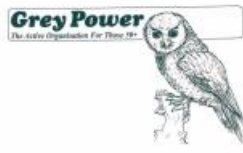


# Inquiry into Aged Care

New Zealand Labour Party  
& Green Party of Aotearoa New Zealand  
with Grey Power

September 2017



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## Key messages from the Inquiry

Our seniors deserve a high standard of care as they age. Labour, Greens and Grey Power collaborated in a comprehensive inquiry in 2010, and have undertaken this follow up inquiry to respond to ongoing concerns and new challenges that have emerged. While improvements have been made since our 2010 Report, this inquiry has found that many of the problems remain.

Older New Zealanders still have significant concerns about the standard and availability of aged care in New Zealand which must be addressed, along with new challenges.

The following recommendations signal the direction of travel both political parties agree to pursuing in aged care. This is an aspirational vision to improve the standard of aged care services for our older New Zealanders, ensure the sustainability of service providers and improve the health of the population.

## Recommendations

1. **Review interRAI governance and implementation of mandatory assessments.**  
Investigate options for extending interRAI to home care services
2. **Review and investigate updating the aged care standards to set a nationally consistent baseline**
3. **Improve the consistency of treatment criteria between District Health Boards**
4. **Establish the Office of the Aged Care Commissioner and a position of Aged Care Commissioner**
5. **Develop improved monitoring and reporting on health outcomes to enhance accountability**
6. **Task the Office of the Aged Care Commissioner to work with stakeholders in the sector to improve outcome-oriented performance measures and investigate the need for a government-backed system to star rate providers**
7. **Require the Office of the Aged Care Commissioner as part of its initial work programme to investigate the effectiveness of complaints processes in residential care facilities**
8. **Encourage the development of more housing that meets lifetime design standards for older people thereby better enabling seniors to age in place, including a review of building standards**
9. **Investigate support for Local Councils to build or upgrade their council housing stock for older people such as the provision of low-interest loans**

10. Support innovation in aged care to provide more inclusive care which caters to the diverse needs of everyone in aged care
11. Increase overall health funding so that it is able to meet inflation and demographic pressures while making up for the shortfall in funding over the last eight years
12. Review the current funding model for residential care and measures to support the viability of small providers serving specific communities, including not for profit providers in small towns and rural areas
13. Ensure that funding contracts include robust performance requirements and transparency in reporting on outcomes.

## Background to the Inquiry

This inquiry was initiated by the Labour Party, Green Party and Grey Power. The initial impetus was to review implementation of the recommendations from the 2010 inquiry, but it was also agreed to update the analysis to take account of significant changes in the aged care system and the health sector since 2010.

The process of gathering views and evidence was undertaken between February and June 2017, drawing on nine public meetings across New Zealand, interviews, research and analysis. A full list of meetings and interviews is attached as Annex 1.

The inquiry also built on the analysis and recommendations of the report “A Report into Aged Care: What does the future hold for older New Zealanders?” in October 2010. While much has changed since our 2010 Report, and some improvements have been made, this inquiry has found that many of the problems remain. Many of the recommendations have not been implemented, others only partially implemented and some not implemented at all. We remain convinced that the quality of care would have been higher, and the outcomes for thousands of people would have been better, if our recommendations had been implemented.

We are grateful for the insights and views expressed by a large number of participants at the meetings, expert evidence and views provided by professionals, providers, sector unions and analysts. The findings of this report are informed by their expertise and their commitment to high quality aged care, but are ours alone.

## Aged Care in New Zealand

This inquiry comes at an important time. One of the key recommendations from our earlier report – increasing rates of pay for staff – has been finally implemented, at least partially. There is also rapid growth in the number of over 65 years old New Zealanders, driven by the baby boomer generation turning 65 years, longer life expectancy and high levels of immigration.

Statistics New Zealand estimates that by 2028 the proportion of the population aged 65 and over will increase from 15% to 19% - an increase of around 350,000 people. By 2068 the proportion 65 and over is forecast to reach 28% of the population.<sup>1</sup>

The Salvation Army has estimated that between 2025 and 2030 “the numbers of people requiring some form of residential care will grow by more than 20% or by over 2000 people per year perhaps to 57,000 to 58,000 beds by 2030.<sup>2</sup> Catering for this demand growth will require an additional 100 bed facility every two and half weeks for these five years.”

People are entering aged care later and later in life. While 10 years ago the average age for someone entering aged care was 75 it has now risen 9 years to 84 years of age.<sup>3</sup>

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<sup>1</sup>[http://stats.govt.nz/browse\\_for\\_stats/population/estimates\\_and\\_projections/NationalPopulationProjections\\_HOTP2016.aspx](http://stats.govt.nz/browse_for_stats/population/estimates_and_projections/NationalPopulationProjections_HOTP2016.aspx)

<sup>2</sup><http://www.salvationarmy.org.nz/sites/default/files/uploads/20151201SPPUSAHomelessbabyBoomersrReportwebv1.pdf>

<sup>3</sup><https://nzaca.org.nz/policy/pay-equity/key-facts-and-figures/>

### ***Dynamics of the aged care residential sector***

Aged care remains dominated by private provision with Government assistance. Of the nearly 700 aged care residential homes in New Zealand 61% are privately owned, 20% owned by non-profit organisations, 19% are publicly listed and 1% have other types of ownership.<sup>4</sup>

The growth in the number of people accessing aged care and the increased age of those entering it places new pressures on the sector.

