Aged Care Association
NEW ZEALAND

Submission to the Health Select Committee on the ‘Inquiry into the aged care sector's current and future capacity to provide support services for people experiencing neurological cognitive disorders’

August 2024

About the Aged Care Association

This submission is from the Aged Care Association (ACA), the peak sector body for the aged residential care (ARC) sector in New Zealand.

We represent over 90 percent of New Zealand's aged residential care sector. We are a powerful advocate, making sure the aged care sector gets the support it needs to provide excellent care for older New Zealanders.

ACA welcomes the opportunity to make a submission to the Health Select Committee on the 'Inquiry into the aged care sector's current and future capacity to provide support services for people experiencing neurological cognitive disorders'.

We would also welcome the opportunity to address the Committee should Oral submissions be available and can support the Committee with any information or data that they might believe helpful for their eventual recommendations.

CONTACT ACA

P 04 473 3159
E office@nzaca.org.nz
W nzaca.org.nz
Level 13, 342 Lambton Quay, Wellington

nzagedcareassociation

nzagedcareassociation

Recommendations

Appropriate services for people with neurological cognitive disorders across the care continuum including from home and community care to residential care, to palliative care

1. Appropriate services across the care continuum would require the design of dementia-friendly model that is well-funded with reduced gaps between each point of transition. dementia.
2. A fit-for-purpose care continuum model would require:
    a. a funding model that recognises the actual cost of care based on evidence, preferably by an independent body similar to the Australian Health and Aged Care Independent Pricing Authority,
    b. wider education services for family / whanau, care staff (both community and Aged Residential Care) and community around dementia and its progression,
    c. funding to enhance Home and Community Support Services, base line level of respite and day care services inside local and hyper local Aged Residential Care (ARC) facilities,
    d. streamlined assessment and smoother transition points for individuals from Home and Community to Residential Care,
    e. public private partnership capacity to redesign existing and build new residential facilities to address growing need using more modern care practices particularly in the area of dementia care and psychogeriatric care,
    f. work on more appropriate alternative accommodation and care arrangements for those below 65 with disabilities currently in ARC facilities to release these beds into elder population and better support those young people.
3. As one of the most rapidly ageing societies in the world, the Small Home Typology Model of Care piloted in Netherlands is an exemplary model to learn from.
4. De Hogeweyk developed an environment that supports a 'normal life' for people living with dementia. This is inclusive of acceptable risk taking in a safe community where people can live a meaningful life with appropriate support. The small house model is a social model that is firmly rooted in freedom of choice and autonomy for the residents.[1]
5. This model has also been replicated in New Zealand, albeit to a smaller extent owing to funding constraints, at the Care Village in Rotorua which is a secure village, and a small rural rest

[1] Dementia Village Website

home called Wyndham and Districts Community Rest Home, which is not secure but uses the Netherlands concept to keep their residents safe but not enclosed.

6. The Association recommends the Committee to review the Needs Assessment and Support Co-ordinator (NASC) assessment processes, to identify the factors contributing to inappropriate care level recommendations for ARC residents. Identifying the factors would be critical to designing standardised solutions which could ensure that NASC assessments remain consistent in quality and timeliness across New Zealand. The Association also recommends that the Committee consider the merit of having ARC providers assess how levels of care need to be adjusted as the resident's decline continues (except for at D6 level of care), which is not appropriately recognised in the current funding model or assessment arrangements appropriately.
7. The Association recommends that a Ministerial Taskforce that includes Peak Body representation be formed with haste to co-design an appropriate delivery system for a continuum of care which includes Home and Community Care, Residential Care and Palliative Care. It is our strong belief that if the care system is designed from the frontline, then it is more likely to be a practical, cost effective and sustainable model as we continue to have an increasing number of our elders who will need this care. We also believe that a model designed by those who deliver the services outside of but funded by the public health service will:
    a. reduce the pressure on public hospitals by utilising ARC facilities and their medical staff to provide short-term primary care services for the elderly in their vacant beds at any given point of time
    b. increase the provision of respite care for carers while actively encouraging primary carers to seek respite when needed
    c. reduce entry-level barriers for ARC facilities to provide home and community support services within their local regions to further strengthen the care continuum, particularly for people living with dementia
    d. Deliver real opportunities for Government to partner with the private sector to increase the provision of all levels of residential care which current modelling continues to project will be needed within the near future.

The funding model, amount of funding available, including best practice and international examples of funding models

8. The Association encourages the committee to require Te Whatu Ora | Health NZ to provide them with the evidence for the current subsidised and maximum contribution settings as we have been unable to establish any equation that connects the actual cost of care to the day bed rate dictated by Te Whatu Ora | Health NZ.
9. We recommend that the New Zealand funding equation be separated into the same three core components - care, accommodation and living expenses – a model currently used in Australia. Every New Zealander, regardless of their socio-economic status, has the right to expect the same level of care from their public or publicly funded health system - the government decided some time ago that they did not want to be in the business of delivery aged care and so asked the private sector to do so while agreeing to fund that provision.
10. However current policy settings establish that it is an individual's personal responsibility to provide for themselves with regard to accommodation and daily living expenses. Outside of a residential care facility, where the individual is unable to provide adequately for themselves, we have a social service that they can seek assistance from. It is our view that not only should a new evidence-based funding model be developed but that it is shifted to this three-component model.
11. It is our view that this will provide greater transparency around the cost allocation to care related expenses which remains the responsibility of Te Whatu Ora | Health NZ and those expenses that should be met by the individual themselves or, upon the completion of the current asset and income testing, be supported by the Ministry of Social Development where they fit the criteria for support.
12. It is our view that this will also assist with current and future conversations regarding the asset and income threshold settings and the individual's responsibility to fund one's own accommodation and living expenses if one can afford to do so.
13. The Association understands that the Te Whatu Ora | Health NZ commissioned funding review is in the second phase around the development of recommendations for a new funding model. However, we are also aware that those leading this development have been tasked to remove pressure from hospitals as opposed to designing a system that addresses the continuum of care that as a side effect would relieve pressure from our hospitals.
14. We have also been informed by the lead of this work that they consider that there is no requirement for greater provision of psychogeriatric care and only an incremental increase in dementia care required. With dementia currently ranked as the second leading cause of death in New Zealand and evidence-based modelling that within the next six years we will

have 100,000 cases of dementia, and within the next 25 years this number will grow to 170,000 cases we are extremely concerned that the lack of recognition of need by Te Whatu Ora | Health NZ means that any system design they put forward will be inadequate for the real need. We strongly recommend that any new proposed model must be co-designed and consulted with the wider sector to mitigate risks of unintended consequences.

