Neami Group Response to the NDIA Pricing Review Issues Paper

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Background

Neami specialises in working with individuals with complex needs who often require the support of a range of services. We work collaboratively with clinical teams, primary health care providers and community organisations to provide high-quality, person-centred support.

The Neami Group (Neami) consists of two organisations; Neami National and Mental Health and Wellbeing Australia (Me Well). Neami has been in operation for over 30 years, initially supporting consumers and carers in Victoria and, in the last two decades, in other States. Established in 2016, Me Well is a wholly-owned subsidiary of Neami National which focuses solely on the provision of specialist mental health services under the National Disability Insurance Scheme (NDIS). Neami's experience with the NDIS includes working in the Barwon Region in the earliest stages of the NDIS roll out.

In recent years Neami's services have diversified, and today, more than 1000 staff provide services to over 9,000 individuals around Australia, spanning community-based mental health, residential mental health, NDIS supports (through Me Well), suicide prevention and housing and homelessness.

Neami draws on the knowledge, capacity and expertise of a national organisation yet works at a local level to develop innovative, localised services that meet community needs.

In all our programs, including in the NDIS through Me Well, Neami is committed to purposeful evidence-based models of recovery that demonstrate positive consumer outcomes and wider community benefits. Supported by our Research and Evaluation team, our work is informed by data and evidence about best practice. Consumer participation is embedded in all aspects of our service design, delivery and evaluation. Our research base enables us to develop and evaluate innovative approaches to meeting consumers' needs.

Me Well specialises in supporting people with a range of mental health needs through the psychosocial stream of the NDIS. Neami and Me Well previously delivered core support services but withdrew from this market more than 18 months ago as we identified that, even with different staffing and operating models, the pricing levels were insufficient for the organisation to break even in this area of work. Since that time, Me Well has focussed largely on the delivery of Support Co-ordination in the psychosocial stream. We are currently working towards an expanded service offering in capacity building and possibly in some specific areas of core supports. Me Well is one of the larger providers of support co-ordination in the psychosocial stream.

Me Well employs 131 people nationally equalling 103 FTE positions. Of that FTE, 15% are in management positions and 85% in operational roles. We have service locations in Victoria, New South Wales, South Australia and Queensland. Our submission to this review is informed by our experience, past and present, in the NDIS, as well as providing supports and recovery focussed services to people experiencing the effects of mental ill health. We advocate for significant price reform in this area in order to:

- enable the needs of participants in the psychosocial stream to be better met
- reflect our commitment to our staff who are currently required to work within a system which is not placing an adequate "price" on the value of their labour and experience
- address the perverse system impacts which are diminishing the capital and viability of organisations which have supported consumers for many decades.

1. Introduction

As noted in the *Background* section, Neami and Me Well have participated in the NDIS since its earliest stages in the Barwon Region. We acknowledge and appreciate the NDIA's transparency in consulting on the Pricing Review, and the release late last year of the *Pricing Strategy*, the *Cost Model for Disability Support Workers* and *Review of Therapy Pricing Arrangements*. We note the Authority's commitment to improving the methodologies underpinning the price control framework and its engagement with the market in pursuit of this aim. We also note the commitments which came out of the national Disability Reform Council late last year and the positive messages they contained for participants, providers and staff who operate in the psychosocial stream of the NDIS.

Our commitment to participating in the NDIS has been driven by our Mission and the desire to offer quality services, underpinned by experience, research, co-design and evaluation, to participants in the scheme. The views which we offer in this submission are informed by our experience in the psychosocial stream, and we are not in a position to make observations more broadly on issues in other areas. It is our view that the scheme faces a number of significant issues which flow from the current price controls and approach, particularly the cost modelling and assumptions about how staff are able to provide services. The price settings for core supports and some aspects of capacity building are below sustainable levels. Providers operating in the capacity building markets last year received a 2.1% price increase compared to 4.5% for those operating in the core supports markets, while work in either stream takes place under the same SCHADS and ERO labour cost environment.

Organisations which have operated in the community based mental health sector for many decades are struggling to break even and are losing money in their efforts, which are mission driven, to meet the needs of participants, even where they have reconfigured staffing models and models of service delivery. This has required service providers to move money from reserves built up over decades to sustain operations under the scheme. This is not sustainable in the short term, let alone medium term, and is increasing the risk of market failure within the scheme *and* in the broader mental health and psychosocial services that are provided outside the scheme. The cumulative impact of inappropriate pricing models and levels on providers over a number of years means that the NDIA needs to act decisively in this review to recalibrate the price control framework and market settings.

