The Treasury

Budget 2017 Information Release

Release Document July 2017

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Office of the Minister of Health

Chair, Cabinet State Sector Expenditure Committee

Care and Support Worker Negotiations

Proposal

1 This paper seeks Cabinet approval for financial and negotiating parameters to proceed with a formal offer to E tū, Public Service Association (PSA), New Zealand Nurses Organisation (NZNO) and the New Zealand Council of Trade Unions (NZCTU) in order to progress the care and support worker negotiations.

Executive Summary

2 Negotiations are underway between the Crown, Employers and E tū, PSA, NZNO and NZCTU (the unions) in order to progress a settlement of the care and support worker negotiations referred to as "the TerraNova case". Unions are claiming a breach of the Equal Pay Act 1972 related to pay equity based on gender.

3 The unions made a formal offer for settlement in June 2016. The estimated cost of this offer is $2.66 billion over five years. This offer has been rejected by Ministers.

4 Since June 2016, officials have been refining and testing the costing model and engaging with other agencies and providers in order to progress the care and support worker negotiations.

5 Ministers indicated they wished to continue to negotiate a settlement that resolves the TerraNova case, rather than returning to court. Officials propose an offer be made using mental health assistants as the acceptable and agreed comparator for the purposes of a pay equity settlement. The cost of this offer is $1.88 billion over five years. Cabinet is asked to agree to new financial parameters to allow negotiations to continue on this basis. This is a significant adjustment to the existing financial parameter of $1.5 billion over five years and relates to the change in comparator from DHB health care assistants to mental health assistants and the shift from comparing base wage rates to total remuneration.

6 If Cabinet agrees to the financial and negotiating parameters, formal negotiations will commence with unions from 14 November 2016. The Minister of Health will report back to Cabinet in early December 2016 on the status of negotiations, and in the event that the Crown's offer is accepted, an implementation strategy.

Background

7 A test case was filed in 2012 in the Employment Court on the interpretation of the Equal Pay Act 1972 [TerraNova vs Bartlett/Service and Food Workers Union (SFWU)]. The case claims that a caregiver is paid less because the work is predominantly performed by women, with reference to what would be paid to a male performing different work involving similar skills, responsibility, conditions and degrees of effort. There are a further 6,000 equal pay related cases filed with the Employment Relations Authority.

8 The Employment Court, and subsequently the Court of Appeal, determined that the Equal Pay Act 1972 did allow for such claims to be pursued. This means the Equal Pay Act is not just targeted at equal pay (the same pay for the same work), but also establishes a statutory pay equity regime (the same pay for work of equal value) for work that is predominantly performed by women.

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9 In June 2015, Cabinet considered a paper that set out the approach for negotiations in response to the TerraNova case (refer Cab Min (15) 18/8). Cabinet, amongst other things:

a) agreed that the Government seek to resolve the TerraNova case out of the courts, allowing the Government to better manage the process and outcomes;

b) agreed negotiations would be tightly focussed on addressing pay and associated workforce issues for care and support workers;

c) agreed that a Crown Negotiator be appointed to lead the negotiations, assisted by the Ministry of Health; and

d) noted that the total package of addressing low pay through negotiations was estimated to cost up to approximately $300 million per annum.

10 Cabinet also considered the principles which the TerraNova negotiations set out to achieve. These included:

a) a stay in proceedings in the Employment Court and possible removal of litigation on the matter of pay equity for care and support workers;

b) a fair pay outcome that represents value for money, and supports a sustainable workforce in the future as demand for care services continues to increase;

c) minimum cost, e.g. keeping pay increases to the minimum necessary to achieve objectives, avoiding back pay and introducing a phased approach to allow new pay rates to be transitioned into the sector at a fiscally responsible rate;

d) avoidance of pay comparisons that would set a precedent for an as yet undecided pay equity regime; and

e) reduction in the risk of workforce shortages.

11 The TerraNova negotiations are limited to care and support workers in aged and disability residential care and home and community support services (including injured clients under ACC). Across the care and support workers sector, there are an estimated 55,000 workers (approx. 29,300 FTE). A detailed breakdown of the workforce can be found at Appendix A.

12 The parties to the negotiations are:

a) the unions: E tū, PSA, NZNO and NZCTU

b) the employers[1]

c) Business New Zealand

d) District Health Board (DHB) representatives

e) Ministry of Health and ACC (as funders).

13 In parallel to the TerraNova negotiations, the Government set up a Joint Working Group (JWG) to recommend principles for implementing pay equity claims. The JWG was led by Dame Patsy Reddy and included Government, employer and union representatives. The JWG completed its work in May 2016 and Ministers are currently considering the recommendations.

14 There have been a number of discussions and exchanges of formal offers to date between the Crown Negotiator, the Ministry of Health, funders, employers, and unions. Negotiations

[1] Aged residential care representatives from the Aged Care Association, Home and Community Health Association (HCHA) and New Zealand Disability Support Network.

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have been protracted and challenging given the complexity of the related workforce and funder issues which must be navigated.

Refreshing financial and negotiating parameters

Shifting the comparator

15 The fiscal parameter noted by Cabinet in June 2015 of up to $300 million per annum was based on the use of the DHB health care assistants as a comparative workforce. This comparator was unacceptable to the unions because it was based on a predominantly female workforce, which would not illustrate gaps in pay equity. The union view is consistent with the pay equity principles recommended by the JWG.

16 In order to move towards a settlement, a new comparator was identified. Mental health assistants are considered by the Ministry of Health to be an appropriate pay equity comparator on the basis that it is a majority male workforce[2] within the health sector. However, the mental health assistants have a higher base wage rate than DHB health care assistants, so using this workforce and its total remuneration (base wage rate and terms and conditions) as a comparator means that the current financial parameters are not sufficient to achieve a pay equity settlement.

17 The Crown Negotiator and the Ministry of Health consider that mental health assistants is a more appropriate comparator on the basis it is a male dominated occupation (i.e. pay rates are unlikely to be undervalued due to systemic gender discrimination) that has reasonably comparable skills, responsibility and conditions of work, and is within the same industry. [36]

Formal Union Offer

18 The unions' most recent formal offer for settlement was made on 10 June 2016 (refer Appendix B). In their offer the unions state that they consider that a settlement using mental health assistants would be a *significant step towards* equal pay but do not accept that a settlement on the basis of their offer would be a full and final settlement of pay equity issues for this group of employees.

19 This current union offer is estimated to cost up to $2.66 billion over five years (refer Table 1 below). The cost is driven by two aspects:

a) the matrix of wage rates from $20.50 to $25.50 per hour[3] phased in over five years. These rates also include monetised conditions[4]; and

b) progression based on *service[5] or qualification* attainment.