15. As mentioned, we are aware that Te Whatu Ora | Health NZ is doing a funding review and we have seen an outline of the suggested future delivery model, we do not have confidence that the driver for the design is what is best for the New Zealanders in need as opposed to releasing hospital beds at all costs. We reiterate our call for a Ministerial Taskforce to be formed with urgency, that includes members of the peak delivery bodies across the home and community, residential and palliative care services. We reiterate our recommendation that any funding system must be evidence based on the actual costs of appropriate levels of care.
16. We further recommend that consideration be given to implementation of a socio-economic overlay to any future funding model, similar to the decile system used in education prior to the implementation of the equity funding model. Such an overlay would give visibility to the need for different funding levels for provision in different communities when considering the provision of fully subsidised beds for those New Zealanders who fall below the asset and income thresholds.
17. We would also advocate for any funding model to acknowledge the need for hyper local provision in small rural communities such as Reefton and that these communities may require a base funding provision standalone from the bed price and ability to charge a premium rate to those who can afford to pay.

Resources available and the ability for the health system to provide appropriate care and what support enables 'aging in place', including for priority populations

18. Our members believe that the COVID settings, allowing those with villages and staffed care units, should be reinstated. This will release a number of workers, currently providing services to village residents, back into the home and community care sector to deliver services to the projected increased number of those assessed for need outside of a village setting.
19. The Association recommends a change of setting to allow our members to bond international students and employ them for 20 hours per week in lower-level care positions while they complete a three-year nursing degree. This would ensure that we have New Zealand trained nurses, who will be confident with the New Zealand work culture, while enhancing

opportunities for them to hone their language and communication skills at a competent and confident standard.

20. The Association strongly recommends that the committee consider the high level of skills required in ARC and adequately incentivise a highly skilled cohort of health workforce into the sector.
21. The Association strongly recommends that the committee acknowledge and recognise the skilled workforce that provides this care to those assessed as in need and note that they are as highly trained and work more independently than their peers at Te Whatu Ora | Health NZ hospitals. However, Te Whatu Ora | Health NZ currently funds them at a lower level than their hospital counterparts. It is our view that this represents ageism on behalf of the government agent and this situation is based upon a lack of recognition of our kaumātua, their needs as they age, and the skill and expertise residential care requires of our staff.
22. The Association strongly recommends that the government better recognise that all communities, even remote and rural regions, require an appropriate level of care provision. The committee must advise for a staggered funding model that support D3 and D6 care provision in rural, regional and hard to staff communities.
23. We also ask the committee to consider recommendations regarding opportunities for public private partnerships to create new provision, especially in the area of dementia and psychogeriatric care.
24. We urge the committee to question Te Whatu Ora | Health NZ on their current policy and instructions to NASCs regarding assessment to gain a bed regardless of its suitability for the individual involved, the facility and the other residents negatively impacted by these inappropriate placements.
25. The Committee must recommend that the Government clarifies and articulates that the 'aging in place' strategy is in fact an 'aging in community' strategy and work with the involved sectors, via a Ministerial Taskforce, to create a provision design that delivers a continuum of care for the diverse communities in which these elders reside.
26. In considering a review of the legislations surrounding adult decision-making for those with cognitive disorders, the Committee must advise that in cases where the 'rights, will and preferences' of an individual with affected decision-making could pose a significant risk of physical harm to themselves and those around them, the 'best interest' approach must prevail.

The process of applying for funding and care resources

27. The current chaos and inability to establish lines of decision-making within Te Whatu Ora | Health NZ, that has become worse since 1st July 2024, is having a direct impact on individuals being assessed at the appropriate level of care required in some areas or alternatively of individuals being inappropriately held in hospital beds in other areas.
28. It is our view that Te Whatu Ora | Health NZ does not have the capacity or capability to redesign the aged care delivery and funding model at this time and that New Zealand does not have the time to wait for Te Whatu Ora | Health NZ to gain that capacity or capability. We therefore reiterate our call for a Ministerial Taskforce to work collaboratively with Government to design these solutions.

Appropriate and sustainable asset thresholds for people with neurological cognitive disorders

29. The Association strongly recommends that any initiative to reconsider the asset threshold must only be undertaken with a strong understanding of the consequences of any change to the individual, to the sector and to the required Government funding. As the lead representative body, we offer our insight and data expertise for this process should it be undertaken.

Projections for future needs for people with neurological cognitive disorders

30. The ACA recommends that ARC providers be encouraged and supported to create facilities that are culturally friendly to people with neurological cognitive disorders from ethnic communities to better ease their transition from home into ARC.
31. The committee must recommend provisions for individuals from different ethnic backgrounds who, through the process of dementia may need a heritage language speaker to care for them.
32. The Association also recommends that all guidelines and legislations concerning the delivery of health and care services under ARC be suitably reviewed to ensure that there is an emphasis on the need for culturally sensitive approaches, including for those with comorbidities and other disorders which may have been previously unseen for their age (such as HIV and Down Syndrome).

Context

33. New Zealand has over 670 aged residential care facilities, with more than 40,000 beds and 35,000 residents. In comparison, Te Whatu Ora | Health NZ oversees 10,748 public hospital beds.

34. For people with cognitive neurological disorders, ARC provides dementia and psychogeriatric care levels with a total of 5503 and 987 beds respectively. In comparison, Te Whatu Ora | Health NZ provides approximately 170 psychogeriatric beds and 20 dementia beds. ARC, therefore, is the largest provider of residential care for those with neurological cognitive disorders.

35. The aged residential care (ARC) sector provides care at four core levels - rest home, hospital, dementia, psychogeriatric and respite care for those above 65 years of age, and care for around 700 younger people with disabilities.

36. People 65 years and older are assessed by Te Whatu Ora | Health NZ's Needs Assessment and Service Coordination (NASC) service and allocated to one of four ARC care categories. The NASC assessor typically uses interRAI assessment tool to assess the person's current abilities, resources, goals and needs before advising a care plan and the type of support services a person may require, of which admission into ARC is one of the support services advised.

37. A person is referred to one of the four care categories depending on their health status at the time of assessment. The four categories broadly encompass the following levels of need[2]:

    a. Rest home care: the resident is assessed as generally able to be independent (are mobile and can feed themselves) but needing assistance with personal care or supervision of activities of daily living. They are assessed as unable to safely live in their own homes (or other community settings) either due to their disability needs and/or lack of informal support.

    b. Continuing care (also known as hospital level care): the resident is assessed as having significant disability, usually in combination with medical problems, which requires 24-hour supervision with Registered Nurse input for their care (e.g., medication management, wound care), and assistance with mobility.

    c. Dementia care: the resident is assessed as needing 24-hour supervision, in a secure environment due to risk of wandering or becoming lost due to memory loss or

[2] Ernst&Young (2019). *Aged Residential Care Funding Model Review.*

confusion. Dementia residents must be provided care in a facility / annex separate to rest home and continuing care.

d. **Psychogeriatric care:** (also known as specialised hospital care) the resident is assessed as needing 24-hour supervision. This level of care is for people with major behavioural issues (including severe dementia or addictions) and need highly supervised secure care, owing to the risk they pose to their own safety as well as to those of the staff and other residents. They need a high level of specialist nursing care.

