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Assessing the equity issues facing aged residential care over the coming decade

NZIER report to Aged Care Matters

15 July 2022

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Authorship

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About Aged Care Matters

Aged Care Matters is a movement of members of the New Zealand Aged Care Association to escalate a national dialogue on the crisis in the aged care sector which is at the tipping point of breakdown. They will amplify the work of the NZACA to urgently address critical government underfunding and advocate for quality care for our older people.

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Key points

Aged Care Matters commissioned NZIER to assess the equity implications of access to aged care under the current funding model. In this analysis, we considered how New Zealand fares compared to international experiences and where the needs are likely to be most acute given recent trends and future projections.

The key findings from our research show that:

- Older New Zealanders are more likely to use aged residential care (ARC) services than older people in other countries.
- Access to ARC services is means tested with some government subsidy provided. However, as costs increase without any significant increase in the subsidy level, then access and the quality of care become increasingly compromised.
- It is difficult to accurately identify government expenditure on aged care, but government spending in New Zealand appears to be low compared to other OECD members.
- Like other parts of the health system, the aged care sector is facing a shortage of skilled and trained staff and increasing staff costs.
- Under the current model, there is little incentive for existing facilities to increase investment in new beds or facilities. This raises the risk that the number of beds available will plateau or even start to fall significantly at a time when demand for aged care will increase, given the ageing population.

On the face of it, the data shows that the most acute needs for ARC services will be Nelson Marlborough, Bay of Plenty and Hawke's Bay. However, people in these regions are more likely to be able to afford private sector services. Once we overlay considerations for deprivation across the regions, we find that the West Coast, Northland, Mid-Central, Whanganui and Tairāwhiti are most likely to be left further behind as the ageing population grows over the coming decades and the system continues to shift towards user pays.

Any reassessment of the funding model for aged residential care should consider these deteriorating inequities. This will ensure all elderly New Zealanders have appropriate access to support and care.

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1 Introduction

Aged Care Matters commissioned NZIER to assess the equity implications of access to aged care under the current funding model. As the New Zealand aged care system shifts increasingly towards a user-pays model, those without the means to pay will face difficulties accessing aged residential care (ARC) services over the coming decades.

These inequities will be exacerbated by the decline in home ownership in New Zealand. Given the elderly in New Zealand have often financed aged residential care by selling their home, declining rates of home ownership reduce this pathway to accessing aged care.

In undertaking this analysis, we considered how New Zealand fares compared to international experiences of government spending on aged care and the provision of aged care in other countries. We also assess a wide range of data from the New Zealand Aged Care Association (NZACA), Ministry of Health (MoH) and Stats NZ to determine where the needs are likely to be most acute. Our findings highlight the growing inequities under the current funding model.

2 Aged residential care in New Zealand

Recent trends

Over the past few decades, access to ARC services has increasingly moved to a user-pays model. This raises issues of inequities over the coming decades, with some portions of the population likely to face difficulties in access. This is exacerbated by the decline in home ownership in New Zealand, which reduces one of the key pathways to access ARC. The elderly in New Zealand have often financed aged residential care by selling their home. For the elderly who do not own a home, this pathway to accessing aged care will not be possible. We discuss this issue further in section 5. As a result, we expect continued deterioration in the affordability of ARC for many New Zealanders over the coming decades.

Aged residential care is part of the spectrum of assistance for older people that includes assistance in their home through to care in aged care institutions. This is consistent with the OECD definition of long-term care (LTC) (see Box 1).

Where the elderly receive aged care matters

As we assess the model of ARC, it is useful to highlight that New Zealanders prefer ageing in their own home and community or “ageing in place” (Dale and St John 2022, 4). In-home services provide support to individuals to maintain an independent lifestyle (often with support from whānau or family), but they are not sufficient to support people to live safely at home when their needs change because of increasingly poor physical or cognitive health.

Government support for ageing in place has increased significantly in recent years. District Health Board (DHB) expenditure on support in the home increased by more than 120% over the ten years 2005 to 2015, while expenditure on residential care increased by more than

50% in the same period. Putting this in context, overall DHB funding only increased by 27% ("DHB Spending on Services for Older People" n.d.).

Funding under the needs assessment framework

The former district health boards currently administer assessments for long-term aged residential care.[1] People are referred for a needs assessment which is administered by the Needs Assessment and Service Coordination (NASC) service within each DHB, using the interRAI framework. The need for residential care can be assessed as rest home, dementia hospital or specialist hospital care, including psycho-geriatric. The needs assessment process also is used to assess the need for in-home support. Following a needs assessment, the individual and/or their whānau or family can choose their preferred care facility.

Aged residential care is provided by a range of private providers in both the for-profit and not-for-profit sectors. Retirement villages are not aged residential care facilities, although many now have facilities for aged residential care. Retirement villages may also have on-site services, such as access to nurse support, meal delivery and transport, that can support their residents to live independently and reduce the need for residential care.

All people over the age of 65 who are assessed as needing aged residential care are deemed to have access to care in the New Zealand health system, but this is increasingly subject to their ability to pay for care. The model for government funding has not been revised since 2000. The Ministry of Health commissioned a review in 2017 (EY 2019), but there has been no update on any work to address the issues raised in that review.

