The New Zealand Aged Care Association's submission to TAS on the 2022/2023 ARRC and ARHSS agreements

26 November 2021

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 (ARC) sector in New Zealand. We represent 93% of the more than 40,000 beds across the country. 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 approximately 700 Young Persons with Disabilities (YPD) residents.
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 2022/2023 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). Some issues have been carried over from last year as they have not been resolved or they have been raised as concerns again by our members.
4. We have a small team 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 16 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

Health System Reform

5. The NZACA supports the negotiation process that has been used over the past three years in determining the annual price increase. As we move toward the creation of a single health entity, it is important that ARC maintain a national contract and that its representatives have the ability to meet regularly with funders. The Joint ARC Steering Group has proved successful, with the collaborative process being at the heart of an excellent working relationship between the NZACA, DHBs, MOH and TAS. The Association would not support a process that saw separate negotiation processes happening within four regional health bodies.

6. The Association has been in regular contact with the Health Transition Unit, a business unit of the Department of Prime Minister and Cabinet, since the announcement of the transition to Health NZ and the Māori Health Authority. As July 2022 approaches, we need ongoing and regular engagement with all relevant parties to ensure a smooth transition for ARC providers and the 36,000 residents they care for.

Pay Parity

7. Pay parity for ARC nurses with their counterparts working in public hospital settings remains a top priority for the Association and our members. Minister of Health Andrew Little has recognised the discrepancy exists yet has indicated it could take a number of years for ARC nurses to gain parity with those working for a DHB.

8. Detailed work done between the NZACA, TAS and the MOH at the end of 2020 resulted in a figure of approximately $85 million being agreed upon as the funding required to address the pay inequity between ARC nurses and DHB nurses as it stood then.

9. The goal posts have since shifted, with the pay scales offered to DHB nurses under the employer offer of September 2021, and accepted by NZNO on 15 October 2021, creating further disparity. The NZACA now estimates that the cost to the ARC sector of achieving full parity with the proposed wage rates set out in the 2021 NZNO/DBH MECA amounts to over $113 million, or a net $101 million (4.8% of DHB funding) after deducting the contribution in the 2021/22 bed-day price.

10. Based on the above information, the NZACA submitted an updated A23 claim for Pay Parity to Chris Fleming, Lead DHB CE Health of Older People on 26 October 2021.

11. It should be noted that from 2019 to 2021, small contributions were made by DHBs toward addressing the relativities between public hospital nurses and ARC nurses. While the NZACA has been appreciative of these contributions, when penal rates and shift allowances are included, ARC nurses are paid on average $10,000 less than a nurse working in a DHB setting (as of December 2020). With the 2021 MECA, the average wage gap is set to increase to in excess of $15,000 per year.

Nursing Crisis

12. Pay disparity, in combination with targeting of ARC nurses by DHBs recruitment agents, has led to an accelerated flow of ARC nurses to DHB employment (as hospital nurses, MIQ nurses, and COVID-19 vaccinators). This has resulted in a nursing staff crisis in ARC.

13. The effect of COVID-19 on immigration has also been a major contributor to the nursing crisis. The NZACA recognises both the efforts of Immigration NZ in allocating MIQ space for critical health and disability workers from November 2021 and Chris Fleming for his instruction to all DHBs of 29 September that ARC nurses on Long Term Skills Shortage Visas are not recruited by DHBs in contravention of their visa conditions.

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14. While some DHBs are taking heed of Chris's instruction, others are not and continue active recruitment of nurses from ARC. The table below shows some instances of DHBs poaching ARC staff; we are happy to provide the Steering Group with further examples.

