The New Zealand Aged Care Association's submission to TAS on the 2020/21 ARRC and ARHSS agreements

15 November 2019

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 39,000 plus beds in 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 around 700 Young Persons with Disabilities (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. We also encourage and recognise industry excellence and innovation through our annual awards programme.

3. This submission on the 2020/2021 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 2020/2021. Many of the issues we raise again this year are the same and remain because of their importance to our membership.

4. We have a small team of six staff based in Wellington and led by Chief Executive, Simon Wallace, a representative Board of 11 directors chaired by Simon O'Dowd and a network of 17 branches around New Zealand. Any enquiries relating to this paper should in the first instance be referred to Simon Wallace, Chief Executive at simon@nzaca.org.nz or by phone to 04 473 3159.

Comment

Annual price

5. The NZACA supports the process that was used in the 2019/20 negotiations in determining the annual price increase. This process involved the Association, the DHBs and the MOH convening a technical panel to model and agree on cost pressures affecting the industry across a range of measures. In all our advocacy and policy work we like to bring an evidence-based approach that is supported with robust data and insight. We would like to see this process used again for the 2020/21 negotiation.

Registered nurses

6. As it has been for the past 12 months, the shortage of registered nurses (RNs) in the ARC workforce is of paramount concern. A change to immigration policy settings, with aged care nurses now on the Long-Term Skills Shortage List (LTSSL), has helped stem losses and assisted recruitment but shortages remain as the supply of New Zealand based graduates and nurses does not keep up with the demands of an increasing ageing population in New Zealand. Indeed, more than 50% of nurses working in ARC are internationally qualified nurses (IQNs).

7. As part of the preparation work for the negotiation of the immigration sector agreements between the Government and the aged care industry, the NZACA has prepared interim estimates and projections of the nursing workforce which shows a current shortage of around 800-900 RNs. Our work has also looked at the demand for, and supply of, ARC RNs out to 2028. We estimate that in 2028 around 6,500 RNs will be needed to work in ARC but if current supply trends continue, we will have around 4,600. Just as we have with MBIE, the Association would be happy to share this information with the DHBs and the MOH to better inform the work of the ARC Steering Group.

8. While there are several factors influencing RN shortages in ARC, our surveys repeatedly tell us that better pay in a public hospital is the single biggest challenge our members face in trying to retain their RNs. Certainly, there have been a few providers who in the past 12 months have increased their wages for RNs to rates at or near those being offered by DHBs which is a welcome move, but funding pressures prevent most providers from being able to do this.

General Practice (GP) accessibility and costs

9. There is a slow but welcome increase in the use of nurse practitioners (NPs) by ARC providers, however, it has not been enough to always meet the service obligations of rest homes. This challenge is accentuated in rural areas where the accessibility of GPs remains a challenge. While there has been work going on in the past 12 months by the ARC/primary care working group, it has made little progress and there has been no measurable difference in GP services to ARC.

10. The matter of GP costs also remains outstanding. From 1 December 2018, the Government announced lower cost GP visits for Community Service Card (CSC) holders which includes residents in ARC. Given the cost of access for this important patient group has decreased, NZACA members could reasonably have expected GPs to renegotiate their agreements taking this increased funding into account and pass on reductions to providers. We know that a directive was issued by the Southern DHB and WellSouth for GPs in their region to pass on the savings to ARC, and this is happening in some other areas, but it is by no means the norm. The matter needs to be fixed for this year's negotiation with a directive issued by all DHBs and PHOs that reductions must be passed on to ARC providers.

Young people with disabilities (YPD)

11. There are around 700 younger people with disabilities (YPD) living and being cared for in ARC facilities. Many of these residents have acute conditions that require an intensive level of care. The YPD bed day rate paid to ARC providers is less than the bed day rate for residents our members care for under the ARRC agreement, a situation that has existed for many years. By way of example, the hospital level rate for ARC in the Wairarapa DHB region is $218.38 per day, compared to $210.98 for a YPD client. In the Mid Central DHB region, the rest home level rate for ARC is $135.95 per day compared to $130.95 per day for YPD, while the hospital rate in Mid Central is $218.03 for ARC and $210.98 for a YPD client. Disparities such as these exist all around the country.

12. ARC providers must pay their care staff in accordance with Pay Equity legislation. These staff are not paid any less in caring for YPD clients, but providers themselves are paid less. The DHBs continuously pass responsibility for this inequity to the MOH who they say is responsible for YPD contracts through Disability Support Services (DSS), a unit of the Ministry. In short, the issue is dismissed by the DHBs on the basis that YPD is a DSS matter. Meantime, our members are left 'carrying the can' and absorbing the cost which is collectively estimated at around $1.5 million per annum. The NZACA has raised this matter several times with the MOH without success and has recently brought the matter to the attention of both the Associate Minister of Health and the Director-General of Health. We would like DHB support to assist our lobby on this matter and correct a long overdue anomaly.

