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Corporate Finance

Home & Community Health Association

Financial Review & Risk Analysis of the Home & Community Support Sector

March 2015

STRICTLY PRIVATE AND CONFIDENTIAL

Final report This report has been prepared for the Home and Community Health Association on the terms set out in the Introduction and the limitations set out in Appendix 1.

Table of Contents

Glossary of Terms

In this Report capitalised terms have the meaning given to them as defined below:

ACC	Accident Compensation Corporation
CPI	Consumer Price Index
DHB	District Health Board
Domestic Assistance	Home care service, aka “Home Help”
EBIT	Earnings Before Interest & Tax
Ezitracker	Specialised technology for tracking real time data
GDP	Gross Domestic Product
HCHA	Home and Community Healthcare Association
IT	Information Technology
KPI	Key Performance Indicator
LCI	Labour Cost Index
LHS	Left Hand Side (Chart axis)
Margin	Operating Margin
MBIE	Ministry of Business, Innovation, and Employment
Min Wage	Abbreviation for Minimum Wage
MoH	Ministry of Health
MSD	Ministry of Social Development
Personal Care	Home care service aka “Personal Attendant Care”
Q1	Quarter 1
RHS	Right Hand Side (Chart axis)
SMS	Short Messaging System, also known as “Text Message”

Executive Summary

Background & Introduction

- The home and community support sector provides domestic assistance and personal care to those injured or in need of assistance, many of whom are aged 65+. The sector has voiced concerns about the sustainability of the current funding model and rates. The purpose of this report is to enhance the HCHA's understanding of current and future risks to the sustainability of the sector.

Approach

- This report has been based upon both financial and non-financial information supplied by a sample of service providers operating within the home and community support sector (that are members of HCHA) as well as publically available information.

Key Issues of Concern

- At the core of concern behind providers is the matter of funding sustainability, which in turn is likely, over the longer term to impact on the operational performance by providers.
- **Historical funding shortfall:** Historically, on average, DHB funder increases have not kept pace with minimum wage and other inflationary pressures. Over the past seven years only 3 regional DHBs, plus the national funders (MoH and ACC) provided increases of more than the minimum wage increases over the same period. Based on average 2014 funding rate increases, Deloitte have estimated that the average provider would have needed to find almost 10% savings in overheads in order to maintain margins.
- As a result of funding shortfalls, providers have sought to find different ways to reduce costs, while not impacting quality of clinical service. This has been through reducing co-ordinator to support worker ratios, halting pay increases, no performance reviews, delayed IT capital expenditure and maintenance decisions, and attempting to save on short term costs such as not hiring an IT implementation manager. Because some of these cost reductions are not real savings, they are incurring other costs in the medium to long term.
- **Current levels of Funding:** Three providers have been struggling with negative margins for the past three years, and in 2014, four out of six respondents had negative EBIT margins. After three years of consecutive losses, one provider is now in a position of negative equity.
- However, there still may be opportunities for some providers to find cost efficiencies, based on analysis of co-ordinator ratios and overhead costs.
- **Funding models**. The current fee for service funding has had its issues, but fixed fee (sometimes referred to as bulk) funding potentially poses a greater risk to providers, due to funding being independent of volumes. If contractual agreements (i.e. expected volumes and volume conditions, and pricing increase adjustments) are not negotiated fairly or monitored correctly, this can put providers at greater risk than the current fee for service model.
- **Current and future staffing issues:** Because of cost cutting efforts and an improving economy, providers are finding it difficult to retain staff when there are perceived superior opportunities elsewhere. Providers are also experiencing difficulty to then recruit suitable replacements with the right level of skills, experience and commitment when they can only pay close to the minimum wage. Over the next twenty years, this is expected to worsen as demand is expected to almost double.
- **Service levels**: Providers are struggling to adhere to higher levels of compliance, and increasing needs and demands from funders.
- **Technology:** Technology can potentially provide cost savings to home and community providers, however, most providers have delayed investment, partially due to lack of funding. In addition, in the short term, there are also implementation and training costs, which must be incurred, and there is still some uncertainty over the benefit of investments.

Conclusions

- Our analysis supports the providers' view that the current funding model is unlikely to be sustainable – particularly in an environment of increasing demand. To illustrate this point, the average provider would have needed to achieve year on year overhead savings of over 7% for the past seven years to maintain their margins. With a scheduled increase to the minimum wage of $0.50 in the absence of any increase in funding, 2015 overhead savings would need to exceed 12.5%.

1. Background and Approach

Background

- The demographics of New Zealand are changing. Over time, these changes are likely to result in substantially increased demand for aged-care services, including from the home and community support sector. The Home and Community Health Association ("HCHA" or “you”) is the voice for this sector, with your main role being to help to ensure that service providers are adequately funded to continue to provide high standards of service.
- However, we understand that a number of these businesses are experiencing stretched resources and funding shortfalls as funding fails to keep pace with costs. Further minimum wages increases, the first being 1 April 2015, will only worsen the situation and pose a risk to the sector as the financial condition of service providers deteriorates.

Your requirements

- The HCHA engaged Deloitte (“Deloitte,” “we” or “us”) to assist with the undertaking of a financial review and risk analysis of the home and community support sector. The purpose of this review is to gather information from a cross-section of HCHA member organisations to:
  - review the financial position of the home and community support sector;
  - verify the financial position of member organisations within the sector; and
  - increase the HCHA's understanding of current and future risks to the sustainability of the sector.
- This review will be used to support the HCHA in discussions with Government officials.

Approach

- This report has been based upon both financial and non-financial information supplied by a sample of service providers operating within the home and community support sector as well as publically available information.
- We selected a sample of 10 HCHA member organisations to participate in a short survey covering, amongst other things, their financial condition, service levels and issues that they see as being critical over the next few years. The organisations were selected on the basis of gaining a representative sample based upon their size, geographic coverage, profit / not-for-profit focus, client focus and likelihood of responding. In addition, we also requested 4 years of audited financial accounts.
- Based upon our original sample of 10 HCHA member organisations, 2 were filtered out and 1 was unable to respond within the timeframe. Of the 7 remaining respondents, 6 provided responses to the qualitative section of the survey as well as audited financial statements, while 5 provided responses to the quantitative section of the survey. The survey respondents cover different geographies, profit / not-for-profit focus and client focus.
- In addition, 1 member organisation volunteered to have a follow-up interview while another supplied rate information for home and community support services relating to 13 funders for the past 7 years (since 2007). A summary of major changes to employer obligations over this time period was also provided.

2. Setting the Context: Funding Models

Funders and Services

- There are two main home and community support services being purchased by funders:
  - **Domestic Assistance:** also referred to as Home Help, which involves tasks such as cleaning; and
  - **Personal Care:** also referred to as Personal Attendant Care, which requires more interaction with the client to do tasks at home.
- The level of Personal Care services required varies depending upon the complexity of the client. Different pay rates may exist for different levels, such as levels 1 and 2, where level 2 is the more complex. However, we understand that Personal Care workers are typically paid at, or close to, the minimum wage in the home and community support services sector.
- Similar Personal Care services are also undertaken in hospitals and residential care facilities. You told us that the pay rates are considerably higher than in the home and community support services sector and that these rates are higher still in Australia.
- There are also new service models such as restorative care. However, we understand they have equivalent Domestic Assistance and Personal Care services.
- Funders include the Accident Compensation Corporation ("ACC"), Ministry of Health ("MoH") and District Health Boards ("DHBs"). The Ministry of Social Development ("MSD") also provides assistance for Home Help to those who are entitled. If an injury or accident (including serious injury resulting in disability) was the reason behind the need of service, ACC will be responsible to fund. If a client is disabled, MoH is responsible, other cases will be covered by DHBs. Each provider will have a different contract with different rates and conditions for each funder they deal with, e.g. ACC includes some travel costs in its rate, MoH and DHB rates currently do not.

Adequacy of Funding Levels

Historical Funding Levels

- All survey respondents were concerned that cost increases over the past 7 years had not been met by funding increases, even allowing for possible productivity improvements. Service providers have responded to this funding shortfall in several ways, which are discussed in more detail later in this report.

Current Funding Levels

- The survey respondents also indicated that, given the cumulative funding shortfalls in the past, the current funding levels are unsustainable.

