health care and social assistance sector, casual part-time work is the biggest employment growth area (National Disability Services, 2016).
- Cortis (2017) notes a range of ways in which the NDIS impacts workers' lives, including risks to quality and safety being linked to the use of casual staff, and untrained staff entering the sector. Other concerns included pay and conditions, loss of penalty rates, and roster changes. The majority of support workers felt they did not have time to do all their job demanded, and they worried about the security of their job.

Part C: Qualitative Perspectives and Literature Review | The Impact of DI

The impact of De-institutionalisation

- Providers we spoke to felt the lingering impacts of DI to different degrees, depending on where in the country they offered their services, how and when their own organisation was established, and the types of services they offered.
- It is interesting to look back at how staff in institutional settings thought community services would play out, and compare those thoughts to the concerns and optimism around ST – the next 'wave' of the evolution of New Zealand's DSS.
- The Donald Beasley Institute published *The impact of deinstitutionalisation on the staff of the Kimberley Centre in* 2008. The facility, which closed in 2006, was the last institution left in the country.
- This section looks at some of the experiences of staff at the Kimberley Centre, and compares these to themes pertaining to ST, building a picture of how DI has evolved and impacted disability service provision. This section then explores some of the regional differences providers experience, since these can often be linked to the legacy of DI.

Gender split change

- The Kimberley Centre employed a range of people, from care and support workers, health professionals and trade people and, of the 349 staff, the split was roughly 60% male and 40% female.
- The PSA and New Zealand Disability Support Network (2012) pointed to DI as contributing to the 'feminisation' of the disability workforce. The providers we interviewed had a mix of gender splits, generally about 70% women and 30% men. However, one provider had a 50-50 split, and also spoke of having an unusually high qualified workforce, with about 40% having tertiary qualifications.

Wage rate fears

- Staff at the Kimberley Centre reported the wages being offered by community providers around 2006 as lower than they were accustomed to earning. The PSA and NZDSN (2012) links the feminisation of the workforce to lower wages, which to an extent has been alleviated by the 2017 pay equity settlement. However, providers are uncertain how ST will affect the certainty of wages and hours for support staff. Some believe wages paid by DHBs are higher than they can afford, which would make securing staff difficult.

Medical assistance

- Staff interviewed in the Kimberley report noted concerns around the availability of medical assistance for residents moving to community settings. While this was not spoken of as a concern among all providers, some were concerned annual health checks for disabled adults were an extra cost, meaning preventable or treatable illnesses might not always be picked up.

Suitability of staff for a 'new way of working'

- Kimberley staff reported not initially being wanted by community services providers, because they were not accustomed to the new way of working – they were not used to delivering services in a 'more empowering and respectful approach.' While the report notes some were eventually employed in community settings, providers today are grappling with the same issue. Many are running two service delivery systems – one under the current contracting approach, and the other under a style they believe is more suitable for ST. One provider said they would only put new staff in their ST team – "None of our existing staff work in the EGL business. We are looking for a completely different person – they must think laterally, be respectful, and being non-judgemental should be a way of life for them".

Part C: Qualitative Perspectives and Literature Review | The Impact of DI

Change and the effect on staff

- The Donald Beasley Institute's report was created to fill a gap in the literature on DI – while much had been written about the effects on residents and their families, few countries undergoing DI had examined the effects on the staff whose working lives were going through upheaval.
- ST will also bring change at least as significant as DI. However, providers are unclear about how ST will affect their business models, their financial sustainability, and their relationships will the people they support. It will also likely bring changes to the skills required from staff, they ways they are contracted and employed, and the expectations from disabled people.

DI and regional differences

- Providers we spoke to painted a complicated picture around regional differences, some of which are driven by the legacy of DI.
- Historical funding for people moved from institutions into community settings was raised as an issue, with providers saying formers residents in the North Island were funded differently to those in the South Island. Areas like Nelson/Marlborough and the Horowhenua, where institutions had once existed and where a high proportion of disabled people resided, received what were perceived to be as 'higher' or 'better' funding arrangements.

Needs Assessment Service Coordination (NASC)

- Provided regionally, the NASC offices deem the appropriate levels of service for disabled people. Some providers expressed frustration with NASC staff, with some saying the concepts of EGL and ST hadn't quite penetrated the assessment services – meaning few people were being referred to programmes like Choices in Community Participation where it was available.