Neami has invested heavily in the delivery of NDIS services through Me Well. Despite different technology and system approaches, different staffing models and difficult decisions to withdraw from some markets, we still run Me Well at a significant loss from an operating point of view. We have had significant grant support from governments to enable projects which assist in the transition to the NDIS. In the current financial year, we have committed 10% of Neami's current reserves to keep Me Well in a position to continue operating, and over the last four years the organisation has made an overall commitment of 50% of historical reserves. These are difficult decisions for Boards to take given their responsibilities to the organisation as a whole, and reflect our commitment to scheme participants and our staff.

We see this submission and our continuing engagement with the NDIA as an important part of our commitment to participants and staff who work in Me Well. We look forward to participating further once the draft findings are released. We urge the Authority to release the Price Guide as early as possible in May to enable providers to establish budgets for the coming year and communicate with certainty to their participants and staff.

In providing more detailed responses we have used the headings and numbering system from the Issues Paper for ease of reference.

Detailed Responses and Recommendations

2. Increasing Flexibility and Reducing Administration

Provider administrative burden

2.1 Are there changes that could be made to … reduce transactional costs for providers – without reducing participants' choice and control?

In striking the balance between choice and control and reducing administrative burden, we note that the current systems mean that unless a participant, the NIDA or LAC has expressly consented to the sharing of Plans and Plan information, that the Plan is not available to the organisation which is providing support co-ordination under the Plan. This increases the amount of time which is required to identify appropriate services and establish a relationship with the participant. A "default" setting so that the Plan was automatically available to a support co-ordinator would reduce administrative and non billable work in identifying participant's needs.

We encourage the NDIA to continue to work to provide more clear guidance for providers on activities which are billable and non billable. We would encourage the establishment of an ongoing "user group" to advise the NDIA in this regard. We similarly encourage the establishment of a process where the NDIA engages with providers regularly through an agreed group forum to receive feedback and simplify rules that are open to interpretation.

2.2 Is there scope for changes in the price controls framework that would give participants greater discretion over use of their budgets – without substantially increasing costs to providers?

Flexibility in use of line items

Neami is strongly supportive of the proposal that participants and Plan Managers have the ability to move budgets from line items which are unspent (or underspent) to another line item where there is spending at limit or potential overspend. This would reduce some of the administrative burden required by plan reviews, provide greater continuity and stability for participants, particularly where their psychosocial support needs change due to the fluctuating nature of mental ill health. Clear accountable processes for the electronic uploading of service agreements which participants can approve through the portal would assist in this regard.

It is our view that where a provider is accredited to offer service under core or capacity building which aligns to a participant's goal attainment, the participant should be able to switch between line items within a service category mid plan.

Multi-year plans

Neami and Me Well believe that the commitment to multi-year plans is beneficial for participants and will also assist providers in reducing non-billable work. We believe that there needs to be a clear and transparent process put in place so participants are fully informed and supported to understand the impact of multiyear plans and that the financial value and content of the plan must be clear. There must also be a clear and accountable indexation process for annual increase in Plan value so that participants are not disadvantaged by future price increases (whether such price increases are regulated or not).

We note that performance under the current scheme in Plan renewals demonstrates a reducing level of Support Co-ordination in second and third year plans. The fluctuating needs of people with a psycho-social disability require a continuing level of Support Co-ordination to enable participants to achieve their goals. Any proposed mechanism for arriving at the value of multi-year plans should not reflect the current general practice, where plan allocations in subsequent years for items which have been underspent in the previous year are typically reduced. A framework which establishes multi

year Plans must safeguard participants from reductions in particular line items over time unless it can bedemonstrated, by the participant's own account, that a particular goal has been achieved.

Responding to periods where participants with psychosocial disability have higher needs

Neami and Me Well support changes to the pricing framework to establish clear and accountable mechanisms for more supports to be provided to participants in times of increased need. This is vital for people who experience mental ill health, given the fluctuating nature of their illness. Pricing structures currently do not provide sufficient flexbility in this regard which raises potential risks for participant safety.

