Strategic Pay

Further Submission of Geoff Summers, Strategic Pay Limited

to

Independent Review of the Relationship Between Physiotherapists and ACC

Prepared by Geoff Summers
Director and Wellington Consulting Team Manager
Strategic Pay Limited

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Level 4, Telco Building
16 Kingston Street, Auckland 1010
PO Box 5313, Wellesley Street
Auckland 1141
tel 09 303 4045
fax 09 303 4045

Level 1, 85 The Terrace
Wellington 6011
PO Box 10 503, The Terrace
Wellington 6143
tel 04 473 2313
fax 04 472 1693

40 Filleul Street
Dunedin 9016
PO Box 188
Dunedin 9054
tel 03 479 0637
fax 03 477 7938

info@strategicpay.co.nz
www.strategicpay.co.nz

Contents

INTRODUCTION 1
ASSESSMENT SOLELY AGAINST PUBLIC HEALTH SECTOR 1
ASSESSMENT AGAINST PHYSIOTHERAPY GENERALLY 2
ANALYSIS OF DELOITTE BENCHMARKING 2
USE OF DHB / PSA SALARY SCALE 3
Employed Physiotherapists 3
Business Owners 4
Deloitte Against DHB Scale 5
FULL PUBLIC SECTOR PHYSIOTHERAPY BENCHMARKING EXERCISE 5
CONCLUSION 5

Introduction

1. The purpose of this supplementary submission is to provide further comment and analysis based on the independent reviewer's draft report. The New Zealand Society of Physiotherapists ("NZSP") has particularly asked me to comment on:

    a. benchmarking against the public health sector only,

    b. benchmarking solely against private sector physiotherapists, and

    c. Ongoing concerns with the Deloitte benchmarking,

    d. benchmarking against the DHB / PSA salary scale.

2. I am happy to do so, but on the basis that I continue to believe our previous work is relevant and should be applied. I have concerns about the use of physiotherapy-only benchmarking, and these concerns support use of our previous analysis. If these are to be put to one side, then the DHB / PSA salary scale should be used, in conjunction with our knowledge of staff experience profiles and business owner characteristics. These also result in somewhat higher salary inputs than those proposed by Deloitte.

Assessment Solely Against Public Health Sector

3. I note the reviewer's preference for benchmarking solely against the public sector due to the public nature of ACC funding. In strict remuneration terms this is not appropriate, as the job market does not isolate people solely within public or private sectors. They are free to move between the sectors according to the sector attraction of each. The competitive nature of the job market therefore suggests that such an approach should not be taken.

4. In practical terms, this puts the private sector physiotherapists at the mercy of the public sector generally in respect of remuneration. The drag effect is peculiar, and not good practice in remuneration assessment. Further, any peculiar funding constraints from organisations like DHBs would flow through to private sector physiotherapists, which is not a market approach.

5. There are no significant equity issues in my view of comparing health sector professionals who operate at the same job evaluation level. This is not comparing police or firefighters with nurses, but people within a comparable sector. Further, the points system itself separates out any brain surgeons who may be in there from those on lesser roles.

6. In spite of this, there are a very few limited private sector organisations which benchmark to the public sector. This is usually on the basis that they operate wholly from government funds. These are the market exceptions rather than the rule.

7. Ultimately, I do not expect that use of a solely public health sector benchmark would be significantly different to my existing analysis. The majority of workers in the existing analysis would be DHB or related, and therefore very much on the public sector line.

8. I am available to undertake this further analysis if required, though it will take approximately two weeks.

Assessment Against Physiotherapy Generally

9. Of much greater concern to me is the Reviewer's suggestion that only benchmarking against public sector physiotherapists can provide a "peer to peer" assessment. In my view this is not correct.

10. The SP10 remuneration assessment system, together with all other variants in the market place, is generally used across professions. We select limited classes, such as the health sector used in this case, to ensure that there is a reasonably comparable group within which salary comparison occurs.

11. However, assessment solely within one profession is itself extremely circular, and is likely to lead to stagnant remuneration. For instance, if the private physiotherapy sector is to benchmark against the public physiotherapy sector, then arguably the public physiotherapy sector should benchmark against the private physiotherapy sector, which within a very short time becomes entirely cyclical.

12. More importantly, the use of other industry information from reasonably comparable professions or jobs accepts that the modern job market is one where skills are reasonably transferable. It is not appropriate to set remuneration on an insular level, or that profession will either attract too many or too few workers.