There have been substantial improvements in the system. New Zealand is the first country in the world to attempt nationwide implementation of the interRAI system to provide comprehensive standardized clinical assessment for aged care support. This is supplemented by certification and surveillance audits to ensure that the sector is delivering the level of care found to be needed.

The updated Healthy Ageing Strategy identifies the importance of a health system that supports healthy ageing closer to home. A person being able to age in their home, if clinically appropriate, contributes to their health and wellbeing where it is properly supported.

Commercial providers in the aged care sector continue to grow. When the 2010 Aged Care Report was done it was estimated 32% of the sector was not-for-profit. Today the New Zealand Aged Care Association estimates this to be 20%. This has coincided with an increase in aged care facilities within the booming retirement villages and the closure and consolidation of smaller independently-owned facilities.

Many of these smaller facilities do not have the size and scale of operations to operate as efficiently as the larger rest homes, with greater investment capital to draw on. They are very sensitive to even a small decrease in occupancy rates, which is inevitable in smaller towns and rural areas. The smaller facilities are predominantly community-based rest homes, faith-based facilities and NGO providers.

Larger rest homes not only benefit from greater efficiencies from their larger scale, but they are also able to benefit from cross-subsidies between their highly profitable retirement village operations and the aged care facilities they provide for residents as they age and need additional levels of care.

### ***Structure of the home and community care sector***

Home and community support services, also known as home care services, encompass a range of services available for people who need support to live at home. For older people, this involves personal care (e.g. getting out of bed and showering), household support (e.g. cleaning, meal preparation), carer support (help for the person who lives with you/looks after you for more than four hours per day), and equipment to help with safety at home. District Health Boards (DHB) fund these services which are delivered following a completed needs assessment from a contracted agency after referral from a doctor. When home support is allocated to a person, the DHB pays a provider organisation (community-based agencies or companies) to deliver the service.

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<sup>4</sup> <https://nzaca.org.nz/policy/pay-equity/key-facts-and-figures/>

Increasing demand for home care services and a failure to fund DHBs to meet the costs of demographic pressures of a growing elderly population, has led to DHBs shifting their funding to deliver more personal care hours per week for higher needs clients and fewer household management hours overall. The home and community support sector has long raised the issue of tightening DHB budgets and the consequent variations in the delivery of services between DHBs.

According to advice to the Director-General of Health from the Director-General's Reference Group for In-Between Travel settlement for home and community support workers (August 2015), there are approximately 70 providers of home and community support services, of which approximately half are not-for-profit providers.<sup>5</sup> They note that over recent years, there has been a trend towards more for-profit providers with a few of the larger providers acquiring smaller providers

The two largest for-profit providers of home and community support services are HealthCare New Zealand Limited (recently acquired Geneva Healthcare) and Access Community Health, who between the both of them share over half the market. There are also several other large/medium-sized private and charitable organisations e.g. Nurse Maude Association, Presbyterian Support, Salvation Army New Zealand Trust. The rest are smaller private providers, charitable, and iwi-based organisations.

### ***Government funding for Aged Care***

Government funding for aged care has failed to keep up with what is required to meet demand and the model of funding is not providing care for all of those who should be receiving it.

There is a national funding mechanism for aged residential care but not for home and community care. This was a recommendation from the Director-General review group report. However, this recommendation was not accepted by the Ministry of Health and has remained parked since 2015.

DHBs are legally responsible for funding residential care services for older people. In practice how this is achieved is by contracting rest home and hospital owners using the residential-care subsidy.

This funding model has caused difficulties as the Government has failed to fund health sufficiently to cover inflation and demographic pressures. Funding for aged care isn't ring-fenced meaning that DHBs can use funding that they receive for older person services to make up for the shortfalls in other health service areas like mental health.

Aged care is too frequently not a priority. In order for DHBs to meet their planned budgets, care services are rationed through reductions in home care services and equipment.

## **Improving the quality and reliability of care**

We have undertaken this inquiry because we have heard too many stories of aged care that is failing to meet the needs of seniors.

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<sup>5</sup> <http://www.hcha.org.nz/assets/DG-REFERENCE-GROUP-REPORT-FINAL-AUGUST-2015.docx>

People like Mary\*, a Housing New Zealand tenant who had to make repeated calls before a leak causing water to “pour in” directly above an electrical outlet was attended to. Or Anne\*, whose brother, who, being unable to pay \$15,000 for eye surgery, ended up blind while waiting for a publicly-funded operation. Or New Zealanders like Gary\*, who was distressed because an elderly woman he knew had been planning to commit suicide because she felt there was no help and “no one to turn to.”

