



# HealthCare Providers New Zealand

## Table of Contents

1.0 Executive Summary.....	2
2.0 Recognition of the Problem.....	3
3.0 Background to Claim.....	4
4.0 General Issues.....	6
5.0 PricewaterhouseCoopers Pricing Methodology.....	7
6.0 DHB's Response to PricewaterhouseCoopers Methodology.....	9
7.0 Integrity of Providers Spreadsheet Model.....	10
8.0 Relationship between Current Prices and Indicative Prices.....	10
9.0 Comparison of Aged Care Derived Rates with DHB MECA Rates.....	11
10.0 Impact of Applying MECA Rates to Residential Care Prices.....	13
11.0 HCPNZ Member Survey (2006).....	15
12.0 Current Wage Rates.....	16
13.0 Appendix 1 Supporting Information from Nursing Bureau.....	17

Prepared By Max Robins,  
Vice Chairman HealthCare Providers NZ

## **1.0 Executive Summary**

This paper has been prepared to support the claim under Clause A23 of the Aged Residential Care Contract on behalf of aged care providers represented by the Provider Coalition Group (comprising HCPNZ, NZCCS and ARCH).

There is little disagreement that the DHB-NZNO nurses Multi-Employer Collective Agreement (MECA) has had a material impact on aged care providers. For example, the Minister has already received advice from the Ministry of Health confirming that the MECA had material impacted the aged care sector, which has resulted in a disparity in wage rates.

Unless this disparity is addressed, the inability to attract staff will seriously undermine the long-term viability and sustainability of the aged care sector. This situation will become even worse when the next level of wage adjustments takes effect from 1 July 2006 and the ongoing corrosive effect of the disparity in wage rates between public hospital nurses and nurses employed in aged care exacerbates recruitment and retention problems.

Aged residential care providers are in a position similar to that of DHBs prior to their settling the MECA. DHBs could not absorb a substantial wage jolt that increased costs above their baseline funding levels without a huge injection of additional funding, and aged care providers cannot increase wage costs above levels that can be sustained under present funding.

It would be completely unreasonable for DHBs to require a different type and level of proof of the cost impacts of the MECA on residential care than they themselves were required and able to apply in their justification for funding the MECA.

HCPNZ has conducted an extensive survey of members with responses from providers representing 51% of the aged residential care beds in New Zealand. The survey revealed that providers have increased wage rates for registered nurses above the level of funding increases, but not to a level that enables us to compete for staff with DHBs.

There is very high turnover of registered nurses, approximately 33% per annum, and we estimate that there are between 425 and 556 vacant nursing positions in the sector.

Nursing bureaus are directly passing on the full cost of the DHB-NZNO MECA, and pay MECA rates to aged care nurses who leave the sector to work for bureaus.

There has been widespread acknowledgement that nurses' wages will have to be increased in aged residential care, to avoid complete destabilisation of the sector.

The overall costs of applying the MECA to residential aged care have been modelled using the assumptions in the PWC report. However the full cost impact to the Crown could not be modelled accurately as DHBs have not provided bed-day information requested by providers during the 2005/2006 A21 review of the Aged Residential Care Contract.

The modelling enables various scenarios to be developed comparing the impacts of changes in base rate only, and the impact of applying weekend and night penal rates. A comparison is made between the MECA's July 2005 and July 2006 effects.

Our modelling demonstrates that there is a cost difference in employing a registered nurse in a DHB, compared with the underlying funding of an FTE in residential aged care of 36% for rest homes, 53% for dementia care and 57% for hospitals. Based on subsidised bed days for the year ending 30 June 2004 we estimate the full impact of the pricing increases needed to address this claim as \$63,391,441.

## **2.0 Recognition of the Problem**

The problem of the disparity between wage rates in public hospitals and aged residential care has been identified by government. Official views on the issue is encapsulated in the following excerpt. In providing advice to the Minister of Health, the Ministry of Health has reported in the Health Report 20059320 (30 November 2005) Released under the Official Information Act

### Paragraph 55

The multi-employer collective agreement (MECA) agreed between DHBs and the New Zealand Nurses Organisation (NZNO) has increased the disparity between wages paid to Registered Nurses in DHBs and ARC. Disparities also exist for lower skilled staff (care workers). A large increase in the disparity in wages between the two sectors changes the incentives faced by workers in ARC and increases pressures on providers.