Whatever mechanism is put in place to address this issue needs to be sufficiently responsive to enable timely service provision for a participant, and minimise administrative burden for providers. It is important that participants are not disadvantaged in their overall plan allocation if additional supports are required at times of increased need.

3. Price Limits for 1:1 Core Supports

Given that Me Well does not operate in this area of the NDIS Market at a substantial scale, we will not make detailed submissions on *every* Guide Question posed in the Issues Paper. As noted earlier, the Me Well Board and management previously made a decision to exit from this market on the basis that the pricing framework could not sustain a viable business and that the level of losses which were being (and would be incurred) meant that to continue would jeopardise the viability of the overall Me Well approach to supporting participants in the NDIS. We note that we have previously corresponded with the NDIA late in 2019 in conjunction with seven other community based mental health providers, on the inadequacy of the *Cost Model for Disability Support Workers* released last year. Our primary concerns in relation to the cost model, however, are also applicable to the costing of Support Co-ordination and Specialist Support Co-ordination.

Through establishing Me Well as a separate entity, Neami has sought to respond to the price settings of the NDIS by employing staff on the SCHADS Award, rather than the existing NEAMI Certified Agreement. Across the psychosocial sector many organisations have established enterprise Bargaining Agreements which provide more generous terms and conditions than under the SCHADS award, whether this be through allowances or more access to types of leave and other supports. NDIS service provision does not exist in a bubble, but happens in a sector which over time has responded to the needs of its staff and, in particular, needs which arise from the nature of working to provide a quality service to people experiencing mental ill health. These EBAs often also recognise the specific needs of peer or lived experience workers, which are different from other staff. The price settings and assumptions do not place sufficient value on this context, nor on the expertise of staff which has been developed over long periods of practice development and evaluation of models which work for participants.

The price settings for NDIS service provision in the psychosocial stream need to recognise the policy drivers that exist in the broader mental health system. These key policy settings include "corporate overheads" that require the involvement of people with a lived experience in service design, delivery and evaluation, robust and increasing levels of compliance and quality systems, a strong emphasis onrecovery focussed service provision amongst many others. Key issues which we believe should be considered in the review of the pricing are:

- Indexation to date has not taken sufficient account of the ERO and its impact on salaries and wages. This means that the base on which the current Pricing Review outcomes will be applied is already set too low
- Addressing the national funding inequity between State and Territory average values of NDIS Psychosocial participant funded packages

- The assumptions regarding the supervisory costs in the model do not recognise the additional daily specialist management and wellbeing support functions required across the psychosocial service delivery market, to maintain the necessary safe working environment and WHS commitments to all front line staff.
- Non-staff costs and overheads are insufficient
- Specifically, there is insufficient allowance for learning and development in the cost model, which does not recognise the necessary support required for staff to deliver a quality service to participants
- The assumptions regarding supervisor cost in the model do not allow sufficient distinction between the salary level of a service worker and the supervisor
- Utilisation rates in the model are unrealistic, do not allow sufficient time for reflective practice, supervision and debriefng which are essential elements of quality practice in the psychosocial sector and critical for occupational health and safety
- The pricing model does not take into account the significant initial costs associated with the psychosocial participant risk assessments, prior to commencement of support services, in order to meet legislative WHS and safe working environment requirements for our workforce.

High Intensity and Standard Intensity Supports

3.1 For High Intensity Supports, is it easy to determine whether the Level 1, Level 2 or Level 3 price limits apply to a given support? If not, how can this be made clearer?

If the Plan and related evidence as to the participant's needs and goals were made more readily available to support co-ordinators, it would provide more insight into participant needs. The current balance struck between individual choice and the Plan not being automatically available to Support Co-ordinators makes it more difficult in some cases to identify a participant's needs.

3.6 In the DSW Cost Model, utilisation refers to the share of working hours (other than when on leave) that are spent in delivering services (billable hours). Are the DSW Cost Model assumptions about utilisation appropriate? If not, how should they be modified and why?

The current utilisation rates are unrealistic. Requiring utilisation rates of between 87.7%-92% does not provide sufficient time for staff to engage in:

- On-boarding and initial training
- Appropriate levels of ongoing training and development necessary for quality service provision
- professional supervision, reflective practice and debriefing
- Any additional needs that a peer or lived experience workforce may require
- Basic aspects of personal hygeine and self care

By setting utilisation at these unrealistic rates the price settings essentially devalue a skilled workforce. They also drive a business model which requires high levels of scrutiny of productivity in a professional environment which (in the psychosocial stream) requires more flexibility in responding to participants' fluctuating needs and complexity. We also note that such high levels of utilisation require rostering and appointment systems which do not respond to the needs of people experiencing mental ill health.