2. Setting the Context: Funding Models

Fee-For-Service Model

- Most funders are currently operating under contracts which pay on a "fee-for-service" basis, whereby funders pay these third party home and community support providers an hourly rate for Domestic Assistance or Personal Care services (including services under restorative care). Providers are paid on the basis of hours delivered, noting that hours delivered must be within those specified in an independent needs assessment.
- Subject to affordability constraints some funders have historically adjusted hourly rates. In theory, indexation rate adjustments should reflect inflationary pressures, but in practice this may not be the basis for all adjustments. Some of the adjustments have been made on a "consumer price index ("CPI") minus X" regime, where X is an efficiency factor, while others have largely reflected the budget constraints of the funder, in some cases resulting in nil or close to nil adjustments in any one year.

Bulk Funding Model

- Under a fixed fee ("bulk") funding contract, a service provider is allocated a fixed pool of money, irrespective of the number of hours delivered.
- In theory, fixed fee funding is suitable when volumes are relatively predictable, case-mix, i.e. average client hours, are stable or predictable and standards regarding efficient service delivery are known. Funding should change annually based upon predicted cost, case-mix and volume changes.
- Bulk funding can incentivise a provider to become efficient in delivering a service. However, it also transfers risk to the provider if costs unexpectedly and / or uncontrollably increase, volumes increase or case-mix complexity increases, as more complex clients equate to more expensive service. In essence, if the forecasts turn out to be considerably more or less favourable, the provider will gain or lose accordingly.
- Depending on contract terms, there can be a perverse incentive for funders to abuse bulk funding by increasing volumes or hours. One survey respondent stated a case where a funder used extensive home and community support work as a substitute for more costly residential care work. There were concerns if this behaviour was not monitored, it would lead to an inequitable situation where bulk funding does not cover provider costs due to volume increases driven by funders.

3. Historical Funding Rate Changes

Historical Funding

- Deloitte was provided rate information for the two main home and community support services, Domestic Assistance and Personal Care. The Domestic Assistance rate is the lower of the 2 rates. This information was provided for national funders - the ACC and the Ministry of Health - as well as 13 DHBs. However, rate information for 2 DHBs was incomplete and the analysis excluded a further 2 DHBs, which had either shifted to bulk funding or a Restorative Care Model (refer page 13 for discussion of this model) at some stage during the 7 year time period.
- The charts opposite set out the funding rate changes since 2007 for the Domestic Assistance rates compared against increases in the minimum wage. Personal Care rate increases are comparable. Note that, for simplicity, as rate increases can happen at different dates over time, rates reflect any increase that incurred in that calendar year.

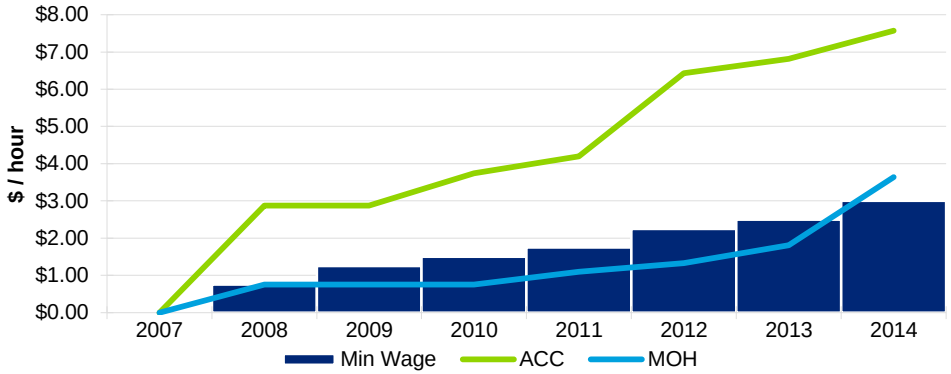
National Funder Rates

- Overall, the ACC's rate increases have covered the increases to the minimum wage in addition to the increases to other cost categories included within the scope of the fee-for-service.
  - It should be noted that the increase in 2012 reflects both an inflationary adjustment and an alignment of the ACC's Domestic Assistance and Personal Care rates.
- The MoH rate did not increase for two years (2009 & 2010), as a result the cumulative increases have not been sufficient to even cover the minimum wage increases up until 2013. The cumulative rate increases over the 7 year period only exceed the cumulative minimum wage increases because of a $1.83 rate adjustment in 2014.

Regional Funder Rates

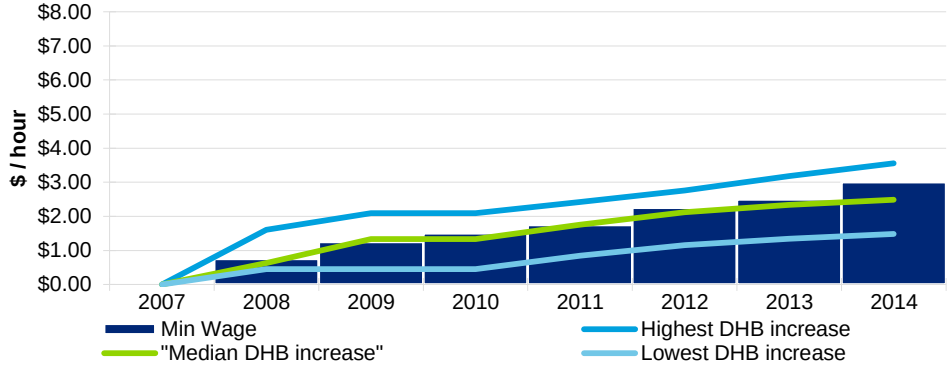
- Over half of the regional DHB funder rate increases, represented by the green "Median DHB increase" line on the bottom chart, have been insufficient to cover the minimum wage increases alone over the past 7 years. Only 3 providers in our sample had increases which were greater than the increases in the minimum wage.

Minimum Wage vs. National Funder Rate Increases



Source: Department of Labour, Home & Community Care provider

Minimum Wage vs. Regional DHB Funder Rate Increases



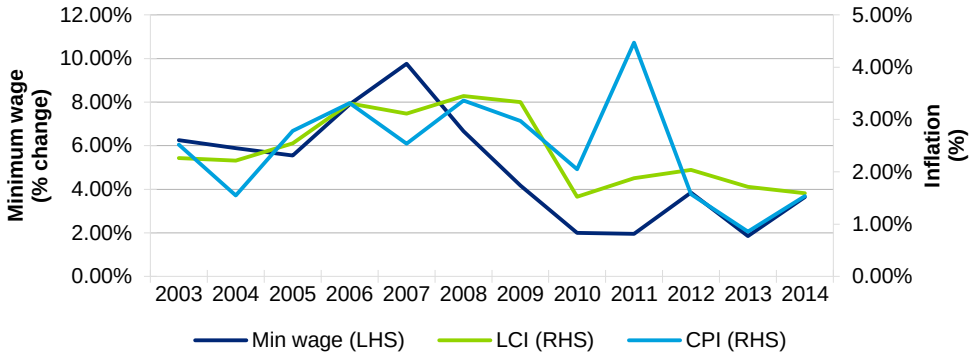
Source: Department of Labour, Home & Community Care provider

3. Historical Funding Rate Changes (cont'd.)

Fee for Service Rates

- Fee-for-service rates implicitly cover:
  - direct labour;
  - direct costs;
  - indirect labour; and
  - overhead costs.
- Note that direct labour costs include both wage costs as well as any direct employer obligations, such as KiwiSaver contributions. It follows that even if funding was increased to fully cover minimum wage increases, there would likely be other costs which were unfunded, such as any KiwiSaver obligations.
- Even in the absence of changes to the minimum wage rate, general increases in labour costs and other input prices mean that the cost of service generally increases each year. In fact, the Reserve Bank of New Zealand in charged with keeping CPI between 1% and 3% over the medium-term.
- The chart opposite illustrates the positive relationship between the labour cost and consumer price indices, measured by the labour cost index ("LCI") and CPI respectively with changes in the minimum wage. The lines typically move together in the same direction, albeit at different rates.
- This relationship is unsurprising, as the minimum wage directly and indirectly affects labour costs, while labour costs are 1 component within the CPI. However, changes in the minimum wage will also flow through the LCI and the CPI, which in turn drives up other non-direct labour costs. In other words, changes to the minimum wage magnify the funding requirements upwards.
- The next two pages provide some further discussion on the relationship to minimum wages.