### Paragraph 56

Providers maintain they are unable to increase ARC workers' pay rates given current bed day rates. This limits their ability to attract and retain staff, which in turn becomes a quality and safety issue and potentially a regulatory issues where

staffing levels fall below those required by sector standards. Providers also incur significant costs from hiring temporary 'bureau' staff to cover absences and shortages.

### **3.0 Background to Claim**

Section A23 of the Aged Residential Care Contract states:

*A23.1 This Agreement may be varied at any time by agreement between both of us and also on the occurrence of any of the following Variation Events:*

*a. Where either of us consider that changes occurring as a result of:*

- (i) any change in law;*
- (ii) significant changes in the health sector environment or costs that are beyond the control of either of us,*

*will have a material impact on the provision of Services including the costs of providing Services.*

*b. Where an Uncontrollable Event occurs. In that case clause A20 will apply in addition to provisions of this clause.*

*A23.2 On the occurrence of a Variation Event, we will both identify and quantify the impact of the Variation Event and will seek expert advice, if necessary, to assist us in doing so.*

*A23.3 If you or another provider invoke this clause A23 in relation to a potential Variation Event, the procedure in this clause A23 will be carried out as a national process on behalf of all DHBs by us, or by one or more DHBs that may include us. As part of the national process, we will take all reasonable steps to notify all providers of aged residential care services and provider representative groups of the potential Variation Event and invite them to participate in the national process.*

On 6 March 2006 the following was sent in a letter to DHBNZ:

*RE: VARIATION TO AGED RELATED RESIDENTIAL CARE AGREEMENT: A23 NZNO MECCA*

*HealthCare Providers New Zealand is authorized to represent its members and the Provider Coalition Group (comprising HCPNZ, NZCCS and ARCH).*

*On March 14<sup>th</sup> 2005 we notified you of a variation event relating to the impact of the NZNO MECA.*

*Subsequently, on behalf of all DHBs you sent a letter dated 5 May 2005 saying that the matter was to be considered by the Health and Finance Ministers as part of the 19 May 2005 Budget.*

*To the best of our knowledge it was not considered by the government as part of the 19 May Budget. If you could provide documents to support your assertion we would be grateful.*

*You also noted on behalf of all DHBs in an email on 24<sup>th</sup> June 2005 that, "If you were able to provide an analysis of actual additional costs incurred by your members from any flow on effect of the nurse pay jolt, then I am sure that this would be helpful. Otherwise any view on flow on impact is purely speculation - we wouldn't want to run a negotiation on that."*

*We are surprised that DHBs have decided to interpret A23 in such a narrow manner. Clause A23.2 states, "On the occurrence of a Variation Event, we will both identify and quantify the impact of the Variation Event and will seek expert advice, if necessary, to assist us in doing so".*

*There is no mention in clause A23 about looking solely at 'actual' impacts. Indeed, in clause 23.6 it notes that the clause is forward looking, i.e., 'A23.6 Where both of us are unable to agree that there is a material impact, or potential material impact resulting from the Variation Event"  
[underlining added].*

*In order to progress this claim, over the course of the last few months we have modelled the impact of the NZNO MECA as required by clause A23.2. Our modelling has quantified the impact of the NZNO MECA at \$60 million GST exclusive.*

*We are happy to take you through our modelling and compare it with your modelling and quantification of the impact so that there can be (a) a reconfiguration of the services required under the contract, or (b) an adjustment to the prices or payments in respect of any services.*

*We have been very patient to date relating to this A23 claim and now believe DHBs need to meet their contractual obligations and urgently deal with this matter.*

*Therefore, we ask that a meeting time be set ASAP to establish a timeframe to complete the A23 process in a timely manner.*

#### **4.0 General Issues**

Settlement of the nurses MECA has had a material impact on aged care providers. The impact has directly increased costs and has significantly affected recruitment and retention of nurses. Unless addressed, the impact will seriously undermine the long-term viability and sustainability of the sector.