20 The current union offer also included:

a) a five year moratorium in which no pay equity claim in the scope of this settlement could be taken against any employer or the Crown;

b) extinguishing all claims for back pay with the exception of Mrs Bartlett (the original claimant); and

c) adjustments to the base wage rates in line with the Nurses Multi Employer Collective Agreement (MECA) over the five year period.

[2] 57% of mental health assistants are male (there is limited data, this is calculated off half of the workforce).
[3] Once fully implemented over five years the rates would range from $22.50 to $25.50 per hour. This is included in the union offer (refer Appendix B).
[4] A monetised rate captures the marginal increases to workforce conditions (such as penal rates, additional annual leave provisions, overtime etc) between the existing workforce and the mental health assistants.
[5] Service is defined as the length of time an employee has been employed e.g. progression based on service means that for every year of work an individual completes they receive a wage increase up to a certain point.

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21 **Table 1: Estimated cost - phased union offer (gross wage costs of settlement)**

		2017/18	2018/19	2019/20	2020/21	2021/22	5 year total
Crown costs	MOH and DHBs	$363.82m	$417.04m	$475.10m	$540.39m	$611.92m	$2.41b
	ACC	$40.00m	$44.00m	$49.00m	$55.00m	$61.00m	$0.25b
	Total Crown	**$403.82m**	**$461.04m**	**$524.10m**	**$595.39m**	**$672.92m**	**$2.66b**
Costs borne privately by aged-care residents		$54.89m	$63.39m	$71.93m	$81.62m	$92.21m	$0.36b
Costs borne by ACC levy payers		$88.00m	$99.00m	$110.00m	$123.00m	$136.00m	$0.56b
Crown cost plus private cost		**$546.71m**	**$623.43m**	**$706.03m**	**$800.01m**	**$901.13m**	**$3.58b**

*Costing assumptions can be found in Appendix C

22 The ACC costs in Table 1 show the impact on cash costs only.

23 Additionally, there is an outstanding claims liability (OCL) increase of $1.5 billion which, under the current funding policy, would be recovered from appropriations over a 3-year period and levies over a 10-year period. Refer Appendix D.

Response to union offer

24 Two options were presented to Ministers[6] on how to respond to the 10 June 2016 union offer, either:

a) Reject the offer, indicate negotiations are over and resume litigation. [36]

b) Reject the offer but indicate that the Crown is interested in pursuing a settlement using mental health assistants as the comparator. [36]

25 Ministers chose to continue negotiating. Accordingly, the Crown Negotiator rejected the union offer but signalled that the Crown will continue to try to reach a settlement.

Recommended approach to Crown offer

26 I consider that the Crown should seek to negotiate a full and final settlement that addresses pay equity on the following basis:

a) Mental health assistants as a wage rate comparator. Choosing a comparator from within the Health sector is consistent with the JWG principles and would be helpful as a precedent should Ministers choose to adopt the principles.

b) A matrix of rates from $17.85 to $25.39 per hour phased in over five years. These rates are based on the mental health assistants' rates (Appendix E sets out the phased rates).

c) A cost of $1.88 billion over five years, with a maximum ongoing cost of $507.25 million per annum.

d) Progression is based on qualification attainment, with no reference to service progression.

[6] Ministers English, Joyce, Bennett, Coleman and Woodhouse.

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e) Mental health assistants' additional conditions are monetised (e.g. penal rates, additional annual leave, overtime) and included in the base wage rates. Refer Appendix F for further information.

f) That all claims for back-pay will be extinguished except for that of Mrs Bartlett.

g) New wage rates come into effect from 1 July 2017.

h) All 6000 equal pay related claims relating to care and support workers wages filed in the Employment Relations Authority will be extinguished.

i) The parties agree that this agreement is a full and final settlement of all pay equity concerns relating to this group of employees.

j) That the unions provide a commitment that this settlement will not be used as a basis for claims for relativity wage increases for other groups.

27 Ministers should note that the proposed Crown offer does not include the following components of the union proposal:

a) The five year moratorium. The proposed Crown offer is full and final as at the date of settlement.

b) Adjustments to base rates in line with the Nurses MECA. [38]

28 The cost to the Crown of a settlement based on the above negotiating parameters is estimated at $1.88 billion over 5 years, with an ongoing cost of $507.25 million per annum, as outlined in Table 2 below[7].

29 **Table 2: Estimated cost - gross wage costs of settlement based on mental health assistants (phased)**

		2017/18	2018/19	2019/20	2020/21	2021/22	5 year total
Crown costs	MOH and DHBs	$231.61m	$280.88m	$334.67m	$394.95m	$461.27m	$1.70b
	ACC	$25.46m	$29.63m	$34.52m	$40.20m	$45.98m	$0.18b
	Total Crown	**$257.08m**	**$310.51m**	**$369.19m**	**$435.15m**	**$507.25m**	**$1.88b**
Costs borne privately by aged-care residents		$35.65m	$43.37m	$51.31m	$60.26m	$70.09m	$0.26b
Costs borne by ACC levy payers		$56.02m	$66.68m	$77.49m	$89.90m	$102.52m	$0.39b
Crown cost plus private cost		**$348.75m**	**$420.56m**	**$497.98m**	**$585.31m**	**$679.86m**	**$2.53b**

*Costing assumptions can be found in Appendix C

30 The ACC costs in Table 2 are the cash cost impact only.

31 Additionally, there is an OCL increase of $1.067 billion which, under the current funding policy, would be recovered from appropriations over a 3-year period and levies over a 10-year period. Refer Appendix D.

32 The gross impact of the cost of this workforce, that being, assumed wage growth is an estimated $1.17 billion over five years.

33 Any agreed, negotiated settlement on these terms will be brought to Cabinet for consideration, along with implementation details. Should the Crown Negotiator require change to the financial, or other negotiating parameters to agree a settlement, he will seek joint approval from the Prime Minister, Ministers of Finance, State Services and Health.

[7] Note that these costs have been developed by the Ministry of Health, with the assistance of MartinJenkins and reviewed by the Treasury.

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Pricing

34 Officials envisage that funding to pay for care worker wage increases will be paid to providers by way of an increase in contract prices. Prices will be increased by estimates of the average impact of higher care worker wages relative to the contract revenue. This will need to be undertaken on a provider by provider basis as part of the contracting process between providers and funders. To illustrate how this might be done, using aged residential care as an example, the calculation of the price increase would be for the four service categories (rest home, dementia, hospital and psychogeriatric). The categories, the current average care worker wage costs and the expected proportion of workers on each of the new qualification-based wage scale will need to be agreed with providers as part of the settlement. Presently it is only possible to estimate the average impact of higher care worker wages relative to the contract revenue received by providers.