The inquiry meetings revealed a number of cases where elder abuse has occurred in rest homes or through home care providers. We have heard stories such as a patient with dementia who kept on falling off her chair onto the floor. She was left there and then propped up on the chair until she fell again and was eventually admitted into hospital.

We want to stress that these stories are not an indictment on the sector as a whole. We heard many other cases of excellent care and particularly of caring nurses, care workers and other staff who were prepared to go the extra mile in order to make the personal connection, form a bond and be kind. Little acts of kindness mean a huge amount. But we have also heard from committed and caring staff how difficult this is to fit in amongst their performance measures, their deadlines, and their paperwork.

Our 2010 report recommended a consistent system for health needs assessments, undertaken across New Zealand, to a national standard. Although the assessment system, interRAI, has been mandated for use by all DHBs, the results are interpreted differently and the level of care that results from the assessments are inconsistent.

This gives rise to the common perception that interRAI is being used as a rationing tool for inadequately funded aged care services. This is reflected in the observation that rest homes previously housed a wide range of ages and abilities, but entry is now restricted to those who are elderly and frail. Measures of performance for care providers are aligned towards the Government’s strategy of enabling seniors to live at home for as long as possible, as a means of containing costs as well as a positive choice for many seniors, but this push to keep people in their homes longer should not be at the cost of adequate health care. Several public meeting participants voiced concern that while the initial interRAI assessment is in person, follow up assessments are by phone, and problems are often not identified.

**Recommendation 1: Review interRAI governance and implementation of mandatory assessments. Investigate options for extending interRAI to home care services**

There is a basic problem with the quality of care due to underfunding of the sector that has not kept up with inflationary costs to cover an acceptable minimum standard of care. Higher standards are increasingly being reserved for those with the means to pay for the extra services that are not covered by Government funding. Those with assets above the threshold for government funding can opt for a premium level of care, as can others who are supported by relatives. This stratification of aged care into different levels of care depending on ability to pay is an unwelcome trend, exacerbating a two tier level of care based on what you can afford. There has been a strong view expressed to this inquiry that the baseline for aged care delivery should be adequate to maintain good health, dignity and wellbeing. As shown in the funding section below, a review of the funding system is long overdue.



### ***The need for consistent standards***

The evidence presented from participants in public meetings showed many cases of neglect and poor quality of health care in some aged care facilities. One meeting attendee said, “Everything looks rosy when you move in, but soon you find out what it is *really* like.” The feedback from meetings and interviews showed the need to investigate baseline standards that could be consistently applied across the residential aged care sector.

The existing standards for residential care coverage were agreed in 2005 as recommended guidelines.<sup>6</sup> The guidelines include standards for staffing by care workers and nursing staff. They are now out of date and are not being consistently implemented. The standards should be updated and made mandatory. “We don’t want guidelines,” said one public meeting participant. “Make the aged care rules mandatory. We need to know where we are going.” The standards covering home and community care<sup>7</sup> are more recent, updated to 2012.

### **Recommendation 2: Review and investigate updating the aged care standards to set a nationally consistent baseline**

There is also a lack of consistency in the application of the criteria for treatment. The clinical priority assessment criteria, a points system that determines whether older people who have treatable problems with their hips, knees, back, shoulders, cataracts and other operations are subject to a ‘postcode lottery’. Points that would be sufficient for getting on the list for surgery in one DHB may not in a different DHB. People suffering pain deserve the same standard of treatment wherever they live.

These shortfalls are reflected in the gaps in health care coverage. Research<sup>8</sup> by Dr Philip Bagshaw and others shows the serious problem of unmet health care needs, especially for operations. An orthopaedic surgeon, Associate Professor David Gwynne-Jones looked at primary elective hip and knee replacement in adults over 20 years of age in the Otago region<sup>9</sup>. Patients undergoing primary elective total hip and knee replacement surgery in Otago in 2014 were more severely disabled than patients receiving surgery between 2006 - 2010. Patients currently being returned to a GP would have qualified for publicly-funded surgery during that period.

The application of restrictive criteria for treatment mean that many seniors do not get treatment until their condition has significantly deteriorated. The long wait for treatment means unnecessary pain, suffering and a loss in quality of life as Grey Power respondents to a member survey on the effect of delayed access elective surgery have disclosed.

One of the surveyed Grey Power members submitted “I am now trapped between several specialists and ACC and couldn’t have an op [sic] unless I chose to pay for it myself. I’m, although drugged up, in constant pain, some of it serious enough to put me into spasms, and I haven’t slept a night through in bed for about five years; have pretty well decided I must go to my grave in pain. Apart from my knee pain, I’m in good health, and my marbles are mostly

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<sup>6</sup> Indicators for safe aged care and dementia care for consumers SNZ HB 8163:2005

<sup>7</sup> <https://www.standards.govt.nz/touchstone/health/2012/may/revised-nzs-8158-standard-helps-ensure-people-receive-quality-home-and-community-support/>

<sup>8</sup> <https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2017/vol-130-no-1452-24-march-2017/7193>

<sup>9</sup> <https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2016/vol-129-no-1432-1-april-2016/6849>

intact; still do the cryptic. Hope at least that you can start some help for others; think it's too late for me.”