Funding of residential aged care has not been increased by DHBs to mitigate the impact of the MECA. There is a potential structural conflict of interest in the contracting arrangement as providers compete with their funders for staff from a common labour market in which the funders pay substantially higher wages and provide significantly superior conditions to their staff.

It is our understanding that DHBs had funding approved in advance of settling the MECA to cover the costs of the settlement. Funding was presumably based on DHBs modelling the potential costs of the settlement for the Government. DHBs did not have to provide evidence of the actual cost of settlement as they were not able to enter into an employment contract in advance of Government assurances that they would fund the costs of that settlement.

Aged residential care providers are in a worse position than DHBs were in before DHBs received the funding jolt that enabled them to settle the MECA:

- (i) providers cannot increase wage rates to levels beyond those that can be sustained under present funding,
- (ii) providers are experiencing high levels of turnover of registered nurses,
- (iii) providers are experiencing considerable difficulties in recruitment
- (iv) there are a substantial number of vacant nurse positions in the sector
- (v) aged care competes directly in the same labour market as DHBs for nurses,
- (vi) DHBs are paying significantly higher rates to their nurses than can be afforded in aged residential care,

- (vii) DHBs control the level of funding to the sector, which is directly related to the wage rates that can be afforded in aged residential care.

In order to quantify the impact of the MECA it is necessary to take into account the differences in wage rates and conditions and apply those to rosters which reflect the impact of weekend and night workloads. This analysis has been completed using the PWC labour assumptions as those assumptions flow through into the prices that are paid by DHBs today.

## **5.0 PricewaterhouseCoopers Pricing Methodology**

In 1999 / 2000 PricewaterhouseCoopers (PWC) was commissioned by the Health Funding Authority to complete an extensive analysis of the cost of providing residential aged care. The pricing methodology was used to inform pricing decisions from 2001 until aged care funding was devolved to District Health Boards in October 2004.

The pricing methodology had two components: A capital cost component and an operating cost component. The operating cost component was further broken down into wage costs and non-wage cost.

The capital cost component provided the basis for differentiating prices between Territorial Local Authorities (TLAs), but the operating cost component was common across all TLAs.

In 2001 the Ministry of Health produced a consultation document in which they published indicative prices. In referring to the indicative prices the MOH stated:

*Based on the costing data outlined above, an indicative rest home, dementia and hospital price has been determined for each of the 72 Territorial Local Authority districts in the country.*

*The Ministry does not have the resources to implement the indicative prices.*

The operating costs identified in the MOH consultation document were applied directly from the PWC pricing methodology choosing the scenario of a 45 bed hospital, a 45 bed rest home and a 15 bed dementia unit annexed to a rest home. It was assumed that all facilities operated at 95% occupancy.

Table 1 lists the operating costs component of the daily bed day price used in the consultation document (indicative prices), and the operating costs in the PWC separated into wage and non-staff costs.

### **Table 1:**

**Operating Costs in Indicative Prices Compared with PWC Operating Costs.**

	Rest Home	Dementia	Hospital
Consultation Document	54.68	72.31	92.53
PWC staff	38.17	52.93	69.85
PWC non-staff	16.51	19.38	22.68
PWC Total	54.68	72.31	92.53

Labour costs were built up from rosters using wage rates that were considered by the HFA to apply in the sector at the time i.e. 1999. These rates were determined by applying the mid point of ranges identified in a report from Victoria University commissioned by the HFA. The report was based on printed rates in Collective Employment Agreements for aged residential care workers.

The rates used to derive the staff costs referred to in Table 1 are presented in Table 2. The PWC methodology made no provision for penal rates at night, on weekends or on statutory holidays.

**Table 2**  
**Wage Rates applied in PWC Pricing Methodology**

<b>Position</b>	<b>Hourly Wage Rates Applied</b>
Personal Care Assistants ( Caregivers)	10.35
Nurse	17.00
Nurse Manager	20.87
Activity Coordinator	11.50
Physiotherapist / Occupational Therapist	15.21
Gardening and Maintenance	11.18
Cleaning	10.03
Laundry	10.03
Administrative Support	12.59
Cook	10.79
Cook Assistant	9.74
Facility Manager	20.43

The PWC wage rates have been built into the baseline model that has been developed to support this claim. This model will be referred to as the HCPNZ model and submitted with this claim.