Flow-on impacts

ACC implications

35 As shown in Table 2 a pay equity settlement will have flow-on costs for ACC. ACC contracts with providers to provide Home and Community Support Services (HCSS) and some residential services.

36 ACC contributes to the cost of non-contracted HCSS (included in the costings above), where services are usually undertaken by private carers or family members. The ACC Board will determine whether to extend the pay equity settlement to non-contracted providers.

37 As ACC also pays for HCSS and residential care services, the rates paid to these workers also fall within the scope of negotiations.

Residential Care Subsidy and Threshold

38 People who enter aged residential care have to pay a portion of the costs themselves. The amount they pay is determined by a financial means assessment based on an asset threshold.[8]

39 Residents with assets below the threshold pay all their income towards their care, apart from a personal allowance of $43.45 a week retained from New Zealand Superannuation[9]. The DHB pays the difference between the resident's contribution and the contracted cost.

40 If a resident has assets over the threshold ($220,000 for singles, $120,000 for couples where one is in care) he/she is required to pay the maximum contribution for their care. As of 1 July 2016 it was in the range of $884.03 to $971.53 per week, depending on where they live (territorial authority). The maximum contribution is set equal to the rest home price.

41 Should wage rates for care and support workers increase as a result of resolutions to current wage negotiations, the rest home price will increase and therefore the maximum contribution will increase.

42 Table 2 shows the proportion of extra costs that would be borne directly by residents in aged-residential care with assets above the threshold. Those residents whose assets are below the applicable asset threshold will not be affected by rest home price increases as a result of a pay equity settlement.

[8] This subsidy and threshold only applies to non-ACC clients as ACC pays the full cost of residential care for injured clients.
[9] Small amounts of interest income are not included.

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43 The wage settlements set out in Table 2 would increase the cost for residents with assets over the threshold by around 15% or $6,900 per annum (or around $130 per week) in year one increasing to 27% or $12,600 per annum (or around $240 per week) in year five.

44 If the Government wanted to reduce the impact on residents who pay the maximum contribution this could be achieved by setting the threshold at less than the rest home price. A legislative amendment would be required, but the change would be simple to implement administratively. However, it is important to note that the saving to residents would be a cost to DHBs. This is because DHBs make up the difference between what the resident pays and the price paid to the provider. Ministers should note, this cost to DHBs will likely be sought from the Crown as a funding pressure.

45 There are 11,070 residents currently paying the maximum contribution and they are mainly located in Auckland, Canterbury and Waitemata DHBs. Further information is set out in Appendix G.

Risks to achieving a full and final settlement

[38]

Alternative approaches

Two staged approach

49 There have been changes in the environment since the TerraNova negotiations started. The pay equity principles recommended by the JWG (currently being considered by Ministers) provide an additional option for Ministers.

50 Ministers may wish to consider a two stage approach as an option for settlement. This would consist of an interim increase to wages followed by (in a year or two) a pay equity process based on the JWG principles. The benefit of this approach is that it would allow the care and support wage rate comparator to be agreed using the JWG recommended approach and process.

[38]

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[38]

If the TerraNova case goes back to Court

53 [38]

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Other potential implications

Horizontal and vertical relativity impacts

58 Employers will have to manage any internal relativity issues. It is important that successful pay equity claims are seen and understood to be 'corrections' to address historic anomalies.

59 Such relativity claims will potentially render pay equity settlement meaningless and create a perpetual cycle of increasing wage rates, i.e. Group A receives a pay equity settlement based on a comparison with Group C; Group B negotiates increases based on relativity with Group A; Group C negotiates increases based on relativity with Group B; Group A seeks another pay equity increase based on the Group C comparator.

60 Officials propose to address this risk by seeking a commitment from the unions that this settlement will not be used as a basis for claims for relativity wage increases for other groups (there are grounds for proposing that this should be a general principle in all pay equity negotiations). However, it should be noted that this is likely to be a contentious issue from a union point of view. There is also a simple labour market consideration that

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providers may have to increase wage rates, not on the basis of any pay equity or relativity reasoning, but because it will not be worthwhile for people take on the responsibility of other care jobs (e.g. therapists, enrolled nurses) when care workers are paid similar rates.

61 [38]

[38]

In-between travel

66 The In-between travel (IBT) settlement was approved by Cabinet in September 2014 [Cab Min (14) 30/6 refers]. It consisted of two parts, 'Part A' concerned the payment for in-between travel and the introduction of legislation governing the payments and extinguishing retrospective and future claims. This has been implemented and the legislation enacted.

67 'Part B' included a review of the HCSS sector and the introduction of 'Regularisation' as defined below:

a) the majority of workers on guaranteed hours

b) training to Level 3 to meet the needs of the population

c) recognition of training in wages

d) a casemix/caseload mechanism to ensure safe workloads and safe staffing.

68 Settlement parties are working towards 'Regularisation' and developing an understanding of the potential costs involved in its implementation. The workforce to which 'Regularisation' applies is a sub-sector of the wider care and support workforce.

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69 If a settlement for care and support negotiations can be reached, further advice will be provided to the Minister of Finance and Minister of Health as to how this could offset elements of IBT (regularisation of hours, training, and recognition of training in wages).

70 I note that Cabinet's approval of the settlement was on the basis that Part B would be managed within existing HCSS funding. Any further proposals need to be justified on their merits.

Future models of care

71 A review of the HCSS sector, including models of care work has commenced. This work is on track be completed by mid-2017 and will be reported back to Cabinet no later than August 2017.

72 The Ministry of Health, DHBs and providers have already commenced discussions as to how contractual arrangements relating to HCSS and Disability Support Services would be reflective of the settlement agreement (ACC has also begun working on how HCSS contractual arrangements would reflect the settlement agreement). This work will continue over the coming months. The expected outcome of the new contracts will be new service delivery models. There are, and will continue to be, linkages of this work to wider Ministry of Health reviews and initiatives including the Healthy Aging Strategy, and the Health and Disability Workforce Strategy.

High level implementation

73 As in the Sleepover settlement (2011) and the In Between Travel (IBT) settlement (2014) for implementation of the TerraNova settlement, key mechanisms for implementation include:

a) Legislation - This would extinguish the claims already lodged and future claims covered by the settlement agreement; and provide a mechanism to ensure employers meet their obligations as defined in the Settlement Agreement i.e. pay workers the agreed minimum wage rate.

b) Contract Variation - For IBT the obligation on Funders to pay the Providers was effected by way of a contract variation which prescribed a new price for the services (this was negotiated and agreed by parties).

c) Employer/Employee contract variation - For IBT the obligation for providers to pay the workers was effected by a contract variation which prescribed the new rates and terms and conditions of employment.