38. While a majority of people in ARC have some levels of cognitive neurological disorders, people with dementia are generally provided care at the D3 (dementia) or D6 (psychogeriatric) care levels.

39. Psychogeriatric care levels are the highest level of care provided in ARC. People with dementia, who have documented evidence of aggressive and violent behaviours or who are at a significantly higher risk of harming themselves or others around them, are referred to D6 levels.

40. The needs assessment process means that ARC funding is demand driven.

41. People over 65 can choose to enter ARC without a needs assessment; however, this means they are ineligible for any government subsidy and must pay the full costs of their care. ARC facilities also provide respite care, short-term care and long-term care for around 700 younger people with disabilities.

42. Sixty six percent of the facilities we represent are owned and operated by religious institutions, charitable trusts, family-owned, not-for-profits, and privately owned facilities. The remaining facilities are operated by listed companies (34 percent of our membership). Across the sector of ARC provision, Te Whatu Ora | Health NZ provides less than 1 percent of the available residential care capacity.[3]

43. According to a 2017 study, 52 percent of those in ARC have cognitive impairment.[4] As the number of people aged 65 and older is increasing rapidly in New Zealand (with the 65+ population estimated to cross 1 million in the next three years), while people are also living longer and entering ARC with more frailty in recent years, these numbers are likely to increase.

[3] Aged Care Association. Aged residential care sector profile 2024
[4] Deloitte (2017). Dementia Economic Impact Report 2016

44. As of 2023, 13.2 percent of beds of the approximately 40,000 beds in ARC were dedicated for dementia care and a further 2.3 percent for psychogeriatric care.[5]
45. The share of dementia beds has gone up by 1.3 percent between 2018 and 2023, but the share of psychogeriatric beds has fallen by 0.2 percent during the same period.[6] Anecdotal evidence from our members suggests that while provision for psychogeriatric has fallen this disguises that actual need within community.
46. The share of residents entering dementia care went up from 11 percent to 13 percent, and psychogeriatric care from 0.9 percent to 1.3 percent between 2016/17 to 2022/23.[7]
47. Individuals assessed as required residential care at rest home and hospital level face an average wait of 137 and 125 days respectively after being identified as a priority for moving out of the home. Those requiring more complex levels of dementia and psychogeriatric face higher average wait times of 169 and 176 days, respectively.[8]
48. Conservative projected estimates suggest that 1,900 net new beds will be required at dementia care levels, and 200 net new beds for psychogeriatric levels in New Zealand.[9]
49. Multiple reports over the last decade have continued to draw attention to the reality that the current daily (24-hour care) rates paid by Te Whatu Ora | Health NZ are manifestly insufficient to support the maintenance and refurbishment of older beds or the building of additional capacity for the recognised and documented number of New Zealanders who will need this care. To address the well-recognised shortage and the inevitable adverse impact on not only the individual, their whānau and family, but the acute hospital services who are currently overwhelmed, solutions need to be delivered urgently.
50. In the process of drafting our submission, we have consulted widely with our members and the ACA Nursing Leadership Group (NLG). The NLG brings together nursing leaders from the ARC sector. The NLG assists the sector and contributes to the work of the Association with policy development, clinical advice, and guidance.

[5] ibid
[6] ibid
[7] Sapere (2024). A review of aged care funding and service models
[8] Sapere (2024). A review of aged care funding and service models
[9] ACA projections based on TAS ARC Quarterly Reporting Survey and TAS ARC Demand Planner 2022 edition

Appropriate services for people with neurological cognitive disorders across the care continuum including from home and community care to residential care, to palliative care.

51. We have heard from multiple stakeholders, including our members, that the model of care continuum exists only on paper. In reality, the system has far too many gaps to enable our kaumātua to access the services that the need as they age, and the level of care required increases.

52. The table below articulates some of the inputs that we have heard from our stakeholders about the challenges that people with cognitive disorders and their whānau experience across the care continuum.

Stage of the care continuum	Challenges faced
Home care by family or loved ones	• Impact on mental and physical health of the carer supporting the person with dementia, including those with violent or aggressive behavioural symptoms of dementia • Lack of equitable access to respite care • Risk of physical harm due to behavioural and psychological symptoms in a person with dementia • Financial impacts from the increased cost of health and social care, and from reduction or loss of income • As conditions worsen, older people face prolonged and unnecessary hospital stays because they cannot access either home support or an ARC home to safely exit hospital[10]
Home care with support from Home and Community Support Services (HCSS)	• Inequitable access to home and community support services heightened for Māori and Pacific people, cultural minorities and people with younger onset dementia

[10] Office of the Aged Care Commissioner (2024). Amplifying the voices of older people across Aotearoa New Zealand

	• Navigating HCSS can be difficult for older people, with recent research finding poor lines of communication and fragmentation of services, affecting quality and equity of care[11] • Geographical inconsistencies in access and quality of HCSS, with lack of services in rural and regional areas of New Zealand[12]
NASC assessment	• Inappropriate assessments of level of care required by NASC assessors due to pressure from the hospital administration or Te Whatu Ora | Health NZ to free up a bed but no suitable dementia or psychogeriatric bed available in ARC). We have heard from members that at times, such inaccurate assessments seem deliberate • Inaccurate assessments leading to high risk and dangerous situations for staff and residents in ARC facilities
Admission into ARC	• Lack of equitable access into appropriate levels of care, particularly within their community • Several challenges for the ARC providers due to inappropriate placements at lower levels of care. It also presents risk to the person with dementia as well as other residents • Extreme delays and challenges in having a person with dementia reassessed by Te Whatu Ora | Health NZ to a higher level of care when they start presenting aggressive and violent behavioural symptoms. We have heard from members that the resistance to amend is often due to lack of appropriate care setting being available in the

[11] Office of the Aged Care Commissioner (2024). Amplifying the voices of older people across Aotearoa New Zealand