Needs Assessment Service Coordination (continued)

- Many providers spoke of under-funding for high and complex needs – in most regions, it was felt there was a shortfall in both funding, and appropriate support from the MoH, for supporting people on the ASD.
- Some providers also felt there was a disconnect between the level of disability in an area, and the level of available funding and, overall, the NASC could improve its funding administration.

Urban-rural divide

- The urban-rural divide is nuanced and complex. Broadly speaking, there are more services – and more appropriate services – available in cities. Providers spoke of smaller, more isolated places - like the West Coast, Central Lakes, East Coast and Coromandel – having their services stretched thinly. One provider spoke of a young female disabled adult having to be housed in a rest home for respite care, because there was no other suitable service available. Another spoke of the difficulty in sourcing a support worker for someone living very remotely – and the provider worried that individual funding was all very well, but would make no difference if that person couldn't employ anyone to provide support because of their isolation.
- At the same time, providers spoke of the great spirit of service in rural areas, and the commitment from staff to the people they supported. Providers away from the larger cities talked of being able to innovate and experiment, without perhaps the constraints experienced by their provider colleagues with more formal oversight and scrutiny.
- While most providers experienced difficulty in recruiting and retaining staff, the issues as to 'why' were not easy to ascertain. Some in the regions felt it was easier to recruit staff, while some in the cities felt they had a bigger talent pool to choose from.
- Perhaps surprisingly, a number of providers believed Wellington was under-resourced, with a limited availability of appropriate programmes for disabled people and their families.

Part C: Qualitative Perspectives and Literature Review | The Impact of DI

Employment services

- Those who provided employment services felt it was easier to place disabled people in work in the regions. One provider said the reason for this was 'multi-pronged': "There is more competition overall in the metro areas. Also, there are often more highly skilled jobs in the cities, so it's harder to compete in those markets."
- Some providers also felt the MSD's regional and national contracts caused confusion for frontline staff, with disabled people referred to an incorrect or inappropriate contract.
- At the same time, providers funded for employment services were pleased with the 'milestone' contracts they operated under, and felt these better reflected the 'true cost' of the services MSD funded them for.
- There were mixed feelings about the impact of ST on employment services – primarily, that it might lead to a decline in overall employment rates for disabled people. Potential casualisation was cited as the cause of this, as providers believed staff consistency was needed to build relationships with employers who could provide repeated opportunities for people.

Possible Responses and Conclusions

Possible Responses and Conclusions | Possible Responses

Key Issue	Possible Reponses	Feasibility and Impact
Costs for residential providers may be greater than funding levels	• Introduce principles to enable a limited amount of model adjustment • Providers find cost savings or reduce margins.	• Public health funding is limited. Principles for residential funding may make model rationale transparent. Clear communication and understanding of this rationale among the funder and providers may make it possible to build in a limited amount of tailoring for individual providers. • Most providers participating in the survey appear to be cost-efficient, with low margins. Many are taking steps already to reduce overheads by shedding staff, for example.
Maintaining relativities between indirect and direct staff at organisations is difficult, as is providing salaries comparable to those in the wider health sector	• Providers cease to maintain relativities. • Providers maintain relativities and seek further compensation. • Work with the wider health sector to address relativities, particularly for management staff.	• Providers may find it hard to recruit and retain management and supervisory staff if relativities are not maintained. • Maintaining relativities seems to be essential to preserve staff harmony. Working with funders and the wider sector on this issue could help to resolve two points – the gap between staff at DHBs vs those employed by providers; and the gap between level 1 and the minimum wage, which may cease to exist by 2021.
The current averaging approach places pressure on providers employing highly qualified staff	• Providers seek to have actual wage costs paid to encourage retention of qualified support staff. • The averaging approach for wage funding is maintained.	• With limitations on public funding, absolute actuals might be difficult to implement, although a greater degree of bespoke funding may alleviate pressures for providers. • Maintaining the averaging approach appears to be leading to perverse outcomes, including a reluctance to hire level 3 and 4 staff.