74 Further, detailed advice will be provided once the Crown is in a position to implement a settlement.

Next steps

75 Assuming Cabinet agreement to the financial and negotiating parameters formal negotiations will commence with unions from 14 November 2016. The Crown Negotiator will table an offer within the agreed parameters on 17 November 2016.

76 The Crown Negotiator and Ministry of Health will provide an update on the progress of negotiations to the Prime Minister, Ministers of Finance, State Services, Health, Workplace Relations and Safety, and ACC following the tabling of the offer. Should it be required, I recommend that we grant the Prime Minister, Ministers of Finance, State Services and Health power to act in order to continue progressing negotiations.

77 I will report back to Cabinet in the week of 5 December on the status of negotiations and, a path forward.

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Consultation

78 This paper has been prepared by the Ministry of Health. The Treasury, State Services Commission, Ministry of Business, Innovation and Employment, Crown Law and ACC were consulted. The Department of the Prime Minister and Cabinet was informed.

Financial Implications

79 The Treasury will advise how and when the revised fiscal parameters will be managed. The Treasury has also provided the comment below:

80 In our view, this paper does not yet provide enough information about what is being proposed (and why) to allow for informed decisions or give confidence about the costings. We recognise that progress has been made over the last couple of months, and that the approach to the costings is now considerably more sophisticated than before. However, a settlement with this workforce is likely to be the single largest item in Budget 17; and there are potential implications for wage settlements in other sectors, for care and support service models, and for individuals meeting the costs of aged care privately. So we think it is important that Ministers have a clear understanding of how a settlement would be implemented, whether the costings are consistent with that implementation strategy, [38]

More work is needed to answer these questions.

81 The Joint Agency report of 1 September (T2016/1671) indicated that firmed up costings would include clarity on price increases for providers and funding increases for district health boards. However, analysis to date continues to focus only on wage rates. There has been limited discussion about how a settlement would be implemented through prices; and no costings work has been done on this basis. Given that these are tripartite negotiations where the cost to the Crown will be determined by the prices eventually negotiated with providers, this seems like a significant omission.

82 The proposal is to introduce a qualification-based pay structure (with significant increments between wage levels). The costing is therefore sensitive to assumed distribution of qualifications across the workforce: more workers with qualifications means a higher cost. The costs presented in this paper assume that the distribution of qualifications under the new wage structure is broadly similar to the current situation (most workers with no qualification; only a few workers with the highest qualification). It is not clear that this is a reasonable assumption. The proposed settlement would tie wage increases directly to qualifications, so more workers can be expected to pursue them.

83 A better sense of how a qualifications-based regime would be implemented might provide more confidence about the robustness of the costings. However, this work has not yet been done. Ideally, we would like to know the answer to some key questions before the Crown commits to qualifications-based wage rates in negotiations. What is the distribution of qualifications that the government considers appropriate for this workforce, and is there a mechanism to achieve this? How will expectations about qualifications be reflected in prices paid to providers? What is to stop providers continuing to use unqualified workers in order to increase their margins?

84 We also think there needs to a fuller discussion of the proposed wage rates, including how they compare to existing rates for this workforce and for mental health assistants. The proposal is to “monetise” employment conditions (extra leave, night and weekend penals, shift allowances, etc.) into basic wage rates. This has the effect of increasing the proposed wage rates significantly above the base rates for mental health assistances, and gets them closer to the wage rates proposed by the unions (based on

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corrections officers). The judgement of the Crown negotiator is that this is more likely to secure a settlement.

85 However, it is important to be clear about exactly what has been monetised, and how this leads to the wage rates proposed. [38]

86 The costings assume that a wage settlement will be phased in over five years. This reduces costs in early years materially (by over $200 million in year 1). [38] At the time of writing, some detailed aspects of the costings still need to be worked through, including particularly the numbers for ACC.

Human Rights

87 No implications have been identified under the Human Rights Act 1993 or the New Zealand Bill of Rights Act 1990.

Legislative Implications

88 New legislation may be required in order to:

a) Ensure employers meet their obligations to pay workers (note that employment agreements would be aligned with legislative obligations).

b) Extinguish any historic and future equal pay claims in this area.

Regulatory Impact Analysis

89 A regulatory impact statement is not required at this time.

Gender Implications

90 The negotiated outcome will address pay rates for low paid workers in predominantly female workforce.

Disability Perspective

91 Alterations to pay rates and models of care and support workers in the disability sector will have positive impacts both for workers and the clients they serve.

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Publicity

92 All public announcements related to this issue will be led by the Prime Minister and Minister of Health. The details will be worked through by Joint Ministers.

Recommendations

The Minister of Health recommends that the Committee:

1 **note** that a test case was filed in 2012 in the Employment Court on the interpretation of the Equal Pay Act 1972 [TerraNova vs Bartlett/Service and Food Workers Union (SFWU)];

2 **note** that the TerraNova negotiations are limited to care and support workers in aged and disability residential care and home and community support services (including injured clients under ACC) and will impact an estimated 55,000 workers;

3 **note** that the unions involved in the negotiations are E tū, Public Service Association, New Zealand Nurses Organisation and the New Zealand Council of Trade Unions;

4 **note** that in June 2015 Cabinet agreed the following Strategy for Negotiations in Response to the TerraNova case [refer Cab Min (15) 18/8]:

4.1 agreed the Government seek to resolve the TerraNova case out of the courts, allowing the Government to better manage the process and outcomes;

4.2 agreed negotiations be tightly focussed on addressing pay and associated workforce issues for care and support workers;

4.3 agreed a Crown Negotiator be appointed to lead the negotiations, assisted by the Ministry of Health;

4.4 noted that the total package of addressing low pay through negotiations was estimated to cost up to approximately $300 million per annum or $1.5 billion over five years.

