Submission

To the Social Services Select Committee on the

Social Security (Long Term Residential Care) Amendment Bill

July 2006

Healthcare Providers New Zealand (HCPNZ) National Office
Level 6, 101 – 103 Molesworth Street,
PO Box 12481,
Wellington
(Phone) 04 473 3159
(Fax) 04 473 3554
Email martin@hcpnz.org.nz

Introduction

1. HealthCare Providers NZ (HCPNZ), is a not-for-profit, national membership organisation which represents all parts of the aged-care residential sector. Collectively, HCPNZ represents more than two-thirds of the aged-care beds in the country, and is the largest association of aged-care residential providers in New Zealand.

2. HCPNZ welcomes the opportunity to comment on the Social Security (Long Term Residential Care) Amendment Bill, and wishes to appear before the committee to speak to our submission. Martin Taylor, Chief Executive, can be contacted at either by phone (04) 473 3159, or by email (martin@hcpnz.org.nz)

Summary

3. Healthcare Providers' submission covers:

   - The proposed amendments to the maximum contribution regime

   - The proposed definitions of “Contracted Care Services” and “Cost of Contracted Care Services”

   - The unintended consequences of the Social Security (Long Term residential Care) Amendment Act 2004 relating to subsidies and License to Occupy (LTO) units

   - Section 141 relating to the 28 day rule.

4. The context for this bill is an environment in which all stakeholders, providers, unions, and the government agree the sector is under-funded. Changes that reduce providers’ financial situation will further undermine the future sustainability of the sector. Therefore, all changes to the existing statutory regime must be evaluated on a costs versus benefits impact relating to the sector's overall financial viability.

Application of the Maximum Contribution to private paying rest home residents.

5. The maximum contribution establishes the amount of money paid by DHBs to providers for residential care services. The specific dollar amount is meant to cover the capital cost, the cost of care and a return on provider’s investment.

6. The bill clarifies that the maximum contribution cap applies to rest home residents whether or not they receive Government subsidy for any level of their care. Therefore, residents who enter care and are not eligible (or chose not to apply) for subsidy under current asset testing levels, will have their contributions capped at the same levels as subsidised residents.

7. Current policy and practice means eligible, needs-assessed persons who are receiving long term care in a rest home, who have a contract with a funder to provide such care but who do not qualify for government funding (through the Social security Act), must negotiate directly with the residential care facility to determine the cost of that service.

8. HealthCare Providers NZ is concerned that the changes proposed in the Bill may reduce consumer choice, build inflexibility into the pricing system, and allow crown entities to intrude into a private law arrangement.

9. However, we support the Bill's intention to maintain funder liability in back pay situations when annual review negotiations are delayed.

Consumer Choice Reduced

10. Choice is an important part of any consumer's ability to ensure their particular needs and wants are met. Consumers of residential care for the aged are no different. The elderly and their families are looking for care facilities in all locations, with innovative designs, that provide an array of services.

11. Setting a cap on what private individuals can pay will reduce the scope of options available in the market, as providers will not take on the risk of building and developing certain types of facilities in a capped market.

12. It needs to be understood that the specific maximum contribution amounts are based on an assumed capital cost and care cost. The assumed capital cost is set at a level to support a facility built on averagely priced land, with averaged sized rooms, with standard fittings.

13. This means the maximum contribution does not take account of the situation where a provider wishes to build a premium facility. Therefore, if this Bill becomes law, the capital component of building a premium facility could not be covered by the capital component on which the maximum contribution is based.

Price System Inflexibility

14. Price fixing as suggested in this Bill is not an appropriate way to respond to the challenges of an ageing population. All demographic modeling confirms that we have an aging population and that governments must find different ways to fund aged care into the future. By attempting to make the funding system around residential care for the aged more rigid, the government is establishing expectations within the general population that cannot possibly be met in future years.

15. HCPNZ believes that those who have the financial means, should pay for their care, and that these individuals should be able to choose a standard

service, as provided to subsidised residents, or choose premium services at a higher cost.

Crown Entities Intruding into a Private Law Arrangement.

16. The arrangement between a non-subsidised elderly resident and a residential care provider is a private law arrangement, subject to normal contract and consumer law protections plus the provisions of the Code of Health and Disability Services Consumer Rights.

17. We believe it is inappropriate for Crown Entities to intrude into this private law arrangement. This position is reinforced by the contract that DHBs have with providers (the Age Related Residential Care Contract or ARRC) which expressly recognizes this approach by excluding non-subsidised residents from coverage. As such thousands of private arrangements for residential care lawfully exist outside the scope of the Social Security Act and the ARRC contract.

