Aged Care Association
NEW ZEALAND

Aged Care Association submission to Ministry of Health on the 'Proposal to increase prescribing duration – Request for feedback'

October 2024

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About the Aged Care Association

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

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

Our members provide rest home, hospital, dementia, psychogeriatric, respite, and palliative care and care for over 900 younger people with disabilities.

Sixty six percent of beds are run by religious institutions, charitable trusts, family-owned, not-for-profits, and privately owned facilities. Most of the remaining beds are operated by listed companies (34 percent), with less than 1 percent provided by Te Whatu Ora.

Residents may be

- very frail and clinically unstable,
- well but disabled and have very high care needs,
- cognitively impaired or with mental health issues, with some requiring a secure environment,
- receiving end of life care.

Funding for aged residential care is a mix of means-tested user-pays and government subsidy.

Aged residential care providers are contracted by Te Whatu Ora to provide care services at a rate that is set annually.

The ACA welcomes the opportunity to make a submission to the *Ministry of Health on the 'Proposal to increase prescribing duration – Request for feedback'.* The submission has been drafted based on inputs from the ACA Nursing Leadership Group (NLG), comprised of 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.

Context

1. The ARC sector provides services across four care categories:
    - 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. The residents 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 supports.
    - Hospital level care or continuing 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.
    - Dementia care: the resident is assessed as needing 24-hour supervision and care, in a secure environment due to risk of wandering or becoming lost due to memory loss or confusion.
    - Psychogeriatric care (also known as specialised hospital care): the resident is assessed as needing 24-hour supervision and care. This level of care is for people with major behavioural issues (including severe dementia or addictions). They need a high level of specialist nursing care.
2. The Age-Related Residential Care Services Agreement is the sector agreement between Te Whatu Ora and ARC facilities, set annually and negotiated by the Aged Care Association. It outlines the staffing requirements as well as the responsibilities for staff across all levels of care.
3. Given the vulnerability and frailty of the residents in ARC, they are assessed periodically by the GPs engaged by the facilities or by the ARC nurses to ensure that their medications are up-to-date. This is requirement under clause D16.5(e)(ii)(1) of the Age-Related-Residential-Care-Services-Agreement, which mandates General Practitioner (GP) or Nurse Practitioner (NP) to assess every resident within 2 to 5 Working Days of admission (except where the Resident has been medically examined not more than 2 Working Days prior to admission), and then not less than once a month, except where the Resident's medical condition is stable as assessed by the GP or NP, or as indicated by the Registered Nurse (RN). In case of Residents assessed as being stable, they may be examined less frequently than monthly, but at least every 3 months
4. ARC facilities also carry regular interRAI assessments to plan care. While most assessments are carried out six monthly, some residents may warrant a shorter wait period between assessments owing to a change in their condition. The resident's prescriptions are also examined during the interRAI assessments.

Responding to MoH questions on the proposal

Do you think this proposal will have the intended benefits, particularly to increasing access to medicines?

5. Yes, we believe that this could have intended benefits for the wider public, particularly those with chronic conditions, while reducing the administrative load for the medical workforce.

6. If Class C controlled drugs are also included in the new proposal, eg. Codeine, it will save on charges being made each month or each three months. However, clarity is needed on whether the exclusion for controlled drugs include all of Class A, Class B and Class C drugs.
7. Extending the period of validity for prescriptions to yearly could reduce the paperwork for the ARC workforce to a certain extent. While residents would still need to be medically assessed regularly, given their frailty, annual prescriptions could work for the cohort of residents with long-term medical conditions.

What risks do you see with giving prescribers the ability to prescribe for up to 12 months?

8. For older adults living at home or in the community, there's also a concern regarding who would be responsible for reviewing the continuation of medication, and monitoring the renal function, blood pressure, blood results etc. on a periodic basis for necessary intervention, if needed. In the case of aged care, RNs would need to ensure that these are being assessed by GPs/NPs during the periodic assessments as mentioned in point 3.
9. From an ARC perspective, our members have shared that ARC health professionals would still need to ensure a strong medicines optimisation approach for older people to ensure medicines remain fit for purpose as their needs change.
10. One of our members submitted that there is a risk a considerable waste as they already see significant amounts of returns from community patients who continue to collect medication but don't take them. They also raised concerns that many patients may end up on medications for a longer duration than necessary, if they are not assessed periodically.
11. When admitting residents from the community it would be helpful to understand whether repeats from a 12-month script can be transferred to the facility pharmacy.

What financial impacts do you think this proposal may have on your business?

12. For ARC facilities, this could bring in some cost-savings, particularly through its long-term residents, as the facilities wouldn't have to pay for repeat scripts every 3 months. However as noted we would anticipate this cost would be added into an overall increase in GP/ NP service charged to cover their loss in practice income.

Would an increase to 6 months, instead of 12 months, mitigate any financial impacts on your business?

13. We don't have enough information to answer the question at this point.

Would you expect health services to increase costs to account for these impacts?

14. We heard from our members that they understand General Practices rely on this income from the issuing of continuation prescriptions, which makes up a significant portion of their annual revenue. They raised concerns about the gap in income being potentially transferred to patients and or aged care to fill.

15. Pharmacies may also see a dip in their incomes from the loss of co-payment from patients. There were concerns from our members that this may also see an increase in the cost of other services to recover the loss.

What barriers are there to successfully implementing this proposal?

16. As outlined above in points 8 to 11.