The New Zealand Aged Care Association's submission to TAS on the 2019/20 ARRC and ARHSS agreements

October 2018

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. 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 2019/2020 Age-Related Residential Care (ARRC) Services Agreement and the Age-Related Hospital Specialised Services (ARHSS) Agreement has been prepared following input from our members. This paper highlights the key issues 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 2019/2020.

4. We have a small team of five 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 seventeen 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

Registered nurse workforce

6. The exodus of registered nurses (RNs) from the ARC industry is having and will continue to have a detrimental effect of the workforce and the care the industry is able to provide unless something is done to enable providers to recruit and retain RNs in our industry.

7. We acknowledge that there are ongoing discussions between DHBs, MOH and providers, however, the pace at which these discussions are occurring is not helping to reduce the impact of RNs exiting the industry.

8. There are two main factors in the number of RNs leaving the ARC industry and providers being able to recruit and retain RNs. First, the lack of better conditions, including pay,

compared to nurses working in other sectors. Second, immigration policy settlings that impact internationally qualified nurses (IQNs).

9. The increase in RNs exiting the ARC industry to work in other areas of the profession has been exacerbated by the settlement of the DHB/NZNO Multi Employer Collective Agreement (MECA) in August. This settlement includes conditions and pay rates that the majority of ARC providers cannot match and thus encourages RNs to leave the ARC industry in search of better conditions in a DHB environment.

10. Second, immigration settings that came into force in February 2017, which moved RNs from the Long Term Skill Shortage List (LTSSL) to the Immediate Skill Shortage List (ISSL), resulted in IQNs no longer having a pathway to residency. This change has left IQNs with feelings of insecurity and undervaluation of their role and ability to create a life in New Zealand.

11. This issue faced by the ARC industry over the RN workforce needs to be addressed immediately before there are long-term impacts that the industry could take years to recover from.

Funding

12. 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.

13. 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.

14. 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. Palliative care funding should follow the resident when discharged from the hospice to an ARC facility.

15. The industry also requires equitable funding for short-term contracts, such as respite and day care services, across all DHBs.

16. 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 and audit costs with local councils required for the Food Act. These requirements are compounding some already onerous obligations that we call compliance creep.

A23 clarification

17. The NZACA seeks clarification on the thresholds under clause A23 of the contract that now apply to support a claim from the industry.

Alternative uses for the NEAT fund

18. Referring to the 1 August 2018 minutes of the Joint ARC Steering Group, we would like to raise our support to three options for alternative uses of the NEAT fund.

19. The fund to be used to:

    a. Support those who require frequent trips for specialist treatments.
    b. Backfill interRAI training costs.
    c. Support graduate nurses entering into ARC.

Fire levies

20. The Department of Internal Affairs (DIA) is beginning work to review the Fire and Emergency New Zealand (FENZ) levies and has sought feedback on the potential impacts for stand-alone rest homes and retirement villages with care facilities attached. Our objective will be to maintain the status quo or at best limit the impacts, meaning that our levies are calculated based on residential rather than commercial property. However, any increases will have an overall impact on ever increasing compliance costs for our members.

Care cost generated outside of the control of ARC providers

21. ARC providers are contracted and funded to provide services to their residents for age-related care. They should not be expected to fund DHB generated care costs. Prescribed treatment and management generated at the time of an acute DHB admission should not become the financial responsibility of an ARC provider. This is beyond what they are funded to provide. For example, a care facility accepts a person with renal failure requiring dialysis three times a week. The facility supplies an escort, ambulance transfer and more. These costs are potentially greater than the total subsidy the care facility receives for that person. Other examples include residents requiring chemotherapy, other oncology services and post op follow up appointments.

Premium charging

22. In relation of clause A13.5, there is significant risk to the industry in the ability for residents to cease taking a premium room. There is significant commercial risk in this clause. If every resident receiving a premium room chose at the same time to go to a standard room then all premium charges could go, resulting in the risk to the provider and also the industry. If increasing numbers of residents cease to pay premium charges this poses threat to the ability of the provider. This could result in a loss of supply in the industry at a time when demand is set to increase.

Primary care accessibility

23. ARC providers, particularly those in more rural areas, are experiencing increasing difficulty in getting general practitioners (GPs) to support the care needs of their residents. The issue relates to accessibility to local GPs and GPs unwilling to do after hours or weekend work.

ARC is a 24/7 service that requires support from GPs over this entire period not just business hours on Monday to Friday. Clinical staff at ARC facilities need to have the appropriate access to a GP at all times to ensure the safety of the residents in their care and also safe clinical practice.

24. We would like to see the scope in the contracts for ARC providers to use nurse practitioners (NP) when a GP is unavailable or one cannot be found to provide the necessary services in ARC.