13. I acknowledge that there is some barrier to moving outside of the physiotherapy profession, due to sunk costs of education and the like. However, the demographics of the profession indicate that there is significant drop off, and practitioners are not spending their entire careers in physiotherapy. This supports the fact that physiotherapy competes with other professions in the job market. This trend is likely to be exacerbated at the level of business owner, where people are clearly demonstrating initiative, management talent, and access to capital. These are qualities with will always make for attractive job candidates across a wide range of professions or job placements.

14. In the final analysis, it is the industry standard to benchmark across professions, and this is not seen in the marketplace as "equity matching". Where we use the health sector, as here, this allegation is particularly inappropriate. There is a high level of contextual comparability to enhance the matching exercise embodied in the SP10 points system.

15. I therefore sound a serious note of caution in benchmarking solely against physiotherapy. However, recognising the Reviewer's current preference for a physiotherapy-only alignment, I go on to discuss both the use of current DHB salary scales, and the potential of running a detailed benchmarking process against the public sector only.

Analysis of Deloitte Benchmarking

16. The Deloitte benchmarking process as currently undertaken is unreliable. The benchmarking of both business owners and staff physiotherapists is, as I understand it, undertaken against the outcomes of an NZSP survey of public sector physiotherapists conducted in December 2004. Those sums then adjusted to take into account a "pay jolt" which was received in the public sector and has subsequently been inflated from its 2004 base through to current levels.

17. I attach a copy of the NZSP December 2004 survey as Appendix 1. That survey has been undertaken on the basis of historic salary scales which existed between DHBs and the relevant providers at a district level as at 2004. I understand that the data was not collected for this purpose. It should therefore not be used for this purpose.

18. The reason why remuneration advice has been sought is due to concerns that historical salaries were very poor and unsustainable. I agree that this was the case. I am therefore concerned that the Deloitte benchmarking for clinical staff was very backward looking in addition to other flaws. The Deloitte Report (March 2007 page 20) assesses the average clinical staff salary against the December 2004 survey, and finds that historic figures are fine as they closely match the December 2004 survey.

19. When most other major cost items are acknowledged to be below market due to historic ACC payment issues, I do not think logically that it is realistic to think that historic clinical staff rates were at a sustainable level. If owners are feeling the financial pinch they are likely to be passing some of this underpayment on to their staff. I now also understand that the analysis at Deloitte Report page 20 included overtime in the $51,441 quoted, which means that the proper analysis point of ordinary time salary would not have shown any parity.

20. The fact that the salaries have been further adjusted by Deloitte in the joint experts' report gives further weight to the fact that there is little reason behind the Deloitte benchmarking. The process seems to be one of picking a number.

Use of DHB / PSA Salary Scale

21. If Strategic Pay's benchmarking is not used, and there is to be benchmarking against any public sector physiotherapy data now available, then that benchmarking should be done against the DHB / PSA salary scale. That scale appears more reliable than the December 2004 survey mentioned above. The benchmarking should be done on a reasoned basis looking at the characteristics of private physiotherapy practices.

22. Using this method there is no way to use a points evaluation, and would therefore fall significantly short of good practice. However, it is a better alternative than the Deloitte efforts to date.

23. Using this data, we would apply the scale as progressing in one year increments. This is only strictly true for the first five levels, and additional steps are merit based or on achievement of a designated position. However, the note to that salary scale indicates that additional progress is "dependent on the achievement of mutually agreed objectives set prospectively at the performance review". In my view, a good faith employer would be required to set objectives which were achievable by staff members, rather than setting unattainable achievement objectives. Annual progress can therefore be assumed.

24. I am aware that the Deloitte model uses base 2004/2005 figures. The salary scale does not have an equivalent at that stage (refer Appendix 2). However, the same inflation rate of 5.7% per annum can be used to deflate the 2006/2007 salary scale levels to base 2004/2005. Over two years this is an 11.7% reduction.

Employed Physiotherapists

25. KPMG provided a formula for appropriate weighted analysis of clinical staff remuneration (page 27 KPMG First Submission). That weighting was gained from an NZSP survey conducted to find out the relative experience curve for salaried staff. A fair remuneration factor in the Deloitte Model should incorporate a weighted staff salary which reflect this practice composition. Otherwise, the reality is that there will be underpayment according to the seniority of staff.