5 **note** that the unions rejected the comparator (DHB health care assistants) on which the $300 million per annum was calculated, as DHB health care assistants are not a predominantly female workforce;

6 **note** the Ministry of Health has identified mental health assistants as an appropriate pay equity comparator;

7 **note** that using the mental health assistants as the comparator requires significant change to the negotiating and financial parameters;

8 **note** the unions made a formal offer of settlement to the Crown on 10 June 2016 costing $2.66 billion over five years;

9 **note** that Ministers of Finance, Economic Development, State Services, Health and Workplace Safety and Relations agreed to reject the union offer on 10 June 2016 but indicated that the Crown is interested in continuing to negotiate a settlement using mental health assistants as a comparator;

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Negotiating and financial parameters

10 **agree** to the following negotiating parameters:

10.1 mental health assistants are the agreed comparator for equal pay purposes;

10.2 a matrix of rates from $17.85 to $25.39 per hour are phased in over five years;

10.3 that the matrix of rates outlined in recommendation 10.2 includes monetised conditions;

10.4 that the maximum outyear Crown cost of the settlement will not exceed $507.25 million per annum (from 2021/22 onwards);

10.5 progression is based on qualification attainment, with no reference to service progression;

10.6 that all claims for back-pay will be extinguished except for that of Mrs Bartlett;

10.7 new wage rates will come in to effect from 1 July 2017;

10.8 all 6000 equal pay related cases filed in the Employment Relations Authority will be extinguished;

10.9 that the parties agree that this agreement is a full and final settlement of all pay equity concerns relating to this group of employees;

10.10 that the unions provide a commitment that this settlement will not be used as a basis for claims for relativity wage increases for other groups;

11 **note** that the cost to the Crown of a settlement based on the above negotiating parameters is estimated at $1.88 billion over five years, with an ongoing outyear cost of $507.25 million, as detailed in the table below:

		2017/18	2018/19	2019/20	2020/21	2021/22	5 year total
Crown costs	MOH and DHBs	$231.61m	$280.88m	$334.67m	$394.95m	$461.27m	$1.70b
	ACC	$25.46m	$29.63m	$34.52m	$40.20m	$45.98m	$0.18b
	Total Crown	**$257.08m**	**$310.51m**	**$369.19m**	**$435.15m**	**$507.25m**	**$1.88b**
Costs borne privately by aged-care residents		$35.65m	$43.37m	$51.31m	$60.26m	$70.09m	$0.26b
Costs borne by ACC levy payers		$56.02m	$66.68m	$77.49m	$89.90m	$102.52m	$0.39b
Crown cost plus private cost		**$348.75m**	**$420.56m**	**$497.98m**	**$585.31m**	**$679.86m**	**$2.53b**

12 **note** the following assumptions used to calculate the costs above:

[38]

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12.3 that ACC costs include the cash impact only;

13 **note** that the proposed settlement would increase the cost for residents in aged residential care facilities with assets over the threshold by about $130 per week in year one ($6,900 per annum) increasing to $240 per week in year five ($12,600 per annum);

14 **note** the estimated number of residents in aged residential care facilities affected by the increase in costs outlined in recommendation 11 is 11,070;

15 **direct** the Ministry of Health to report back to Cabinet before the end of August 2017 with an update on the review of the Home and Community Support Services sector models of care work;

16 **note** the Crown Negotiator will table an offer with the unions on 17 November 2016 based on the agreed parameters in recommendation 10;

17 **note** the Crown Negotiator and Ministry of Health will provide an update on the progress of negotiations to the Ministers of Finance, State Services, Health, Workplace Relations and Safety, and ACC following the tabling of the offer;

18 **delegate** power to act to the Prime Minister, Ministers of Finance, State Services and Health should the Crown Negotiator require changes to the financial, or other negotiating parameters to agree a settlement;

19 **note** the Minister of Health will report back to Cabinet in the week of 5 December 2016 on the status of negotiations and, in event the Crown's offer is accepted, an implementation strategy.

Authorised for lodgement
Hon Dr Jonathan Coleman
Minister of Health

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Appendix A - Workforce

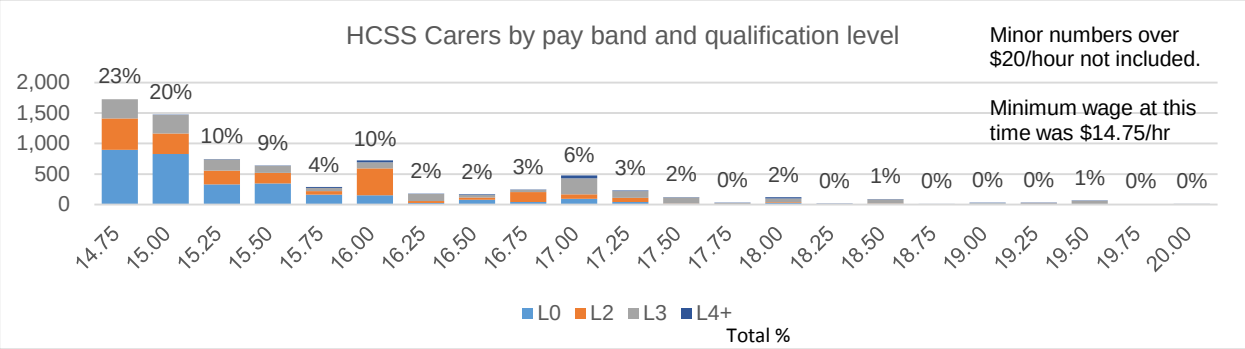
Home and Community Support Services

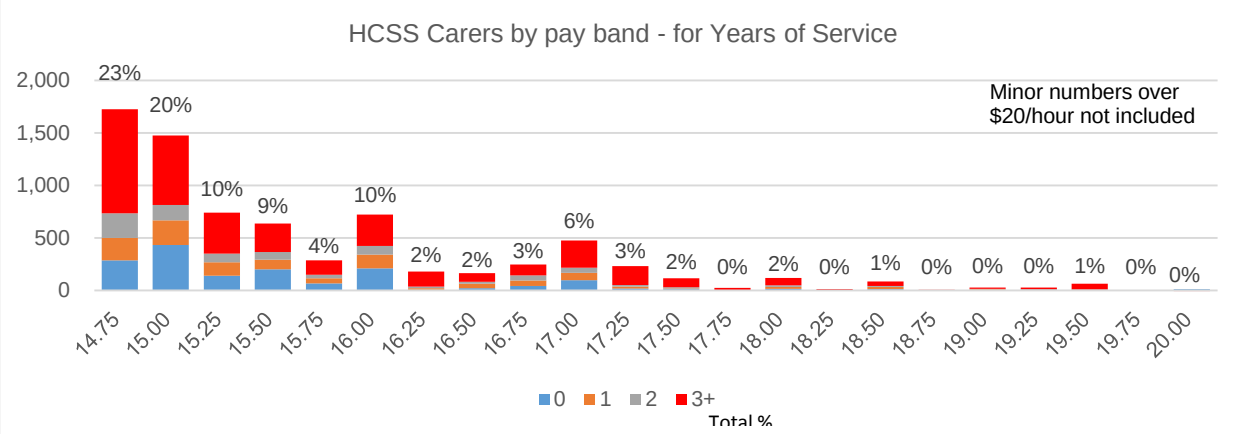
1 Home and Community Support Services (HCSS) are funded by the Ministry and DHBs.