[12] Office of the Aged Care Commissioner (2024). Amplifying the voices of older people across Aotearoa New Zealand

	region or to mitigate the increased cost to Te Whatu Ora | Health NZ • Lack of an activated EPOA or limited resources to go through the PPPR process for a court-appointed representative • Family members insisting on rest home or hospital level care even for residents presenting with symptoms of neurological cognitive disorders • Poor awareness about dementia progression among loved ones resulting in conflict between family/whānau and ARC providers • In facilities without psychogeriatric units, lack of adequate support from NASC when a resident's medical conditions deteriorate and their behavioural symptoms require the increased supervision and security provided in psychogeriatric care levels, leads to clinical and management issues for ARC providers

53. Recommendation: Appropriate services across the care continuum would require the design of a dementia-friendly model that is well-funded with reduced gaps between each point of transition.
54. A fit-for-purpose care continuum model would require:
    a. A funding model that recognises the actual cost of care based on evidence, preferably by an independent body similar to the Australian Health and Aged Care Independent Pricing Authority,
    b. wider education services for family / whānau, care staff (both community and ARC) and community around dementia and its progression,
    c. funding to enhance HCSS, base line level of respite and day care services inside local and hyper local ARC facilities,
    d. streamlined assessment and smoother transition points for individuals from Home and Community to Residential Care,

e. public private partnerships to redesign existing and build new residential facilities to address growing need using more modern care practices particularly in the area of dementia care,

f. work on more appropriate alternative accommodation and care arrangements for those below 65 with disabilities currently in ARC facilities to release these beds into the 65+ population and better support those young people.

55. As one of the most rapidly ageing societies in the world, the Small Home Typology Model of Care piloted in Netherlands is an exemplary model to learn from.

56. De Hogeweyk developed an environment that supports a 'normal life' for people living with dementia. This is inclusive of acceptable risk taking in a safe community where people can live a meaningful life with appropriate support. The small house model is a social model that is firmly rooted in freedom of choice and autonomy for the residents.[13]

57. This model has also been replicated in New Zealand, albeit to a smaller extent owing to funding constraints, at the Care Village in Rotorua which is a secure village, and a small rural rest home called Wyndham and Districts Community Rest Home, which is not secure but uses the Netherlands concept to keep their residents safe but not enclosed.

58. **Recommendation:** The Association recommends the committee review the NASC assessment processes across Aotearoa, to identify the factors contributing to inappropriate care level recommendations for ARC residents. Identifying the factors would be critical to designing standardised solutions which could ensure that NASC assessments remain consistent in quality and timeliness. The Association also recommends that the committee consider the merit of having ARC providers assess how levels of care need to be adjusted as the resident's decline continues (except for at D6 level of care), which is not currently recognised in the funding model or assessment arrangements appropriately.

59. **Recommendation:** The Association recommends that a Ministerial Taskforce that includes peak body representation be formed with haste to co-design an appropriate delivery system for a continuum of care which includes home and community care, aged residential care and palliative care. It is our strong belief that if the care system is designed from the frontline, then it is more likely to be a practical and sustainable model as we move toward the increasing number of our elders who will need this care. We also believe that a model designed by those who deliver the services outside of but funded by the public health service will:

[13] Dementia Village Website

a. reduce the pressure on public hospitals by utilising ARC facilities and their medical staff to provide short-term primary care services for the elderly in their vacant beds at any given point of time
b. increase the provision of respite care for carers while actively encouraging primary carers to seek respite when needed
c. reduce entry-level barriers for ARC facilities to provide home and community support services within their local regions to further strengthen the care continuum, particularly for people living with dementia

The funding model, amount of funding available, including best practice and international examples of funding models.

60. Sector stakeholders have long been advocating that the current funding model is no longer fit-for-purpose.
61. As per the current funding model, the average bed day prices in ARC in 2022/23 were as follows:
    - Rest home: $176.45
    - Dementia level: $232.67
    - Hospital level: $279.14
    - Psychogeriatric level: $311.16[14]
62. A 2023 survey found that more than half (56 percent) of respondents' facilities made a net loss in the 2022/23 financial year (equating to a loss of $4.24 per operating bed day).[15] This affects the sector's potential to sustain operations, discourages much needed investment in new stock and innovation which can help reduce Te Whatu Ora | Health NZ waiting times, and leads to alternative funding models which increases inequitable access issues for 60 percent of New Zealanders who fall below the asset and income threshold.
63. The Sapere review commissioned by Te Whatu Ora | Health NZ also noted that a substantial increase in funding was required, or the consequences could include reduction in new builds and beds in the sector, increased focus on premium rooms and ORAs, which with other compounded factors would increase financial barriers to accessing ARC.[16]

[14] CCPS payment data as reported in the Sapere report. Sapere (2024). A review of aged care funding and service models
[15] Ansell Strategic (2023). New Zealand Aged Residential Care Financial Performance Study – Summary of Findings
[16] Sapere (2024). A review of aged care funding and service models

64. We heard from one of our members, who are the only providers offering psychogeriatric care in a region with a significant ageing population, that after years of cross-subsidising their facility owing to poor funding from Te Whatu Ora | Health NZ, they had no choice but to suggest shutting down their facility, requesting Te Whatu Ora | Health NZ to provide alternative residential arrangements for the residents in their care. Realising the seriousness of the situation, Te Whatu Ora | Health NZ were able to provide a suitable funding situation for the provider. However, we would not like this to be the norm, where our members are pushed to the brink of considering bed closures before they are adequately supported to keep their operations sustained.
65. Those entering at the more complex levels of dementia and psychogeriatric face higher average wait times of 169 and 176 days, respectively. Studies show that it costs the government approximately $1,700 per patient per day to care for someone in a hospital ward. ARC services are significantly less expensive. Therefore, a substantial cost to the economy arises when the hospital patients have to wait to be transferred to care facilities. Even at an evidence-based bed price for ARC services, covering the actual cost of care, the Government could make significant savings and reduce waiting times for patients in Te Whatu Ora | Health NZ by utilising the ARC sector to provide both respite, recovery and residential care for those aged 65 and above.
66. We have also heard from our members that Te Whatu Ora | Health NZ is controlling the number of dementia beds allowed to be operational in a facility, by capping the maximum allowance of 20 beds per facility entrenched into the ARRC services agreement. We have been informed by members that with the level of skilled care required, and the requirement for dementia and psychogeriatric care units to be in a standalone build, a minimum of 68 beds is required to break even under the current funding model.
67. The funding model also does not adequately incentivise the provision of psychogeriatric care in ARC. The Association notes that there is no psychogeriatric provision in many parts of New Zealand such as the Wairarapa and that those in need of these services have to be transported out of their community to Manor Park Private Hospital in Lower Hutt. At the time of writing, the Lower Hutt facility had 100 percent occupancy. We were also made aware that people with dementia, having been assessed by NASC as requiring D6 level of care were either being held in local hospitals or local residential care facilities at lower levels without the appropriate means to care for them, while being at an increased risk of physical harm to staff and residents. We have been informed by our members of cases where Te Whatu Ora | Health NZ has had to fund an individual for 24/7 monitoring of a resident due to the inability

to place them into an appropriate residential setting. We have also received several submissions from our members where they have pointed out cases of physical abuse, including sexual assault on other residents and staff members, by residents who were assessed as requiring D6 care levels but were being cared for at D3 levels due to unavailability of D6 beds.

