The New Zealand Aged Care Association's submission to TAS on the 2018/19 ARRC and ARHSS agreements

November 2017

New Zealand Aged Care Association

Introduction

1. This submission is from the New Zealand Aged Care Association (NZACA), the peak body for the aged residential care industry in New Zealand. With over 580 members, we represent over 90% of the approximately 38,000 beds of the country's aged residential care (ARC) industry. Our members range from the very small stand-alone care homes to the large co-located sites that include care services and retirement villages. Our members' services include rest home, hospital, dementia and psychogeriatric care, as well as short-term respite care and a small number of YPD beds.
2. Advocating and lobbying to government to shape policies and create an environment that helps our members provide outstanding quality care is at the heart of what we do. We provide leadership on issues that impact on the success of our members. We also produce valuable research, professional development opportunities, information and publications to help our members make informed business decisions, improve capability and keep them up to date with industry developments.
3. This submission on the 2018/2019 Aged Related Residential Care (ARRC) Services Agreement and the Aged Related Hospital Specialised Services (ARHSS) Agreement has been prepared following input from our members. This paper highlights the key issues that the NZACA would like to see addressed as we enter the upcoming negotiation process with District Health Boards (DHBs) and the Ministry of Health (MOH) on the ARRC Services Agreement and the ARHSS Agreement for 2018/2019.
4. We have a small team of six staff based in Wellington and led by Chief Executive, Simon Wallace, a representative Board of eleven directors chaired by Simon O'Dowd and a network of sixteen branches around New Zealand.
5. Any enquiries relating to this paper should in the first instance be referred to Alyson Kana, Senior Policy Analyst at alyson@nzaca.org.nz or by phone on 04 473 3159.

Comment

Pay equity

6. The pay increase received by care and support workers under the Care and Support Workers (Pay Equity) Settlement Act (the settlement) is supported by the NZACA and is well deserved by these workers. This is an area the Association has campaigned for over a number of years. However, the settlement needs to be fully funded.
7. There are a significant number of providers who are financially in deficit because of the settlement with a number of rest homes having closed, including some larger facilities. These closures are a direct result of a complex settlement that was implemented too quickly.
8. Not only are there providers who the NZACA has been working to get transitional funding for, there is an even larger group of providers for whom the cost impacts on their business

have been significant and they are expected to absorb these costs. This is not only affecting small providers but again larger providers as well, the result of which will be less capital in the industry for developments, improvements and renovations.

9. The settlement has also had a significant impact on the ARC industry and the environment within which providers operate. The implementation timeframe was too short and did not give providers time to adjust their businesses to the new environment that they are now operating within. This has resulted in a number of providers facing significant financial implications and we know that 100 providers have requested the tool from the MOH to assess their situation.

10. These issues are likely to be exacerbated further following the new Government's announcement of the statutory Minimum Wage progressively increasing to $20.00 per hour by April 2021. The Government will need to address these increases in Minimum Wage to ensure the sustainability of the ARC industry.

Funding

11. Initial reports following the 18 April 2017 announcement of the settlement said it would be fully funded but this has not been the case and is putting significant financial pressure on the industry. Many NZACA members are being forced to make staff redundant, cut back rosters or reduce care hours. For the 2018/19 year, the mechanism used to apportion the appropriated funding under the settlement needs to be reviewed. We welcome an early discussion on an alternative way of funding the settlement from 1 July 2018 and understand the MOH is working on this.

12. The MOH met the cost of up to four weeks' leave (160 hours) held by full-time equivalent (FTE) staff for balances held by employers prior to 30 June 2017 and paid to employers at the new legislated rates that were effective on 1 July 2017. Many employers in our membership have been left out-of-pocket as a result of a decision that does not take account of staff with leave greater than four weeks. Had there been more time before the implementation of the pay equity settlement, then employers could have actively managed these leave balances down.

13. Having been left out-of-pocket due to leave liability, our members are concerned as to how leave will be funded from 1 July 2018 and beyond as the pay rates continue to rise under the legislation.