Premium charging

13. The DHBs have already flagged that greater transparency for so-called 'premium charging' would be an issue for this year's negotiation after it was excluded last year. Furthermore, DHBs have said they will require the publication of so-called 'median' charges by all ARC providers with the intent that publication of information about premium charging will come into effect from 1 July 2020. The NZACA has agreed it will engage with the DHBs on this matter.

14. In a related issue, the Association will again place on the table clause A13.5 concerning the ability of residents to opt out of paying an accommodation supplement on a premium room after five months. The concerns around this opt-out clause are the same as they were last year - if every resident paying an accommodation supplement chose to opt-out, then fewer such supplements would be paid, posing a real threat to the financial sustainability of almost every ARC provider in the country. The NZACA would like to see the opt-out clause removed.

Rurality adjustor

15. The financial sustainability of our members in rural and remote areas of the country is particularly challenging and is a matter that has been discussed previously around the table of the ARC Steering Group. The matter has been included as a primary recommendation in

the Funding Model Review (FMR), but given how critical this is for our rural members we would like to see the rurality adjustor (if that is what it is to be called), as a 'quick win' from the FMR and introduced from 1 July 2020.

Respite and other short-term contracts

16. For some time now, DHBs have been paying respite and other short-term contract rates at lower prices than ARRC agreement bed day rates with a great deal of inconsistency between one DHB region and another, and without good reason. This is an equity issue that effectively places less value on the care of short term and respite residents compared to long term care residents. The NZACA would like to see a nationally consistent approach to the funding of respite and short-term contracts.

OPCAT, dementia unit monitoring and the Ombudsman

17. The Office of the Chief Ombudsman has started his function to monitor secure dementia units under the Optional Protocol to the Convention Against Torture (OPCAT) with orientation visits now occurring throughout the country. The full and formal inspection regime will start on 1 July 2021. In total, the Ombudsman has been allocated $29 million over four years to undertake this role.

18. The concerns that we expressed last year are yet to be addressed and include not only the duplication of this function with the role carried out by HealthCERT and the operational impact and disruption for staff and residents, but also recommendations made by the Ombudsman that may impose cost burdens onto providers. On this last point, the suggestion made by Ombudsman staff that such recommendations could be used by our membership as leverage for funding is somewhat naïve.

Health and disability sector standards

19. The NZACA raised this matter at the ARC Steering Group meeting in October. We are concerned the aspirational goals of this work, as well as being difficult to achieve, could result in yet more compliance for the membership. The Association's clinical advisor is representing the membership on this work, but we will be pushing back on what is being proposed and we are raising this issue with both the Minister and Associate Minister of Health.

Care costs generated outside the control of providers

20. This matter has been on the ARC Steering Group table for some time and has been discussed at length in meetings over the past 12 months. Our members are funded to provide services to their residents for age-related care, but 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.

21. Last year we provided an example of an ARC facility accepting a person with renal failure requiring dialysis three times a week. That facility supplies an escort, ambulance transfer and more with the costs of doing this greater than the total subsidy the care facility receives

for that person. Other examples include residents requiring chemotherapy, other oncology services and post operation outpatient appointments. There needs to be a consistent approach applied across all DHBs, so our members are not out-of-pocket.

Enduring powers of attorney (EPOA), capacity and repayments

22. This area was flagged as an in issue last year and is in urgent need of reform. There are situations where residents who have been assessed as requiring care and placed into an ARC facility without an EPOA in existence with the provider then dependent on a court order to receive a subsidy. The NZACA is aware of two cases in the past year where its members are incurring growing and significant debts as MSD withhold payment of the subsidy until a court order is obtained which can sometimes take months. Cultural and affordability issues can often be a factor as to whether an EPOA is in place. This area will come under increasing scrutiny from the Chief Ombudsman who has said EPOA documentation will form part of his brief for the inspection of secure dementia units.

Other matters

23. The **End of Life Choice Bill** passed its Third Reading on 13 November and will now go to a binding public referendum at the General Election in 2020. Inevitably there will be situations where assisted dying takes place in ARC facilities, so we will need to look at the obligations of staff and facilities if the referendum passes.

24. An outbreak of **Carbapenamese Producing Enterobacteriacae** (**CPE)** occurred in an ARC facility this past winter and measures are being considered to mitigate and/or manage future outbreaks. Such measures include a review of the ARRC contract to enforce screening in all facilities for superbugs, a ramping up of MOH guidelines and CBE management guidelines and protocols. If these measures are implemented, this will mean yet more cost and compliance on providers for which they are not reimbursed.

25. Changes to the **Community Pharmacy Services Agreement** are being touted as part of a strategy to standardise national contracts. In many cases, our members have long-standing arrangements with their local pharmacies that work well and if any changes are proposed the sector should be consulted.

26. Concern remains amongst the membership on the **dementia unit standards** in the ARRC contract that restrict providers to using the Careerforce modules which are outdated and do not meet industry needs. We would like to see a change to the contract so that our members have the option of using alternative Level 4 dementia programmes.

End.