Monitoring of dementia units under Optional Protocol to the Convention Against Torture (OPCAT)

25. On 6 June 2018, Justice Minister Andrew Little gazetted new responsibilities for the Chief Ombudsman in monitoring and inspecting the treatment of people detained in privately run aged care facilities, known as dementia unit.

26. This is an extension to the Chief Ombudsman's OPCAT mandate to ensure decent and humane treatment of people held in detention. It addresses New Zealand's international obligations to have independent inspections.

27. While we have been assured by the Chief Ombudsman that the cost of the inspections will be funded by Parliament, we are concerned about the operational impact of the inspections and the cost of implementing any recommendations.

28. An experienced OPCAT team would carry out inspections, which we have been told would compose of five or six members. This size of team is bigger than the auditing teams that carry out our current contract audits and we are concerned the size of the team will have an impact on the operation of the business.

29. In his reports on the inspections to Parliament and the United Nations, the Chief Ombudsman will highlight good practice, identify areas for improvement and make recommendations. If recommendations are made, where a cost is involved, who will pay for the change? If providers are to cover the cost this is another example of cost burden being passed to providers for factors that are beyond our control.

Enduring Powers of Attorney (EPOA)

30. Given the increased acuity of residents, providers are increasingly encouraging potential residents to look at having an EPOA in place. Also, with OPCAT now being administered by the Office of the Ombudsman, it is becoming more important for residents to either have an EPOA or court order regarding where they reside.

31. The DHBs through their Needs Assessment Co-ordinator Service (NASC) should have responsibility to ensure residents understand the role of an EPOA and encourage them to put one in place. In the case where an individual is deemed to be mentally incapable and an EPOA is enacted, it should be the responsibility of the NASC to ensure someone has the authority to consent to them residing at the provider's facility and care. There is inconsistent practice amongst DHBs. Providers are not resourced nor funded to take on this responsibility.

32. Also, funders are refusing to pay increased levels of care if there is no legal representative. This is putting legal certainty regarding consent before care.

Pharmacy

33. Changes have been made to the community pharmacy contract (known as the Integrated Community Pharmacy Services Agreement, ICPSA) during 2018 that can have a significant impact on ARC providers and the services they receive from pharmacies. Under ICPSA services provided to ARC providers are subject to local commissioning. This means each DHB can limit the number of pharmacies within their DHB region that can supply pharmaceutical services to ARC providers. Under the previous community pharmacy contract all pharmacies could supply services to ARC providers.

34. The three Auckland Metro DHBs are currently consulting on an Enhanced Residential Care Pharmacy Services plan that would see the current 128 pharmacies that supply services to ARC providers reduced to 10 pharmacies. Feedback from members in these DHBs tell us they have no issue with their pharmaceutical services and they wonder why such a change is proposed.

35. We would not like to see a system change that is working effectively for the two main parties involved (ARC providers and their residents and pharmacies) for the sake of change. The proposed change has a potential to have a significant impact on the current relationships between ARC providers and their pharmacies, reduce service coverage and bring in postcode health.

36. Service change needs to go through a proper process and only change if there is a need for change. We are yet to see the proof that the proposed change is necessary.

End of Life Choice Bill

37. Our Association has made both a written submission and oral statement to the Justice Select Committee strongly opposing the End of Life Choice Bill. Assisted dying goes against the values and existence of our services.

38. If the End of Life Choice Bill is legislated the NZACA will be seeking an exemption for rest homes from this law. We will also need to look at the obligations of providers and their staff in relation to the ARRC Services Agreement and the implications on the industry.

Repayments

39. In relation to clause A6A, where liability to pay is linked to subsidised residents there is a gap where the DHB sends a resident that to ARC lacks capacity and has no EPOA or court orders. In this case there can be a delay in obtaining a subsidy. This should not be at the risk of the provider. Where a resident lacks capacity the DHB should be responsible for getting court orders and should apply for the subsidy.

InterRAI

40. We would like to see a two-week grace period for the completion of the initial interRAI assessment be included in the contract. Currently, there are no exceptions in the contract

and audits of care facility's interRAI can result in findings and corrective actions. This results in a significant amount of additional work for a care facility which may already be under pressure to maintain currency.

41. As a general comment, a change in the way interRAI assessments are completed could reduce the burden of the initial assessment on ARC providers. Veronique Boscart who presented on 'The international context of interRAI to deliver quality aged care: Big ideas for strengthening care in New Zealand' in relation to Canada at the NZACA conference this year, noted in Canada the majority of the interRAI work is completed by a public health assessor before the resident enters the residential care setting, meaning that the interRAI work completed by the residential care facility initially is minimal. Our present system is the opposite and becoming ever increasingly costly.