Possible Responses and Conclusions | Possible Responses

Key Issue	Possible Reponses	Feasibility and Impact
Qualifications and education offered are not seen as relevant, particularly for System Transformation	• Work with funders to complete a stocktake of disability qualifications. • Continue to self-fund training. • Collaborate on shared technology-based training platforms. • Investigate opportunities to work with professionals from other sectors, like youth justice and education. • Investigate the learnings from the Future Social Services Institute in Victoria to understand potential applicability to the New Zealand context.	• This would be useful to identify the current offering of qualifications and any gaps. If appropriate, the sector could look to develop robust training to suit the purposes of the people they support, and training which amplified the 'professional' mind-set and skills needed. • Providers are undertaking a lot of training at their own expense which may not be sustainable over the long term – though a certain amount of self-funding may always be required. • Online and e-learning appear to be popular, so providers might find cost savings by pooling resources. • System transformation may require working more closely with other sectors. Learnings from working with people in education, who work with complex behaviour, might uplift skills more generally for the sector. • Learnings around a 'centre of excellence' may contribute to uplifting skills in the sector.
Retention and recruitment is often a challenge for providers	• Seek to develop tailored recruitment strategies to attract people from a range of backgrounds to support individuals. • Foster relationships with training providers to develop a pipeline of talent coming through the sector.	• It appears providers are already trying to better match staff with people, and this will only become more widespread with ST. • Strengthening the links between education providers and employers would develop a stronger pipeline of talent and would not necessarily have to impose a large financial burden.
There is uncertainty around the impact of ST on individuals, staff and provider organisations	• Work with unions and government agencies to monitor and evaluate the impacts of ST on the workforce and the people they support, particularly with regard to casualisation. • Work collaboratively with government agencies to understand the effects of ST on the cost of service provision, and monitor financial sustainability of providers.	• Casualisation can have a substantial impact on the workforce and individuals, and maintaining a watching brief could pick up issues early on. • In any system-wide change it makes sense to establish a monitoring and evaluation plan in order to track the expected benefits and risks, and manage issues.

Possible Responses and Conclusions | Conclusions

Funding and cost pressures

- Provider margins have narrowed over time, both for property-owning and non property-owning providers. Providers point to the 2017 pay equity settlement as a contributor, with wage costs rising and the averaging approach impacting providers to various degrees. Based on our analysis, it appears the yet-to-be-released Residential Pricing Model does not incorporate some of the 'realities' of residential support, including meals, transportation requirements and medical supplies.

Pay relativities

- The issue of relativities is multi-layered. The first is maintaining relativities between staff covered by the 2017 pay equity settlement and those out of scope – generally managers and supervisors. The second is the relativity gap between roles at disability providers and similar roles in the wider health sector, which can make recruitment difficult. The third is the narrowing gap between the level 1 pay equity band and the minimum wage. Based on our analysis, the minimum wage and level 1 may reach near-parity by 2021.

Education and training

- The current offerings from Careerforce are not always seen as relevant by the sector and, to fill that gap, providers are investing in bespoke training for their staff. It has been suggested funding for training has shrunk dramatically. Providers are seeking education and training fit for System Transformation and a professional sector, and are already active in recruiting a more diverse workforce to better match staff to the people they support.

Impact of System Transformation

- While supportive of the Enabling Good Lives principles, providers are uncertain how System Transformation will affect the people they support, their staff and their businesses. These cover three broad issues: the true cost of service provision and the expectations individual budget-holders may have; working conditions, particularly casualisation; and financial sustainability given the imposts of a new way of working.

Overall conclusion

- The disability sector has experienced the effects of a range of policy and legislative changes since the last institution closed in 2006. While providers are excited about the benefits of System Transformation, there appears to be noticeable cost pressures on providers, with margins closing as they invest to upgrade their operations and upskill their staff. The pay equity settlement also appears to have impacted providers and, despite the uplift in wages, some providers experiencing difficulty retaining and recruiting staff, and finding the 'right' staff for the people they support.

Appendices

Appendices | A1: Scope

Scope of services

- Deloitte has been engaged to provide NZDSN with the following services:

Part A:

- A 10-year overview of the Government's annual funding changes, in relation to MoH and MSD DSS-funded services, compared with:
  - the CPI and other general cost increases, including minimum wage adjustments; and
  - compliance costs changes, including for example employer contributions to KiwiSaver, the effect of Mondayising public holidays, and any other policy or regulatory changes which have impacted on provider cost profiles.
- A literature review on overseas trends around technology and workforce, which may assist NZDSN develop new policy platforms in the future, and to put into context the issues the local sector is facing.