Minimum Wage Changes and Inflation Rate



Source: Department of Labour, Statistics New Zealand

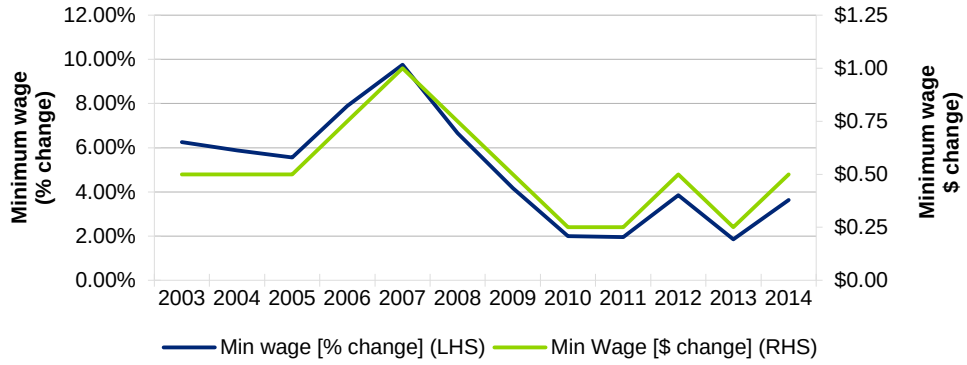
- These relationships are not perfect though, due to a range of other factors. For example, there have been changes to employer KiwiSaver obligations. When KiwiSaver began in 2007, the minimum employer contribution rate was 1% of gross salary. In 2009, this rate increased to 2%. In 2013, it again increased, to 3%. Although not all employees in the home and community support industry will be KiwiSaver members, KiwiSaver participation rates ranged from 45% to 74% across the Survey Respondents.

4. Minimum Wage Trends

Historical Minimum Wage Changes

- The chart opposite illustrates the dollar and percentage changes to the minimum wage since 2003.
- Since 2002, the minimum hourly wage rate has increased by 25 cents, 50 cents, 75 cents or $1.00. Over time, as the minimum wage has increased, the percentage impact of a given increase has had less of a percentage impact. For example, the 50 cent increase to the $8.50 minimum hourly rate in 2004 had a circa 5.9% impact, whereas the same increase 10 years later in 2014 only had a 3.6% impact.
- While the percentage impact is decreasing, the real impact to businesses of having to fund these changes is another matter. The Government recently announced that the minimum hourly wage will increase by 50 cents to $14.75 on 1 April 2015. Survey respondents noted significant funding shortfalls at current levels, meaning that the situation will worsen considerably at the new higher minimum wage rate.
- Based on minimum hourly wage of $14.25, a 50 cent increase would be circa 3.5%.

Minimum Wage Changes



Source: Department of Labour, Statistics of New Zealand

4. Minimum Wage Trends (cont'd.)

Historical Minimum Wage Relationships

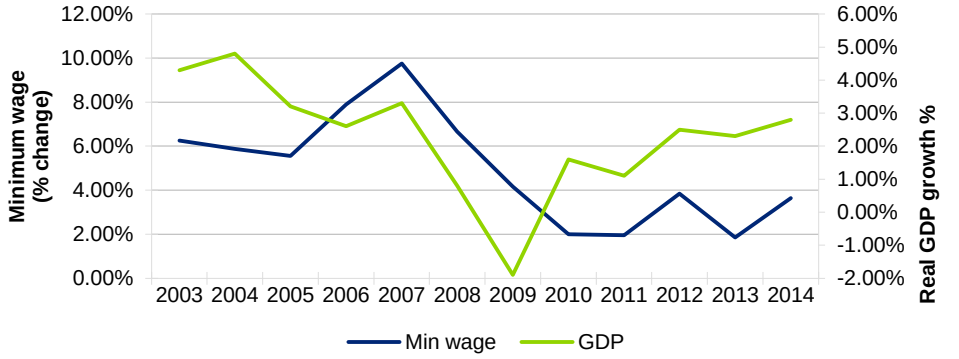
- The top chart opposite illustrates the positive relationship between the New Zealand employment rate and the percentage change in the minimum wage. The bottom chart illustrates a positive relationship between New Zealand gross domestic product ("GDP") and the latter.
- The Ministry of Business, Innovation 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 home and community support related costs or contracts funded by MoH, ACC 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.
- If these general relationships are maintained, as the economy continues to grow and the unemployment rate fall, relatively large increases to the minimum wage, in the vicinity of 50 cents or more, could be expected.
- Survey respondents commented on significant funding shortfalls at current levels, meaning that the situation will worsen if the minimum wage rate continues to rise.

Minimum Wage Changes & Employment Rate

Source: Department of Labour, Statistics of New Zealand

Minimum Wage Changes & GDP

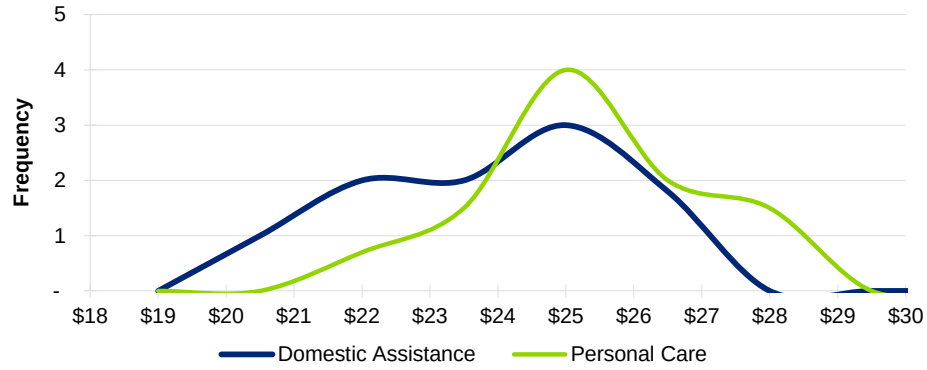


Source: Department of Labour, Statistics of New Zealand

5. Current Funding Levels

- The chart opposite illustrates the distribution of the most current (2014) funder support worker "Fee for service" rates across funders, including ACC, MoH and Regional DHBs for both Domestic Assistance and Personal Care rates. Of particular note are the following details:
  - lowest domestic assistance rate is $20.59;
  - average domestic assistance rate is $24.09;
  - highest domestic assistance rate is $27.55;
  - lowest personal care rate is $22.64;
  - average personal care rate is $26.04; and
  - highest personal care rate is $28.73.
- This chart also shows that:
  - there is a significant divergence both in hourly rates between domestic assistance and personal care and across the survey respondents;
  - the lowest personal care rate, excluding provisions, of $22.66 is still higher than the lowest domestic assistance rate $20.59;
- In general, survey respondents feel that these rates are below levels required to run sustainable businesses.
- Some service providers have moved from a traditional fee-for-service model for domestic assistance and personal care to other funding models, for example bulk funding. Similarly, some providers have shifted to a restorative care model. These providers have been excluded for comparison purposes.
- Two funders, the ACC and the MoH, have recently aligned their support worker rates, i.e. aligned their Domestic Assistance and Personal Care rates. This alignment could be due to viewing the labour as interchangeable or simply to simplify the contracts. So if a worker visited a client for 2 hours in the roles of personal care and domestic assistance, they would be paid a single rate and would not have to account for personal care and domestic assistance time separately. However, there is still a considerable difference between the rates as between the two funders.

Funder Support Worker Rates (Fee for service)



Source: Home & Community Support Provider

6. Service Levels

- A recurring theme in the qualitative response section of the survey was the pressure that increased service level expectations were creating which was changing the nature of the services being delivered.

Restorative Care Model

- In 2011, Health Workforce NZ (a business unit of the National Health board which works with the MoH to consolidate planning, funding, workforce planning and capital investment) published a report "Workforce for the care of older people". This report had several recommendations which impact the care sector, including the recommendation of shifting to a "restorative care model"
  - At least 1 DHB was identified as having transitioned to this model.
- The restorative care model changes the nature and role of home and community support workers.
  - Many workers in this sector currently undertake simple duties, such as cleaning, on behalf of their clients as part of a "domestic assistance" role.
  - Under the restorative care model, workers are required to become facilitators and trainers to assist the client to return to independence, instead of doing the tasks, such as cleaning, for them.
  - In addition to training, this requires changes in both "culture" and worker attitudes.
  - This service is currently funded via fee for service.