General comments

42. ARC providers should receive the Winter Energy Subsidy Payment for all those over 65 as the providers who pay the power bills on behalf of the resident.

43. Further comments on contractual issues are attached in appendix 1.

Concluding remarks

44. 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.

Appendix 1: Contractual issues

Ref	Issue	Comment	Solution
A2.2	We must use our best endeavours to provide the Services. Providers are not funded to a level of providing best endeavours services. It would be good to understand from the MOH what they expect in the context of a best endeavours service. This obligation also requires us to provide a best endeavours service that meets and strategy/standards that are developed by the MOH. Consider if a strategy change would require an agreement change.	A best endeavours obligation is unreasonable. ''Best Endeavours'' An obligation to use your "best endeavours" is much more onerous than to use your "reasonable endeavours". While this is not an absolute requirement to do absolutely everything possible, it has been found that such an obligation is quite burdensome and may mean that the party contracting to use best endeavours may have to undertake everything practicably possible to fulfil its obligations even if this involves taking steps which incur financial loss (even significant loss) on their part. However, it is important to keep in mind that the difference between incurring financial loss and having no regard for your own financial interest is quite pronounced.	Change to reasonable endeavours. To the extent that any strategy review changes the way the Providers are required to perform the services, then this should require the parties to negotiate changes to the ARRC in good faith, especially if the standard/strategy change would have a financial impact, i.e. staffing levels. This would mean that a party is generally not required to take actions that might prejudice them unless they have specifically contracted to do so. Rather than requiring a party to take every possible action, "reasonable endeavours" requires that party to take actions a reasonable person would do in the same circumstances. While a party can be expected to have an "honest try" at achieving the desired outcome, they would not usually be expected to perform tasks that may be to their detriment.
A5A.1&2	DHBs have the ability to provide prospective residents with information about provider's that they consider may influence their choice.	This is very broad and there is no obligation to provide this information to us in advance for comment/correction.	Any information is first provided to the provider and there is a right of correction/comment

Ref	Issue	Comment	Solution
A9.2	Repayment of overpayments.	We must notify DHB immediately (should be promptly). Repayment to resident is due the later of ten working days after notification and the day before the DHB is due to pay us the next payment. Clause D13.3db states this is 20 working days. Inconsistent.	Notify DHB promptly and 20 working days to pay.
A11.1	DHBs have ability to withhold all or some of payments for various breaches.	This right is not linked to the loss the DHB suffered. This seems more like a penalty and stick to get things done.	Ability to withhold should be linked to damage caused, subject to a cap.
A11.2	DHBs can withhold five percent for material breaches.	Again, this is not linked to the loss suffered and may be excessive.	Ability to withhold should be linked to damage caused, subject to a cap.
A16.5	DHB may advise family about audit where they have serious concerns about health and safety of resident.	Wouldn't the DHB need to comply with Health Information Code.	They would need to comply with all laws.
A22.1	Ability to withhold payment for breach.	DHB can withhold payment and take action to remedy breach. Provider must pay DHBs costs of remedying breach. This is a very broad right.	Clarify what would constitute an urgent action to protect the health and safety of residents. This should be a serious risk to the health and safety. Amount withheld should be linked to loss and subject to a cap.
A22.2	Right to appoint temporary manager.	Linked to circumstances in A22.1. This is a broad right with indemnity for claims and costs.	Should there be some notice period and link to serious risk to health and safety.

Ref	Issue	Comment	Solution
A24.1	Termination for material breach.	This is an immediate right with no remedy period.	There should be a remedy period. Also what constitutes a material breach should be better defined. DHBs have made comments regarding material breaches by providers, which shows the lack of understanding and clarify regarding a material breach.
A24.8	Ability to terminate on 12 weeks' notice.	This is too short for termination for convenience.	Longer notice period, potentially with DHB having longer period than provider.
A25.1	DHB won't continue to pay if we don't inform residents of termination and don't facilitate departure as soon as possible.	The departure of the resident is provided they have somewhere to go.	There needs to be an acknowledgement that the DHB has a role to play in placing the resident somewhere else. Obligation to pay should not be linked to informing them and having them depart as soon as possible.
A28	Indemnity for breach.	This is unduly onerous. The contractual measure of damages should be sufficient. With duty to mitigate, etc. should apply.	Delete.
C3.1	Amount of Residential Care Subsidy	The formula calculates the payment as the amount of the maximum daily price less the amount the resident must pay. There is no clause which states that the resident must pay their amount. This links back to A13.1.	Insert clear right to charge resident for the amount they must pay under this calculation.
D2.1	Access	We must arrange or facilitate a resident to obtain services from another person. This is potentially an onerous obligation as we cannot actually arrange them in all cases and this imposes an	Change to reasonable endeavour obligation as this will be outside our control.