26. The figures indicate that a weighted clinical staff salary should be comprised 25.1% from 0 to 4 years' experience 9 (DHB steps 1 – 5), 24.7% from 5 to 9 years' experience (DHB step 6 -10), and 50.2% from the 10 years plus category (DHB step 11 to 15).

27. Taking the DHB 2006/2007 mid point to represent each of these bands (levels 3, 8, and 13 respectively), one gets an average salary of $65,690 in 2006/2007 terms. Regressing this back to the 2004/2005 base using 11.7%, one gets a base salary of $58,809 in 2004/2005 (compare Deloitte $50,000 in 04/05).

28. In my view the above calculation shows the minimum amount that should be included in the Deloitte model as a salary figure for employed clinical staff. It is only by this weighting that there can be parity between the DHB scale and the private sector. I would recommend inclusion of this figure if Strategic Pay's analysis is otherwise not accepted.

29. As a comparison, the $50,000 now input into the Deloitte model can be inflated to the 2006/2007 salary scale period. This gives a figure of $55,850 for the 06/07 year. This is lower than the comparable figure of $65,690 that I have derived. Importantly, the Deloitte figure is at the 5-6 year salary scale, which does not reflect the general experience profile of a practice. This shows the importance of weighting to appropriately reflect practitioner experience profiles.

Business Owners

30. As to the salary level for business owners, the information provided by NZSP indicates that business owners generally have an experience level of at least 10 years. This experience level is likely to range up to 30 years and beyond, making either the step 10 or even the step 10 – 15 midpoint inappropriate. As has been discussed, there are likely to be a number of people on individual contracts, and these will be people in senior positions significantly above this scale.

31. The salary scale is therefore not reflective of the full range of salaries, and it is likely to be people in the position of business owners who are not represented on this scale. The reality is that business owners show initiative, leadership, and a broad range of skills to get their own practices off the ground. One would naturally expect that they would therefore be at the top of the scale or beyond. I would therefore adopt the top of the scale as the representative point for business owners, though I believe that they should still be beyond this point, as is reflected in my previous benchmarking exercise.

32. The 06/07 figure for step 15 is $82,086. I would recommend the inclusion of the 06/07 rate directly into the Deloitte model at 04/05 without any reverse inflation, due to the factors I have just discussed. However, if inflation was reversed out, the $82,086 would come to a total of $73,487.91 in the 2004/2005 modelling year. This is well above the $62,930 proposed by Deloitte, but still too low in my view.

33. Inflating the Deloitte figure to the 2006/07 year, we get $70,293. This is the equivalent position on the DHB salary scale of steps 10 to 11. In my view this is at the bottom end of the DHB management scale. Assuming anything even close to yearly progression, as one can expect for business owners, this is far too low. If our external analysis is not to be used, then I would recommend the figures of $83,086 (preferably) or as a minimum $73,488 for inclusion in the Deloitte model at base 2004/2005.

Deloitte Against DHB Scale

34. This analysis shows that the Deloitte approach, even in its own terms, is neither logical or robust. The critical factor it misses is analysing where salaries should sit on the DHB salary scale. In the case of staff it completely fails to recognise the staff mix, which is of equal importance as the adoption of the correct salary level in the first place.

35. Although the above analysis and Deloitte's analysis are effectively against the same benchmark of the DHB scale, I believe that the above assessment is more reflective, though still short of the mark.

Full Public Sector Physiotherapy Benchmarking Exercise

36. If a full public sector physiotherapy benchmarking exercise were to be undertaken, then in my view this would require use of a system such as our company's SP10 system, or that of one of our competitors such as the Hay Group or Mercer HR Consulting. The public sector would have to be surveyed to assess the size of each role being undertaken, and the equivalent remuneration. This could then be compared against the private sector evaluations which have already been undertaken by Strategic Pay and endorsed by Deloitte.

37. This would be a broad ranging exercise and would require significant commitment of resources, as well as commitment from the public sector to engage in this exercise. It would take significant time to organise and undertake this exercise, and there must be some question as to whether DHBs would all take part.

38. Given adequate participation then, subject to my concerns about an intra-profession benchmarking, I am satisfied that this approach would have reasonable prospects of success for employed private sector clinical staff. It is likely to incorporate a reasonably adequate number of results at points levels which would be equivalent to those of employed private sector staff.

39. However, for the business owners, I would be concerned that those within physiotherapy departments may not produce results, or sufficient results to be robust, which are comparable to the size of the role undertaken by business owners. This is because it is the business owner's very broad range of responsibility and financial, legal, HR and marketing decisions which contributes to the size of their role.