Training

- Several respondents mentioned contractual requirements to increase staff training requirements, which puts pressure on providers in several ways:
  - **Training costs:** In the short-term, there are direct staff training costs as well as opportunity costs if training is during work hours; and
  - **Higher pay rate expectations:** Staff that have undergone more training typically expect to be paid more than less trained staff.

Complexity of Care

- Community care work encompasses a wide variety of roles and tasks. More complex clients require higher skilled work, and there is anecdotal evidence that the proportion of complex care is increasing.

Service Substitution in the Health Sector

- Due to the cost pressures in the wider health sector, there is a general trend towards identifying and leveraging "cheaper" substitutes for similar services. In some instances, it might be using a similar role in a different way, while other times it might be using a new role. For example:
  - nurses doing tasks that have traditionally been done by doctors; and
  - community care workers taking on more responsibility.
- One provider mentioned a case where a DHB requested 20 hours from a care worker instead of sending the client to a residential care facility which would have the equivalent of a community care worker.
- Another example is the START pilot program that Waikato is trialling. Under this program Non-Acute Rehabilitation is being shifted from the hospital to the home instead. This is expected to be overall more cost efficient (beds can be utilised for other needs and lower cost resources) for DHBs than delivering this service in the hospital. It is also expected to have other benefits from clients expecting improved rehabilitation outcomes. If successful, this pilot program may be implemented at other DHBs across the country. While programs such as these will be good for DHBs and the wider health sector, however, it will add even more pressure on to the home and community care sector.

Other Issues.

- One respondent specifically noted concern over contract requirements to pay for minimum number of hours. At present, workers are only paid on the basis of hours delivered, but under this proposed change, providers may also need to compensate employees for unutilised time, while still being funded for hours delivered.

7. Financial Statement Analysis

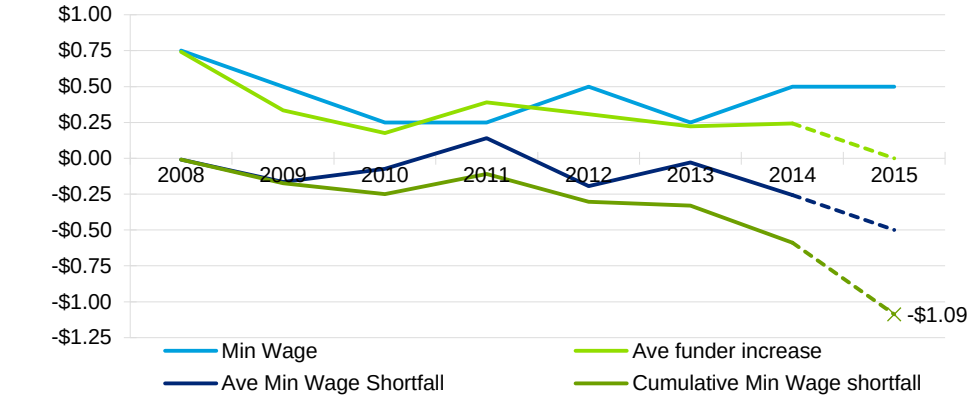
Funding Shortfall

- The top chart opposite compares minimum wage increases against average funder increases. Average funder increases were calculated using a weighted average of regional DHB funder rate increases. The average minimum wage shortfall was calculated from the difference between the minimum wage increase and average funder increase.
- In 2010, only 3 funders gave an increase. In 2009, those same funders gave $nil increase as there appears to have been a "freeze" on increases in the 2009-2010 period due to the global financial crisis.
- The only year when there was not a material shortfall (on average) was 2011. However, it appears this may have been due to increases designed to (partially) compensate for $nil increases in 2010.
- In the absence of any funding increases in 2015, the cumulative average minimum wage shortfall over the past 8 years would increase to $1.09 from 1 April 2015 when the minimum wage increases to $14.75.
- If on-costs were to be considered, the cumulative shortfall of minimum wage and on-costs have been estimated to be $1.66. Since providers have costs other than direct labour, the average minimum wage shortfall only reflects a portion of the shortfall experienced by survey respondents.
- The average minimum wage shortfall almost mirrors the minimum wage: when minimum wage increases have been high, the shortfall has been large. In the past 5 years, the biggest shortfalls have occurred when minimum hourly rate increased by 50 cents.

EBIT

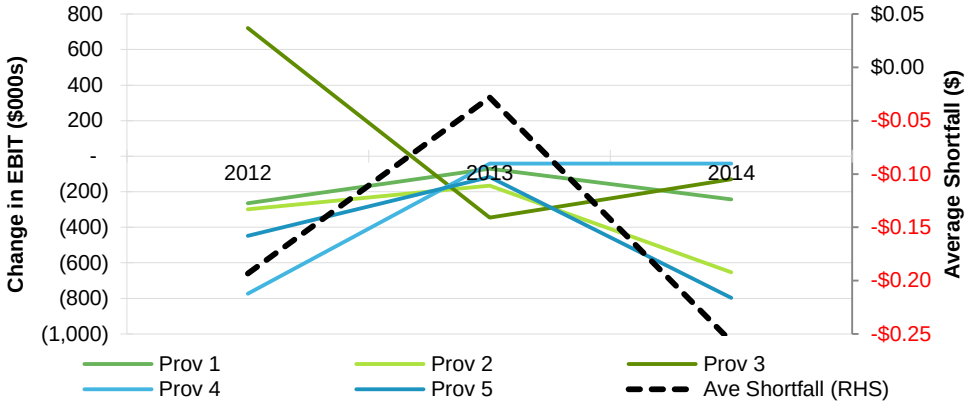
- The bottom chart illustrates the changes in earnings before interest and tax ("EBIT") for 5 survey respondents from 2010 to 2014. Note that as EBIT is calculated from audited financial statements for the respondent's whole organisation, it may also include impacts from outside of the sector.
- Since some service providers only work in particular regions, the average shortfall will be less relevant to them, meaning that they may have experienced a greater or lesser shortfall than average.

Minimum Wage vs Average Funder Increase



Source: Department of Labour, Home & Community Care

Change in EBIT vs Minimum Wage Shortfall



Source: Provider Audited Financial Statements, Deloitte

7. Financial Statement Analysis (cont'd.)

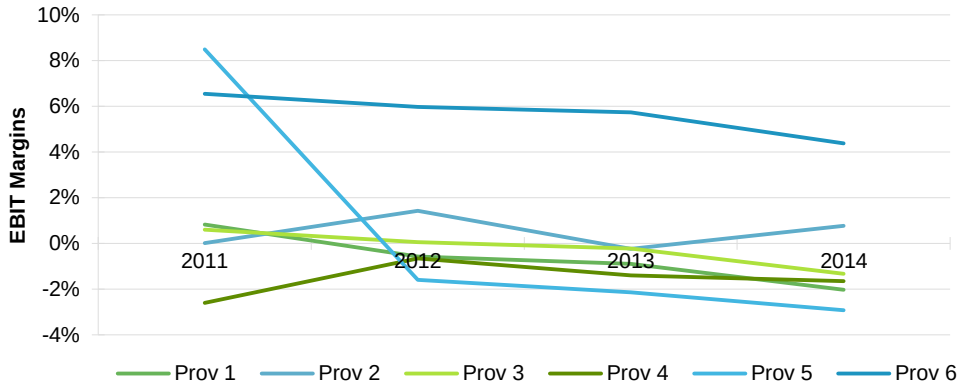
EBIT (cont'd)

- Three out of 5 providers (1,2 and 5) have results that are consistent with the average minimum wage shortfall.
- Note that 1 provider was excluded from this chart, as it had year-on-year revenue increases ranging from 8% to 28% across the 4 years, which has impacted on its EBIT levels, whereas the other providers had relatively stable revenues.

EBIT Margins

- The chart opposite shows the survey respondent's EBIT margins based upon their audited financial statements. As mentioned previously, since some businesses operate multiple lines of business, these EBIT margins may not solely reflect the home and community support sector, although it appears that all of the respondents financials display a consistent trend.
  - Five providers have had an overall decline in EBIT margins over the past 4 years. The only provider with a stable or slightly improved EBIT also increased revenues by circa 50% since 2011. It may be that they are gaining economies of scale, which has improved their profitability.
  - Three providers have had negative margins for three consecutive years, 2012-2014. In 2013, five had negative margins.
  - One provider has accumulated so many losses over the past three years that it now has a negative equity position.
- The sample represents some of the largest providers, which should have the most competitive cost structures through economies of scale.
- It should be noted that some providers fund a portion of the business from non-operational sources of revenue such as grants and investments. These funding sources can be unreliable from one year to the next.