Relativities

14. Throughout the pay equity talks we advised the then Government's negotiating team that there would be pay relativity issues with both nurses and housekeeping staff: nurses because a lift in caregiver pay rates would see them earning at or close to a nurse's pay, and housekeeping staff who would see caregiver rates lift well beyond the rates paid to cleaners, cooks and gardeners. The negotiating team ruled nurses and housekeeping staff out of scope of the settlement saying the original court case taken related only to caregiver roles.

15. As we said, the relativity issues are now beginning to surface and creating tension and unease in some aged care workplaces. Demands for pay rises from nurses, some as high as 19%, are now being made to some employers, demands that cannot be met. Housekeeping staff are also seeking pay rises. These relativity issues for other aged care workers are an issue that will need to be urgently addressed, especially as union demands gather pace.

Qualification equivalency

16. Compounding the sustainability issue has been a qualification equivalency process which maps individual qualifications held by employees to the New Zealand Certificate in Health and Wellbeing. This process has resulted in some staff previously on pay bands Level 0 or Level 2 due to their length of service with the employer now being transitioned to pay bands Level 3 or Level 4 due to their qualifications. The best example of this is internationally qualified nurses (IQNs) who are working as caregivers here in New Zealand. This qualification equivalency decision made by Careerforce (the industry training organisation for aged care) came after the funding had been locked in on 1 July 2017, meaning our members are faced with paying staff more but not being remunerated for this. The impact has been felt right across our membership, including smaller rest homes, those in rural areas, those run by welfare, trusts or religious-based organisations and some larger operators with multiple sites.
17. Under the legislation Careerforce is recognised as the relevant training industry organisation for making decisions on qualification equivalencies. The NZACA feels strongly that Careerforce should have been consulting with the industry when making these decisions. We are hearing from our members that many of the caregivers with qualifications deemed to be Level 3 or 4 equivalents do not have the experience or training to work at these levels.
18. Our Association has taken a number of actions to voice the impact this is having on our members and while this concern has seen high level meetings held with the MOH, the Tertiary Education Commission (TEC), the New Zealand Qualifications Authority (NZQA) and Careerforce, the qualification equivalency process continues, meaning that our members have no control over their costs as more staff are transitioned to Level 3 or 4 pay rates even though they may not be performing a Level 3 or Level 4 role.
19. The NZACA has sought and is now awaiting legal advice on a possible judicial review of the qualification equivalency process.

Dementia unit training standards

20. In 2017 a working group was set up to review the dementia unit standards in the ARRC contract and in light of training requirements, legislated following the pay equity settlement. The NZACA would like an update on the work of this group, particularly around monitoring the two training requirements. Also, the NZACA would like to know whether in the current environment it is appropriate for affected employees to meet both training requirements within 12 months.

General

21. Our members have raised concerns around the training requirements set out in the legislation and the impact these will have on the industry now and in the coming years. The model penalises care facilities that have trained and retained current staff. It provides the wrong incentive for hiring the right staff for a care facility. In the short period of implementation, there has been no way for providers to manage the balance of staff on pay band L0-4 to match the actual caregiver needs of the business.
22. Concerns have been raised from within the industry that over the next four years funding will not match the numbers of staff reaching higher qualifications. Our members will have to actively manage staff to reduce numbers at the higher qualification levels, an impact that will be felt by all providers.

Funding

23. Funding for the ARC industry needs to be tied to the Aged Care Price Index (ACPI), as opposed to the Consumer Price Index (CPI). The CPI is not an accurate reflection of the inflationary pressures on the ARC industry. The CPI measures the rate of price change in goods and services purchased by households. The aged residential care industry is a business industry and subject to business costs; measuring inflation in terms of changes in the price of goods and services purchased by households is not realistic for our industry. For this reason, Statistics NZ developed the ACPI with input from the 2010 Aged Residential Care Service Review and the NZACA. This superior indicator of cost inflation faced by the industry is updated quarterly by Statistics NZ.
24. In the year to June 2017, the ACPI rose 2.6%, which was higher than the CPI increase of 1.7%. It also exceeded the ARRC funding increase for 2017/18 of 1.8%. However, the cumulative effects of a succession of annual movements are more revealing of financial pressures on our members over time.
25. Figure 1 illustrates the cumulative effect of increases in the ACPI and CPI since the ACPI began in June 2010. The increase over June 2010 to June 2017 in the ACPI was 20.5%, nearly twice the cumulative increase in the CPI of 11.6%.