18. Furthermore, if the proposed changes in the Bill become law, these private arrangements will become unlawful. We believe this issue needs to be considered carefully as it is our understanding that legislation should in general, have prospective effect only.

Maintaining the funders' liability in back pay situations.

19. Each year funders and providers review the contract price, and if (a) the price changes, and (b) the review finishes after 1 July, then the price increase is deemed to be retrospective. Retrospectively also means that the gazetting of new prices will happen after 1 July. In this situation DHBs are liable to pay the difference between the previous gazetted price and the newly gazetted price for all residents, both private and subsidised.

20. Two of the last three review rounds have resulted in back pay being necessary, as DHBs have been unable to finalise any decision made in meetings with providers due to their slow decision making processes. DHBs have also told providers during the last review in June 2006, they would not be paying back pay under any circumstances, despite having done so in the past.

21. Providers believe it is likely that a proposal will come from the Ministry of Health on behalf of DHBs seeking to limit their liability to back pay for some residents or all residents.

22. We believe any move to limit DHBs' back pay liability would undermine the present contract review process, as (a) it would remove one of the main incentives for DHBs to make decisions in a timely manner, and (b) it would increase the pressure on providers to sign unacceptable contract variations.

23. Recommendations:

That private paying rest home residents, who require residential care do not have their fees capped at the Maximum Contribution as set in the Gazette notice under section 152 of the Social Security (Long Term residential Care) Amendment Act 2004.

That the funders' liability to pay the difference between the previous gazetted price and the newly gazetted price, for all residents in back pay situations, be maintained.

The proposed definitions of "Contracted Care Services" and "Cost of Contracted Care Services",

24. The Bill amends section 136, which is the Interpretation for Part 4 of the act. New definitions of contracted care services and cost of contracted care services are substituted, and new definitions are inserted for contracted care provider, section 88 notice, and service agreement. The proposed definitions are:

"contracted care services means services that are---

"(a) provided by a contracted care provider; and
"(b) provided to an eligible person who has been needs assessed as requiring long-term residential care in a hospital or rest home indefinitely; and
"(c) in relation to a particular person, the services necessary to meet the person's assessed long-term residential care needs

"cost of contracted care services means, in relation to a resident assessed as requiring care, the amount that---

"(a) is the cost of the contracted care services provided by a contracted care provider to meet the resident's assessed long-term residential care needs; and
"(b) is specified in the service agreement or section 88 notice that applies to the contracted care provider as the price payable for those services, whether or not the services provided to the resident are wholly or partly funded under that agreement or notice."

Contracted Care Services

25. The proposed changes are only necessary if non-subsidised residents are covered by the Act. We believe the Act's current definition provides an appropriate framework to allow providers and funders to establish the practical parameters of services under the ARRC contract.

26. Any proposal to define contracted care services to a greater extent in legislation would bring too much inflexibility into the system, which would

undermine both funders' and providers' ability to respond to different service demands in future.

Cost of Contracted Care Services

27. The proposed changes are only necessary if non-subsidised residents are covered by the Act. We believe that the current definition in the Act is appropriate. We also support the proposed definition, in the event that Parliament proceeds with extending the proposal to cover non-subsidised residents.

28. Any proposal to alter the definition would need careful consideration. We believe any move by DHBs or the Ministry to move away from a definition that focuses on price and not cost is inappropriate. If the definition focused on price then there is potential for the funders to argue that they have filled their obligations, without ever having to address the issue of costs and contracted care services.

29. Recommendations:

    That the status quo remains in relation to the definition and intent of 'contracted care providers'.

    That the status quo remains in relation to the definition and intent of the 'cost contracted care providers'.

The unintended consequences of the Social Security (Long Term residential Care) Amendment Act 2004 relating to subsidies and License To Occupy (LTO) units.

30. HealthCare Provider's NZ believes the Bill provides an opportunity to clarify the law so an elderly person, who is means assessed as needing care, and means assessed as being able to receive a subsidy, can receive their subsidy while living in a License To Occupy (LTO) unit attached to a residential care facility or incorporated into a residential care facility.

31. Presently this is not the case. Following the implementation of the Social Security (Long Term residential Care) Amendment Act 2004, DHBs are interpreting the law in a manner which excludes elderly residents (who have been needs assessed as requiring long term care and means assessed as entitled to a subsidy) from receiving that subsidy in an LTO unit within a residential care facility.