EBIT Margins



Source: Provider Audited Financial Statements, Deloitte

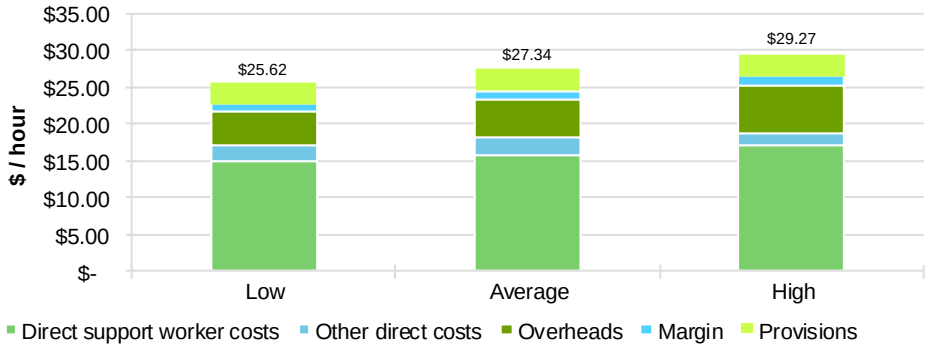
Cost Reduction Measures

- Respondents noted that they had reduced co-ordinator support worker ratios to the point where only a minimum level of clinical quality can be delivered. However, service quality has diminished in some cases, for example, if a support worker is sick, clients are not always informed of a new support worker, which can be an issue with clients. In addition:
  - One respondent stated they halted pay increases for some staff;
  - Two respondents ceased granting performance pay or reviews;
  - One respondent maintained its ratios by delaying information technology ("IT") maintenance; and
  - One respondent has changed their co-ordinator structure, meaning that co-ordinators are needing to upskill and multi-task more.
  - Although some reductions have been achieved through efficiency gains, most cost reduction measures have been "short-term" solutions with medium to long-term costs, and are therefore not reflective of a sustainable cost structure.

8. Current Provider Costs

- The chart opposite sets out the cost of service for the lowest, average and highest cost respondents, including a provision for leave. Note that for the low and high cost bars, while some respondents may have lower or higher cost components, as defined below, they were not necessarily the overall lowest or highest cost provider and so these values have not been included in the bars.
- Deloitte has calculated an hourly dollar cost of service using current financial information from the quantitative section of the survey. It is comprised of the following 4 components:
  - **direct support worker costs:** these were based upon a weighted average of wages;
  - **other direct costs:** these includes provisions for unpaid work, such as meetings, and co-ordinator labour, based on current co-ordinator: support worker ratios;
    - Five of the respondents indicated they are operating at sub-optimal co-ordinator levels, so these rates do not necessarily reflect the level of costs required to operate sustainably.
  - **overheads:** these were estimated by dividing the total overhead costs for delivering the service by hours delivered;
    - As noted previously, respondents may have more than 1 division, meaning that the value for overheads is sensitive to the overhead allocation, which may differ across respondents.
  - **a margin:** the median margin that respondents believed they needed to be sustainable was 5%.
- The wage component of direct support worker costs ranges from 64% to 71% of the total cost of service for the survey respondents (including on-costs).
- Leave provisions can vary depending on whether leave is taken up or not. This means that a range is provided based on assumption that none or all of the leave has been taken.

Dollar Cost Structure per Hour of Service



Source: Respondent information

- The total cost of service, including and excluding leave provisions, for the low, average and high cost respondents are as follows:
  - low, excluding leave provision, is $22.66;
  - low, including leave provision, is $25.62 (first bar shown);
  - average, excluding leave provision, is $24.43;
  - average, including leave provision, is $27.34 (second bar shown);
  - high, excluding leave provision, is $26.39; and
  - high, including leave provision, is $29.27 (third bar shown).
- The lowest cost respondent has a higher leave provision than the highest rate, as the provider has a higher leave allowance for holidays, sickness and bereavement leave.
- The following section will analyse these components in more detail.

8. Current Provider Costs (cont'd.)

Direct Support Worker Costs

- Direct support worker costs are the largest component of service provider costs, ranging from 61% to 68% of the total cost of service.
- The majority of providers are already paying direct support workers at the minimum wage so any cost savings will need to come from another source.

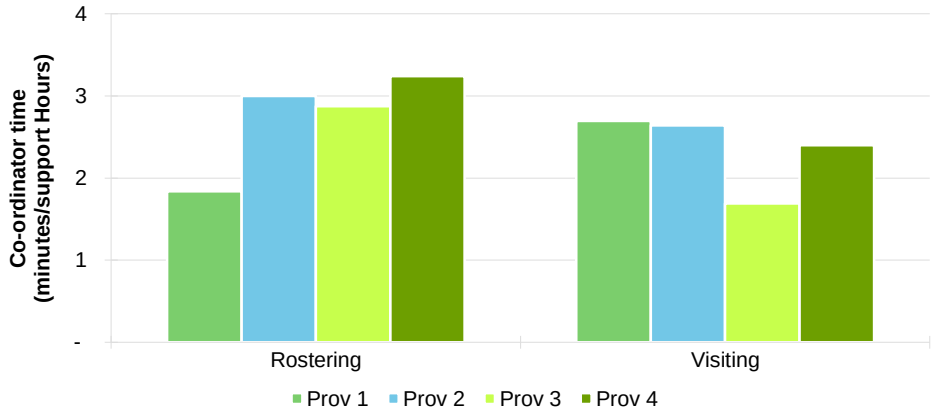
Other Direct Costs (mainly Co-ordination Costs)

- Other Direct Costs are circa 9% of the cost of service, and are mainly co-ordination costs.
- The top chart opposite illustrates the co-ordinator to support worker hours for rostering and visiting staff, which is a proxy for the ratio of co-ordinators to support workers.
- Five out of 6 respondents stated that they had reduced their ratio of co-ordinators to support workers to sub-optimal levels.
- One provider takes circa 60% of the time of any other provider, which could be due to their recent IT investments. Another provider uses circa 75% of the visiting time that other providers use.
- These differences indicate that there may be some efficiencies and scope for cost reduction. However, without knowing the resulting quality implications and the other costs that might be incurred if levels are sub-optimal, no definite conclusion can be made.

Overhead Costs

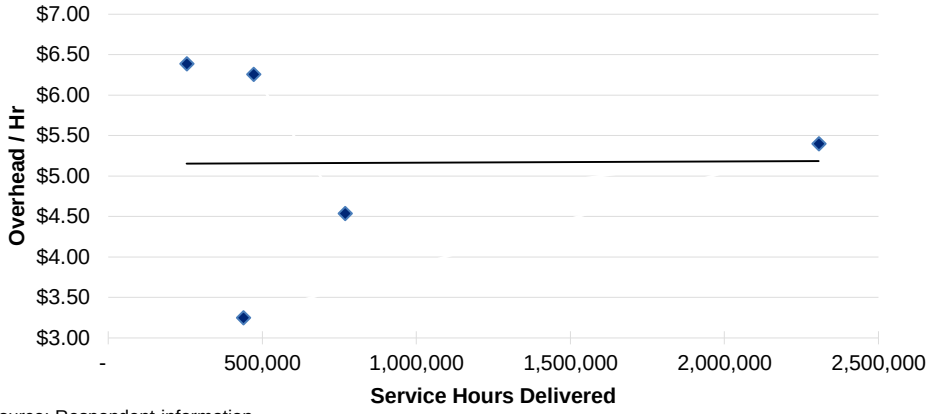
- As noted previously, respondent overhead information is based upon an allocation of overhead.
- The bottom chart opposite illustrates that there is no clear relationship between the average overhead per hour and service hours delivered. However, there could be a stronger relationship if service hours from other divisions were included.
- The respondents with the highest and lowest overheads per hour delivered least hours in the sample.

Co-ordinator time



Source: Respondent information

Overhead vs Service Hours Delivered



Source: Respondent information

8. Current Provider Costs (cont'd.)

Margins

- In economics, a sustainable margin is where the provider makes zero economic profit, which means a provider makes the same amount of money operating the business as they would putting that capital in an investment of similar risk. The margin also needs to account for required levels of maintenance or capex replacement and/or investment. So if providers are expected to acquire any IT software or hardware, the margin should reflect this. The margins estimated from providers ranged from 5% to 8% of revenue.