The public health system does not fully finance the cost of aged residential care. Residents are charged a fee which is capped by the *maximum contribution* calculated annually by the Ministry of Health. The maximum contribution varies from district to district, ranging from $163.82 to $177.62 per day in the year 2021/2022 and is equivalent to the rest home contract price (Director-General of Health 2021).

A resident can fund aged residential care by paying the fees privately, or they can apply for assistance through the Residential Care Subsidy or loans scheme. To qualify for the Residential Care Subsidy, a resident must have a needs assessment (NASC) recommending long-term care and meet the financial eligibility criteria. Anyone choosing to move into aged residential care without a needs assessment is not eligible for the Residential Care Subsidy.

Access to the Residential Care Subsidy is means tested, including both income and assets. The means test determines how much the resident can contribute toward the cost of care and the subsidy makes up the difference. Residents are expected to meet the costs of residential care from their assets, and the limit on total assets is relatively low, $239,930 or less, reducing the eligibility for the subsidy (Dale and St John 2022, 7).

The maximum contribution is based on a 'standard room', which is defined as a *room without the additional features of a permanent or fixed nature that constitute a Premium Room* ("Age-Related Residential Care Services Agreement" 2021, 35). Increasingly aged care facilities are providing 'premium rooms' that are slightly bigger, have ensuite bathrooms or have a better view. Residents have to pay privately for premium features which are not covered by the residential care subsidy.

[1] It is not clear how the NASC services will be administered following the disestablishment of the DHBs on 1 July. See section 4 for further discussion of this.

Challenges facing the aged care sector

A number of issues are of concern to the sector. As elsewhere in the health sector, key staff shortages exist, especially among registered nurses. The DHB contracts provide guidelines on staffing to meet the needs of the contracted care services. At hospital level care, at least one registered nurse must be on duty at all times. Nursing and care staff pay has also been increasing.

The models of care are also changing significantly and quickly. As the average age of those entering aged residential care increases, the need for rest home care is declining, while there is an increasing need for hospital and dementia care. There is a growing shift to dual-purpose beds that can be used for rest home and hospital-level care, but this means that staffing has to be adjusted with the change in use. There are inconsistencies in the assessment of need, so residents assessed at rest home level may really require hospital-level care. It has been argued that this is a way of reducing the cost to the public funding agencies. The shortage of registered nurses means that some facilities can admit rest home residents but not hospital level residents, although the return on hospital level beds is slightly better for the care facility.

Aged care facilities

The definition of a 'standard bed' is vague ("Age-Related Residential Care Services Agreement" 2021, 35). As the care needs of residents become more acute, some features, such as access to ensuite bathrooms, might be considered standard rather than premium. Some of the features that are currently classified as premium might be considered standard, to ensure that facilities can meet standards for handling residents, infection control and cultural diversity.

There has been little investment in building new or upgrading aged residential care facilities outside the Retirement Village sector, where the facilities are increasingly integrated with their wider residential offerings. Most ARC facilities in retirement villages are currently available to non-residents, but this may become less accessible as the retirement village residents age. Retirement villages are increasing building [ORA] beds (see section 3), which are targeted at their residents. Some retirement villages have a resident population willing to pay for a higher level of care than mandated by the current aged residential care system. These villages have little incentive to maintain facilities and beds within the current regime and may choose to restrict access for people who are not already resident in their village to their ARC facilities. The Retirement Villages Association (RVA) and the NZACA do not support their members restricting access to ARC facilities. Overall, there is an increasing gap between those that can afford to pay for aged residential care and those that have to rely on the basic care.

3 Occupational Rights Agreement beds

Not all beds that fall within the aged residential care category are subsidised. Beds that are in the types of dwellings that are common in retirement villages (apartments and villas, with their own kitchens and set up for independent living) are typically under an occupational rights agreement (ORA), which is a contract between the occupant and the facility and, while the occupant may receive "assisted living" services, these are self-funded.