## **6.0 DHB's Response to PricewaterhouseCoopers Methodology**

District Health Boards have acknowledged that the PWC methodology forms the basis from which current prices have been derived. In their response to ARC Provider Representatives on the General review of the Aged Residential Care Contract carried out by District Health Boards under a National Framework for 2004 /05 District Health Boards state:

*Whilst acknowledging the history of the PWC pricing model and the fact that it had a role to play in getting the sector to current pricing level, DHBs are neither required nor in a position to either review or update the model within the scope of this general review of the agreement.*

District Health Boards also stated that:

*Almost all providers of aged residential care services have contracts with DHBs with prices that are in accordance with a Territorial Local Authority Pricing Schedule (TLA Pricing Schedule) that was adopted by the Ministry of Health back in 2001.*

*The TLA Pricing Schedule was updated in 2002 and 2003 to reflect price increases that were granted by the Ministry at those times.*

*The TLA Pricing Schedule lists the 73 territorial local authorities across NZ and indicates the price by facility type (Rest Home, Dementia, and Hospital) that should be paid to providers within each TLA. The prices across TLAs vary to reflect different costs within different areas particularly the cost of land. In general, each DHB has more than one TLA within its boundaries.*

*DHBs have used the TLA pricing Schedule as the basis for applying pricing decisions made for 2004 / 05 to ensure continuity of the schedule and to maintain national consistency.*

In expanding on their pricing offer, DHBs explained:

*The first was a decision to increase all prices on the TLA schedule and create a new base TLA pricing schedule for 2004 / 2005.*

It is clear from these statements that DHBs understand that residential care prices are derived from the PWC model and that the price adjustments they have made have been applied to the TLA pricing schedules, and are therefore adjustments to the underlying modelled prices.

## **7.0 Integrity of Providers Spreadsheet Model**

The HCPNZ model calculates the potential flow on effects of the DHB-NZNO Multi-Employer Collective Employment Agreement (MECA) and was developed from the assumptions and rosters used to build the PWC pricing model. The baseline scenario produces the same labour costs as the original PWC model.

The model was presented to the Working Party on Support Services for Older People and People with Disabilities. While questioning some of the assumptions about the extent to which the flow on effects would occur, officials on the working party accepted the technical integrity of the model. <sup>1</sup>.

That presentation was based on a scenario where caregiver wages applied in the DHB - NZNO MECA, would also flow on at the same rate to aged care providers. The flow on effect to non-nursing occupational groups is not part of this claim.

The HCPNZ model was also used to calculate the impact of the Holidays Act on residential aged care. The model was reviewed extensively by the Ministry of Health and Audit New Zealand and used to inform the final calculation of the cost impact of the Holidays Act.

## **8.0 Relationship between Current Prices and Indicative Prices.**

Residential care prices were increased to the 2001 indicative prices with effect from 1 June 2003.

DHB's applied further price increases in two general reviews since funding was devolved from the Ministry of Health. Prices were increased by 3% with effect from 1 July 2004 and 3% with effect from 1 July 2005. A further 1% was added to prices from 1 July 2005 to compensate providers for the effect of the additional costs arising from the Holidays Act.

As the wage rates used in the PWC report were used to calculate the indicative prices, the July 2004 and July 2005 prices increases can be applied to those wage rates to reflect the rates underlying current aged residential care pricing.

The underlying nurse wage rates paid to providers through aged residential care prices are presented in Table 3. These are referred to subsequently as the aged care derived rate.

**Table 3**

---

<sup>1</sup> Report of Working Party on Support Services for Older People and People with Disabilities Feb 2005, Page 35.