Provisions

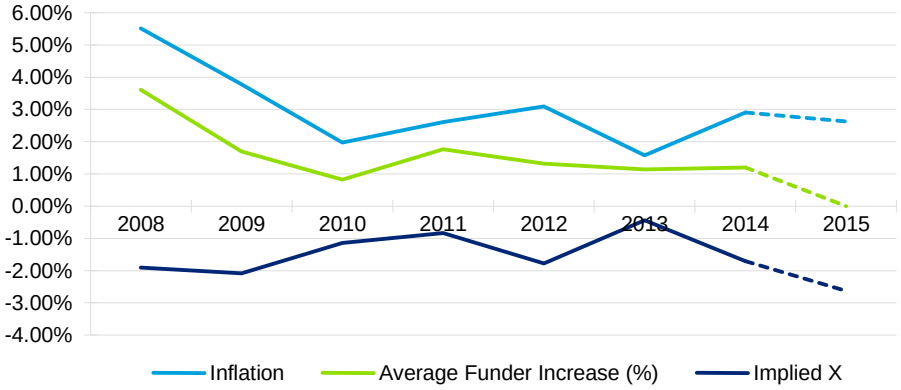
- Insufficient financial information by division was available to ascertain what provisions are historically required for this sector. These have been excluded from most analysis, which will produce conservative estimates of shortfalls.

Implications

Implied X efficiency factor

- If we calculate the a weighted minimum wage/CPI/LCI adjustor to cover costs, and compare against the average % rate increases from funders, the difference will be an implied X factor for efficiency gains.
- The following inflationary adjustors and weightings have been used to calculate weighted inflation in the top chart opposite:
  - Minimum wage increases (~ 65% based on direct support worker costs)
  - LCI increases (~ 9%, based on co-ordination costs)
  - CPI increases (~ 26%, based on all other costs).
- The top chart opposite shows the implied X efficiency factor adjustments for regional DHB funders. The chart looks similar in shape to minimum wage ($) shortfall, except for the earlier years, where because the base rate is low, a low shortfall could still be relatively large % shortfall.
- In most years, the implied X efficiency factor has ranged from -1% to -2%.

Weighted inflation adjustor and Average Funder Increases



Source: Statistics New Zealand, Department of Labour, Home & Community Care Provider, Deloitte

Sustainable X efficiency factor levels

- If it is assumed that overhead costs (circa 21% of costs) are the only means left where efficiency gains can be made, and there is a 2.5% efficiency factor on the entire rate, this equates to a circa 12.5% (2.5%/21%) reduction in overhead costs that needs to be achieved to maintain 2014 profit margins.
- In theory, efficiency gains are easier to identify in an immature market, but over time as inefficiencies are identified, it will be more difficult for businesses to identify significant cost efficiencies, unless there is a change in their cost structure. Deloitte has estimated that a business in this sector would have needed to find average year on year overhead savings of more than 7% for the past seven years to maintain their original profit margins. It is unlikely that a business could have consistently identified savings of this magnitude over the past seven years.
- As mentioned earlier, providers have struggled to save costs through efficiency gains, and have instead resorted to reducing costs through unsustainable means, and absorbing a reduction in margin.

9. Future Provider Costs & Technology

Potential for Technological Advancements

- Technology could potentially change the nature, need and means of home care assistance. In this section, we briefly cover current technologies and technological trends.
- However, it is important to consider the costs associated with technology, including:
  - upfront capital expenditure;
  - implementation and testing costs; and
  - user training.

Co-ordinator and Administration Assistance

- Software and hardware upgrades could assist co-ordinators by helping with:
  - the management of the client relationship;
  - rostering;
  - support worker compliance;
  - monitoring support workers; and
  - verifying service delivery (e.g. Ezitracker).

Mobile Technologies and Telemedicine

- The advance in mobile technologies could be used to help deliver services via alternative communication mediums. For example:
  - video conferencing could be used instead of physical visits; and
  - automated SMS messaging could be used instead of phone calls between clients, support workers and co-ordinators.
- There is also the potential for improved monitoring and self-management through mobile applications and software, which would reduce the number of care hours required.

Mobile Technologies and Telemedicine (cont'd.)

- Mobile technologies are being used overseas to leverage lower skilled workforces by enabling them to undertake simple tasks that a higher skilled worker would otherwise be required for.

Robotics and Home Care

- Overseas, robots are being considered as alternatives for simple client tasks, such as cleaning (e.g. robot vacuum cleaners) and meal preparation.
- In Japan and Canada, robots are even being used to assist with therapeutic care.

Technology Investments made by providers

- Survey results indicated that 3 respondents had recently made major IT investments, whereas the other respondents had delayed them. In particular:
  - One respondent had delayed IT maintenance, which was now impacting on server reliability; thus incurring more costs.
  - One respondent had acquired new a new IT system, but did not have the funds to employ an expert implementation manager and for training; and
  - None of the respondents with new IT systems had owned them long enough to confirm the planned cost savings from their investment.

10. Turnover, Retention & Recruitment

Remuneration issues

- A number of survey respondents noted that they felt that their staff were being underpaid, but that there were insufficient resources to pay them more. Furthermore, several respondents noted that they had been forced to remove performance-based pay for some roles in an effort to contain costs.
- One respondent noted that there was also dissatisfaction by qualified staff that they are not able to fully utilise their skills to help people due to contract service boundaries.

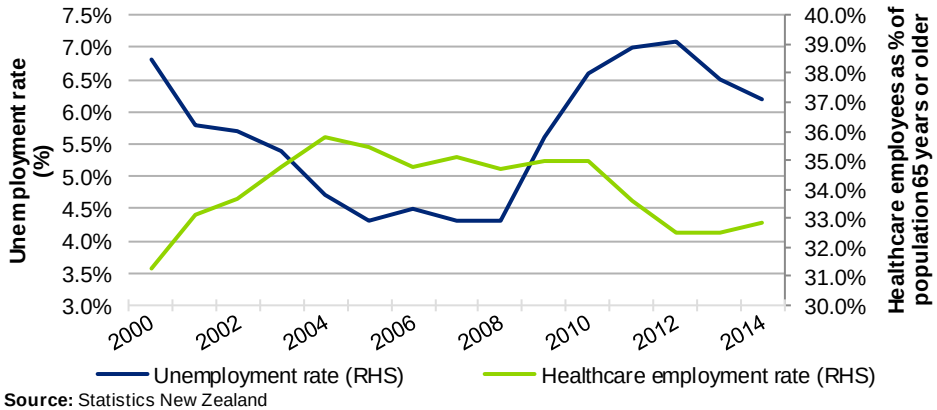
Turnover and working conditions

- Five out of 6 survey respondents noted that they had issues with staff turnover, particularly co-ordinator turnover. However, the respondents which had an issue with turnover, had also reduced their ratios of co-ordinators to support workers, which had increased the pressure and workload on existing staff. This has led many of them to feel overworked and has resulted in high turnover rates.
- One provider noted that it has an internal key performance indicator ("KPI") of a salaried staff turnover rate of 8% or less and 10% or less for support workers. These KPIs are currently in excess of 15% and 20% respectively. In turn, high staff turnover further exacerbates the staffing issues.

Recruitment

- Higher turnover has resulted in the increased need to recruit. One provider stated that due to difficulties recruiting the right people for the long term, they have needed to have depend on using "agency" staff at higher rates.
- Currently, all of the respondents had stated concerns over recruiting suitable staff at the support worker and co-ordinator level with the right skills, experience and dedication. Level of remuneration has been stated as a major factor to be unable to attract the human capital required.