68. As per data shared in the Sapere report, Te Whatu Ora | Health NZ's contribution towards funding for ARC services in 2022/23 was 57.24 percent of the total costs. The equivalent share by the Australian government was 72.3 percent for the same period.[17]
69. Under the new Australian AN-ACC funding model, the Independent Health and Aged Care Pricing Authority (IHACPA) provides annual AN-ACC price recommendations, providing much required transparency in an evidence-based process of setting funding rates.
70. The model recognises three core components of ARC services – care costs, daily living fee and accommodation costs.
71. **Recommendation:** The Association encourages the committee to require Te Whatu Ora | Health NZ to provide them with the evidence for the current subsidised and maximum contribution settings as we have been unable to establish its existence.
72. **Recommendation:** We recommend that the New Zealand funding equation be separated into the same three core components - care, accommodation and living expenses as the AN-ACC model. Every New Zealander, regardless of their socio-economic status, has the right to expect the same level of care from their public or publicly funded health system - the government decided some time ago that they did not want to be in the business of delivery aged care and so asked the private sector to do so while agreeing to fund that provision. But it is each individual's personal responsibility to provide for themselves in the area of accommodation and daily living expenses - where they are not able to provide adequately, we have a social service that they can seek assistance from. It is our view that not only should a new evidence-based funding model be developed but that it is shifted to this three-component model. This will provide greater transparency with regard to Te Whatu Ora | Health NZ direct to care costs and strengthen the relationship between those individuals and the Ministry of Social Development where they fit the criteria for support. It will also assist with current and future conversations regarding the Asset and Income threshold settings and the individual responsibility to fund one's own accommodation and living expenses if one can afford to do so. The Association understands that the Te Whatu Ora | Health NZ commissioned funding review is in the second phase of arriving at recommendations for a

[17] Australian Government (2023). Financial Report on the Australian Aged Care Sector

new funding model. However, we would strongly recommend that any new proposed model must be consulted with the wider sector to mitigate risks of unintended consequences.

73. While we are aware that Te Whatu Ora | Health NZ is doing a funding review and we have seen an outline of the suggested future delivery model, we do not have confidence that the driver for the design is what is best for the New Zealanders in need, as opposed to releasing hospital beds at any cost. We again call for a Ministerial Taskforce to be formed with urgency, that includes members of the peak delivery bodies across the home and community, residential and palliative care services. We reiterate our recommendation that any funding system must be evidence based on the actual costs of appropriate levels of care.
74. Recommendation: We further recommend that consideration be given to implementation of a socio-economic overlay to any future funding model, similar to the decile system used in education prior to the implementation of the equity funding model. Such an overlay would give visibility to the need for different funding levels for provision in different communities when considering the provision of fully subsidised beds for those New Zealanders who fall below the asset and income thresholds.
75. We would also advocate for any funding model to acknowledge the need for hyper local provision in small rural communities such as Reefton and that these communities may require a base funding provision standalone from the bed price and ability to charge a premium rate to those who can afford to pay.

Resources available and the ability for the health system to provide appropriate care and what support enables 'aging in place', including for priority populations.

76. The sector has significant concerns that the Government has interpreted ‘aging in place’ to mean ‘aging at home at all costs’.
77. In the next 20 years there will be 660,000 over 65-year-olds who will be renting. We do not see landlords as being particularly understanding about the many modifications a standard house may need to accommodate an individual assessed currently as needing residential care.
78. ‘Aging in place’ should be considered as ‘Aging in Community’ - where there is the provision of home and community, residential care and palliative care available in the community you live.

79. We refer to our previous comments regarding the need for a funding model to recognise that some smaller communities may need a multi-faceted provider who is supported through a base funding plus model.
80. A strong 'aging in community' strategy also needs to be holistic in its approach and look at other factors such as the availability of a skilled workforce, strengthened assessments, among others.

Workforce for providing home care

81. The Association has significant concerns around the current direction of Te Whatu Ora | Health NZ with its behind the doors redesign of the delivery model.
82. We understand that the driver for Te Whatu Ora | Health NZ is to release 200,000 bed nights per annum from the hospital service. The minimal information we have been able to gather to date suggests that Te Whatu Ora | Health NZ is working on a model to lower the number of New Zealanders assessed as requiring residential care by 20 percent and leaving these New Zealanders at home.
83. We acknowledge that with the appropriate resourcing that our home and community colleagues may be able to increase and train their current workforce to delivering a part of this vision. However, we have heard from Te Whatu Ora | Health NZ representatives that they have modelling that puts the required workforce to service this number of elders assessed as needing support at approximately 8,000 FTE.
84. It is important to note that the demographic requiring care is continuing to increase. We do not believe that our home and community colleagues will be able to upsize their workforce to deliver this quantity of service to the growing demographic without a change to the settings allowing Retirement Villages and Residential Care facilities to provide in home care support to their residents as they did during the Covid pandemic.
85. Recommendation: Our members believe that the Covid settings, allowing those with villages and staffed care units, should be reinstated. This will release a number of workers to the home and community care sector to deliver services to those assessed for need outside of a village setting.

Workforce in ARC

86. 71 percent of the ARC staff are on visas. An immigration policy that is conducive to maintaining a steady stream of health workers is crucial to the sector.

87. The recent changes to Accredited Employer Work Visa, both for employees and employers, has the sector concerned about its potential to employ internationally qualified workers.
88. Furthermore, we are also concerned about the future of the Care Workforce Sector Agreement, which is due to expire in October, which has played an important role in employing close to a third of the total workforce (close to 2000 workers) in ARC since 2022.[18]
89. Moreover, the recent change in competency assessment for nurses with the introduction of the Objective Structured Clinical Examinations (OSCE) have reduced the number of days for which nurses are trained in a New Zealand setting. There are concerns among those in the sector that this system would bring forth nurses who aren't work-ready for the ARC sector.
90. Recommendation: The Association recommends a change of setting to allow our members to bond international students and employ them for 20 hours per week in lower-level care positions while they complete a three-year nursing degree. This would ensure that we have New Zealand trained nurses, who will be confident with the New Zealand work culture, while enhancing opportunities for them to hone their language and communication skills at a competent and confident standard.
91. However, even with immigration policies that work for the sector, one of the key concerns in ARC has been its inability to retain the staff in ARC itself. According to a survey undertaken by the Association, the annual turnover trend for ARC staff was close to 31 percent in 2023 (a total of 2,419 workers in care roles alone), up from 25 percent in 2019.
92. Members have submitted that a significant majority of the workforce, particularly nurses, either move to Te Whatu Ora | Health NZ where they are notably better paid (35.5 percent of nurses in 2023), or they move out of the country (8.8 percent). The underlying motivation for the move, as noted by members, is the comparative low salaries in ARC.
93. For those with dementia and psychogeriatric needs we need highly trained and experienced staff. While a high level of care is guaranteed and certified via the ARRC agreement between Te Whatu Ora | Health NZ and ARC providers (which requires staff at dementia care levels to have undergone special training) and regulatory audits, the staff turnover could still pose a problem, as the familiarity between residents and staff (which is critical for those with cognitive neurological disorders) is compromised.
94. Pay parity for nurses working in Te Whatu Ora | Health NZ and ARC as well as pay equity for care workers are, therefore, vital for ensuring a steady stream of highly skilled workers in the sector.