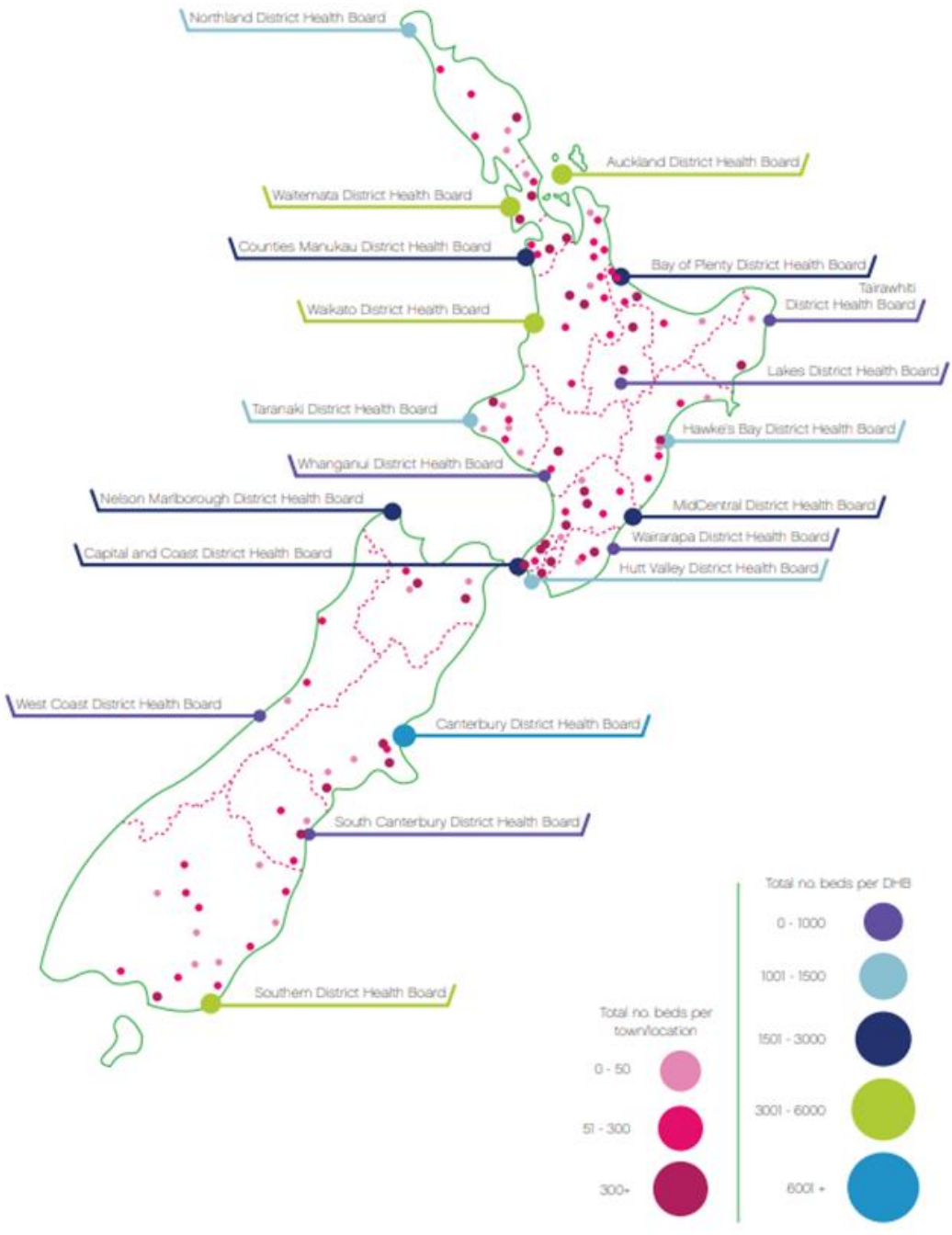
An increasing number of aged residential care beds are occupied under an ORA in retirement villages. The greatest increase in beds is also categorised as ORA beds (Reid 2022, 12). An ORA for residential care does not necessarily imply that the occupant is resident in an aged residential care facility, although these beds are designated as rest home or hospital level. The resident is more likely to be living in an independent villa or apartment designated as “assisted living” or “care support” (Saville-Smith, James, and Bawden 2019, 21).

In their survey, Saville-Smith et al. characterised ORA beds as a third tier of care provision based on the resident’s ability to pay, where tier one is a standard room, tier two a premium room with additional payments, and tier three is a room provided through an ORA for care (page 32).

Residents with an ORA for residential care will not be publicly funded under the residential care subsidy unless they have been assessed under the NASC system as needing care. Some residents could then qualify for the residential care subsidy. The subsidy will not cover the full cost of care.

Including ORA beds in the statistics on aged residential care beds masks the changes in provision in the sector. This analysis has primarily focused on non-ORA beds on the basis that the public funding model more directly covers these. The growth in ORA beds implies that the future model of care in the aged residential care sector is shifting and may not be available to all New Zealanders. As discussed earlier, declining home ownership rates reduce one of the key pathways to access the ORA type of aged residential care. This shift towards self-funding of aged residential care reflects funding pressures in the non-ORA part of the sector.

Figure 1 ARC beds by location and DHB



Source: NZIER, Ministry of Health (Certified Rest Home providers, downloaded May 2022)

4 Health reform

Hauroa Aotearoa/Health NZ was formally established on 1 July 2022. At that time, the 20 DHBs were legally disestablished. There will initially be four regions that will work with 20 districts whose geographic coverage will be the same as the current DHBs. It is expected that these districts will develop into "localities" that reflect particular whānau or communities' needs for Tier 1 services, including ARC services. National leadership teams will be established to deliver services across a number of objectives and policies, including the health of older people (Health New Zealand and Māori Health Authority 2022). This suggests that there is an opportunity to review the delivery of services to support the health of older people.

We have used data supplied by the NZACA to support our analysis. This data, using their annual member survey data and the TAS[2] Quarterly Bed Surveys, is reported against DHB regions. For this reason, we have opted to use the former DHB regions as the unit of analysis. It is not clear how the transition to localities will affect service delivery.