Ref	Issue	Comment	Solution
		absolute obligation to have the resident receive the service they are supposed to have access to.	
D.3	Requirements for provision of service	These are absolute requirements. However, many of them are aspirational or not always possible to comply with. This means they can be somewhat meaningless but do provide unnecessary potential contractual breaches. For example, the services must: • Actively encourage residents to maximise their potential for self-help and involvement in the wider community – it is unclear what this means nor what is required to maximise these things. How would this work for psychogeriatric or severe dementia? • Ensure a culturally appropriate service – while we may meet the needs of some cultures it will not always be possible to meet the needs of all cultures • Needs to maximise health potential – I'm not sure what this means nor if we can actually do this.	Amend service philosophy to align with realistic requirement of services and what providers are funded for.
D5.3	Form of philosophy	This must meet the communication needs and capabilities of prospective residents, their family/whanau, any service that refers a prospective client or persons engaged in the provision of the services.	Delete

Ref	Issue	Comment	Solution
		It is unclear what this requires or why it is necessary.	
D8.1	GP records	This must be signed and dated by the GP. With a move to digital records need to sign and date not achievable.	Amend to allow electronic records without need to sign.
D9.1	Handover report	Obligation to have status report for each resident on handover based on that resident's care plan. It is hard to believe that this is possible for every resident at each handover. This is more likely to be a general status that is available in records. Handover would deal with immediate issues.	Amend to reflect what happens in reality.
D12.3	Obligation to advise of non-subsidised resident of eligibility to become subsidised.	Providers will only know that if they know of the financial circumstance of residents. This is not practical.	Delete.
D12	Notify of subsidy requirements	There are obligations here on the provider to notify residents of subsidy requirements. Surely NASC does this. This adds unnecessary information to the admission process. This seems unnecessary duplication.	Delete
D13.1	Residents or their nominated representatives must sign admission agreement	If resident doesn't have capacity and has no representatives this is not possible. Also, some do not sign. Providers cannot force anyone to sign an	Obligation to provide or DHBs should only send prospective residents that have legal representatives.

Ref	Issue	Comment	Solution
		admission agreement. If they don't sign should they be discharged to the DHB?	
D13.3	Information in admission agreement	Several elements are either not practical or are not necessary. This impacts readability of admission agreement. • Rights to review of means test • List of items excluded. This adds to length of agreement • Itemised additional services – not practical and they change • Provisions relating to staffing and fire protection, etc. are meaningless • Obligation to have right to pass on information for audits – is this necessary? • Transport policies	Adjust to reflect things that are meaningful to residents and assist with simple and easy to comprehend agreements. There is a mountain of paper residents receive on admission. This should be streamlined for understanding.
D14.2	Obligation to ensure access for residents to excluded services	For some of these this doesn't make sense, i.e. insurance. For others, ability to ensure access is beyond a providers control, i.e. specialist assessment.	Delete
D15.1	Building must meet needs of residents	This is part of the accreditation process. This is unnecessary.	Delete
D15.2	Accommodation requirements	Garden and outside area are part of accreditation.	Delete
D16.1Abii	Additional services	Covered elsewhere	Delete

Ref	Issue	Comment	Solution
D16.3i	RN to ensure care plan meets needs	This includes spiritual and cultural abilities. Unclear how RN knows how to meet these.	Delete
D16.5d	Activities programme to include community.	This is an absolute requirement, but not always possible.	Delete
D16.5e	Provider must contract one or more GPs	They are not always available and will become more scare. This should not be an absolute obligation.	Change to reflect reality
D16.5iv	Resident to pay cost over what provider pays its GP.	If no GP available, what is the provider funded for?	Include cap of what providers must pay up to.
D16.5evi	Must provide access to specialist services	This is beyond the control of the provider. How do they provide access to specialist services that they don't provide but the DHB does?	Delete.
D17.3b	Must meet staffing needs determined by RN	Funded to level of NZ standard. Unclear if this requires high staffing levels. This is difficult given recruitment issues and RN leaving for DHBs.	Delete
D18.2	Pharmaceuticals	Clarify that only obliged to provide subsidised pharmaceuticals. The recent Auckland area Pharmaceutical review potentially cuts across the ARRC requirements. Any particular DHB requirements need to be consistent with ARRC requirements, service specifications and what providers are funded for.	Any DHB changes need to be reflected to ARRC and funding model.

Ref	Issue	Comment	Solution
D18.3	Complex dressing cost	This is unnecessarily complicated and administratively burdensome. Also, no link to staff costs.	Simplify
D20	Provider must ensure access to other services	Provider does not provide these services and therefore has no control over whether they can be accessed.	