2 Home and Community Support Services are services to help people live at home. These services are typically household management and/or personal care. People who are eligible for Ministry-funded services are mostly under 65, meet the Disability Support Services eligibility criteria and have had a needs based assessment confirming home-based support services are required.

3 DHBs fund services that enable older people to be supported to live in their own homes. People who are eligible for these services are mainly over 65 or have a chronic long-term illness and where it has confirmed that home-based support is required.

4 Across the home and community support sector (both Ministry and DHB funded services) there are an estimated 24,000 workers or approx. 7800 FTE.





Aged Residential Care

5 DHBs are responsible for funding aged residential care services. Aged residential care services are for those who are assessed as not being able to live safely at home, even with support.

6 Across this sector there are an estimated 22,000 workers or approx. 14,500 FTE.

7 Many caregivers in this sector are also paid at or close to the minimum wage, with a median rate of $15.50 an hour. The average length of service is around 4 years and while those with more years of service will generally earn a higher hourly wage, some of the longest serving workers are still paid at close to minimum wage.

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Community Residential Living (Disability)

9 Community Residential Support Services allow people with disabilities to live in a home-like setting in their community, while receiving support for up to 24 hours a day. This might include help with things like shopping, preparing and cooking meals, household chores and personal care. People eligible for these services will generally be under 65, with a long-term intellection, physical or sensory disability not covered by ACC and an assessment has determined that their needs are best met by community residential support services.

10 Across this sector there are an estimated 9000 workers or approx. 7000 FTE in disability residential care.

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Appendix B – Union offer

Care and Support Equal Pay Negotiations
Union Offer for Settlement

The following is a formal offer for settlement from the unions in regard to the *Bartlett v TerraNova* equal pay case.

The unions believe that the equal pay rate for care and support workers is $26.00 an hour on the basis of a flat rate for all ordinary hours worked. However, we believe the following position would be a significant step towards equal pay and would allow the Government and employers some breathing space of five years through until **1 July 2021** in which equal pay claims in the sector would not be pursued or re-litigated. These rates would replace current rates and scales (including any existing service or qualification payments) although would not replace other remuneration conditions contained in existing individual and collective agreements.

These minimum rates below would increase during the period 1/7/16 to 1/7/21 by the percentage of any wage increases gained in collective bargaining for the DHB NZNO Nurses MECA so as maintain their currency.

	Effective from the following date	>1year service No qualifications	Either 1 year service or Level 2 qualification	Either 2 years service or Level 3 qualification	Either 3 years service or Level 4 qualification
Caregiver and support worker pay rate.	1/7/16	$20.50	$21.50	$22.50	$23.50
Caregiver and support worker pay rate	1/7/17	$21.00	$22.00	$23.00	$24.00
Caregiver and support worker pay rate	1/7/18	$21.50	$22.50	$23.50	$24.50
Caregiver and support worker pay rate	1/7/19	$22.00	$23.00	$24.00	$25.00
Caregiver and support worker pay rate	1/7/20	$22.50	$23.50	$24.50	$25.50

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If this position was agreed by the Government the unions could agree to withdraw all the care and support cases in the aged care residential, home support and disability support sector (covered by the scope of this process) filed in the Employment Relations Authority, although the settlement for Kristine Bartlett would need to involve full back payment.

We should note that a settlement will not take place without written agreement detailing the steps to be taken to support the union parties having unhindered access for ratification purposes to all care and support workers who would be bound by the settlement without any interference by employer parties.

Background to the Union Offer for Settlement

The unions agreed to postpone their efforts to push ahead with the E tū Employment Court case on the principles and the setting of an equal pay rate for Kristine Bartlett on the basis of negotiations with the Government and employers on an equal pay settlement that spanned the whole of the care and support sector funded through Vote Health. This postponement was to finish on 31 March 2016.

The unions were informed by the Government negotiator that there would be no agreement on a comparator outside of the public health sector. There was mention of mental health assistants or public hospital health care assistants as comparators they would consider.

While the unions rejected the limiting of comparators to these public health sector health care assistants, we did some calculations of the collective agreements applying to PSA DHB mental health assistants and NZNO DHB health care assistants and noticed that their remuneration was substantially more than what pertained in the care and support sector.

The 2016 base pay rates, for instance, for the PSA DHB mental health assistants were between $17.00 and $23.35 an hour and for the NZNO DHB health care assistants from $17.71 to $21.44 an hour

However, these workers received conditions on top of these pay rates that added substantial amounts to their remuneration package and needed to be taken into account in any calculation if we were to explore what the real difference between the proposed Government comparators and the care and support workers. The Joint Working Group of Pay Equity had emphasised this in their document:

“Equal pay is remuneration (including but not limited to time wages, overtime payments and allowances) which has no element of gender-based differentiation.”

These conditions were:

- 5th weeks annual leave after 5 years service
- 10 days sick leave from the date of employment every year
- 1 week’s long service leave every 5 years
- Public holidays all paid at T2
- 5 days per year of shift leave entitlement for any worker working between 5 p.m. and 8 a.m.
- Weekend penal rates of T0.5 extra
- Night rates (8 p.m. to 6 a.m.) of T0.25 extra
- Overtime rates of T1.5 for the first three hours and then T2

The unions compared these conditions from the Government comparators with the collective agreements that existed in the aged care residential sector and have estimated that if the

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difference in remuneration across the workforce was converted into an hourly rate it would add between $5.00 and $6.00 an hour on to base rates.

We believe that the settlement offer the unions are making is very reasonable because:

- It is within the total remuneration of the Government proposed equal pay comparator
- It is phased in over 5 years
- even though we do not accept that it is equal pay it gives certainty to the care and support sector for a substantial period of time in which other major developments (eg regularised hours in the home support sub-sector) are occurring
- it settles the *Bartlett v TerraNova* case and is likely to see the other care and support cases withdrawn

John Ryall, Kerry Davies, Sam Huggard, Cee Payne

Union Care and Support Sector Negotiators

10 June 2016

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Appendix C – Cost assumptions

Cost impacts have been measured for the Ministry of Health/DHBs, ACC and costs born privately by aged care residents.

ACC costs have been calculated using a top-down approach based on recent expenditure data. This approach identifies the wages portion of total amounts paid to providers and adjusts this between current (status quo) wage rates and the proposed settlement wage rates. ACC costs form 23% of total Crown costs.

Costs for Ministry of Health and DHBs have been calculated separately for Aged Residential Care (ARC); Home and Community Support Services (HCSS); and Community Residential Living, including Respite and High and Complex needs (CRL). MOH/DHB costs form 77% of total Crown costs.