5 Home ownership

Aged residential care provides both care and accommodation.

One of the five areas for action identified in *Better Later Life He Oranga Kaumātua 2019 to 2034 A strategy for making the future better for New Zealanders as we age* (Tari Kaumātua, the Office for Seniors 2022) is *Creating diverse housing choices and options* so that "people can age in a place they call home, safely and where possible independently". Eight indicators have been identified to track progress in meeting this goal:

- The number of over 65-year-olds who are in severe housing deprivation.
- Access to social housing – number of days taken to house over 65-year-olds on the public housing register 2016-2021.
- Percentage of over 65-year-olds on the public housing register housed each year 2016-2021.
- The percentage of over 65-year-olds who report their house is always or often colder than they would like in winter.
- Percentage of over 65-year-olds who report that their house has a major problem with dampness or mould.
- Percentage of over 65-year-olds who report that their home needs major repairs or maintenance.
- Percentage of over 65-year-olds who live in a household that spends more than 30% of its disposable income on housing costs.
- Percentage of over 65-year-olds who own their own home without a mortgage ("Better Later Life Strategy – Key Indicators" n.d.).

[2] Technical Advisory Services

The recent review of the indicators shows that there has been no real change in outcomes across these indicators. In 2021 the share of people aged over 55 who own their home without a mortgage was about 70%, but this is projected to decline. The number of older people who will own their home with a mortgage is projected to increase.

Demand for social housing in New Zealand has increased significantly over the past five years, as represented by the numbers on the Ministry of Social Development's housing register. The number of people over 65 on the housing register has also increased. On average, they are waiting over 12 months to be housed, and the percentage of housed on the housing register has declined from 58% in 2017 to 30% in 2021. This does reflect the increase in the number on the housing register and the shortage of suitable social housing that meets the needs of older people.

Better Later Life identifies that access to *a secure place to live is fundamental to achieving wellbeing* (page 32). Living in rental housing is often not secure, making ageing in place difficult. *In a context where there are few legal tenure security protections, short-term tenancies are common and there is a lack of stock targeted to older tenants, they can struggle to find and keep a home that meets their needs* (James 2019).

The shift in home ownership and increased demand for rental housing has two implications:

- Housing has been a significant part of New Zealanders' asset holdings, and this is recognised in the calculation of the resident's contribution to the costs of aged residential care. Selling the family home has funded access to long-term care. A decline in home ownership will increase the number of people that will need government subsidies for access to aged residential care.
- The lack of rental housing that meets the needs of older people increases the possibility that these people become effectively homeless as their needs change. This could translate into an increased need for aged residential care.

6 International context

Situating the New Zealand model of aged care in the wider international context allows us to identify strengths and weaknesses in the current model and opportunities for improvement. This discussion draws on two sources: the OECD's work programme on Ageing and Long-term Care (OECD n.d.) and the Australian Royal Commission into Aged Care Quality and Safety (Royal Commission into Aged Care Quality and Safety 2021).

International comparisons of the provision of aged care, including aged residential care, are difficult because there is little consistency across countries. The OECD has been analysing the provision of LTC since 2005. It uses the System of Health Accounts 2011 developed by the OECD, EU and WHO, to provide "*a framework for the measurement of health and LTC spending and a demarcation between health and social spendings*" (OECD 2020, 5). The data is derived from the Joint Health Accounts Questionnaire (JHAQ).

This framework includes long-term care for children and adults with disabilities and long-term care for older people.

Box 1. What is included in LTC spending?

A System of Health Accounts 2011 defines total long-term care expenditure as the sum of long-term care (health) and long-term care (social).

LTC (health) includes medical or nursing care (e.g. wound dressing, administering medication, health counselling, palliative care, and medical diagnosis with relation to a LTC condition), and personal care services which provide help with activities of daily living (ADL), such as support with food intake, bathing, washing, dressing, getting out of bed, and managing incontinence.

LTC (social) consists of assistance services that enable a person to live independently. They relate to help with instrumental activities of daily living (IADL) such as shopping, cooking and performing housework. It also includes subsidies to residential services in assisted living facilities (as well as expenditure on accommodation).

LTC (health) can be further broken down into the key modes of provision: inpatient LTC (mainly in nursing homes) and home-based LTC (when care is delivered at people's homes).

LTC services can be provided by a range of health professionals and institutions but also by family members in that case a care allowance is paid. Uncompensated work by informal carers is excluded. (Mueller and Morgan 2020, 2)

New Zealand has not submitted data to the most recent JHAQ. The OECD has derived estimates from national sources for New Zealand (and Australia, Chile, Turkey and the United States). The estimates for New Zealand's total expenditure on LTC are based on the *Health Expenditure Trends in New Zealand* (Ministry of Health 2012). The OECD estimated that the share of total expenditure on LTC in GDP would be about 1.5% and commented that this would likely define a lower limit (OECD 2020, 43). This was based on the expectation that the share of expenditure on LTC would have increased over the last decade. This estimate includes national expenditure on disability services (EY 2019, 422).