The demand on a workforce to consistently achieve these 88-92% cost model utilisation rates is also a significant disincentive and disadvantage to the recruitment and employment opportunities of peer workforce with lived experience continuing on their own recovery journey. It is our submission that a utilisation rate of 75% would be more appropriate.

3.7 Are the supervision ratio assumptions in the DSW Cost Model appropriate? If not, what not and what evidence?

The supervision ratio assumptions are flawed as they cost the rate of a supervisor under the SCHADS Award at the same rate as the staff who work reporting to them. This is a fundamental flaw and doesn't reflect normal relativities or classification practices.

3.9 Does your organisation pay allowances to disability support workers on top of their salaries?

No, Me Well currently employs staff under the SCHADS Award.

3.10 Does your organisation pay payroll tax?

No

3.11 What was your organisation's expenditure on workers compensation premiums in 2018-19? How was this calculated?

Me Well currently pays a workers compensation premium of 1.962%

3.12 In the DSW Cost Model, corporate overheads refer to all costs unrelated to the salaries and salary on-costs of direct care staff and their direct supervisors. What was the level of your corporate overheads in 2018-19 expressed as a percentage of all expenditure on the delivery of NDIS supports? Please provide details of the makeup of these overheads.

It is our submission that the pricing review and cost model should provide greater transparency about what the "corporate overheads" includes. We submit that a figure of 10.5% does not make sufficient allowance for robust quality and risk management activities, nor sufficient allowance for basic "back of house" costs required to sustain a viable organisation. The Pricing Review should recognise that NDIS service provision is undertaken by organisations who also operate in areas funded by State and Commonwealth governments (noting that increasing amounts of Commonwealth funding is provided through Primary Health Networks). The funding environment we operate in at all levels sets insufficient allowances for funding corporate overheads and is unsustainable at current levels. Each arm of government expects the costs of service (back of house and management) to be subsidised by organisations at unrealistic levels. It is our recommendation that a more appropriate figure would be 15-18%.

3.13 In the DSW Cost Model, margin refers to the excess of revenue (from the NDIS) over expenditure on the delivery of NDIS supports. What was the level of your margin in 2018-19 expressed as a percentage of all expenditure on the delivery of NDIS supports?

Me Well made no margin and operated at a loss. It is our submission that the margin available should recognise that most providers in the psychosocial operate in the public health or charitable sector, where the policy settings by the Australian Charities and Not-for-Profits Commission expect a prudent provider to be retaining surpluses and reserves. To the best of our knowledge, a significant number of providers in the psychosocial sector are struggling to break even in the NDIS sector, let alone retain margin or "profit".

5. Capacity Building Supports

Capacity Building Price Limits

5.1 Are the current price limits for capacity building supports adequate? …

Neami and Me Well believe that the prices are not currently adequate. For providers who are offering capacity building as a stand alone offering (eg not as part of an overall package that has supported independent living attached) there is no viable financial gain in offering any activity in this category. According to recent Me Well calculations a psychosocial capacity building worker at 100% utilisation only generates $16 per week net return, which is neither a realistic scenario or a sustainable business offering.

Psychosocial participants are highly disadvantaged in the utilisation of the NDIS plan and progress towards their recovery journey and outcome goals when they are unable to engage with and access quality and regular capacity building activity, however at the current price point it is not a financially sustainable offering for many service providers. This is seeing market exits from NDIS of capacity building service providers in the psychosocial space and evidence of ultimate market failure.

This has particularly been the case since the 30 June 2019 cessation of PIR, PHaMs and D2D funding streams under which greater flexibility and funding levels were available to meet individual participant unique recovery and episodic needs.

While the NDIS pricing model has begun the address the question, in particular for support coordination, to travel time to enable face to face contact with psychosocial participant, it has not made any allowance for the mandatory kilometre reimbursement rate to an employee under the SCHADS Award. This cost, of 78 cents per KM is fully burdened upon the organisation cost structure. In the psychosocial sector a major proportion of participants require ongoing face to face engagement in their homes or community.