Part B:

- An assessment of the Residential Pricing Tool, which will reference work already completed by NZDSN and the Provider Representative Working Group, comprising:
  - reviewing the underlying model which supports the Residential Pricing Tool developed by the MoH (with KPMG), and associated material provided by NZDSN, to understand and provide an independent perspective on the basis for the model assumptions and approach;
  - a high-level assessment of the impact of the 2017 pay equity settlement among NZDSN members;
  - providing an overview of funding differences across different regions of New Zealand;
  - Assessing the longitudinal impact of the deinstitutionalisation programme.

Scope of service (continued)

- It is intended for Part A and Part B to be accorded equal weight in the report, with Part A being a broader overview of revenue and cost pressures impacting on your members, while Part B is a deeper dive, albeit still relatively high-level analysis of the proposed RPM and Tool, which is an issue affecting a subset of your members. Our report will highlight key findings based on the evidence and analysis undertaken by Deloitte. Where appropriate, the report will include conclusions from our analysis and make suggestions as to further actions.
- The following matters are excluded from the scope of our Services:
  - Benefit analysis;
  - Solutions and recommendations regarding alternative commissioning models and next steps.
- We understand that the analysis is being commissioned from us to assist with your ongoing engagement with the Health, Associate Health and Social Development Ministers, and officials from the Ministries of Health and Social Development, regarding funding and pricing for DSS. Our report (the Report) will be prepared for this purpose (the Purpose) and no other.
- The scope of our work will be limited to the matters set out in this letter.
- In undertaking this engagement, we will provide:
  - A high level of support from Deloitte team members, who will work with you and your members collaboratively;
  - Research into historical funding rate changes, and regional differences;
  - An examination of the Residential Pricing Tool;
  - Financial statement analysis of selected members (with their permission and engagement);
  - Design and dissemination of a survey of up to 14 of your members;
  - Analysis and synthesis of themes and key findings into an easily understood report;
  - A draft report for your review and comment, followed by a final report.

Appendices | A2: Restrictions and Disclaimer

Restrictions and limitations

- This report is not intended for general circulation or publication, nor is it to be reproduced or used for any purpose other than that outlined in section 1 without our prior written permission in each specific instance. We do not assume any responsibility or liability for losses occasioned to NZDSN, its directors or shareholders or to any other parties as a result of the circulation, publication, reproduction or use of this report or any extracts there from contrary to the provisions of this paragraph.

Reliance on information

- In preparing this valuation we have relied upon and assumed, without independent verification, the accuracy and completeness of all information that is available from public sources and all information that was furnished to us by NZSDN and its providers.
- We have evaluated that information through analysis, enquiry and examination for the purposes of forming our valuation opinion. However, we have not verified the accuracy or completeness of any such information nor conducted an appraisal of any assets. We have not carried out any form of due diligence or audit on the accounting or other records of NZDSN or its providers. We do not warrant that our enquiries have identified or revealed any matter which an audit, due diligence review or extensive examination might disclose

Disclaimer

- This report has been prepared with care and diligence and the statements and conclusions in this report are given in good faith and in the belief, on reasonable grounds, that such statements and conclusions are not false or misleading. However, in no way do we guarantee or otherwise warrant that any forecasts of future profits, cash flows or financial position of NZDSN or its providers will be achieved. Forecasts are inherently uncertain. They are predictions of future events that cannot be assured. They are based upon assumptions, many of which are beyond the control of NZDSN and its management. Actual results will vary from the forecasts and these variations may be significantly more or less favourable.
- We assume no responsibility arising in any way whatsoever for errors or omissions (including responsibility to any person for negligence) for the preparation of this valuation to the extent that such errors or omissions result from the reasonable reliance on information provided by others or assumptions disclosed in this report or assumptions reasonably taken as implicit.

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- Deloitte's Master Terms of Business forms part of the engagement letter with NZDSN, dated 30 June 2018. The Master Terms of Business contains Deloitte's standard clauses relating to indemnity from third party claims and limitations of liability to NZDSN.

Appendices | A3: Sources of Information

Sources of information

- In undertaking our work, we have relied on the following sources of information:
  - NZDSN 2017 annual report;
  - NZDSN residential pricing and pay equity presentation to MoH;
  - Residential Price Tool / Model received from NZDSN;
  - Annual reports for the 14 providers surveyed;
  - Survey responses from providers (along with additional follow up information);
  - DSS 10 year funding from MoH;
  - MSD 10 year funding from MSD;
  - Qualitative interview responses from providers.
- We have also had discussions with the following people:
  - Garth Bennie: NZDSN CEO;
  - Toni Atkinson, MoH
  - Sacha O'Dea, MoH
  - Kelvin Moffat, MSD
  - 14 providers along with key members from their management team.