In the year ended June 2015, the combined DHB expenditure on support services for older people, including residential care, support in the home, support for carers, hospital-based rehabilitation and assessment, coordination and other services, was $983 million, of which 60% was on aged residential care ("DHB Spending on Services for Older People" n.d.). This implies that DHB spending on LTC for older people is about 0.45% of GDP.[3]

About 63% of residents in aged residential care receive a residential care subsidy for their care (Reid 2022, 23). Because the level of the subsidy varies, this will not cover the full cost of care for these residents. The private spend on aged residential care will match if not exceed the DHB contribution.

As part of its wide-ranging review of aged care quality and safety, the Australian Royal Commission commissioned several research reports. The *Review of International Systems for Long-Term Care of Older People* (Dyer et al. 2020) categorised LTC systems by the level of access to support services in the home and aged residential care and the reliance on consumer funding. Systems with high access and high government funding, i.e. low reliance on consumer funding, were regarded as high performing (page x). The report noted that there isn't a strong relationship between the national age dependency ratio and government spending on LTC (page xi).

New Zealand has high access and reliance on consumer spending, particularly on aged residential care. It scores well on coordination with other health services, quality, consumer choice and entitlement. Denmark and Germany scored highest with the highest levels of access, the lowest level of cost-sharing, high-quality standards and integration with other health services (page xi).

New Zealand ranks near the top of international comparisons with respect to the number of people in aged residential care, with 14.6% of the population aged 80+ in aged residential care in 2019. Using a similar measure to New Zealand, Australia has about 13.9% of the 80+ population in aged residential care (page xii). New Zealand also ranks quite high on access to home-based LTC, with 25% of the 80+ population receiving home-based LTC [2016 - EY].

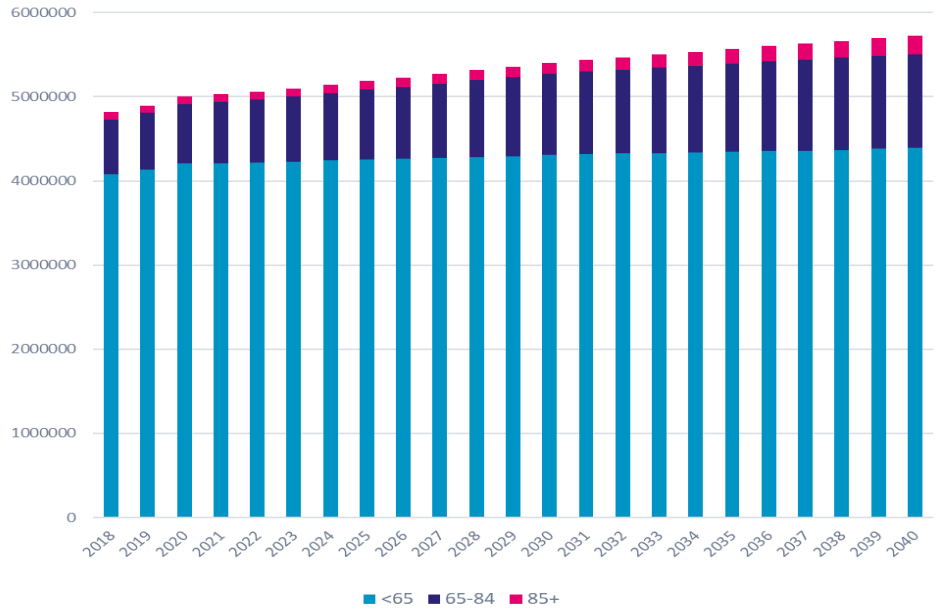
There has been a trend away from institutional or residential care in LTC, particularly in Europe, with a greater emphasis on community-based care.

[3] Government expenditure on national disability support services was about $1.1 billion in the year ended June 2015. This suggests that the total government expenditure on LTC, as defined by the OECD, was about 1% of GDP.

7 Aotearoa New Zealand

Like its OECD counterparts, New Zealand's population is ageing, with an increasing share of older people. At the same time, people are living longer, so the number of people aged 85+ is increasing.