5.2 Should different price limits be introduced for capacity building supports delivered at different times of the day and days of the week, in line with the arrangements for core supports? If so, for which capacity- building supports should these differential price limits be introduced? How should they be calculated? Please provide evidence – for example, if award provisions drive salary costs for specific types of capacity building workers.

Neami believes that pricing for capacity building supports, including support co-ordination, should reflect the Award requirements. Me Well staff work under the SCHADS award, which pays different rates depending on the time of day, day of week the supports were delivered – this is a legal requirement which should be reflected in the price settings.

The price guide must be in line with the award rates to protect the ongoing financial sustainability of providers offering services in these categories. In addition, many service providers use the same pool of staff to deliver both core and capacity building work – the benefit to participants being that they can form ongoing stable relationships with their support workers, and work more effectively towards achieving their goals. Providers benefit by having a smaller headcount (thus smaller overhead cost) as well as being able to package services together where plans allow. However the administrative burden placed on providers having to use two different methods of calculating rates is significant and a more consistent approach across core and capacity building would reduce the burden on providers in this respect. In the area of Support Coordination, or more broadly specific psychosocial capacity building, there is no recognition in the pricing model that reflects the ongoing engagement with participants outside of the assumed Monday to Friday day shift.

Consumables

5.3 Should the NDIA allow capacity-building providers to recover the cost of consumables as part of the service delivery costs in cases where this is a necessary part of the support offering? How should these costs be factored into the NDIS price control arrangements? How would any Safety and Quality issues be managed under this arrangement?

It is Neami and Me Well's submission that providers should be able to recover the costs of consumables, providing it is not the core item being delivered (eg some consumables were used in the course of delivering capacity building activities, rather than some capacity building being delivered in the supply of capital supports).

Service providers should not be required to be registed for incidental use of capital, however there may need to be a reasonable limit on what can be claimed as incidental capital supports under capacity building, and it should also only be claimed in conjunction with a claim for capacity building in this way.

Safety and quality issues could be addressed through a program where service providers complete an online module that ensures they understand the base requirements for delivering incidental capital supports (without requiring registration) and providers are required to provide details of incidental capital supports provided if required by the agency (eg through an audit or request for information).

Indexation

5.4 Do the current indexation arrangements for the price limits for capacity building supports appropriately maintain their value? If not, what is the appropriate way to reset the price limits on these fees each year in order to maintain their value?

The indexation for capacity building has not historically fully accounted for the increase flowing from the annual Fairwork undexation and Equal Remuneration Order, which has left providers to absorb the full cost. If the current approach to indexation is to be maintained it is our submission that the appropriate ABS Wage Price Index to use is the Public Healthcare and Social Assistance.

Other issues

5.5 Are there any other issues with the price limits for capacity building supports?

Yes. It is our submission that the TTP should be available for line items in the capacity building supports. The reality is that most providers in the capacity building area are struggling with similar transformational and investment issues to those experienced under Core Supports. There appears no clear rationale why the TTP is not available for Capacity Building service provision.

It is Neami and Me Well's submission that the review should address the significant disparity between the average package value of psychosocial packages between States and Territories across the nation. All NDIS service providers operate under the same national Modern Award (SCHADS) and largely similar high proportion of direct labour as a proportion of overall costs. Largely, in line with the NDIA own pricing 'glide path' policy all providers nationally now operate to the same price schedule, yet the discrepancies between states in total average plan values remains so fundamentally different that there is a significant problem in the pricing and associated assessment of reasonable and necessary participant plans. The issues arising from the disparity also impact design and sustainability of national business models.

6. Plan Management Supports

6.3 Is a fixed monthly service fee the best pricing structure? …

Greater transparency in the actual cost of maintaining the service would be achieved by making this an hourly charged line item, with a monthly maximum. Providers would need to account for the activity undertaken in charging this fee, based on guidelines of acceptable activity provided by the agency. A separate chargeable line item for travel and non-face to face (6.6 and 6.7) would enable the agency to analyse data in relation to the service fees, which may highlight the use of the monthly service fee is actually comprised of some activity that could be allocated to non-face to face or travel activity.

Capacity building and training in plan administration and management

6.4 Currently, the price limit (per hour) for capacity building and training in plan administration and management is higher than the price limit (per hour) for core supports. Is this reasonable? If yes, why? If no, why not?