DHB	Comment from NZACA member
Capital and Coast	I have an issue with a new RN that I recruited from overseas, she was poached by our local DHB after waiting 5 months for her to come and getting a visa based on the employment contract that we offered her. Only to announce 24 hours before she was due to start – that the DHB had offered her a job. I'm challenging the DHB on their ethical stance around their behaviour of stripping the ARC sector of talented nurses.
Whanganui	We keep losing nurses to the DHB. I've had two resignations in the last month. The vaccination programme is also taking nurses out of the available pool, and with the borders closed we are not getting the CAP students. We are quite worried about it.
Northland	Our RNs are being actively poached we had one who applied at DHB before Christmas and was turned down - she was not leaving us as wanting residency. DHB admitted that they went through past applications and called her. On speaking to the RN they offered higher pay and assistance with residency process - their initial pay offer was less than ours but they kept upping it until it was greater.
Southern	DHBs continue to recruit new grads and CAP nurses, where before the DHB required CAP nurses to work in aged care for at least 12 months - this is poor management by the DHB.
Waikato	All 3 nurses have said they have made the decision to resign as the DHBs are paying more including allowances. One RN said she has been offered financial assistance with her permanent residency application.

15. The impact of the ARC nursing crisis has been felt across the NZACA's membership. A survey carried out by the Association in mid-2021 showed 900 RN vacancies in ARC, close to 20% of the workforce. This figure continued to increase in the latter half of the year.

16. The NZACA is aware of more than 20 sites that have had to either close beds or temporarily halt admissions due to lack of RN cover. The shortage of RNs has a negative flow-on effect for other ARC workers, with clinical nurse managers, facility managers, and caregivers all expected to pick up additional hours and duties to continue to provide the care and support residents require. It is a challenge for ARC providers to meet both staffing obligations under

the ARRC/ARHSS Agreements and the Health and Safety at Work Act (2015) with fatigue and burnout becoming more commonplace.

17. The lack of supply of RNs has seen wages increase as DHBs and ARC alike are forced to enter wage bidding to recruit and retain staff. Members are also reporting a much more extensive and time-consuming process being required to recruit staff.

18. The NZACA's Nursing Leadership Group is considering how a sustainable ARC nursing workforce can be built to reduce turnover and fill the increased number of RN positions with NZ trained nurses, however this is a longer-term initiative. Sufficient funding for the industry to offer pay packages to facilitate retention of RNs working in ARC and attract graduate NZ nurses is needed now to level the playing field in the RN market.

COVID-19

19. COVID-19 is here to stay for the foreseeable future and ARC providers face significant additional costs associated with increased infection prevention and control (IPC) measures. In September, the NZACA estimated the cost to ARC of the then three-week lockdown to be in excess of $17 million. Its call to Government for funding to cover this has not been acknowledged to date.

20. As we move to the COVID-19 Protection Framework, with the virus in the community, it is time to normalise COVID-19; its associated costs need to be embedded within the bed-day rate.

21. Providers continue to face increased costs of consumables due to supply shortages, along with the requirement to purchase significantly higher quantities of PPE to meet the need for staff, visitors, and residents. Likewise, the need to isolate residents and stand down staff identified as being at risk of transmitting COVID-19 is an undeniably vital precaution, which comes at a high cost to providers.

22. The requirement to fit test ARC workers that may have to wear an N95/P2 mask is costly for providers. According to the MOH, when providing care for patients known or suspected to be infected with pathogens transmitted by the airborne route, such as COVID-19, healthcare workers must wear P2 or N95 masks. Further, MOH state that "fit testing of P2/N95 particulate respirators is required unless the Ministry of Health deems an exemption can be applied due to exceptional circumstances". The issue lies in that fit testing comes at a cost. It is frustrating that the DHBs provide their own staff with fit testing but do not extend this to ARC. There is an inconsistent approach currently, with a few DHBs having recognised the issue and offered some support to ARC. For P2/N95 masks to be safe and effective, fit testing needs to be re-checked every 12 months, when the wearer experiences a change that affects the seal, or when the model or brand of the mask is changed, making this is an ongoing issue which needs to be funded accordingly.

23. The COVID-19 Public Health Response (Vaccinations) Order 2021, while welcomed by the sector, adds another level of cost and compliance, particularly in terms of record keeping,

standing down of unvaccinated staff, and recruitment which needs to be acknowledged and funded.

24. The relaxing of restrictions and move to the traffic light system represents an added risk for ARC. Visits will need to be carefully managed and risk assessed, with providers requiring additional staffing hours to safely manage the process.