Because many of the stories Grey Power hears are heart-breaking, they asked the current Minister of Health “does the cost of delayed elective medical treatment for older people outweigh the costs of the household help, accidents because of physical impairment etc.?”

The response received from the Ministry of Health was that “this has not been specifically assessed... But it is equally important to focus on early intervention, so that people's health does not deteriorate to a level where secondary or tertiary care is required.”

### **Recommendation 3: Improve the consistency of treatment criteria between DHBs**

## **Strengthening accountability**

The number and seriousness of problems identified in this inquiry shows that there needs to be a mechanism that can be accessed when things go wrong in the system. In the 2010 report, we recommended the establishment of an Aged Care Commissioner. The introduction of an Aged Care Commissioner was supported by numerous meeting attendees at various locations across the country. The Health and Disability Commissioner due to the broad responsibility of their role is not seen to be sufficiently focused on the needs of the growing numbers of people receiving aged care. As the number of people receiving aged care services grows, there needs to be a trusted channel for investigation of serious complaints and a champion of rights for those in the sector.

This is particularly important with an apparent increase in the frequency of elder abuse (although this may result from greater awareness of the issue). A paper prepared for the Aged Care Association and Grey Power in 2013 suggested that a key focus of an Aged Care Commission would be to investigate allegations of different forms of elder abuse – emotional, financial, physical and neglect, with a particular focus on investigating financial abuse.<sup>10</sup> As shown by Age Concern, financial abuse is the most prevalent form of abuse and has been growing. This is compounded by the increasing incidence of dementia that creates an extreme form of vulnerability to abuse.

### **Recommendation 4: Establish the Office of the Aged Care Commissioner and a position of Aged Care Commissioner**

The 2010 Inquiry called on residential care facilities to advertise their fee structures and any additional charges openly, and to measure their current organisational performance against clinical indicators with the results to be freely available on an aged care website. The inquiry also called on support service providers to provide a transparent pricing model to determine fair prices and fair returns.

There have been improvements in implementing an auditing system in residential care facilities, after a case was taken to the Ombudsman by Consumer NZ. Residential providers are required to be audited against a set of standards, with the results published on the Ministry of Health website. The Ministry of Health has worked to improve the transparency of

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<sup>10</sup> <http://www.scoop.co.nz/stories/PO1310/S00206/aged-care-commissioner-needed-to-protect-the-elderly.htm>

their information, but it is still difficult for the public to understand the performance of residential providers on the basis of the audit reports.

Aged care providers choose an auditor from a list of designated auditors and a pre-announced visit is used for a detailed audit. Generally these certification audits are valid for a period of up to 4 years.<sup>11</sup> Within the periodic audit period or if a serious complaint is reported, there is an unannounced follow up audit. There is at least one unannounced audit carried out around the middle of a rest home's certification period, regardless of whether a serious complaint is reported or not. Our 2010 inquiry recommended expanded use of unannounced visit to improve the rigour of auditing.

Routine inspections look at approximately 50 standards and 101 criteria within the standards that can be used for audits of rest homes.<sup>12</sup> A review undertaken of the audit process by AUT showed improvements in the auditing process, including the use of interviews with the patient, family and staff to assess outcomes.<sup>13</sup>

However, public meeting participants raised the issue that the auditing system does not provide adequate information on the performance of the residential providers or home care providers. A number of smaller rest homes also criticise the auditing system for its compliance-heavy approach. As the Office of the Auditor-General's report pointed out in 2009, and in subsequent follow up reports, information on the outcomes for patients is crucial to provide assurance that a high standard of care is being delivered. The Auditor-General's report on rest homes concluded that the certification of rest homes has not provided adequate assurance that rest homes have met the criteria in the Standards.

A report in 2011 on home-based support services (home and community support services) by the Office of the Auditor-General reached a similar conclusion, and cautioned that the Ministry of Health and DHBs did not have adequate information to determine whether seniors had adequate care and support. A follow up report in 2014 showed little progress on the key issue of better information and was again followed up in June 2016. They found that the Ministry has abandoned their previous approach and were developing a new set of indicators. The process is still underway.

Indicators of the quality of care already existing in established standards, such as factors used in interRAI assessments - falls, pressure ulcers, pain, depression and activities of daily living.<sup>14</sup> The information to report on these measures is now being collected in the interRAI database and collated by provider and form the basis for performance reporting. The outcomes data should be publicly available and regularly reported in an accessible form.