**Impact on Underlying Wage Rates of Price Adjustments.**

	Indicative Price Operating Costs	July 2004 3% Price Adjustment	July 2005 3% Price Adjustment
Nurse wage rates	\$17.00	\$17.51	\$18.04

**9.0 Comparison of Aged Care Derived Rates with DHB MECA Rates**

A summary of the essential differences between the aged care derived rates, and aged care terms and conditions and the MECA is presented in Table 4.

**Table 4**  
**Summary of Rates and Allowances**

	Residential Aged Care	MECA Rates 1 July 2005	MECA Rates 1 July 2006
Base Rate - New Graduates		17.79	19.23
Base Rate - Bottom Step	18.04	19.81	20.82
Base Rate - Top Step	18.04	24.04	25.96
Public Holidays	1.5 Times	2 Times	2 Times
Weekends		1.5 Times	1.5 Times
Night Allowance		1.25 Times	1.25 Times
Over time		1.5 Times	1.5 Times

If DHB rates are applied, the cost of employing 1 full-time equivalent (FTE) registered nurse on the rosters used in aged care differs slightly across the three care categories because of the different staffing ratios used in the PWC methodology at different times of the day and week.

A comparison of the annual cost per FTE registered nurse between the current aged care derived rate and the MECA Rates is presented in Table 5. A FTE is defined as 40 worked hours per week (i.e. excludes paid absences such as annual leave and sick leave); however the costs of annual leave and sick leave have been added to the cost of employing an FTE.

These costs, presented in Table 5, have been calculated using the fourth step of the 5 step MECA scale (\$22.20 at July 2005 and \$23.37 at July 2006).

**Table 5**  
**Comparison of Costs of Employing per FTE**

Aged Care Derived Rate		MECA July 2005		MECA July 2006	
		Excludes Weekend and Night Allowances	Includes Weekend and Night Allowances	Excludes Weekend and Night Allowances	Includes Weekend and Night Allowances
Dementia	43,081	53,021	62,614	55,800	65,895
Rest Home	43,327	53,319	55,878	56,113	58,806
Hospital	43,081	53,021	64,286	55,800	67,655

## 10.0 Impact of Applying MECA Rates to Residential Care Prices

The MECA rates have been applied to registered nurses, nurse manager and manager rates. The relativity between manager rates and nurse manager rates and registered nurses have been applied at the same percentage as that used in the original PWC report.

Table 6 compares 4 scenarios with the labour component of the current price providing the corresponding price adjustment needed to bridge the gap.

**Table 6**  
**Impact of Applying MECA Rates to the Labour Cost Component of Residential Care Bed-day Price**

	Baseline			Using MECA RN Rates			Price Adjustment		
	Rest Home	Dementia	Hospital	Rest Home	Dementia	Hospital	Rest Home	Dementia	Hospital
Scenario 1	41.29	57.34	75.50	43.05	59.35	82.22	1.76	2.01	6.72
Scenario 2	41.29	57.34	75.50	43.54	59.91	84.10	2.25	2.57	8.60
Scenario 3	41.29	57.34	75.50	43.29	60.64	87.89	2.00	3.30	12.29
Scenario 4	41.29	57.34	75.50	43.80	61.27	89.96	2.51	3.93	14.46

Baseline: Wage rates increased from rates in indicative prices in proportion to 2004 and 2005 price adjustments.

Scenario 1: RN Rates based on second to top step on MECA. July 2005 Rates. No penal payments

Scenario 2: RN Rates based on second to top step on MECA. July 2006 Rates. No penal payments

Scenario 3: RN Rates based on second to top step on MECA. July 2005 Rates. Includes penal payments

Scenario 4: RN Rates based on second to top step on MECA. July 2006 Rates. Includes penal payments

During the 2005 /2006 A21 General Review of the Aged Residential Care Contract, providers asked DHBs for detailed information about the number of subsidised bed-days by service. **DHB's have not provided that information.**

In order to quantify this claim, providers have had to rely on high level subsidised bed day information provided by the Ministry of Health for the year ending 30 June 2004.

The impact of this claim is calculated using that data. The PWC report did not include psycho geriatric care. We have assumed that psycho geriatric care will incur the same impact as hospital level care while accepting that this is likely to understate the impact on psycho geriatric care.