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Appendices | A4: RPM Calculations

Input assumption specific to client

Labour cost ($15.75) Min wage rate - April 17
+ Loading (23.8%)
= Loaded hourly rate

Input assumption specific to client

Appendices | A4: RPM Calculations

2 **House Maintenance** = **Contents Insurance** + **Lawn Mowing** + **Maintenance** + **Depreciation**

Contents Insurance	Lawn Mowing	Maintenance	Depreciation
$787.65 (quote based on 5 person household) = $157.53 per person	$30 per fortnight (based on 5 person household) =$156 per person	$699.89 per person estimate based on 2003 Deloitte survey indexed to 2017	24% depreciation based on $8,771 of contents =$2,105.01 per person

3 **Transport** = **Vehicle Costs** + **Insurance Costs**

Vehicle Costs	Insurance Costs
$6,381.80 – based on data obtained from ECCA on June 17	$698.13 – based on the average of 8 quotes obtained from interest.co.nz

Appendices | A4: RPM Calculations

4 **Food and Household Supplies** = **Food cost per person** + **Household cost per person**

Fruit and Vegetables
Meat, poultry and fish
Grocery food
Non-alcoholic Beverages
Restaurant meals and ready to eat food

Household supplies per person

Model Assumptions - Food and household supplies (weekly cost) per person

Number of people in a household	1	2	3	4	5
Average weekly household expenditure per person					
Food	81.6	86.6	73.1	69.0	63.6
Fruit and vegetables	11.5	10.6	7.9	7.9	6.9
Meat, poultry and fish	12.9	12.9	9.9	10.1	8.9
Grocery food	34.2	33.9	30.8	30.5	29.2
Non-alcoholic beverages	4.9	5.3	4.7	4.0	3.5
Restaurant meals & ready-to-eat	18.1	24.0	19.9	16.5	15.2
Food cost included in model	**63.5**	**62.7**	**53.2**	**52.5**	**48.4**
Other household supplies	4.7	4.2	3.4	3.4	2.7
Total unindexed food and supplies	**68.2**	**66.9**	**56.6**	**55.9**	**51.1**
Total indexed food and supplies to 2017	**70.1**	**68.7**	**58.2**	**57.5**	**52.6**

Source: 2013 Household Economic Survey

5 **Utilities** = **Telecommunications per person** + **Energy cost per person**

Telecommunications equipment
Telecommunication services

Household energy cost

Model Assumptions - Utilities (weekly cost) per person

Number of people in a household	1	2	3	4	5
Average weekly telecommunication costs per person					
Telecommunication equipment	-	0.6	0.9	0.4	-
Telecommunication services	23.8	15.6	12.6	9.9	7.5
Household energy	30.7	22.5	16.1	14.0	12.5
Total unindexed telco & energy cost	**54.5**	**38.7**	**29.6**	**24.3**	**20.0**
Total indexed telco & energy cost to 2017	**54.2**	**38.6**	**29.3**	**24.2**	**20.1**

Source: 2013 Household Economic Survey

Appendices | A4: RPM Calculations

6 **Overheads** = **Overheads** + **Management Costs**

2013 Price	Stationery (30.9)
2013 Price	Office rental (6,714.2 shared across 20 clients)
2015 Price	Phone rental (1,188.0 shared across 20 clients)
2015 Price	Mobile – business (684.0 shared across 20 clients)
2015 Price	Other opex (1,200.0 shared across 20 clients)
2015 Price	Postage (0.45)
2015 Price	Vehicle reimbursement (0.77 per km, assuming 20km per client)
2015 Price	Depreciation on fixed assets (total value of $5,761) at 24%

x Standard effort / Number of clients

Management costs (79,267 based on Hudson salary data across several management roles) – assume 1 hour per client per week
+
Admin / Accounting costs (41,267 based on average salary data of several admin roles) – assume 0.5 hours per client per week

7 **Medical Supplies** = **Medical Supplies**

Medical products, applications and equipment per person

Model Assumptions - Medical expenses (weekly cost) per person

Number of people in a household	1	2	3	4	5
Indexed medical expenses to 2017	5.3	5.3	3.4	2.4	2.0