#### **Recommendation 5: Develop improved monitoring and reporting on health outcomes to enhance accountability**

In our 2010 report, we recommended a star rating system for aged care facilities. A private sector rating system has now been established, covering rest homes and retirement villages (but unfortunately not home care providers). 'Aged Advisor' works in a similar way to the highly popular Trip Advisor. 'Aged Advisor' ([www.agedadvisor.nz](http://www.agedadvisor.nz)) uses ratings and comments

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<sup>11</sup> <http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits>

<sup>12</sup> Ibid

<sup>13</sup> <http://www.health.govt.nz/publication/improving-outcomes-age-residential-care>

<sup>14</sup> <http://www.interrai.co.nz/assets/Data/2015-16-National-interRAI-Data-Analysis-Annual-Report.pdf>

from members of the public to rate facilities on a five star scale. Even though public ratings systems are not entirely reliable and can be manipulated, it is a welcome step forward in providing public information.

There is more that needs to be done. In an opinion piece for INsite, Consumer editor David Naulls said the individual experiences of residents and their families need to be heeded by the sector.<sup>15</sup> “We continue to hear from people who tell us their relative – often their mother or father – has been in a home where there have been failings in care. We also hear from people who have experienced good care and are full of praise for the home. Unfortunately, there are more of the former than the latter. More than the bare statistics, it’s these experiences – good and bad – that the aged care industry needs to listen to and learn from.”

In particular, there is little in the way of auditing and ratings systems for home care providers. There is information available from DHBs to those assessed as needing home care, but there is little public information on the performance of providers. Eldernet ([www.eldernet.co.nz](http://www.eldernet.co.nz)) has information on the options available but no information or feedback on the quality of the service from different providers. The most important information comes from the experience of those receiving home care, but there is currently no rating system or audit system that would allow members of the public to provide feedback on the performance of home care providers. This was an issue that was frequently raised by participants in the public meetings.

There is a government-mandated five star rating service in the United States, using outcome measures to rate aged care providers. A model similar to this could provide a more authoritative guide on the performance of different facilities and home care providers.

**Recommendation 6: Task the Office of the Aged Care Commissioner to work with stakeholders in the sector to improve outcome-oriented performance measures and investigate the need for a government-backed system to star rate providers**

There is a complaints mechanism to the Health and Disability Advocacy Services, under the Health and Disability Commissioner, on residential or home care, but feedback from our inquiry meetings showed that few participants knew how to access the service and some who had complained were critical of the complex procedures and the time that it took to resolve complaints. Last year, there were few complaints received by the Health and Disability Commissioner on rest homes (5% of complaints) or home care (3% of complaints). During our inquiry meetings we heard back from participants saying that the process was slow and cumbersome, sometimes taking several years before a complaint is resolved.<sup>16</sup>

There is also an Advocacy Service within the Health and Disability Commissioner’s office that intervenes to resolve complaints and problems. We heard good feedback on the Advocacy Service in supporting resolution of problems through negotiating solutions.

Staff and organisations within the system find it difficult to raise concerns with the performance of the private sector providers or government agencies. Feedback from various meetings indicates that providers and employees have been reluctant to speak out because of fear of retribution for themselves and their organisation. It appears that a climate of mistrust has grown, particularly as a result of a lack of effective communication and dialogue

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<sup>15</sup> <http://insitemagazine.co.nz/2015/05/05/rating-rest-homes-is-it-about-time/>

<sup>16</sup> <http://www.hdc.org.nz/media/302689/hdc%20annual%20report%20year%20ending%2030%20june%202016.pdf>

over issues such as funding for the Pay Equity settlement and the lack of delivery on undertakings from the Director-General's Reference Group report.

**Recommendation 7: Require the Office of the Aged Care Commissioner as part of its initial work programme to investigate the effectiveness of complaints processes in residential care facilities**

## Improving housing options

The Government's approach to keep seniors in their home for as long as possible can create difficulties for families. Often seniors are left by themselves and lack companionship and contact with others. Those entering rest homes are significantly older than in the past, with high levels of care required. There are currently few options for those able to make a transition from living in their family home into housing that can draw on shared facilities, and provide companionship, community and support through shared services. Research by Philippa Howden-Chapman has shown that well-designed houses are safer for seniors as they age, and costs the Crown less overall once ACC and treatment costs are included.<sup>17</sup>

Renters are in a particularly difficult situation, as rents have increased faster than the accommodation supplement, particularly in Auckland. This has been exacerbated by long waiting lists for Council or Housing NZ accommodation, and by the sale of some Council houses that were previously allocated to seniors. The numbers of seniors who do not own their own home is rising, and this group are particularly vulnerable. The inquiry heard evidence about cold and damp living conditions, making residents sick, and poor maintenance of their houses.

This is corroborated by research from Massey University showing that home owners have a greater sense of security and higher quality of life.<sup>18</sup> The government's strategy of encouraging ageing at home only works if seniors have a safe, healthy and secure home.