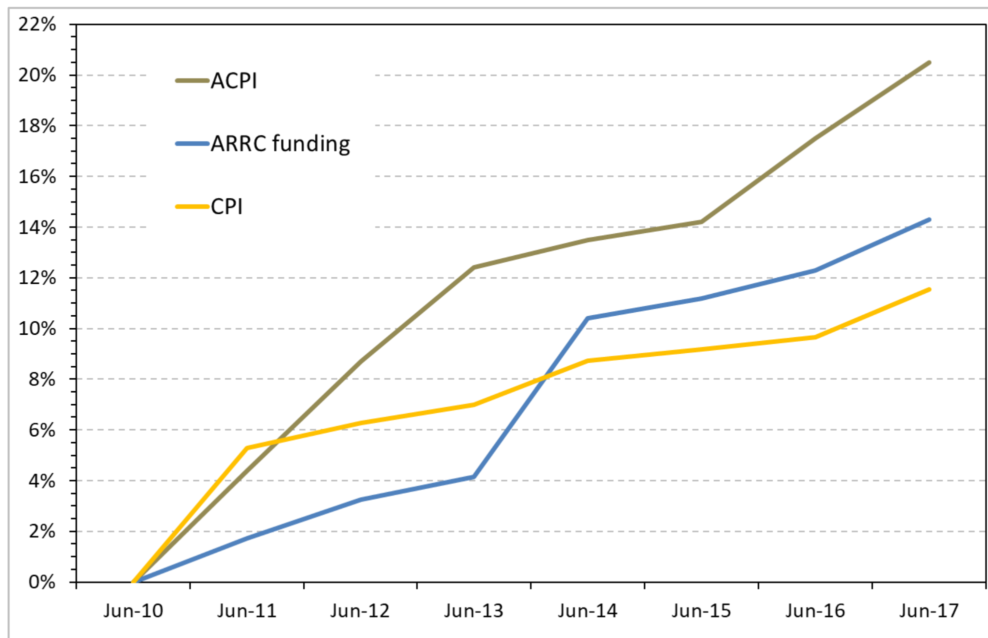

Figure 1: ARRC funding compared to ACPI and CPI – percentage increase since June 2010
Sources: The NZACA; Statistics New Zealand

26. Of more concern is how the increase in costs faced by the aged care industry over this period has outstripped the increase in funding. The cumulative increase in ARRC over the seven years to June 2017 was 14.3%, well below the increase of 20.5% in the ACPI over this same period.

Other points

- The industry continues to support increased numbers of residents with additional care needs than what the current funding provides for, such as palliative, end-of-life and bariatric care. The industry requires funding to allow them to fully support these residents.
- For example, palliative and end-of-life care have higher costs due to acute clinical needs and very short lengths of stay. Palliative funding for the ARC industry needs to be similar to that received by hospices. Our members provide the same care.
- The industry also requires equitable funding for short-term contracts, such as respite and day care services, across all DHBs.
- As noted above, the industry is facing significant cost pressures in relativities as a result of the pay equity settlement. The industry needs acknowledgement for an event that was outside of its control.
- Also noted has been the cost implication of the new Government's announcement that the Minimum Wage would increase to $16.50 per hour in April 2018 and then to $20.00 per hour by April 2021 and the impact this will have on our industry. Not only will this rise in the Minimum Wage impact the pay equity legislated pay rates but also other occupations, such as kitchen hand, cleaning and laundry staff, that are paid close to the current Minimum Wage. The industry needs to be to receiving funding that will address these impacts to remain sustainable.

Premium charging

27. Given the new environment within which members are now operating we would like to see the rules around premium charging removed. Our members are now facing significant costs, and although the ARC funding review is said to address the funding issues around pay equity, these changes are unlikely to come in for the 2018/19 year. Here and now our members need the premium charging rules in the ARRC agreement removed so they can stay in business.