Source: 2013 Household Economic Survey

Appendices | A4: RPM Calculations

8 Specialist Services Therapy = Specialist Services Therapy

$27.73 per person per week based on a Feb 2003 value indexed to 2017

Appendices | A4: RPM Calculations

Category	Assumption	Source
1. Staffing costs		
Support worker hourly wage	$17.97	Payscale.com for residential support workers
Sleepover staff hourly wage	$15.75	Minimum wage as at April 2017
Hourly wage loading	Annual leave (20 days) Sick and Berv (10 days) Stat days (11 days) Training (2 days) ACC Levy (1.22%) KiwiSaver (3.0%)	Input assumptions
2. House Maintenance		
Total value of house contents (for 5 people)	$58,789	Based on contents estimates from 4 providers (note a different number is used in the model then described in the notes in column I of the model)
Contents insurance (5 people)	$787.65	Based on internet quote (May 2017) for an Auckland rented house with no alarm
Lawn Mowing (per residence)	$30 per fortnight ($156 per resident per year)	Based on quotes from Trademe for lawn mowing businesses once a fortnight in summer and 3 weeks in winter
Maintenance cost (per resident)	$699.89	Based on a 2003 Deloitte survey indexed to 2017
Depreciation	24%	Input assumption
3. Transport		
Vehicle cost (per resident)	$6,381.80	Based on ECCA information as at June 2017
Car insurance (per resident)	$698.13	Based on quotes from Interest.co.nz

Appendices | A4: RPM Calculations

Category	Assumption	Source
4. Food and Household Supplies		
Food cost	Fruit and Veg ($6.9 – $11.5 per person) Meat (per person $8.9 - $12.9 per person) Grocery food ($29.2 - $34.2 per person) Beverages ($3.5 - $5.3 per person) Restaurant meals ($15.2 - $24.0 per person)	2013 Household Economic Survey
Household supplies	Household supplies ($2.7 - $4.7 per person)	2013 Household Economic Survey
5. Utilities		
Telecommunications equipment and services	Teleco equipment ($0 - $0.9 per person) Telco services ($7.5 - $23.8 per person)	2013 Household Economic Survey
Energy cost	Household energy ($12.5 - $30.7 per person)	2013 Household Economic Survey
6. Overheads		
Overhead costs	Stationery ($30.9 per person) Office rental ($6,714.2 shared across 20 clients) Phone rental ($1,188 shared across 20 clients) Mobile ($684 shared across 20 clients) Other opex ($1,200 shared across 20 clients) Vehicle reimbursement ($0.77 per km assuming 20km per client) Postage ($0.45) Depreciation on fixed assets (24%) Standard effort (input assumption) Number of clients (input assumption)	2013 prices 2013 prices 2015 prices 2015 prices 2015 prices 2015 prices 2015 prices Input assumption Input assumption Input assumption

Appendices | A4: RPM Calculations

Category	Assumption	Source
6. Overheads (continued)		
Management costs	$79,267	Based on Hudson salary data across several management positions
Management time spent per week	1.0	Input assumption that management spend 1 hour per client per week
Admin / Accounting Costs	$41,267	Based on average salary data across several admin roles
Admin / Accounting time spent per week	0.5	Input assumption that admin/accounting spend 0.5 hour per client per week
7. Medical Supplies		
Medical costs	Medical supplies ($2.0 - $5.3 per person)	2013 Household Economic Survey
8. Specialist Services Therapy		
Specialist therapy costs per week	$27.73	February 2003 value indexed to 2017

Appendices | A5: Glossary

Glossary of terms

In this report capitalised terms have the meanings given to them as defined below:

ACC	Accident Compensation Corporation
ASD	Autism Spectrum Disorder
CPI	Consumer Price Index
CRM	Client Relationship Management
DHB	District Health Board
DI	De-institutionalisation
DSS	Disability Support Services
EAP	Employee Assistance Programme
EGL	Enabling Good Lives
GDP	Gross Domestic Product
HES	Household Economic Survey
LCI	Labour cost index
MBIE	The Ministry of Business, Innovation & Employment
MoH	The Ministry of Health
MSD	The Ministry of Social Development
NASC	Needs Assessment Service Coordination
NDIS	National Disability Insurance Scheme
NZDSN	The New Zealand Disability Support Network
ORS	Ongoing Resourcing Scheme
OT	Oranga Tamariki
PSA	Public Service Association
RPM	Residential Pricing Model
ST	System Transformation
W&I	Work and Income

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