Options are emerging to meet the needs for a transition from living at home towards shared services. As one example, the Abbeyfield homes in different cities across New Zealand have provided an affordable model of clustered accommodation around shared meals, housekeeping and facilities.

**Recommendation 8: Encourage the development of more housing that meets lifetime design standards for older people thereby better enabling seniors to age in place, including a review of building standards**

**Recommendation 9: Investigate support for Local Councils to build or upgrade their council housing stock for older people such as the provision of low-interest loans**

## Supporting innovation

There is growing diversity amongst older New Zealanders, as life expectancy increases and as our society becomes more culturally diverse. New Zealand has the opportunity to learn

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<sup>17</sup> <http://www.healthyhousing.org.nz/publications/>

<sup>18</sup> [http://www.massey.ac.nz/massey/about-massey/news/article.cfm?mnarticle\\_uid=678BB22D-B53A-93AA-4176-21193FB3A60E](http://www.massey.ac.nz/massey/about-massey/news/article.cfm?mnarticle_uid=678BB22D-B53A-93AA-4176-21193FB3A60E)

from well-established models overseas, including Dutch models for dementia care, the Danish ‘Nursing Home for the Future’ and the UK active living concept.<sup>19 20 21</sup> In Auckland, the Selwyn Foundation has developed its ‘Selwyn Way’ approach through learning from international experience.<sup>22</sup> Across New Zealand, the Eden Alternative facilities have been developed around the Eden Principles that include community engagement and interaction with young people in activities.<sup>23</sup>

As New Zealand’s cultural diversity grows, catering for the needs of our ethnic communities is a major challenge for the aged care sector. During the inquiry we heard the story of a woman, born in India, with strong religious beliefs, and a vegetarian, being served meat because of a lack of cultural sensitivity from staff. There are examples of new culturally-appropriate models of aged care emerging, including the partnership between Bhartiya Samaj and Bupa, and the Whare Aroha model for dementia care attuned to Maori communities.<sup>24 25</sup>

Individualised funding is also being promoted as an innovation, using the model of funding for disability services to promote a contractual relationship between the provider and the patient. While this decentralised model has some cost advantages, it encourages a casualised deregulatory model that provides few protections for vulnerable seniors or workers.

We must ensure well rounded care, involving the whole family. Family members need respite care, especially those caring for family members with dementia. They are on the front line and need support. We think there is merit in the proposals made by Dementia NZ for the role of a navigator to help those who have been diagnosed with dementia, and their families, through the difficult process of providing care.

There must be respect for the individual and their diverse needs, treating them as people who have needs for fulfilment, socialising, companionship and stimulation as well as sound nutrition and living conditions. An active and healthy lifestyle improves longevity and quality of life. We also need to ensure people in aged care have engagement with the community and a range of ages and ethnicities.

**Recommendation 10: Support innovation in aged care to provide more inclusive care which caters to the diverse needs of everyone in aged care**

## Providing adequate funding

Underlying the problems of aged care is the lack of government funding. One public meeting attendee, Rob\*, described the situation in a local rest home where one Registered Nurse at one time was responsible for the care of 86 patients. It took nearly a month for a second Registered Nurse to be added. The government defends its funding for the health sector by stating that health funding as kept up with population growth and inflation but this ignores the ageing of our growing population and people living longer. Data from Infometrics uses the changing demographics and adjustment for inflation to calculate changes in the real level of

<sup>19</sup> <http://twistedifter.com/2015/02/amazing-village-in-netherlands-just-for-people-with-dementia/>

<sup>20</sup> [http://www.fremtidensplejehjem.dk/media/14969/fp\\_koncept\\_engelskfinal.pdf](http://www.fremtidensplejehjem.dk/media/14969/fp_koncept_engelskfinal.pdf)

<sup>21</sup> <http://www.msn.com/en-nz/news/world/the-retirement-village-where-women-are-living-years-longer-than-everyone-else/ar-AAAn7nyg>

<sup>22</sup> <http://www.selwynfoundation.org.nz/careers/about-us/the-selwyn-way/>

<sup>23</sup> [http://www.edeninoz.com.au/html/s01\\_home/home.asp](http://www.edeninoz.com.au/html/s01_home/home.asp)

<sup>24</sup> <http://www.radionz.co.nz/news/national/255906/age-care-%27isolating%27-for-ethnic-groups>

<sup>25</sup> <http://www.wharearoa.org.nz/>

funding over time. Under current spending plans to 2018, there is a \$2.3 billion cumulative shortfall in funding of core crown health expenditure since 2009/10.<sup>26</sup>

There have been suggestions that DHBs have not ring-fenced funding for aged care, and funds have been diverted to other priorities, within an environment of funding shortfalls. Unfortunately, information is not available to be able to assess this robustly. Interviews have suggested that the perceived lack of priority for aged care issues results from greater attention given to directly managed services delivered through hospitals or DHB-managed programmes, rather than aged care which is contracted out to providers. None of the current Government's national targets for DHBs addresses aged care issues.