32. We believe the Act was not intended to have this effect on the elderly. The ARRC clause change was:

No Other Benefit For Services

A14.1 To avoid doubt you must not be party to any other arrangement (for example, a licence-to-occupy or similar arrangement) that results in you effectively receiving payment, benefit, or value whether from us or any other Person, for the supply of the Services, or any component of them, to a Subsidised Resident, whether or not the arrangement was entered into before you commenced receiving payment under this Agreement in respect of that Subsidised Resident.

33. At the time provider representatives contested this change, as legal advice confirmed the legislation did not make this change necessary. However, DHBs forced this change on providers by withholding a funding increase until agreement was reached.

34. It also needs to be noted that this change is cost neutral for DHBs, i.e., there is no question that the elderly person is eligible for funding.

35. The DHB interpretation of the Act has lead, and is leading, to situations where elderly couples have to separate in order to access care they are entitled to. For example, in a recent case an elderly couple, married for 57 years, were told they would have to live in different parts of a residential care facility if the wife was to receive a subsidy. In this situation the wife was assessed as needing rest home level care, and means assessed at being eligible for a subsidy. Her husband however was not yet at a stage that he needed rest home level care.

36. In order to stay together they bought a LTO unit that was part of a rest home complex. The DHB told the couple that the wife could not receive a subsidy if she was in a LTO unit. However, she could receive the subsidy in another room in the same facility, i.e., the wife could move out of the unit, into a single room next door and the DHBs would pay the subsidy.

37. We believe the DHB interpretation of the Act is not what Parliament intended. In the Act, it appears the intention was not to preclude the elderly from holding an LTO in order to receive a subsidy. This is supported by the Act's wording of sub-clause 4(a) in the definitions in Part 2 of Schedule 27, which states that a resident's assessable assets include the value of the "right to be repaid on termination of an occupation license".

38. This clause suggests that the Act contemplates that an LTO can form part of a resident's assets when being assessed, and as such should have bearing other than the asset value on whether they require long-term subsidized residential care. To put parliament's intention beyond doubt it is necessary to draft an additional sub-section (5) for Section 141 such as:

(5) The funder's liability arising under subsection (2) is not affected by the fact that a person to whom this section applies, occupies or will occupy a dwelling or room within a rest home or hospital (as those terms are defined in the Retirement Villages Act 2003) pursuant to an

occupation right agreement (as also defined in that Act)."

39. We believe elderly couples should be supported by legislation and DHBs in aging together. It is entirely appropriate that the funding system is flexible enough to take into account the reality that couples do not age at the same pace or require continuing care at the same time. Allowing couples to receive care in an LTO unit achieves the best possible outcome for all parties concerned.

40. <u>Recommendation:</u>

    To clarify the law confirming that residents who have been needs assessed as requiring long term residential care and means assessed as being eligible for a subsidy are able to hold an LTO and receive their subsidy.

Section 141 relating to the "28 day rule".

41. Under section 141(4) of the Act a 28 day rule was created as set out below:

    141. Funder's liability in respect of persons whose assets are equal to or below applicable asset threshold—

    (4) If the person's assets are equal to or less than the applicable asset threshold more than 28 days before the date of means assessment that establishes that fact, the funder's liability arises on the date that is 28 days before the date of means assessment.

42. This rule sets an absolute limit on funders' liabilities relating to the date of a means assessment. The rationale behind this change was to encourage residents to return their paper work in a timely manner and to limit a DHB's liabilities, to stop the occasional large invoice following a late means assessed. Before section 141(4) came into force there was no time limit of this nature.

43. Over the course of the last 18 months, providers and residents have found the 28 day rule too short in many situations. For example, the family may be having difficulty dealing with the situation or complications could arise in preparing an application for means assessment. These complications can arise in sitations where a resident is unable to sign the document because of dementia and a court process has to be entered into or when issues arise surrounding determining appropriate powers of attorney.

44. Therefore, drawing on the experience of residents and providers we believe the 28 day rule should be extended to 90 days.

45. <u>Recommendation:</u>

    That section 141(4) et al, be amended from 28 days to 90 days.

Conclusion

46. Taking into consideration all the relevant information surrounding population growth and residential care utilisation, it is unlikely that the Government will be able to sustain current service delivery levels or funding levels in the aged residential care sector.

47. Therefore, it is imperative that the Select Committee give consideration to the question of whether it is appropriate to fix a price cap on private non -subsidised residents, considering the real and immediate need to develop flexible funding and pricing a model which can respond to the challenges of a diverse ageing population. The bill in its current form does not assist in address these challenges.

48. Healthcare Providers NZ looks forward to discussing these issues with the Select Committee.

Martin Taylor
Chief Executive
HealthCare Providers NZ