Unemployment Rate & Healthcare Employment Rate



Source: Statistics New Zealand

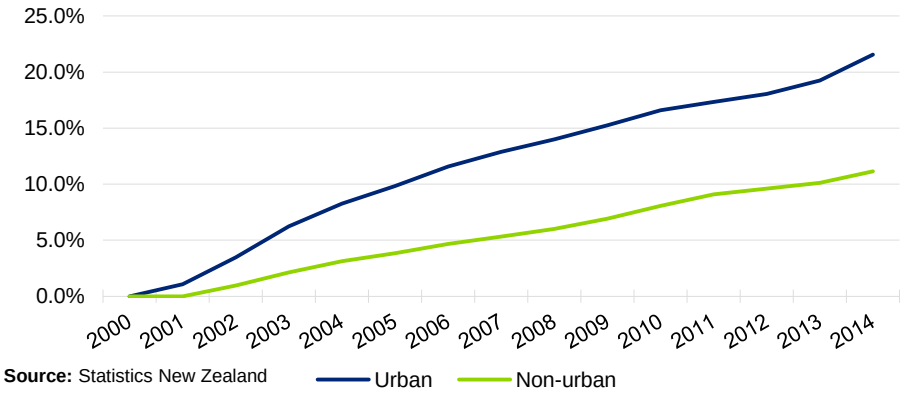
Supply Issues

- Several providers stated that turnover has increased in recent times as they economy has recovered. This supposition is supported by the chart above, which shows that the New Zealand unemployment rate against the proportion of those employed in the healthcare sector to those aged 65 and older. There appears to be somewhat of an inverse relationship between these 2 series, supporting the assertion that as the economy strengthens, evidenced by the decreasing unemployment rate, it is more difficult to hire new staff particularly at minimum wage rates.

11. Regional Differences

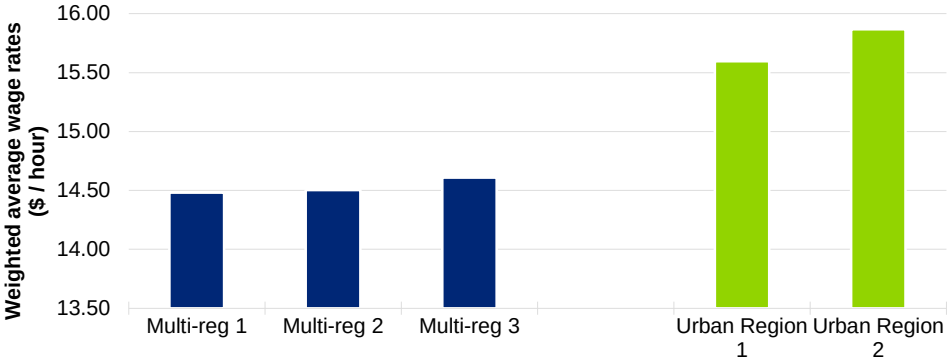
- One survey respondent with nationwide operations noted that it found that staff turnover was higher in urban regions as there are more minimum job opportunities. To explore this further, we conducted analysis of trends in the urban regions.
- The top chart opposite supports this contention. The chart shows that population growth in the main urban centres of Auckland, Wellington and Christchurch (represented by the blue "Urban" line) has been significantly larger than in the less urban centres based on data from Statistics New Zealand. Taking this together with the labour supply chart on the previous page, suggests that it is most likely to be job opportunities driving staff turnover. This will also make it relatively more difficult to hire new staff in the sector
- The calculation of service provider rates also noted regional differences, with higher wages being required to attract and retain workers in the urban centres.
  - Direct labour costs, that is, the average wage component of provider rates, were found to be higher for 2 respondents, which only serviced urban regions.
  - All other respondents in the sample either served multiple regions or had national coverage and on average had a lower cost base.

Cumulative Urban and Non-Urban Growth



Source: Statistics New Zealand

Average Wage Component of Provider rates



Source: Respondent information

12. Long Term Demand and Supply for Home Care Services

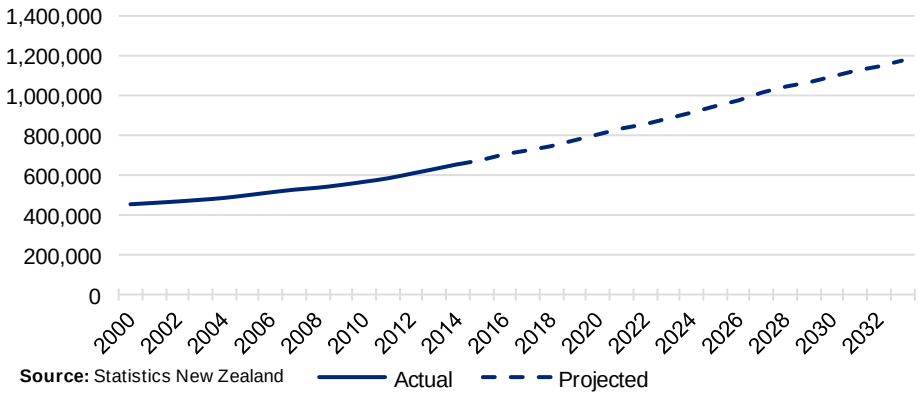
Long Term Demand for Home and Community Services

- As the chart opposite shows, the New Zealand population aged 65 and older has increased steadily over time and is projected to continue to almost double in the next 20 years. Proportionally, this will move the population over 65 from c. 14% to c. 22% of the population. It is also the demographic most likely to need home and community support.
- While an increase in volume is not an issue per se, it would be an issue if the supply of services in the sector was insufficient to meet the demand and there was to be no cut-back in the level and quality of services, given the public good nature of the market.
- In other words, in the absence of allowing the free market mechanism of price increase to reduce demand, it is relatively more important in this case to focus on the supply-side of the market to identify any issues.

Long Term Supply for Home and Community Services

- In 2013, 54,600 people were on the minimum wage, which was estimated at 2.4% of all employees in NZ.
- Table 2.1 in BERL Economics' *Health and Disability Kaiawhina Worker Workforce* report, notes that, as of 2013, using information from the 2013 census, there were circa 35,600 care workers. This figure is comprised of an estimated 29,859 personal care workers and 5,772 aged or disabled care workers.
- If it is assumed that if the demand for carers doubles within 20 years, this equates to 73,000 care workers required to undertake home and community care.
- If the number of people on minimum wage increases at the same rate as the population growth of people between 15-65 (c. 10%), then within 20 years time, there will be c 59,500 people on the minimum wage. Which is 13,500 less than the approximate number of carers required.
- So the combination of increasing demand outpacing expected supply will put pressure for wages in the sector to increase.

New Zealand Population Aged 65 & Over



Source: Statistics New Zealand

13. Possible Responses to the Funding Concerns

This section of the report considers some of the issues that we have identified in our analysis, together with possible responses and a cursory examination of their feasibility. It is far from exhaustive.

Key Issue	Possible Response(s)	Feasibility & Impact
As the minimum wage and other costs increase, so too does the funding requirements, in an environment where services are publically funded.	• Readjust funding model and / or funding rates.	• Public health funding is limited. If DHBs can leverage home care work more to substitute more expensive services, they may be able to reallocate some of the savings to increased funding of home care work.
	• Aligning payments to a more patient-centred model where payments relate to specific services rather than hourly rates. Under this model services are defined and service price adjustments are based upon an objective sector cost model, which takes into account agreed-upon cost drivers, such as fair wage rates, client complexity etc. Key cost drivers could be indexed to known cost indices to ensure that the service providers are not bearing the uncontrollable cost risk and are incentivised to reduce costs to improve their margins.	• The challenge here will be to identify a rate card based around services, which is rationalised down to a sensible mix. • It would be desirable to standardise a single service mix and rate card across DHBs.
	• Providers find cost savings or reduce margins.	• Most providers that participated in the survey appear to be cost-efficient, with low margins. • To gain further cost efficiencies will either require funding for investment, or a consolidation via a merger or acquisition.
	• Some (partial) user-pay system may be able to reduce the ultimate cost to government and / or increase the revenue to service providers.	• It seems unlikely that any form of user-pay system would be adopted. However, in the face of unsatisfactory service, people may be increasingly willing to pay for improved service.

13. Possible Responses to the Funding Concerns (cont'd.)

Key Issue	Possible Response(s)	Feasibility & Impact
As the minimum wage and other costs increase, so too does the funding requirements, in an environment where services are publically funded (cont'd).	• Commit to a fixed funding envelope for home and community support funding at a national, instead of regional, level across all DHBs. Contract with all providers on a consistent basis nationally, providing greater flexibility for funding to flow where the demand is greatest. Agree a nationally consistent payment mechanism which provides protection against the possibility of demand exceeding the capacity to supply at given rates of funding. • The funding envelope could be broken down to a DHB level at least notionally, and then tracked regionally, to allow certain policy initiatives and trade-offs to be made at the national level, rather than having these made at the regional level.	• Under the Fee-for-Service and Bulk Funding models, home and community support businesses provide as many services, at whatever complexity, are required within funding baselines. • If there are relatively more complex services in a particular region, service providers will be relatively worse off. The same is true if the cost of service is relatively higher in a particular region. By allocating pre-paid services to service providers, their financial viability is not unfairly impacted by their client mix: – regional funders would not be over (under) compensated given the complexity of their clients as they would have services, not funding to allocate; – regional funders would not be financially impacted by regional service provider cost differences; these would instead be transferred to the service providers to manage on a national basis (which some may be doing already); – service providers would have more volume certainty, i.e. they would know the volume that they need to deliver, which could allow for more efficient and effective resource allocation; – service providers would be financially unaffected by their client mix as the cost differences would have been dealt with upfront at the national procurement phase.