Palliative and end-of-life care

28. Palliative and end-of-life care continues to be an issue at the top of our members' minds. The NZACA accepts that the ARC funding model review will specifically look at palliative and end-of-life care, however, the acute clinical needs and short lengths of stay compared to pre-2000 when the ARRC agreements and funding mechanisms were introduced don't reflect the situation providers are dealing with in 2018 and it is unlikely to change.

29. There is clear evidence to show that more people will be dying each year, and people will be dying at older ages with increased presence of frailty and comorbidities including dementia. Recent projections[1] estimate that in the next 20 years the number of deaths in New Zealand is projected to increase by almost 50%, from the current rate of around 30,000 per annum to 45,000 per annum in 2038 and to 55,500 by 2068. In 20 years, over half of those deaths will be in the age group 85 years and over. Deaths at the oldest ages will be predominantly women. Based on historic patterns of place of death, the need for palliative care is projected to increase between 2016 and 2038 by 37.5% in public hospitals, 84.2% in aged residential care and 51.8% under hospice care (including those under hospice services in aged residential care and in the community).

30. The 2017 Adult Palliative Care Review[2] shows the need for national standards. However, such standards cannot be imposed on the industry without the commensurate increase in support and funding. We believe there is currently an inequity of funding between hospice and ARC given the number of New Zealanders dying in our care facilities.

Primary care costs

31. Primary care costs and availability are unsustainable for the ARC industry. Our members note that costs of primary care services include $250 for signing a death certificate, $15 for a Medi-Map script, and $150 to $240 for a new admission. Our industry cannot sustain these costs associated with the care of residents on a fixed weekly fee.

32. The provision of services under Clause D.16.5 e. puts a huge cost burden on providers. Unless there is a realistic increase in the day rate to cover these services, then we seek removal of some costs that are accrued to providers under this clause.

[1] Professor. Heather McLeod, 2016.
[2] Ministry of Health. (2017). *Review of Adult Palliative Care Services in New Zealand*. Wellington, New Zealand: Author.

33. Additionally, the ARC agreement requires each new resident to be examined by a GP or nurse practitioner within two working days of admission (Clause D16.5 e.i.1). The majority of care facilities do not have their own GP or the ability to determine when the GP is able to examine a new resident. We believe the ARRC agreement should be amended to ensure providers 'make their best efforts to ensure' a new resident is examined by a GP or nurse practitioner within two working days of admission.

34. Also, those who reside in an ARC facility need to have access to the same government subsidies as those in the community. There is no reason why residents who reside in ARC facilities and receive primary care services should not be eligible for government subsidies alongside their peers who reside in the community. The NZACA would like to see older New Zealanders who reside in care facilities be given the same access to GP subsidies as those in the community.

Dementia

Dementia unit certifications

35. There has been a considerable amount of feedback from NZACA members concerning individual DHB autonomy around the certification of dementia units which creates inconsistency in decision-making from one region to another. Rest home and hospital level care are subject to the Health and Disability Sector Standards (HDSS), whereas dementia units are required to "satisfy the DHB". This practice is illogical given the HDSS apply to all levels of care and are audited by designated audited agencies accordingly. The NZACA would like to see the removal of such unilateral decision-making by individual DHBs on dementia units, and responsibility placed with a single agency.

InterRAI

36. InterRAI, having been mandatory in our industry for nearly two and a half years, is becoming embedded in members' care facilities and their practices. The NZACA continues to work with interRAI New Zealand on improving the interRAI experience for our members.

37. Our members want to see a nationally consistent approach to the applications of interRAI assessments. People requiring residential care in the far north should have the same care requirements when entering a residential care facility as those in the deep south, and everywhere in between.

38. Our members have reported that there continues to be inconsistency across the DHBs regarding assessments and their individual approaches to potential changes in levels of care. The time it takes to review an application for change in level of care varies from one day through to several months in some exceptional cases. Average times across each DHB vary. It is essential that all ARC residents receive the same levels of care and the same access to changing levels of care regardless of where in New Zealand they live. Our members need DHBs to commit to a timeframe within which reassessments are confirmed.