	Subsidised Bed days <sup>2</sup>	Scenario 1	Scenario 2	Scenario 3	Scenario 4
Rest Home	6,647,311	11,691,947	14,956,685	13,319,867	16,669,915
Dementia	708,017	1,423,586	1,820,156	2,338,852	2,783,385
Hospital	2,820,644	18,965,786	24,263,350	34,669,684	40,790,190
Psycho geriatric	217,681	1,463,670	1,872,505	2,675,606	3,147,951
Total Cost	10,393,563				

This, however, does not take account of the increase in the maximum private contribution for hospital and dementia care, which we could not calculate without the data requested from the DHBs. This would reduce the overall fiscal impact for the Crown.

<sup>2</sup> Subsidised Bed day data supplied by the MOH

## 11.0 HCPNZ Member Survey (2006)

HCPNZ surveyed members in December 2005 and January 2006 to collect baseline data about the sector.

Responses were received from 320 facilities which HCPNZ estimates is 39% of all facilities in New Zealand. However respondents operated 16,989 beds which is estimated to represent 51% of the beds in the sector. We are confident that the sample size is sufficiently large to give a very valid picture of the sector.

At the time of the survey there were 361 vacancies for nurses. If this figure is extrapolated by beds (51% of beds were surveyed) it provides an estimate of **approximately 700 nursing vacancies** in the aged care sector.

The total number of nurses employed by providers who responded to the survey was 2,271, suggesting a total sector nursing workforce of between 4,400 to 5,800 nurses. Using the mid-points of both ranges would suggest that vacancies in aged care are at a higher level than those in DHBs before the MECA settlement (13.7%). Various reports from the Ministry of Health have identified around 2,000 vacancies in the District Health Board Nursing Workforce before the MECA settlement from a workforce of 20,000 nurses (10%.)

Nursing vacancies in aged care have a more significant impact than they do in the acute sector, as the ratio of nurses to other staff is much lower. A single nursing vacancy can mean that 100% of the nursing positions on a particular shift cannot be filled by a nurse. The minimum staffing for a hospital under the aged residential care contract requires there to be **one** registered nurse on duty at all times.

### **33% of registered nurses employed in the aged residential care sector left their jobs in the last year.**

This compares extremely unfavourably with District Health Boards when they considered there was a crisis in their nursing workforce. The College of Nurses has published on its web site ([http://www.nurse.org.nz/leadership/ls\\_cost\\_study.htm](http://www.nurse.org.nz/leadership/ls_cost_study.htm)) a copy of the report "The Cost of Nursing Turnover and Its Impact on Patient Outcomes. A Longitudinal New Zealand Study". The report states:

*Thirteen DONs reported that nursing turnover was a problem, or it was becoming an increasing priority. This was turnover that normally ranged between 12% and 25%. Five DHBs, primarily in the main cities of New Zealand, reported turnover rates that were at or over 20%. DHBs in regional areas were more likely to report that there was low turnover, or they had not felt major turnover issues for some time, reporting turnover rates of 5% to 10%. Negative impacts due to nurse*

*shortages included bed closures, restricted elective surgery, reduced inpatient admission and ED service restrictions.*

## **12.0 Current Wage Rates**

Providers have increased rates for registered nurses above the level of funding - the average rate for RNs from the HCPNZ members' survey was \$19.84 compared with the aged care derived rate of \$18.04. Clearly providers have had to fund some of the impact of the flow through effects of the MECA above the level of funding increases, but with funding lagging behind the market rate for nurses, have not been able to match the DHB MECA rate. Residential care providers are in exactly the same position as DHB's were, prior to DHB's receiving the funding jolt that enabled them to increase nurses wage rates.

Providers are being forced to pay MECA rates to nursing bureau staff, and with the high level of vacancies in the sector, this is imposing considerable cost burden on the sector. We have attached as Appendix 1 copies of letters from nursing bureaus in which they explain the reasons for increasing their charges.

Bureaus have not only increased base rates in line with the MECA rates, but also pay comparable penal rates.

## **13.0 Appendix 1 Supporting Information from Nursing Bureau**