1. ARC costs (48% of MOH/DHB costs). These costs are calculated using actual volume and wage-rate data from the MOH's ARC Demand Model and checked against DHB quarterly surveys of ARC providers. Separate calculations are performed for Dementia, Hospital, Psychogeriatric and Resthome residents. Specific qualification and years of service data is not available for ARC care workers so an average distribution has been applied based on analysis of HCSS and CRL results. ARC calculations also include an adjustment to take account of weekend and night penal rates.
2. HCSS costs (31% of MOH/DHB costs). These costs are calculated using actual volume and wage-rate data from the March 2016 MOH Home and Community Support Services Workforce Survey. This survey provided detailed information for 7,500 carers, comprising approximately 52% of hours worked by the HCSS workforce. The detailed data was pro-rated up to reflect the cost of total hours worked. The survey provided wage-rate, qualifications and years of service data for every carer, and cost modelling was performed at the individual carer level.
3. CRL costs (21% of MOH/DHB costs). Detailed data was not readily available for individual CRL carers so a top-down approach has been used. Similar to the ACC approach, this takes total costs paid to providers by MOH's Disability Support Services, isolates the wages component, and applies changes in wage rates between the status quo and the proposed settlement. Distributions of carer time across qualifications and years of service were sourced from a 2015 survey of providers conducted by the New Zealand Disability Support Network (with responses covering about 79% of the total workforce).

Key assumptions in the Ministry of Health/DHB modelling include:

4. The costing measures the incremental cost of the proposed move to new wage rates. It develops a status-quo cost over 5 years, taking into account estimated increases in carer hours worked (average 3.3% p.a.), increases in the minimum wage [38] and general wage-rate increases for people not on the minimum wage [38] Overall, wage-rate growth is [38]
5. The methodology replaces the status quo wage-rates in the underlying data with the proposed settlement wage rates (which assume underlying growth of [38] , and the difference in the calculations is the incremental cost.
6. Wage costs for the proposed settlement are referenced to the DHB MECAs and include monetisation of extra entitlements. The Step 1 (entry rate) is $19.85/hr. The Step 4 rate (Level 4 qualification of higher) is $25.39/hr.
7. Wage-rate on-costs of 26% (for all leave, ACC, Kiwisaver, and work on public holidays) has been added to all costs.
8. An allowance has been made to take account of weekend and night penal rates, primarily impacting ARC costs.

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9. A shift of the workforce into higher qualifications has been assumed, driven by the incentive of greater pay. The base case results assume annual slides of 5% from Level 0 to Level 2 and Level 2 to Level 3; and 2.5% from Level 3 to Level 4.

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Appendix D – Outstanding claims liability impacts

Below is the impact on the outstanding claims liability (OCL) under the union offer.

Under the union offer, there is an outstanding claims liability (OCL) increase of $1.5 billion which, under the current funding policy, would be recovered from appropriations over a 3-year period and levies over a 10-year period.

	2017/18	2018/19	2019/20	2020/21	2021/22	5 year cost
Funding Adjustment ACC Appropriations	$155m	$155m	$155m	-	-	$0.46b
Funding Adjustment ACC Levy payer Accounts	$103m	$103m	$103m	$103m	$103m	$0.52b

The initial recognition of the OCL increase is likely to be treated as a claims experience change within actuarial gain/(loss) on Outstanding Claims Liability (i.e. excluded from OBEGAL). The ACC actuarial calculation of future appropriations and levies would be impacted by:

- the change in costs relating to the life time costs of new claims (i.e. future claims);
- the funding adjustment for the increased OCL as noted in the table above.

Below is the impact on the outstanding claims liability (OCL) under the Ministry offer.

Under the Ministry of Health offer there is an OCL increase of $1.067 billion which, under the current funding policy, would be recovered from appropriations over a 3-year period and levies over a 10-year period as follows:

	2017/18	2018/19	2019/20	2020/21	2021/22	5 year cost
Funding Adjustment ACC Appropriations	$110m	$110m	$110m	-	-	$0.33b
Funding Adjustment ACC Levy payer Accounts	$74m	$74m	$74m	$74m	$74m	$0.37b

The initial recognition of the OCL increase is likely to be treated as a claims experience change within actuarial gain/(loss) on OCL (i.e. excluded from OBEGAL). The ACC actuarial calculation of future appropriations and levies would be impacted as noted above.

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Appendix E – Proposed Ministry phased rates

The rates below show the phasing in on 2016 dollars

	Year 1	Year 2	Year 3	Year 4	Year 5
Settlement scenario - 2016 Dollars	At 1 July 2017	At 1 July 2018	At 1 July 2019	At 1 July 2020	At 1 July 2021
No qualification	**17.85**	**18.35**	**18.85**	**19.35**	**19.85**
Level 2 qualification	**19.70**	**20.20**	**20.70**	**21.20**	**21.70**
Level 3 qualification	**21.54**	**22.04**	**22.54**	**23.04**	**23.54**
Level 4+ qualification	**23.39**	**23.89**	**24.39**	**24.89**	**25.39**

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Appendix F – Mental Health Assistant wage rates and monetised conditions

The table below sets out the base rates and the monetised conditions included in the proposed rates for the care and support worker negotiations.

DHB MHA MECA rate	Band 1 Level 0	Band 2 Level 2	Band 3 Level 3	Band 4 Level 4+	Band 5 Not used
DHB MHA MECA current hourly rate (at end of 2016)	**17.12**	**18.67**	**20.23**	**21.89**	*23.35*
Fifth week annual leave for >5 years service	**0.11**	**0.12**	**0.13**	**0.15**	*0.16*
1 week long service leave (1 day accrual each year)	**0.07**	**0.07**	**0.08**	**0.08**	*0.09*
Shift leave for those working nights in residential facilities (average 3 days)	**0.02**	**0.02**	**0.02**	**0.02**	*0.03*
Rate for work on Public Holidays is T2	**0.44**	**0.48**	**0.52**	**0.56**	*0.60*
Extra 5 days sick leave (10 total)	**0.33**	**0.36**	**0.39**	**0.42**	*0.45*
Overtime (proportional cost taken from DHB HCA data)	**0.22**	**0.24**	**0.26**	**0.28**	*0.30*
Weekend Penals (T1.5)	**1.24**	**1.35**	**1.46**	**1.58**	*1.69*
Night Penals (T1.25)	**0.31**	**0.34**	**0.37**	**0.40**	*0.42*
Total monetised rates (detailed calculations)	**19.85**	**21.65**	**23.46**	**25.39**	*27.07*
Total monetised rates (as used in modelling)	**19.85**	**21.70**	**23.54**	**25.39**	*n/a*

The table below sets out the differences between the unions costing of the monetised rates and the Ministry of Health's.