[18] As per confidential data provided by Immigration New Zealand to the Aged Care Association.

95. It is also important to note that Registered Nurses (RN) in ARC are needed to have more autonomous decision-making and clinical expertise, while catering to a larger patient care workload than their peers in Te Whatu Ora | Health NZ hospitals. ARC nurses are also required to have high level of critical thinking skills to be able to make critical health decisions independent of any team support that is a feature of hospital work.
96. Recommendation: The Association strongly recommends that the committee consider the high level of skills required in ARC and adequately incentivise a highly skilled cohort of health workforce into the sector.
97. Recommendation: The Association strongly recommends that the committee acknowledge and recognise the skilled workforce that provides high levels of care at ARC, and note that they are as highly trained and work more independently than their peers at Te Whatu Ora | Health NZ hospitals. However, through the daily bed rate, Te Whatu Ora | Health NZ funds them at a lower level than their hospital counterparts. It is our view that this represents ageism on behalf of the Government agent and this situation is based upon a lack of recognition of our kaumātua and their needs as they age.
98. Recommendation: The Association also strongly recommends that the government better recognise that all communities, even remote and rural regions, require an appropriate level of care provision. The committee must advise for a staggered funding model that support D3 and D6 care provision in rural, regional and hard to staff communities.

Training opportunities

99. The Age-Related Residential Care Services Agreement signed annually between Te Whatu Ora | Health NZ and ARC providers, requires care givers assigned in dementia care levels undergo specialised training to achieve specific unit standards described in the agreement. However, we have heard from our members that the limited number of training providers providing these unit standards and the cost for undergoing the training have been a barrier in encouraging more care givers to undergo the specialised training.
100. Recommendation: We reiterate our earlier comment to promote wider education services for family / whanau, care staff (both community and ARC) and community around dementia and its progression.

NASC assessments

101. NASC assessments determine the appropriate level of care to which a resident is to be admitted within ARC.

102. We have heard from several of our members that the quality and timeliness of assessments vary significantly from region to region.

Voices from ARC

"There's a noticeable lack of rural support when elderly with dementia (D3) escalate to Psychogeriatric (D6) level of care. We can transfer D3 to hospital level of care and vice versa but do not offer D6 and rely on NASC and other facilities to accept them.

When a D3 resident deteriorates due to their illness an urgent iCatt referral is sent. This normally requires 3 consistent days of recorded behavioural pattern. Then the psychogeriatric team come and assess.

I can think of 4 occasions since October where we had D3 residents become D6 and there was no available bed for them. They had to stay with us for over 3 weeks and only then got moved due to unswerving follow-up. For example, we had a gentleman who was deteriorating mid-June with his inappropriate sexual behaviour escalating putting the vulnerable female residents at risk. We had to contact TACT/Crisis team on 27th June for help. He was prescribed 3 days of chemical restraint. This facility does not have practice or policy on Chemical restraint, yet we were informed that we could not transfer him to ED / Acute Medical Ward. We went to Timaru to pick up the medication as the pharmacy here was closed. We closely monitored him with one-on-one during the long weekend. He was signed off as D6 level of care on the 2nd of July. Unfortunately, NASC could not find him a D6 placement. I heard from the NASC team that there was 20 -D6 beds available, ready for admission, but no facility would accept him.

We have received a HDC complaint on the way a D6 resident in November 2023 was manged in our facility due to long delay in moving him out and risk of loved ones also in care. It is still in the HDC process. When I reminded the team of this, they did move him. On the 19th July he was transferred to Acute Psychiatric ward due constant phone calls / communication as we were getting family complaints, ongoing risk to other residents, caring for someone out of our scope of our practice/contract, and the staff wellbeing. When I asked about extra funding for this gentleman since he required one-on-one monitoring, I was told that it only occurs after he becomes D6 and only for a short period – like one week. We had this gentleman for over 3 weeks after the iCatt referral process."

- ACA member and ARC provider from Geraldine

103. We are hearing from a growing number of our members that NASC assessors often inappropriately assess the level of care needed. Often, this is done when there's pressure on the assessors to expedite the discharge of residents from hospitals into ARC when there's a shortage of beds at the appropriate level. Several of our members have shared that they have, in more instance than once, received a resident assessed at rest-home or hospital level care, even when they presented notable symptoms of dementia.

104. We also heard from our members that NASC assessors often fail to differentiate between D3 and D6 levels, often assessing people at the lower level of care. "The dementia

units, it seems, are being used for mental health assessment by NASC. We've had instances of a resident being admitted into D3 level of care and then being re-assessed at D6 level within days because of aggressive and violent behaviour towards other residents," submitted one member.

105. **Recommendation**: We strongly urge the Committee to question Te Whatu Ora | Health NZ on their current policy and instructions to NASCs regarding assessment to gain a bed regardless of its suitability for the individual involved, the facility and the other residents negatively impacted by these inappropriate placements.

Aging in place

106. The Association acknowledges the rationale behind the 'aging in place' strategy, particularly given the wider public's desire to age at home. However, the Association also feels very strongly about the strategy being resource-focussed and not output-driven.

107. 'Ageing in place' is, in our view, being used as an economic outcomes model and not a well-being or care model.

108. ACA's review of interRAI assessments in 2020/21 showed that of those who reported feeling lonely at the time of their final Home Care Assessment, 82 percent of people no longer felt lonely after around six months of aged residential care (ARC), and only 18 percent continued to report feeling lonely.[19]

109. The analysis also showed that 60.3 percent of people reported improved levels of pain in the six months after entering an Aged Care Facility, with a total of 95.9 percent reporting either improved or sustained levels. In addition, 74.7 percent of people showed an improved CHESS or overall health stability score, with 92.5 percent reporting either improved or sustained levels. These are key areas that impact on an older person's overall health and wellbeing, showing that care at ARC has a much better outcome on the health and wellbeing of those aged 65 and above compared to when they age at home.