Even before the pay equity settlement, home care providers and unions were concerned over insufficient funding for the provision of services. Improvements in pay and conditions of workers have resulted in further pressures since the funding agreements were not adjusted to fully recover the additional costs incurred. The introduction of pay for In-Between Travel and guaranteed hours have been important steps to avoid loading the costs of travel onto health care workers, and to prevent further casualization of the workforce. The Ministry of Health undertook on repeated occasions to source through the government budget processes extra funding to cover additional costs, to cover additional costs but to date have failed to deliver on that undertaking.

### ***Pay Equity Settlement***

During the inquiry, the long running negotiation was concluded to settle the legal case brought by Kristine Bartlett with the support of trade unions (known as the TerraNova pay equity claim). This was crucial in delivering improved pay to around 55,000 care workers, a welcomed huge step forward. These workers will receive stepped pay increases from around \$16 per hour at entry level to \$19-27.00 per hour for those who have more than 12 years' service or Level 4 qualification. This is a long awaited recognition of the dedication and hard work of care workers, and encouragement for young people considering a career in health care.

The low pay for care workers was one of the key recommendations of the Labour and Greens inquiry in 2010, as well as the Caring Counts report from the Human Rights Commission. The current Government failed to act to raise wages, even after Katherine Bartlett's case was launched in 2012. After the case was won, the government finally agreed to negotiate and the Care and Support Worker (Pay Equity) Settlement Bill came into force on 1 July this year.

However, the pay equity case has raised crucial issues for implementation and highlighted long-standing problems in the aged care system. The residential care sector gained an increase in their contract payments as a results of the settlement<sup>27</sup>. However, this does not appear to cover all of the costs associated with the change with smaller providers reporting a cost to funding gaps for long-term employees who will receive a well-deserved substantial increase in their wages

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<sup>26</sup> [https://d3n8a8pro7vhmx.cloudfront.net/nzlabour/pages/8181/attachments/original/1496806582/2017\\_Estimated\\_Core\\_Crown\\_Health\\_Expenditure\\_May\\_2017.pdf?1496806582](https://d3n8a8pro7vhmx.cloudfront.net/nzlabour/pages/8181/attachments/original/1496806582/2017_Estimated_Core_Crown_Health_Expenditure_May_2017.pdf?1496806582)

<sup>27</sup> These are specified in [Ministry of Health Operational Policy Documents: Rest Home \\$9.41; hospital \\$13.92; dementia \\$14.21; psycho-geriatric \\$16.18 per bed day](#). For home and community care providers the formula is additional labour costs plus an average on-cost of 20.9% and payment for 2 days FTE equivalent annual training.

The Aged Care Association has warned that 100 small and rural facilities (out of their 600 members) have advised that they will struggle to meet the additional unfunded costs of the increased wages.<sup>28</sup> A concern raised by public meeting participants, is that as a result staff are likely to be lose their jobs and facilities will be forced to close. The consolidation of the sector will likely accelerate, with reports emerging from across rural New Zealand of facilities closing down or cutting back.

A Steering Group has been established to review the way that DHBs fund aged care services under the Aged-related Residential Care Agreement. However, the review has only recently been initiated and it is expected to take at least a year, up to two years before the report is finalised and longer before recommendations are implemented. A number of aged care providers may not be able to continue operations under the current inadequate funding contract. However, any investigation of increased support for small rest homes should be contingent upon them delivering a higher level of personalised service, or service in a location where other options are limited.

### ***Extending pay equity coverage***

There may also be additional costs beyond those currently envisaged. Staff in professions other than health care workers also receive modest pay, and they have suffered from a loss of relativity compared with their colleagues. Registered Nurses with considerable responsibility are now paid little more than a Level 4 caregiver. There is an urgent need to address pay equity concerns of mental health workers who often work side by side with care workers.

The Government also needs to take action to guard against adverse impacts that might follow from increasing pay for care workers. For example, loading additional costs onto providers will inevitably result in pressures for replacing experienced staff by those with less experience, cutting staff or hours, or reducing the level of services. We are hearing anecdotal reports of providers creating new roles that will not be covered under the TerraNova pay equity settlement in order to pay staff less.

The pay equity settlement should also be accompanied by greater emphasis on training and career development. The quality of care is almost entirely reliant on the skills and commitment of staff, so investment in training, supporting and enhancing the work of staff are crucial. Investment in the sector will need a change from a model focused on the push to continually drive costs lower and lower. There is a place for competition but it should not come at the cost of investment in workers and systems, and quality of service delivery.

Aged care providers currently have an incentive to increase their profits or balance the books through lower staff costs and, in the absence of robust closely monitored standards, compromises in the quality of care. The current review of the funding model for aged residential care provision should examine the pros and cons of a model that provides funding directly for staff costs that are derived from needs assessments, and separate funding for facilities costs.