25. ARC's response to the Delta outbreak has been exemplary. We take this opportunity to recognise the efforts and sacrifice of residents and their loves ones also. The sector is now calling on Government for support to reconnect families and facilitate safe visiting.

26. The NZACA has called on Government for a suite of measures to support safe visiting to ARC at Level 3 and moving forward into the traffic light system, these include access to funded rapid antigen testing (RAT) kits, booster shots for residents and staff before Christmas 2021, and mandating double-vaccination for visitors to care homes. RAT will be a key line of defence for keeping the virus out of care homes; should these not be supplied by the MOH directly, we will seek funding through the negotiation process.

Rural inequity

27. The financial sustainability of our members in rural and remote areas of the country has again been raised in representations to the Association this year, with our members in these areas paid substantially lower bed-day rates than their counterparts in urban areas. Addressing rural inequity was pushed out to the Funding Model Review (FMR), but the delay in that process because of COVID-19 means it has still not been addressed. Each year the funding gap between rural and urban ARC sites increases and puts rural areas at a further disadvantage. Given how critical this is for the short-term survival of our rural members we would like to see this matter prioritised and resolved for the 2022/23 contract year.

28. The health system reform has promised to address postcode lottery care and to "improve care quality and equity, while ensuring the services you receive close to home reflect the needs of your community" (Our health and disability system, DPMC, April 2021). When the single nationwide health service comes into effect in July 2022, its goal of equity needs to be reflected in ARC funding.

29. Using the example of Hamilton and Raglan, less than 50km apart, the maximum contribution rate in Raglan (Waikato District) at $1056.65 is $27.86 per resident, per week less than Hamilton City. The average property price is now higher in Raglan than Hamilton, with little difference in council rates for comparative properties. A provider in Raglan will pay higher costs for non-urgent ambulance transfers and incur freight charges that urban providers don't. This is in contradiction with the premise for lower rural TLA rates, being that rural areas have a lower cost of property and living.

30. Care homes in rural areas play a vital role in their communities, not just for those who need residential care, but for the day care, respite and volunteer services such as meals on wheels they offer. Yet, due to the inequity in the TLA rate system, these are the facilities most at risk of closure. Residents in these independently owned, rural care homes are often those who

cannot afford to pay any accommodation supplement for their care, meaning the providers often don't have the same ability to supplement their income as those in larger centres.

Palliative care

31. ARC is a primary provider of end-of-life care. The accumulation of multiple co-morbidities as people age often results in an extended period of physical and functional decline requiring intensive nursing support and 24-hour care in ARC.
32. This issue has been pushed back to the FMR, however the matter cannot wait for this process. A rate higher than hospital-level care needs to be swiftly put in place to compensate providers for what is clearly the more intensive support required for palliating residents.

Rest home level care

33. The issue of residents being assessed and admitted at rest home level, when in reality they require hospital level care has again been flagged by the NZACA's membership as a major concern. This too is an issue that has been moved to the FMR and will be addressed by the move to a RUGs-based funding structure. We raise this issue again here as, until resolved, it is costing our members a great deal of time and resource as they are expected to provide a level of care to many residents which they are not funded for. The reassessment required to move residents to their correct level of care is adding unnecessary pressure onto the sector, particularly given the shortage of RNs. Until this issue can be resolved by the FMR, a substantial increase in the rest home level rate which reflects the inconsistencies of the current assessment system is needed.

Capital underinvestment

34. One of the greatest barriers to meeting demand is that current financial returns for aged residential care operations that are reliant on subsidy funding alone are insufficient to support investment in building new capacity and replacing ageing facilities.
35. The 2019 Funding Model Review found that: "Providers developing new facilities or completely refurbishing existing ones are unable to make a market rate of return solely on the four care category contract prices." Particularly rural providers may struggle to attract funding to support the refurbishment of their facilities or expansion to accommodate changes in demand.
36. The NZACA, ARC consultant Max Robins and Rawlinson's Ltd analysed returns on capital, involving capital cost growth compared with increase in the bed day rate since the current funding model was introduced in 2000 and presented the findings to the ARC Steering Group.
37. The NZACA was notified that the DHB CEs collectively rejected restoration of capital returns as a factor to be incorporated in the 2021/22 price settlement. However, the issue of lack of capital returns leading to under-investment in ARC has been accepted as being of concern and relevance to the CEs, and another mechanism may be developed to address it. We are

seeking agreement now as to how capital underinvestment will be dealt with in the 2022/23 negotiation.