110. 'Aging in place' also places guilt on the carers who may be unable to care for their elderly loved ones at their own homes for various reasons. Several empirical studies have noted that caring for loved ones at home puts a toll on the physical and mental health of the carers. Often elder abuse by carers is also associated with stress and intense workload of looking after a dependent person. Aging in place can, therefore, pose risk to both the cared as well as the carers.

[19] New Zealand Aged Care Association (2022).

111. We are also receiving feedback from our members that individuals who are quite evidently unable to care for themselves, despite having been previously assessed as requiring dementia, psychogeriatric or hospital level care have had their assessment altered upon articulating their desire to remain at home. We suggest that the Committee work with the New Zealand police to review the number of physical harm incidents by an individual with behavioural symptoms of dementia, assessed as requiring psychogeriatric care but released by Te Whatu Ora | Health NZ to live at their home. We can provide more detail on this should the committee wish.

112. 'Aging in community', the Association believes, would be a better approach, wherein community includes a continuum of care, being home and community care, residential care and palliative care. The strategy also promotes socialisation and prevents isolation and loneliness among the elderly which we also note has been lacking from any conversations by Te Whatu Ora | Health NZ on the suggested new model of provision.

113. As mentioned previously we see the current focus of Te Whatu Ora vas one to release pressure from hospital beds and not to design a practical, sustainable continuum of care system for our elders to remain in their communities.

114. It is also worth highlighting that to date Te Whatu Ora | Health NZ has not made any reference to palliative care when articulating its vision for the reform of the aged care sector.

115. However, to strengthen the 'aging in community' model, there's a need to address unequitable access to ARC, particularly dementia and psychogeriatric care. There are notable regional disparities in the availability of D3 and D6 levels of care across the country. This affects a person's ability to choose a facility within their community while staying close to their whānau and friends.

116. One of our members shared that family members often get upset when a person is assessed from D3 to needing D6 level of care, as this might mean moving them to a further off location, depending on which region they are in, given the fewer number of D6 beds around the country.

117. The availability of D3 and D6 level beds across the country on 14.08.2024 looked as follows[20].

	D3 total beds	D3 vacant beds	D6 total beds	D6 vacant beds
Northland	228	4	20	5
Waitemata	628	39	127	2

[20] Data from Eldernet. Reported vacancies, at times, tend to be higher than actuals as facilities report anticipated vacancies.

Auckland	373	30	46	15
Counties Manukau	261	5	49	2
Waikato	555	44	63	7
Bay of Plenty	267	36	32	0
Lakes	84	7	19	3
Tairawhiti	67	8	No beds	0
Taranaki	205	40	26	6
Whanganui	84	2	20	2
Hawke's Bay	229	30	62	14
Wairarapa	80	7	No beds	0
MidCentral	246	10	21	2
Capital & Coast	275	17	88	5
Hutt Valley	176	15	47	0
Nelson Marlborough	215	16	36	1
West Coast	15	0	20	2
Canterbury	969	88	248	21
South Canterbury	60	4	20	0
Southern (Otago)	291	21	55	0
Southland	117	11	20	0
Total	5425	434	1019	87

118. It is incredibly concerning that there are no psychogeriatric bed provisions in Tairawhiti and Wairarapa, which compels the whānau of a person assessed as requiring D6 level of care to move them to another location. This is unacceptable as it goes against the ethos of the 'aging in community' principle.

119. **Recommendation:** The Committee must recommend that the Government clarifies and articulates that the 'aging in place' strategy is in fact an 'aging in community' strategy and work with the involved sectors, via a Ministerial Taskforce, to create a provision design that delivers for the diverse communities in which these elders reside.

Decision-making for people with cognitive neurological disorders in ARC

120. While there are guidelines and legislations in place to protect decision-making for people with cognitive neurological disorders, the issues with these policies have been well-documented since the past several years.

121. We have heard from our members that they are faced with an uncomfortable dilemma when they are asked to care for a resident at D3 or D6 levels of care, who may not have an Enduring Power of Attorney (EPOA) in place.

122. Ngā Paerewa guidelines also recommend under subsection *1.7.7: All residents have an Enduring Power of Attorney that has been enacted, where an EPOA is not in place the provider is supporting actions to have one appointed.*

123. However, our members have shared that given the costs of securing an EPOA or a court-appointed representative, several residents and their whānau are unable to secure these before admission into ARC. Facilities are then presented with a situation where they can either admit the resident with guarantee from the family members that they will secure a court order (which often takes several months) or deny them admission into their facility owing to fears over possible negative repercussions.

124. The Association is also concerned about the possible implications of the shift from 'best-interest approach' to the 'rights, will and preferences' approach for those with affected decision-making, as proposed in the recent Law Commission review. We are concerned that this, combined with Te Whatu Ora | Health NZ's focus on reducing their spending, could lead to more people with dementia, including those with behavioural symptoms, being sent to live in their homes, despite having the clinical need for D3 or D6 levels of care. This would not only cause huge financial and social implications for their families and whānau but also increase the risk of physical harm both to the individual and their carers.

125. **Recommendations:** In considering a review of the legislations surrounding adult decision-making for those with cognitive disorders, the Committee must advise that in cases where the 'rights, will and preferences' of an individual with affected decision-making could pose a significant risk of physical harm to themselves and those around them, the 'best interest' approach must prevail.

The process of applying for funding and care resources.

126. The Association acknowledges that the process of applying for funding and care resources is more relevant from the perspective of the ARC residents and those having been assessed as requiring residential care, which the Association would not be in a position to provide.

Voices from ARC

In April of this year, we had put forth an application to transition 23 rest home level care beds from rest home to dementia care at Nelson Street, having noted a critical shortage of dementia care beds in Mid-Central (only 7 vacancies). However, even as of August, we have not had any clarification on whether the application would be considered. We have been made to understand that this delay is due to a restructuring of Te Whatu Ora | Health NZ, and that it is likely to be processed once the regional leadership takes over.

In the interim, we have seen a fall in admission into rest-home level care to an unsustainable average occupancy of 82 percent during the last half of 2023. This was a decrease from 94 percent in the first half of the year. The delay in approving the request to transition 47 percent of their current beds into D3 care level has significantly impacted our ability to receive the adequate level of funding to keep our operations sustainable, even as the sector faces a shortage of dementia beds in the region.

- ACA member and ARC provider's submission to ACA

127. However, we have heard from our members about the challenges with applying for reconfiguration of beds to higher levels of care. One such submission is noted above.