	Union Estimate		Ministry Estimate
	Range	Midpoint	(using MHA rates)
5th Week Annual Leave	$0.177-$0.214	$0.20	$ 0.14
10 days sick leave (extra 5)	$0.27-$0.32	$0.30	$ 0.39
1 week's long service leave after 5 years	$0.035-$0.043	$0.04	$ 0.08
Public Holidays paid at T2	$0.05-$0.06	$0.06	$ 0.52
5 Days shift leave for workers on night shift	$0.124-$0.15	$0.14	$ 0.02
Overtime	$0.50	$0.50	$ 0.26
Weekend Penal rate	$2.53-$3.06	$2.80	$ 1.48
Night rate	$1.48-$1.78	$1.63	$ 0.37
Total	$5.166-$6.127	$5.65	$3.26

Key differences between Ministry of Health and the unions assumptions:

Weekend Penals: It is not clear what scope the unions have used. The Ministry has costed for 2/7 of the hours worked in Aged Residential Care (assuming equal distribution across all days of the week).

Night Penals: The unions have assumed that a third of the workforce would qualify for these rates, while the Ministry assume they would only apply to the 20% of hours in Aged Residential Care worked on night shift (about 10% of total settlement hours).

Shift Leave: The unions have said a third of the workforce would get five days. Actual DHB entitlement is between 1 and 5 days depending on the number of night shifts worked. The

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Ministry of Health has applied an average of 3 days across 10% of hours (nights in Aged Residential Care again)

Long Service Leave: The unions have allocated this to 50% of the workforce at 1 day a year, while the Ministry of Health has allowed for all workers (our cost is higher).

Public Holidays: The unions cost estimation is much lower than that of the Ministry of Health's. It is not clear why.

5th week annual leave after 5 years: The unions have estimated that 50% of the workforce would be eligible, whereas the Ministry of Health data suggests it would be more like 35% to start with (although we have allowed for increases over time)

Overtime: The unions have made an assumption rather than a calculation. The Ministry of Health has used DHB's proportional spend on overtime compared to base wage rate costs for DHB health care assistants.

Sick Leave: It is unclear why the estimates differ.

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Appendix G – Threshold implications

Q and As

How long are people in care?
Median length of stay is 18 months

Average age in care?
85 years old

How many are currently below the threshold?
21,000 people

How many people are currently paying the maximum contribution?
11,070 – Refer table and graph below

On average how long does it take for a person to spend their savings/assets before they reach the threshold?
The median person never does, only 1,200 of 11,000 cross the threshold each year.

Residents who own assets above the asset threshold pay the maximum contribution
The effect on these residents of an increase in the price paid to providers to compensate them for increases in carers' wages is estimated to be as follows.

Potential increase in cost to maximum paying residents				
Overall increased funding sought $M	Base resident payment $/year GST incl	New resident payment $/year GST incl	Extra resident payment $/year GST incl	Percent increase in resident payment
$260	$47,212	$54,110	$6,899	15%
$300	$47,212	$55,168	$7,956	17%
$322	$47,212	$55,754	$8,542	18%
$475	$47,212	$59,812	$12,600	27%

The location of residents paying the maximum contribution is as follows:

2. Location of Residents paying the maximum	
District Health Board	**Projected Maximum paying Residents 2017/18**
Auckland	1,400
Bay of Plenty	600
Canterbury	1,500
Capital & Coast	900
Counties M	700
Hawkes Bay	400
Hutt	300
Lakes	190
Mid Central	400
Nelson M	400
Northland	300

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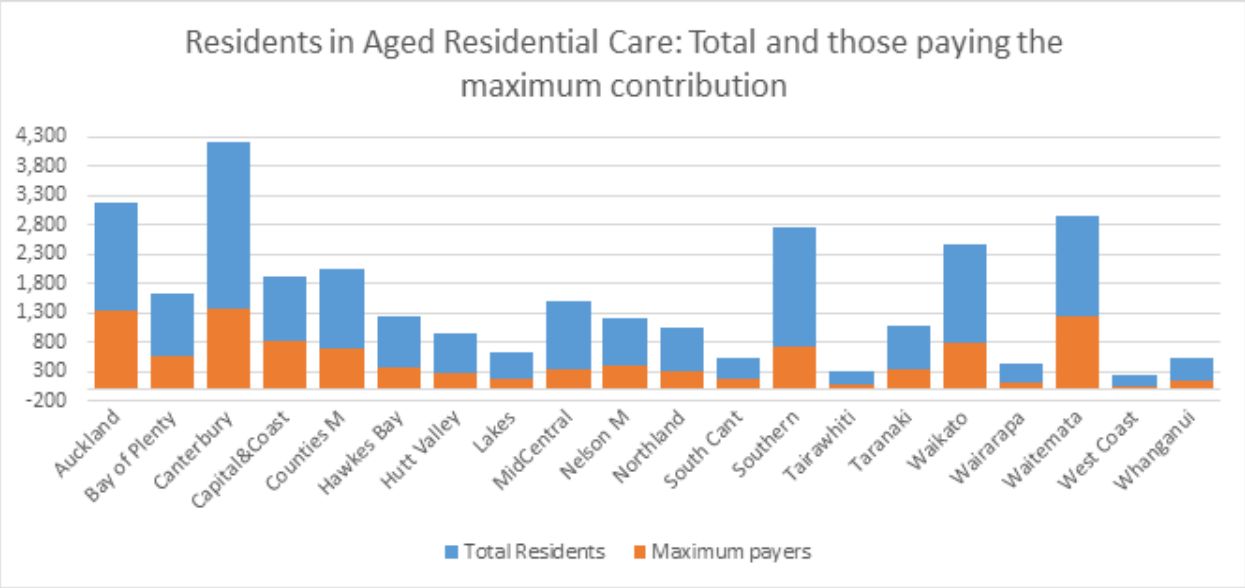
South Cant	200
Southern	800
Tairawhiti	70
Taranaki	400
Waikato	900
Wairarapa	120
Waitemata	1,300
West Coast	50
Whanganui	140
Total	**11,070**



If Ministers wanted to reduce the impact on residents who pay the maximum that could be achieved by setting the maximum contribution at less than the rest home price. A legislative amendment would be required, but the change would be simple to implement administratively. The saving to residents would be a cost to DHBs as DHBs make up the difference between what the resident pays and the price paid to the provider.

Relief by setting the maximum contribution at less than the price		
Overall increased Funding Sought $M	Percent of new rest home price required to give full relief	Extra cost to DHB of full relief for residents $M ex GST
$260	87%	$70
$300	86%	$81
$322	85%	$87
$475	79%	$129

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