Figure 2 New Zealand population projections

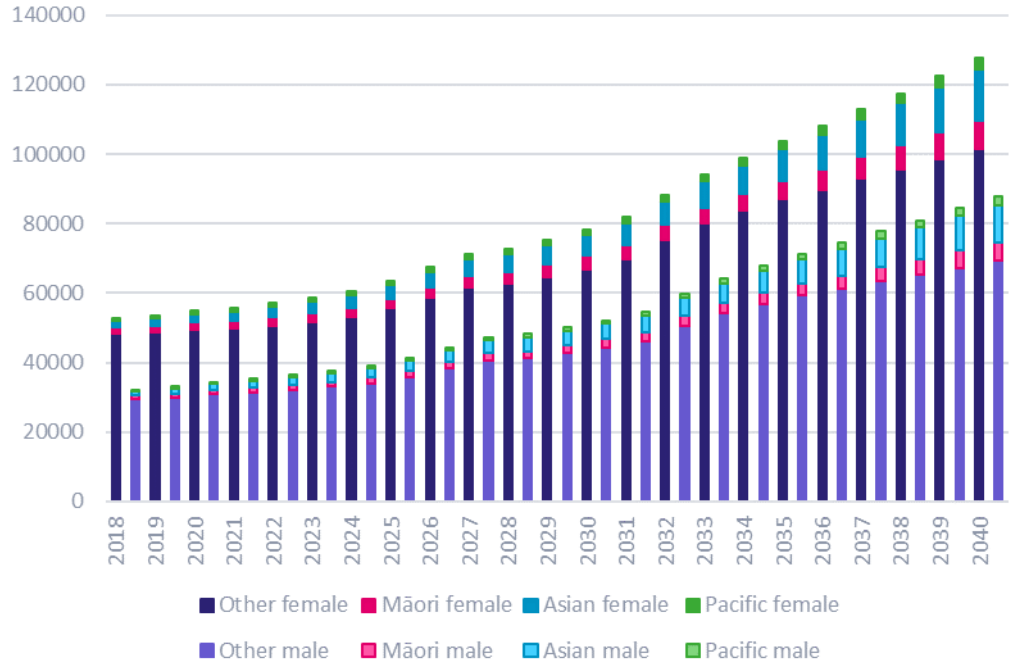


Source: Ministry of Health

People aged 65+ can access aged residential care in New Zealand, but the predominant age group is the 85+ group. We have used that group for the demographic analysis.[4] Figure 2 shows the ethnic and gender split of the 85+ population up to 2040. Although the share of Māori, Pacific and Asian people is rising in the 85+ population, it will continue to be predominantly New Zealand European through to 2050. In 2018 females made up about 62% of the 85+ population. This is expected to decline slightly to 59% in 2050.

[4] We recognise the lower life expectancy of Māori and Pacific people may mean that assessing the 85+ year age group may result in under-estimation of the aged care needs of these ethnicities.

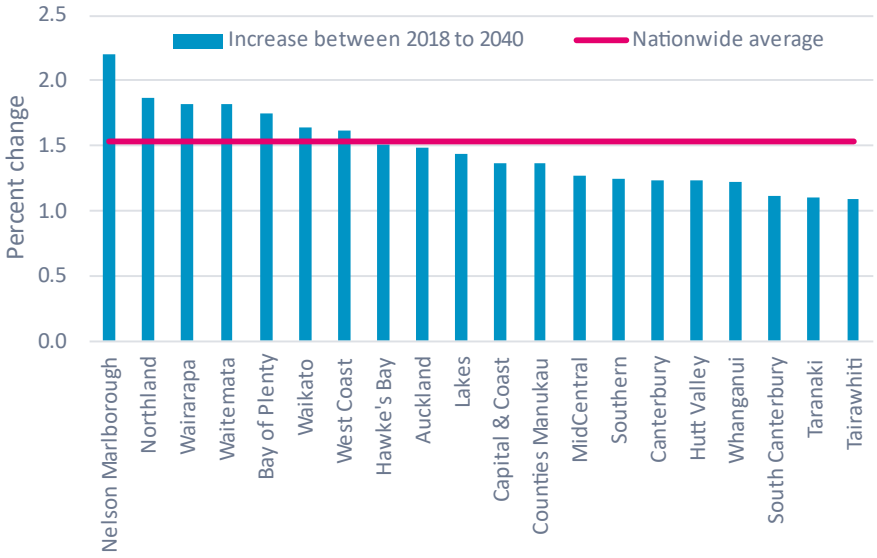
Figure 3 85+ population by gender and ethnicity



Source: Ministry of Health

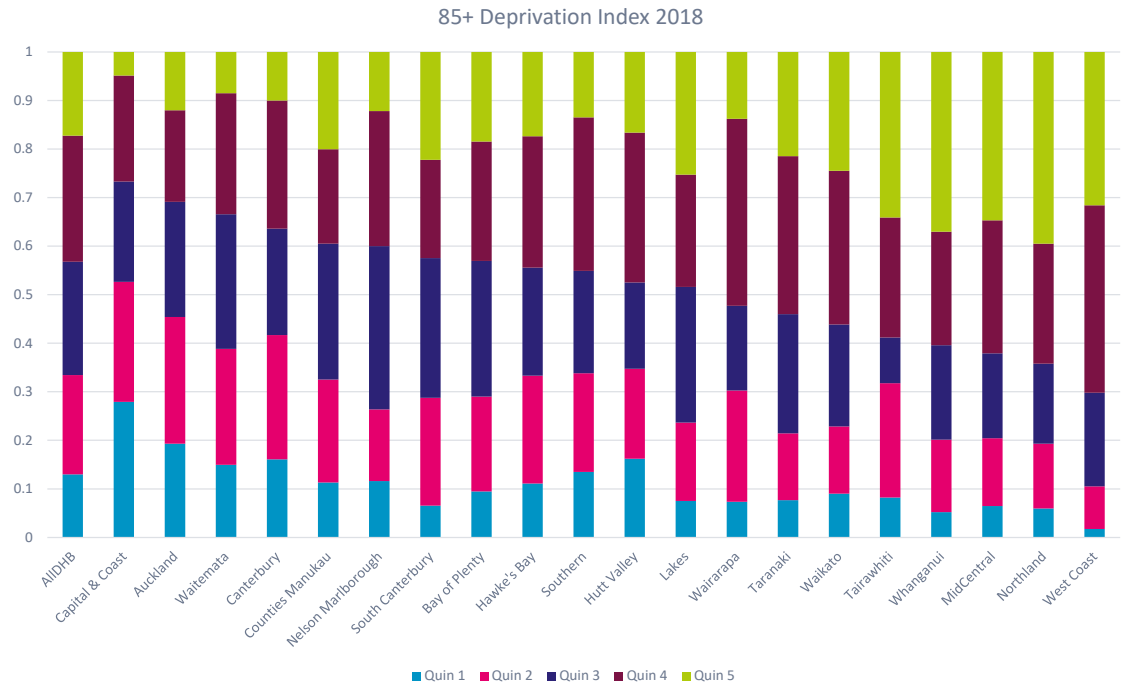
The regions with the largest increase in the 85+ population compared with the national average from 2018 to 2040 are projected to be Nelson Marlborough, Northland, Wairarapa, Waitemata, Bay of Plenty, Waikato and the West Coast.