**Recommendation 11: Increase overall health funding so that it is able to meet inflation and demographic pressures while making up for the shortfall in funding over the last eight years**

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<sup>28</sup><http://www.radionz.co.nz/news/national/334402/struggling-rest-homes-need-10m-to-adjust-to-pay-equity-deal>



**Recommendation 12: Review the current funding model for residential care and measures to support the viability of small providers serving specific communities, including not for profit providers in small towns and rural areas**

**Recommendation 13: Ensure that funding contracts include robust performance requirements and transparency in reporting on outcomes**

## **Future sustainability**

Sustainability of the sector will be hard to achieve if there is a consolidation of aged care delivery into fewer and fewer rest homes and home care providers. In particular, the impact of past under-funding has fallen heaviest on smaller rest homes, home care providers, and non-for-profit enterprises providing additional services and higher staffing ratios. The formula for increased costs was based on averaging across the sector; smaller facilities often have a mix of more experienced staff and have costs that are higher than the large rest homes. Interviews with the Aged Care Association also revealed that the larger operators are able to cross-subsidise the low margin aged care provision with profits from the retirement village.

There has been consolidation in the sector, with the share of the larger, for-profit providers growing rapidly. While this has also been associated with an increase in average size of facilities, most of the facilities have 40-100 beds with 11% of facilities providing 25% of the beds are larger than 100 beds. With major new developments underway or planned this is likely to change significantly in the next few years.

Under current funding provisions, there will be an acceleration of the closure of rest homes in rural areas and smaller towns and cities. The Health Select Committee was presented with evidence of many small care facilities that would be unable to cover the additional costs of the TerraNova Pay Equity Settlement due to higher than average staffing levels. This issue was frequently raised in letters from the Geraldine Retirement Village and the Cunliffe Rest Home. Subsequent closures of facilities like the Naenae Rest Home are indicative of the likely acceleration in closures of smaller rest homes.

These pressures and trends will inevitably change the nature of the sector. In both residential and home care there has been a strong rooting of services in local communities, often through church or faith-based services, community organisations or NGOs. These provide local services that meet needs that would otherwise not be provided by commercial operators.

The inquiry heard evidence that many people in rural areas like Golden Bay/Takaka are deeply concerned that any further closure of facilities would mean that those needing residential care would have to go to the nearest city (Nelson/Stoke). This already occurs for access to specialist services.

When older people move out of their community, it means that friends and relatives need to travel long distances to visit. This leads to a significant dislocation from their support networks and a burden on relatives. It also breaks the strong place-based ties to the land, the community and the environment. A similar dynamic is occurring across rural and small town New Zealand.

This is likely to result in a future where there will be fewer and fewer options for those living in rural areas, small towns and even smaller cities. It should be recognised that this consolidation is not inevitable. It is an outcome of the funding model.

## **Conclusion**

Our seniors deserve a high standard of care in their later years. Progress has been made since Labour, Greens and Grey Power undertook a comprehensive inquiry in 2010. The standard of care delivered in facilities and the home has improved. However, there is still inconsistency in care provided and some patients are suffering unnecessarily. Despite improvements in auditing, strengthened standards and accountability are needed and this report contains recommendations for improvement.

There has been important progress in improving pay for aged care workers. However, the implementation of the Pay Equity legislation must be fair to providers, be funded adequately and provide career opportunities and training for young New Zealanders, to help meet the projected growth in demand. The funding model used to provide aged care needs to be reviewed to meet the changing needs of the sector, particularly smaller and rural aged care providers. Additional funding will be required in health to address unmet needs for elective surgery and the costs of providing a good standard of care for all.

There are challenges ahead, particularly in dealing with the impacts of the housing crisis that has resulted in higher rents and a fall in home ownership. Purpose-built accommodation, such as the community-based housing pioneered by Abbeyfield and others, will be needed to provide a transition between living at home and the level of care provided in rest homes. There are exciting innovations being trialled in the sector and these need to be encouraged. The recommendations in this report will support opportunities for community engagement, support and companionship, as well as consistently high standards of aged care for all New Zealanders.

## **Annex 1: Process for the Inquiry**

Public meetings held with Grey Power in 2017:

Takaka, 10 February  
Lower Hutt, 17 February  
Levin, 17 February  
Nelson/Stoke, 23 February  
Rotorua, 28 March  
Waitakere, 18 April  
Christchurch, 19 April  
Dunedin, 28 April  
Auckland City, 18 May  
North Shore, 19 May  
Auckland AGM, 15 June

Interviews with stakeholders in 2017:

Grey Power, 21 March  
New Zealand Aged Care Association, 1 February, 12 April & 22 June  
Selwyn Foundation, 3 April  
Age Concern, 30 May  
Retirement Commission, 2 June  
Access Health, 23 June  
Geneva Health, 26 June  
Home and Community Health Association, 29 June  
Consumer NZ, 6 July  
Council of Trade Unions (CTU) including NZNO and PSA representatives, 22 July  
Dementia NZ, 25 July  
Elizabeth Knox Rest Home, 31 July