Ngā Paerewa Health and Disability Services Standard

38. Ngā Paerewa Health and Disability Services Standard NZS 8134:2021 was approved for use by the Minister of Health on 24 June 2021 and will replace the current Standards from 28 February 2022.

39. While the NZACA fully participated in the process to develop the new Standard, it voted against the final version of the Standard as it recognised that many of the new criteria will be onerous, costly, and impractical to implement in ARC facilities, particularly in the timescale that was originally set out. We understand the Standard is the foundation stone on which the care of older people in residential care is based. For this Standard to be implemented, the aged residential care sector will require extra resource, support, guidance, and funding to meaningfully implement the requirements.

40. The NZACA commissioned PwC to prepare a report to provide a fuller picture of the scale of change needed, the likely costs (both financial and otherwise) of this change, and the support that owners and operators of care homes will need to implement the changes.

41. In its draft stages, the PwC report notes a difficult commercial environment, limited cultural knowledge, a depleted workforce and sometimes precarious finances weigh heavily on ARC providers. Before they can achieve the outcomes specified by the revised Standard, providers in the ARC sector will face a range of challenges. PwC worked with case study providers to identify the financial costs of compliance, more information on which can be provided upon completion of the report.

Pending repeal of Support Workers (Pay Equity) Settlements Act 2017

42. Residual issues resulting from an underestimated 30 June 2021 LCI still need to be resolved. Providers are currently required to pay rates for which they are not being fully funded.

43. The Pay Equity Settlement has increased the funding and the remuneration for the kaiāwhina workforce. The last statutory increase under the Act has been that of 2021 and the sections of the Act that deal with annual increases in care worker's pay and funding to meet this are repealed from 1 July 2022.

44. The NZACA wishes to engage with the Ministry of Health as a matter of urgency in advance of the Pay Equity Act repeal date in order to avoid potential proceedings under the Equal Pay Act relating to services performed after this date, and to secure further funding to enable the sector to maintain higher pay rates and ongoing pay increases for care workers employed by aged care providers.

45. The MOH has already cancelled a meeting to discuss Pay Equity scheduled in October. Time is of the essence, and we have growing concerns about this process, which will require major resource from the NZACA. Our members require certainty going into the New Year.

Increased costs/inflation

46. The NZACA will again provide an estimate of costs related to the general increase in purchased goods and services that match those that Statistics NZ uses in calculating the Aged Care Price Index (ACPI), with the view of receiving a subsequent uplift in service level prices.

47. Increasing wage costs, established from both the Quarterly Employment Survey (QES) and Labour Cost Index (LCI) need also to be taken into account in the price offer.

Minimum Wage

48. NZACA was invited by MBIE to submit on the Minimum Wage Review 2021. Due to the very short timeframe provided by MBIE to respond, we were unable get feedback from our membership in order to provide a full submission. We did provide MBIE with a written response and a copy of our still valid 2020 submission.

49. Setting indicative rates until 2024 would help our members plan ahead and assist with setting more accurate budgets that reflect the actual cost pressures they face across all areas of their business. Our view is that any increases in the minimum wage must be matched by Government funding and kept in line with the CPI and ACPI.

Care costs generated outside the control of providers

50. This matter has been on the ARC Steering Group table for some time and has been discussed at length in meetings over the past 24 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.

51. Previously, we have 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 nationwide approach applied so our members are not out-of-pocket.

Conclusion

52. In this submission, the NZACA has aimed to include the most important matters that have been submitted to us for consideration in the coming year's negotiation. However, our list is by no means exhaustive and officials accepting feedback should also consider separate submissions that will have been made by individual providers, whether NZACA members or not. We look forward to working through this and other submissions with you beginning with the ARC Steering Group meeting in December.

End.