Figure 4 Projected increase in 85+ population by DHB between 2018 to 2040



Source: Ministry of Health

Figure 5 DHB regions ranked by deprivation index, Quin 4 + Quin 5



Source: Ministry of Health

Household income and wealth are significant factors in calculating an individual's contribution to the cost of aged residential care. As the costs of aged residential care increase ahead of the maximum contribution determined by the Ministry of Health, those that can pay will have better access to aged residential care. Stats NZ publishes data on household net worth, but this is not available by region.

Deprivation has been a factor in determining the level of funding for DHBs. Figure 5 ranks the DHB areas by the share of the population aged 85+ that falls within deprivation quintiles 4 and 5, where quintile 5 is the most deprived, and quintile 1 is the least deprived. In line with MoH guidance, we consider quintiles 4 and 5 as the portions of the population to be deprived, and hence likely to have difficulty accessing ARC services. This is based on the University of Otago New Zealand index of socioeconomic deprivation (NZDep 2018). NZDep2018 combines nine variables from the 2018 census to identify eight dimensions of deprivation (Atkinson, Crampton, and Salmond 2021).

This indicates that the DHB regions where more than 60% of the population aged 85+ falls within deprivation quintiles 4 and 5 are West Coast, Northland, MidCentral, Whanganui and Tairāwhiti. At the other end of the scale in Capital & Coast, Auckland, Waitemata, Canterbury and Counties Manakau, less than 40% of the population falls within deprivation quintiles 4 and 5.

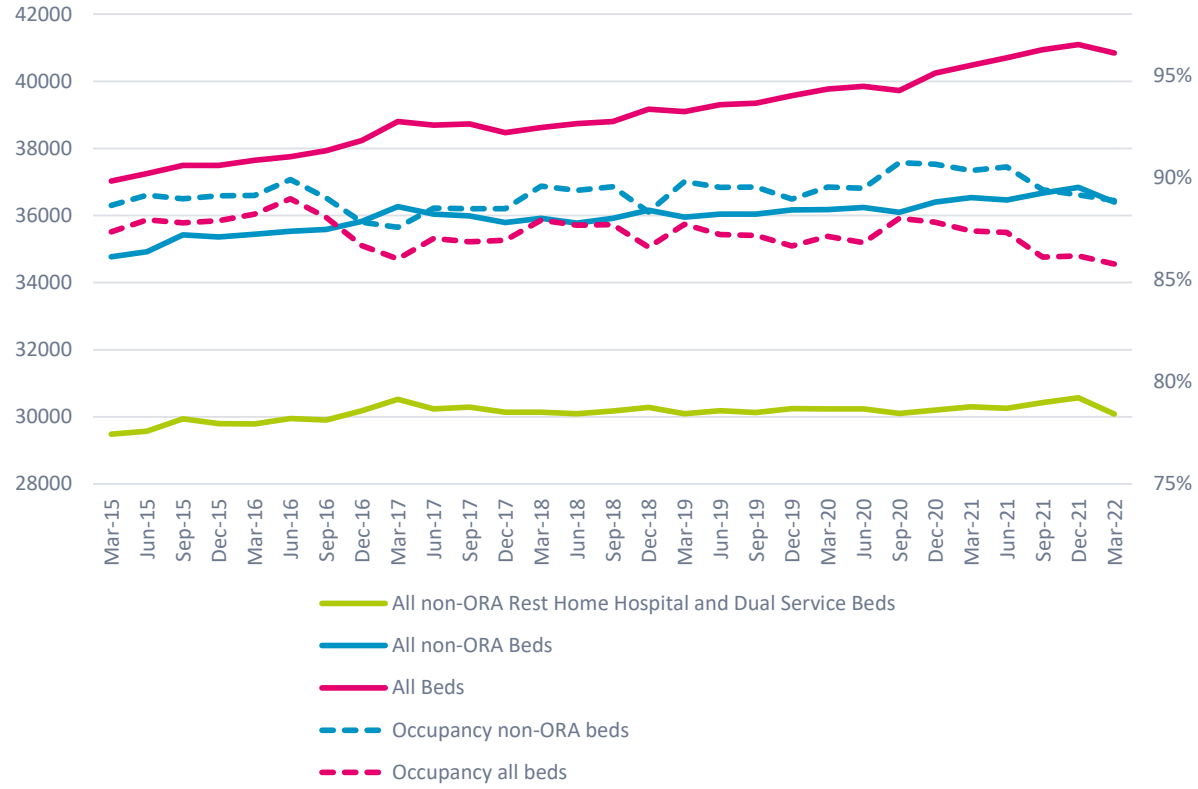
Population projections for the DHB regions assume that these proportions remain constant for the period of the projections from 2018 to 2040.