Capacity building in financial and administrative supports is a more complex process than other day to day support activities, particularly for the psychosocial cohort. For effective service delivery, the capacity building worker would need experience/knowledge of working with those experiencing mental ill health, as well as how to deliver capacity building support in finance and administration – this not only requires a more developed skill set on the part of the worker but will also take a longer time to achieve results.

6.5 Is the current price limit (per hour) for capacity building and training in plan administration and management reasonable? Please provide evidence of the costs of delivering this support.

As discussed above, providing these supports is an inherently more complex offering than other capacity building support activity. As such, the worker is likely to attract a higher salary level, as well as needing more funded hours to deliver results.

As such, the hourly rate should be closer in line with delivering support that enables the participants to design and build their supports (level 2 coordination of supports) within a complex service delivery environment. The current rate for Level 2 COS is $98.06, and the CB plan management rate is $60.16 which is a difference is $37.06 per hour.

Provider travel and non-face-to-face activities

6.7 Should plan management providers be permitted to bill for provider travel when providing capacity building and training in plan administration and management supports? If yes, why?

If this the participant gives consent and the fee is included in the schedule of supports under the service agreement – yes. Face to face training may be the most appropriate learning method for a participant.

6.8 Should plan management providers be permitted to bill for non-face-to-face time when providing capacity building and training in plan administration and management supports? If yes, why? Please provide examples of non-face-to-face activities that should be billable.

Yes, with some guidelines. As mentioned in response to 6.5,tThis type of capacity building support is more akin to Level 2 COS, so similar guidelines on non-billable time should apply.

9. Cancellation rules

9.1 Is the 90 per cent threshold appropriate to recover the costs of a cancelled appointment? Should this threshold be raised or lowered?

The current cost model is based on a pre-tax margin of 2%. If a cancellation is only billed at 90%, the provider is still incurring a cost for that hour of support.

9.2 Does the two business days' notice provide adequate time to providers to make alternative arrangements (for example, rearranging staff or finding a replacement participant)?

If a provider has a reasonably well managed rostering and scheduling function/process they may be able to reallocate the resources. Finding replacement participants relies on an organisation have a consumer base that is large and diverse enough – which many service providers may struggle to do.

10. Provider travel rules

Provider travel time limits

10.1 What proportion of travel episodes related to the delivery of NDIS supports by your organisation exceed the claimable time limits specified in the NDIS Price Guide and Support Catalogue? Please provide evidence.

Almost all Me Well participants are located at a distance that exceeds the 30-minute travel limit.

Non-labour costs

10.5 On average, what additional non-labour costs per kilometre travelled do you incur because of provider travel? Please provide evidence.

Employees operating under the SCHADS Award, when using their own vehicle, receive 78 cents per KM reimbursement that is not covered in the provider travel pricing.

10.6 Does the additional cost per kilometre depend on the type of vehicle or other factors? If so, please provide more details? Please provide evidence.

The cost of travel applies to employee owned vehicles. Where organisational pool vehicles are used there is an equivalent capital, operational and running cost per KM that the organisation incurs which we believe is not currently sufficiently catered for in the provider travel pricing.

11. Establishment fees

Establishment Fees

11.1 Are the current rules about who can charge establishment fees appropriate? If no, why not?

The existing hurdle rule of "..at least 20 hours of personal care/community access support per month…" is unfairly biased to organisations that deliver personal care or community access. It is further unreasonable as every participant, regardless of service type and quantum, requires the establishment of basic records and associated intake processes – to meet ongoing NDIA Compliance reporting, WHS monitoring, and basic documentation and records establishment. Our experience is

that fully absorbed initial establishment cost is nearer $2,500 per participant prior to signing for any service agreement and commencement of support serviced delivery.

11.2 Are there any other supports where it might be appropriate for providers to charge establishment fees? Please explain why establishment fees would be appropriate in these cases?

It is Neami and Me Well's submission that the Establishment fee should apply whenever a participant where they engage with a new provider. For the reasons set out in response to 11.1.

Indexation

11.4 Currently the price limits for establishment fees are not indexed each year. Is this reasonable? If not, what is the appropriate way to reset the price limits on these fees each year in order to maintain their value? Why?

At a minimum the FWA annual wage increase should apply recognising the direct labour costs of these establishment processes.