Compliance creep

39. The enactment of relatively new legislation like the Fire and Emergency New Zealand Act (2017) and the Food Act (2014) continue to add significant increases in costs of compliance, for example, the increase in the fire levy for all commercial buildings and registration and audit costs with local councils required for the Food Act. These requirements are compounding some already onerous obligations that we call compliance creep.

Ambulance

40. The NZACA welcomes the introduction of the ambulance fund established this year. It has been brought to our attention by some members that the threshold for eligibility may exclude some care facilities in rural areas. We recommend the fund be reviewed in March to understand the take-up and determine if the threshold is too high.

Bariatric

41. The industry welcomes the sharing principles on bariatric equipment but as with ambulance, there needs to be a review in March to see how the principles are working.

YPD contracts

42. We were pleased to see that the funding for YPD contracts for 2017/18 was aligned to 1 July and we would like to see this continue in 2018/19 and beyond. We also understand the MOH continues to explore the alignment of the YPD contracts to 1 July each year alongside the ARRC and ARHSS agreements. The NZACA would like to see this work progress completed in time for the 2018/19 year and commencement date of 1 July 2018.
43. Members have told us that the YPD hospital rate should be aligned to the ARC hospital rate as such residents are high need.

Technology

44. There has been little or no progress in this area and while our members continue to embrace interRAI which has been a major culture change for the industry, we continue to have to deal with archaic paper based systems, for example, those used by HealthPAC.
45. We know that the health sector as a whole is rapidly moving to ever more online systems. It cannot be denied that online systems regularly save costs to DHBs and MOH, as routine procedures become streamlined, for example, electronic dispensing will provide cost savings to Pharmac. Many of our members have a desire to take on more technology, however, this can come at a cost, particularly regarding investment in computers and software. We believe that by incentivising our members to continue to make these investments, there will be more efficiency across the industry, both in terms of time and money.
46. New electronic systems within the New Zealand healthcare structure need to be developed to include ARC providers. Currently, electronic links are frequently established between

secondary providers and the medical centres, but these do not include ARC facilities. As an example, Advanced Care Plans for residents and general public need to be accessed by all health professionals who are engaged in that individual's care and the access must be timely. It is essential that these can be accessed by the correct people as and when needed. If there is any move to develop a system to access these electronically, ARC providers need to be involved in the conversation.

Electronic signatures

47. With the advancement of technology and the increasing use of electronic records, electronic forms of signing clinical records should be recognised and accepted. Clauses D7 and D8 need to reflect the practice of allowing electronic signatures on clinical records.

A23 threshold

48. Given the cost impressions being faced by our members and the industry in this new environment, it is time to review clause A23 and the 1.5% threshold.

Temporary absences

49. Currently under clause A7.1 b. temporary absences from a care facility for a resident to be with family/whanau or friends are funded for up to 28 days in any financial year. Where a family/whanau or friends of a resident can be supported by the care facility to care for the resident the NZACA would like to see allowance in the ARRC agreement for a total of more than 28 days in any one financial year. For example, should a family/whanau wish to have their father at home every Saturday night and the care facility is confident the environment is safe for this to happen, then there should be the ability for this to occur. This could be on a case-by-case basis and in agreement with the funding DHB.

ARRC agreements for a new care facility

50. We would like to see a streamlined process and agreed timeframe put in place within which newly built ARC facilities receive an ARRC agreement. This is an area that needs improvement as currently there is no specific process. Once a care facility has a provisional audit it is said to take four to six weeks for the application for a new care facility to be signed off by the DHB. However, in practice this is not occurring and it can be several months before the contract is received.

Speech language therapists

51. There needs to be consistency across all DHBs in terms of the provision of speech language therapists. Speech language therapists should be specifically identified as completing specialised assessments that are not currently included in the services provided.

Concluding remarks

52. There may well be other issues not canvassed here that arise in the meantime and if they are significant we reserve the right to bring these to the table at the ARC Steering Group before the conclusion of next year's negotiation.

End.