40. Comparison to a team leader, even one managing up to 40 people, would not bring the job size into line with that of business owners. This is another of the criticisms of the Deloitte exercise, as this is their preferred benchmark. The likely equivalent level for business owners would be senior management, at the level of manager for the whole of a physiotherapy department, allied health services department, or beyond.

41. This indicates that there would in my view be practical difficulties in undertaking a robust benchmarking exercise against the public physiotherapy sector.

Conclusion

42. I continue to consider the initial Strategic Pay study as best practice, and providing relevant salary information. I further have significant concerns about the use of physiotherapy-only benchmarking, which would be considered poor industry practice. However, if that is to be used, then the current Deloitte attempt is very poor. I believe that they fail to give any real rational for their benchmarking.

43. When one applies knowledge of physiotherapy practices and private sector job roles to the DHB salary significantly larger weighted clinical staff salaries and owner salaries are derived. If physiotherapy only benchmarking is to be used, these figures should be used in preference to the Deloitte figures.

Geoff Summers
Director and Wellington Consulting Team Manager

Phone: (04) 473 2515
Mobile: (027) 44 55 000
Email:geoff@strategicpay.co.nz

Results of Physiotherapy Remuneration Survey
District Health Boards – December 2004

Salary Range by Position (excludes senior positions with individual employment contracts)

Position	Minimum		Median	Mean	Maximum		Median	Mean
	From	To			From	To		
New graduate / entry level physiotherapist	$29,948	$36,988	$32,791	$33,330	$31,000	$45,640 [1]	$35,358	$36,257 [1]
Rotational/staff physiotherapist	$31,000	$38,808	$36,013	$35,541	$33,101	$46,357 [2]	$41,839	$41,895
Senior physiotherapist	$34,295	$46,689	$42,056	$41,986	$40,983	$52,642 [2]	$47,455	$47,633
Team/clinical leader/advanced practitioner [3]	$40,245	$56,796	$47,904	$48,380	$45,711	$64,677	$52,770	$54,261

[1] Nine respondents only reported a maximum salary for new graduate / entry level physiotherapists with one reporting a maximum of 9 steps to $45,640. The next highest maximum salary in this category was reported as $38,500.

[2] One DHB reported a maximum salary of $64,677 (top of scale) for all of the following positions:

- rotational / staff physiotherapist (next highest reported $46,357)
- professional supervisor or equivalent role (does not have designated senior physiotherapists)
- professional leaders

Please note that this maximum salary has been excluded from the rotational/staff physiotherapist and senior physiotherapist categories in the above table but has been included in the team/clinical leader/advanced practitioner category.

[3] Fourteen respondents only reported salary ranges for this category; the remaining three respondents reported that team/clinical leaders/advanced practitioners were on individual contracts.

S- Salaries public

Att 2

PSA - DHB Salary Scales – Terms of Settlement

Allied and Public Health

Note: includes Dietitians, Pharmacists, Physiotherapists, Occupational Therapists, Podiatrists, Speech Language Therapists, Social Workers, Needs Assessors, Psychotherapists, Needs Assessors, Visiting Neurodevelopmental Therapists, Specialised Seating Assessors, Dental Therapists, Health Protection Officers and Health Promotion Officers

Steps	05/06 $	06/07 $	Auto Step Movement
15	77,265	82,086	No - Merit Step or Designated Position
14	75,185	79,367	No - Merit Step or Designated Position
13	72,558	77,612	No - Merit Step or Designated Position
12	69,931	74,460	No - Merit Step or Designated Position
11	67,304	71,308	No - Merit Step or Designated Position
10	64,677	67,911	No - Merit Step or Designated Position
9	62,050	64,177	No - Merit Step or Designated Position
8	59,423	61,472	No - Merit Step or Designated Position
7	56,796	59,636	No - Merit Step or Designated Position
6	51,277	56,304	* Additional Progression
5	46,920	54,000	Yes
4	43,054	48,600	Yes
3	40,085	46,000	Yes
2	38,601	43,300	Yes
1	35,632	40,000	Yes

* Access to the additional progression step from Step 5 to Step 6 is dependent on the achievement of mutually agreed objectives set prospectively at the performance review undertaken when the employee is on Step 5. Progression shall not be denied where a performance review is not completed through no fault of the employee.