13. Possible Responses to the Funding Concerns (cont'd.)

Key Issue	Possible Response(s)	Feasibility & Impact
There is a growing demand for home and community support services in an already stretched sector which is placing additional financial pressure on funders	• Taking steps to reduce demand by, for example, changing service eligibility policy/rules.	• In an aging society where people are living longer on average and with high expectations of the public health sector, any changes to policy / rules appear more likely to result in increased demand for services in the community.
	• The scope of services required to be delivered could be altered to reduce staff workload and /or cost.	• Any change to the scope of services would need to be consistent with policy objectives for care models such as the restorative care model adopted by some of the DHBs.
	• Capping service levels or the scope of services so that clients must pay for additional services. This could potentially be means-tested.	• While feasible and consistent with other changes to primary care funding models (e.g. prescription co-payments), however perhaps unlikely in an environment where there is a push to move service delivery out of (free) secondary care settings into the community.
	• Incentivise "unpaid" family care of elderly residing with family via a tax credit.	• There is precedent for this in Ireland, where they have a home carer tax credit- IT66. However, it is unclear what the incremental benefit of this will be in New Zealand, as there may already be a large existing base of family care, so the tax credits could outweigh the potential benefit.

13. Possible Responses to the Funding Concerns (cont'd.)

Key Issue	Possible Response(s)	Feasibility & Impact
There are issues hiring and retaining staff in the home and community support sector.	• Improve conditions for those already in the sector, for example by implementing initiatives to reduce workload or improve pay.	• Given the nature of the sector, reduced workload is unlikely without increased funding for additional staff and/or investments in technology.
	• Supplementing the labour supply pool, working with MBIE's Immigration Services.	• This is contrary to the Government's skilled immigrant policy focus, other than for seasonal labour.
There are a number of service providers running independent businesses, each with their own relatively large overheads.	• If there was some common infrastructure across the sector, e.g. sector-wide training programmes, a sector-wide client database, there would be some scope to reduce overheads, and thereby increase profitability.	• There may be some scope and desirability for some of the smaller service providers to pool certain common infrastructure items.
There is likely to be a considerable amount of deferred capex to be provided for in the coming years.	• One-off funding could be used to help service providers to meet these costs in the face of increased labour costs. Superior systems could also be used to drive efficiencies and hence cost reductions elsewhere in the businesses.	• Increased operational funding is more likely to be feasible, but could be tied to expectations regarding service uplifts over time which rely on appropriate investments.

14. Key Areas of Risk: Conclusions

Funding Model Risk

- DHBs have traditionally funded home and community support services based on a fee for service model, which is adjusted for rate increases annually. Some DHBs have moved to a fixed fee funding model, which has been set based on assumed levels of volumes and service. However, depending on the contract, DHBs can have an incentive to increase levels of volumes when home care contracts provide a cheaper substitute for alternative health services, which exposes providers to the risk of greater than expected volumes with no additional funding.

Historic Funding

- The sector mainly employs low skilled workers who are remunerated at levels close to the minimum wage. Over the past seven years, the minimum wage has increased by $3.00. Over this same time period, only 3 regional DHBs, plus the national funders (MoH and ACC) provided increases of more than $3.00.
- The average shortfall between minimum wage and funding increase has been worst in 2012 and 2014, when minimum wage increases were 50 cents.

Current Funding Levels

- The accumulation of funding shortfall has led to five out six providers surveyed to experience a decrease in EBIT margins, and for three major providers to have had three years of negative EBIT margins. As a result, one provider is now in a position of negative equity on the balance sheet.
- As a result of funding shortfall, providers have sought to reduce costs where they can without falling below minimum clinical quality standards. This has been through reducing the ratio of co-ordinators and/or through delaying capital investment. Over the long run this is likely to mean higher costs.

Increased Service Levels, same funding

- Providers have reported concerns of increasing service level demands and compliance from funders. The prime concern is that providers are expected to carry out a “different” service, yet not be compensated for the additional training, transition and increased skilled labour costs associated with delivering a higher level of service.

Staffing Issues

- Providers have reduced or not increased staff related costs as part of their response to insufficient funding levels. As a result, workers have higher workloads, in addition to some workers not getting pay increases. This has resulted in increased employee turnover.
- Turnover has been worse in the urban regions which have grown more than non-urban regions.
- In addition to short-term recruitment issues due to turnover, there are long-term concerns with the demands from an aging population which is expected to almost double within 20 years. However, the working population between 15-65 are only expected to increase by c. 10%, which will make it more difficult to find workers wanting to work at minimum wage.

Overall Conclusions

- Our analysis supports the providers’ view that the current funding model is unlikely to be sustainable – particularly in an environment of increasing demand. To illustrate this point, the average provider would have needed to achieve year on year overhead savings of over 7% for the past seven years to maintain their margins. With a scheduled increase to the minimum wage of $0.50 in the absence of any increase in funding, 2015 overhead savings would need to exceed 12.5%.

Appendix I: Restrictions & Limitations

- In providing our advice and assistance 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 HCHA and its members that participated in our survey. We have not corroborated the information received and, to that extent, the information may not be reliable.
- We have not carried out any form of due diligence or audit on the accounting or other records of the HCHA or its members. We do not warrant that our enquiries have identified or revealed any matter which an audit, due diligence review or extensive examination might disclose.
- 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 advice and assistance 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.

Appendix II: Sustainability Review Scope

The following points set out the scope points received from Julie Haggie on 27 November 2014 to cover in our work.

1. **Quantitative data collection:**
   a. Select a representative sample of member organisations (7-10).
   b. Review financial reports for last four years of those organisations, looking at:
      i. Turnover in community services funding
      ii. Profit in community services funding
      iii. Use of reserves or other sources of funding to top up or supplement community services.

2. **Quantitative data collection:**
   a. Using the same sample member organisations, ask those organisations to complete the HCHA costing model (not including travel).
   b. Ask those organisations to estimate, using the model, the increased payroll cost of an increase in the minimum wage of:
      i. 25c, with and without maintaining pay relativities.
      ii. 50c, with and without maintaining pay relativities.

3. **Quantitative data collection:**
   a. Receive data on seven years of minimum wage increases to contract rate from Healthcare NZ, and consider assumptions on the impacts of that data on sector sustainability.

4. **Qualitative information:** Ask sample member organisations to comment on:
   a. Decisions they have made in relation to numbers of coordinating staff over the last 3-5 years, and any financial and/or quality impacts they see as a result.
   b. Any impacts of increasing workload on staff or coordinators.
   c. Impact on staff retention, staff motivation and recruitment in a climate of financial restraint.
   d. Whether financial restraints have led them to make decisions in relation to technology or other infrastructure in the last 2-5 years, and any financial and/or impacts they see as a result.
   e. What they consider to be a reasonable level of profitability, that would enable them to invest in service development.
   f. What they are most concerned about over the next two financial years (in terms of both financial cost and service delivery).

Appendix III: Qualitative Questions

The 8 questions that were included as part of the survey that was sent to our sample of service providers in the home and community support sector are shown below.

1. What decisions have you made in relation to the number of co-ordinating staff within your organisation as a result of funding constraints?
2. What financial and / or quality impacts have you seen as a result of the above?
3. Have you noticed any impact on staff or co-ordinators as a result from an increased workload?
4. Within you organisation what (if any) impact have you noticed on staff retention, staff motivation and recruitment in a climate of financial restraint?
5. What (if any) decisions have you made regarding investment in technology and other infrastructure within the last 2-5 years as a result of financial constraints?
6. What financial and / or quality impacts have you seen as a result of the above?
7. What would you consider to be a reasonable level of profitability over the coming two years that would allow you to invest in service development?
8. What are you most concerned about over the coming two years in terms of both financial cost and service delivery?

   Question Response + Additional Note

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