Aged Care Association
NEW ZEALAND

Aged Care Association submission to the Disability Support Services Taskforce

November 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 1000 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 Disability Support Services Taskforce. This is a two part submission. The first part summarises the points discussed during the online consultation between the DSS Taskforce representatives, the Association, and two of the Association members offering YPD care in ARC. The second part outlines our proposed funding model for YPD provision in ARC.

Part One: DSS Taskforce Consultation Notes | 19th Nov

Summary of inputs shared:

- Need for clarification from NASC regarding admission of YPDs in ARC. It was mentioned that there's no freeze on new admissions.
- There should be transparency in ARC funding for YPD across the sector. The Association supports a multi-year sector-wide contract for YPDs in ARC.
- Clear criteria to be shared for why certain YPDs are referred into ARC.
- There should be a holding rate for beds that are being held by facilities for incoming YPD residents. ARC (non-YPD) residents normally pay this rate themselves.
- YPD residents' expectations need to be better managed with a three-party conversation at the time of NASC assessment. NASC assessor, whanau and resident, and the provider need to set resident expectations before admission.
- No interRAI assessments are carried for YPD at the moment. Therefore, facilities have little opportunity to understand the full breadth of clinical issues that a YPD might have. Often cognitive or behavioural issues are not communicated to the facilities at the time of admission. InterRAI assessments must be mandated for YPDs as well and facilities should receive the full understanding of a resident's clinical and behavioural needs.
- YPD needs are more complex than hospital level care. NASC assessments should recognize varying degrees of acuity within YPD in ARC and the rates should be set accordingly.

Other recommendations:

- YPD who are in residential care should have the right to have the facility recognised as their home and have any specialist services delivered to their "home" as it would be for other disabled residents living in their homes
- Addressing the sexual needs of YPD must also be recognized. Suggested including that as part of the NASC assessment.
- Residents who may be eligible for dual funding should be recognised at the NASC assessment stage and the information should be shared with the facilities at the time of admission.
- Currently, no costs are being paid to the providers for assessing people into respite or for specifically holding respite beds in their facilities for carers of YPDs. This needs to be remedied to ensure that there is a sufficient supply of respite beds for YPD.

Part 2: ACA asks around YPD provision

Specific to ARC multi-year contract:

YPD entered into ARC care should be considered and contracted separately from all other "residential" care contacts.

Unlike Community Residential care, such as Hohepa or in community houses, the level of care required by the individuals entering an ARC facility is predominately toward the high level of physical/clinical support specifically needed due to their disability.

An ARC facility is required to meet multiple clinical / accommodation and living activity standards in the delivery of their primary business, which is aged residential care. None of their settings are changed or compromised when the YPD is the resident.

There are no financial variables available to the ARC facility that might raise concerns of inappropriate application of the fee for service being provided by MSD to the assessed eligible individual. It is our understanding that of the approximately 7000 individuals considered to be in residential care by MSD, a maximum of 1,100 are inside an ARC facility.

Based on the above we seek consideration of being tagged low risk and separating ARC from all other provisions of residential care. As the peak body of the ARC sector, we would welcome the opportunity to negotiate a multi-year sector-wide evidence-based contract. While we are keen to move to a multi-year sector-wide contract this would be dependent on the outcomes of discussion on the following points.

A. Evidence-Based Pricing Model:

Many nations across the globe are currently addressing the rising tide of an aging population. Perhaps not gaining as much attention is the rising number of citizens surviving and, in many cases, thriving with multiple levels of abilities and health needs. In both cases it stands as democratically evident that governments are expected to plan and provide for those citizens.

Our Australian neighbors have a recently invested in multiple actions to ensure they are building their capacity to address at least the forementioned point regarding aging. One of the constructive actions they have undertaken is to empower an Independent Health and Aged Care Pricing authority. It's relevance to this conversation is acknowledgement that those individuals who meet the criteria of YPD on the whole require what is currently referred to as hospital level care and attention.

Post the recent fixing of the "daily bed rate by resident" by Te Whatu Ora the current average bed-day rate at hospital level for aged care is $298.01. As this revenue falls substantially below the amount required to cover all expenses there is now an average premium charge of $40 per day per person on top of that bed-day rate throughout New Zealand. The Independent Pricing Authority of Australia has calculated that the same level of care provided in a room with ensuite appropriate for hospital level care as being $580.84 (converted from Australian dollars to New Zealand dollars).

However, we also understand from our members that the clinical needs of YPDs vary significantly depending on their level of disabilities. We therefore propose a transparent, evidence-based pricing model which recognizes the need for funding at different levels of care.Any consideration of a

sustainable funding model should be based on a price that can be evidenced directly to the care and support required.

B. Split revenue model:

However, we would also propose the opportunity to provide greater transparency to the funder and the public of the charges through a segregated pricing model is considered. This will ensure greater understanding of where the state's responsibility and the individuals' responsibility lies regarding costs.

The table provided below shows the breakdown of costs at Hospital level care currently used in Australia.

Component	Sub Component	Class 11 (Hospital level care)
Care	Fixed: Base case tariff for standard MMM 1-4 Variable: AN-ACC Class (InterRAI)	$124.37 $210.67
	Sub-total	$335.04
Daily Living	Basic Daily Fee Additional Service Fees Hotelling Supplement	$61.96 $46.60 $11.24
	Sub-total daily living	$119.80
Accomodation	Single room + ensuite	$126.00
Total		$580.84

Carer Respite

Recognizing that many families wish to continue to care for their whanau for as long as possible, but that carer fatigue can impact negatively on both the carer and the individual requiring care, we suggest that regular access to short-term respite care be considered as part of any negotiated multi-year sector wide contract. Currently, ARC residential care providers for YPD are not paid for holding respite beds. A holding charge would ensure that sufficient number of respite beds are available when there's a need for one.

In Australia the rate of the respite supplement (on top of the appropriate care rate) is equal to the maximum rate of accommodations supplement payable for eligible permanent care recipients in the same facility (thought without means testing).

However financial recognition of the admission process costs would need to be negotiated to encourage greater use of respite, thereby better supporting informal carers with the intent of

enhancing their efforts for longer periods in the life of their loved one where both parties deem this desirable.

Admission costs

The admission process is clinically heavy and the cost of this is not considered currently in the funding model. Again, we point to the recent advances in the Australian provision with the introduction of their "Initial entry adjustment payment". This payment is payable each time a permanent care recipient enters a residential aged care facility. It helps to cover the costs associated with transitioning a new resident into care and is paid at the level of NZ$ 1628.43 per admission.