ACA recommendations:

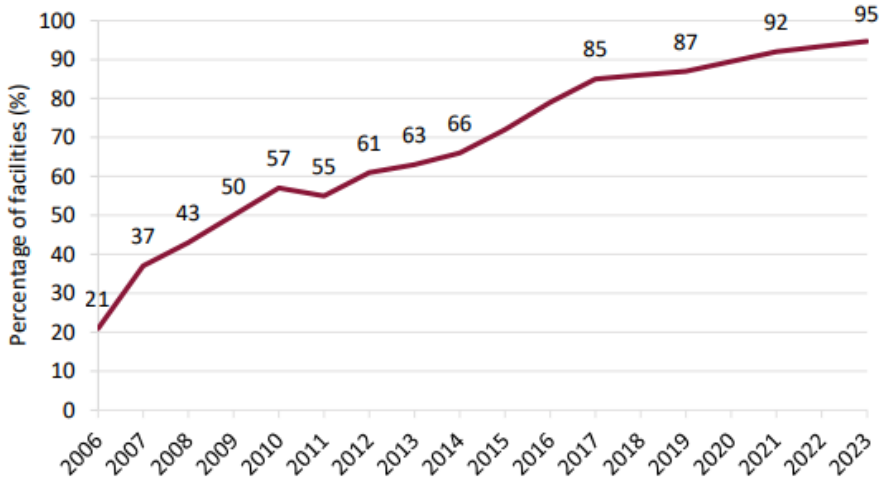
128. The current chaos and inability to establish lines of decision-making within Te Whatu Ora | Health NZ, that has become worse since 1st July 2024, is having a direct impact on individuals being assessed at the appropriate level of care required in some areas or alternatively of individuals being inappropriately held in hospital beds in other areas.
It is our view that Te Whatu Ora | Health NZ does not have the capacity or capability to redesign the aged care delivery and funding model at this time and that New Zealand does not have the time to wait for Te Whatu Ora | Health NZ to gain that capacity or capability. We therefore reiterate our call for a Ministerial Taskforce to work collaboratively with Government to design these solutions.

Appropriate and sustainable asset thresholds for people with neurological cognitive disorders

129. Years of underfunding into the ARC sector have compelled a majority of the facilities to introduce premium charges for residents to cover the gap between government funding and the actual cost of delivering care.

130. The Association has critically evaluated the current asset thresholds and modelled for the impact on funding that different levels could have for the sector. The Association would be happy to provide a detailed submission on this topic, if it is in the interest of the Committee.

131. The graph below shows the increase among facilities offering accommodation supplement for premium room services, 2006 to 2023.[21]



132. Owing to the increase in premium rates, residents have already been compelled to absorb a significant share of the gap between government funding and actual costs of care.

ACA recommendations:

133. The Association strongly recommends that any initiative to reconsider the asset threshold should be evidence based and be undertaken with wide consultation among sector stakeholders and ARC resident representatives. No amendment should be made until the daily rate itself becomes evidence based ideally by splitting that funding into three separate components – care, accommodation and living expenses – and is set by an independent body.

Process for diagnosing neurological cognitive disorders and the effects of diagnoses on funding and treatment.

134. Members have submitted that residents coming into ARC often get diagnosed at lower levels of care, with the ARC facilities having to apply for reassessments within days of their admission, which Te Whatu Ora | Health NZ is increasingly reluctant to do. We believe

[21] Source: ACA member survey, October 2023

that this has been contributed to by the ongoing dialogue on cost pressures, as this has become increasing difficult since 1st July 2024.

135. It places an additional burden on ARC providers, who have to provide care and additional staff resources to care for the residents at a higher level, while they wait for mental health services to appropriately reassess them.

136. ARC services are frontline services for the most vulnerable group of elderly in our country, and as such we understood our sector to be a priority of Government. It is inappropriate for Te Whatu Ora | Health NZ to delay in reassessments, thereby putting other residents and staff at risk, due to funding constraints.

137. It is particularly difficult for facilities where they only provide D3 level of care and not D6 level. We have heard from members that the wait times for getting residents reassessed by mental health services when their clinical conditions worsen varies significantly across regions, with some members waiting for several days even as the conditions and care requirement for the resident continues to worsen.

138. **Recommendation:** We reiterate our submission made earlier in the report recommending a review of the NASC assessment processes.

Projections for future needs for people with neurological cognitive disorders.

139. Projected estimates suggest that 1,900 net new beds will be required at dementia care levels, and 200 net new beds for psychogeriatric levels in New Zealand.

140. We are concerned that recently a Te Whatu Ora | Health NZ representative with responsibility for the redesign of the Aged Care sector articulated their belief that psychogeriatric levels would remain relatively flat for the next decade. We do not know what evidence has been used to support this position but find it difficult to understand considering general population growth, the rise in overall mental health service needs among the current population, and the growth our members are seeing in alcohol and drug connected cognitive decline that tend to manifest in more aggressive and violent behaviours. An unevidenced belief such as this from the designer of the “new” delivery and funding model presents a very real risk to any investment in psychogeriatric care provision.

141. Te Whatu Ora | Health NZ’s Health Status Report published earlier this year notes higher age-standardised prevalence of dementia for Māori and Pacific people than European and Asian populations. Recognizing health inequities across the population is an important step towards designing solutions that address them.

142. The Association recognises the New Zealand Government's efforts in promoting culturally appropriate care through healthcare guidelines such as the Ngā Paerewa Health and Disability Services Standard and Pae Ora strategies.

143. However, as the New Zealand population continues to diversify, there's a need to look at other ethnic communities as well. Te Whatu Ora | Health NZ's Health Status Report 2023-24 notes that the age-standardised rate of utilisation of ARC beds is significantly lower for Asian people than for Māori, Pacific people and European/Other people, in all regions.

144. With medical advancements, people with various disorders such as HIV, Down Syndrome among others are living longer and entering ARC, including in D3 and D6 levels of care. Owing to their social circumstances, caregivers and health practitioners in ARC settings would need to be trained in proving appropriate care responses, which are respectful of their medical conditions.

ACA recommendations:

145. The ACA recommends that ARC providers be encouraged and supported to create facilities that are culturally friendly to people with neurological cognitive disorders from ethnic communities to better ease their transition from home into ARC.

146. The committee must recommend provisions for individuals from different ethnic backgrounds who, through the process of dementia may need a heritage language speaker to care for them.

147. The Association also recommends that all guidelines and legislations concerning the delivery of health and care services under ARC be suitably reviewed to ensure that the emphasise the need for culturally sensitive approaches, including for those with comorbidities and other disorders which may have been previously unseen for their age (such as HIV and Down Syndrome).