8 Aged residential beds by DHB

In New Zealand, aged residential care beds are classified into four categories by the health sector: rest home, hospital, dementia, and psycho-geriatric. As the needs of those entering ARC have increased, there is less distinction between rest home and hospital-level care in some cases and a shift to designating beds as dual use so that they can be used for either rest home or hospital-level care as required. For this reason, we have combined rest home, hospital and dual-use beds.

We have kept dementia beds separate as there is potentially a different model of care, and the facilities required for dementia care are less likely to be multi-purpose.

Figure 6 ARC beds and occupancy



Source: TAS ARC Quarterly Reporting Survey compiled by NZACA

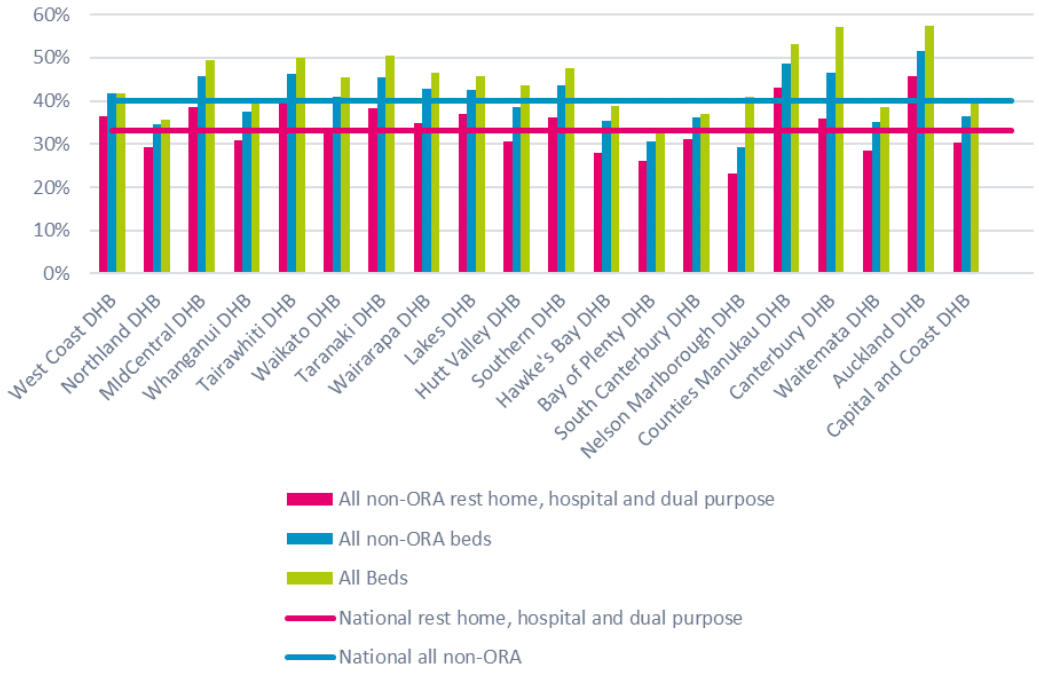
Figure 6 graphs the supply of non-ORA beds and all beds, including ORA beds, nationally. This indicates that the total beds available have been growing, but this has been primarily in ORA beds. There has been a decline in the number of beds in the last quarter, but this is not uniform across all regions (see Appendix A).

The decline in bed numbers has not been matched by a rise in occupancy rates. EY commented on the decline in occupancy rates in 2019 (EY 2019). Recent commentary from NZACA suggests this apparent anomaly in the data could be explained by facilities choosing to defer new admissions because of the COVID-19 outbreak, as well as the impact of the

shortage of Registered Nurses (McDougall 2022b). The shortage of registered nurses and rising staff costs mean some aged care facilities are not admitting people with complex multi-morbidity.

Another factor contributing to this trend decline in occupancy rates is that potential residents are wary of entering aged residential care because of the impact of COVID-19-related measures. There is a possible perception that residents are more likely to contract COVID-19 in an aged residential care facility, although COVID-19 mortality in ARC has been relatively low in New Zealand compared with other countries. A more important factor may be the restrictions on non-resident access to aged care facilities that have limited contact with whānau and others.

Figure 7 ARC beds as % of 85+ population, March 2022



Source: TAS ARC Quarterly Reporting Survey compiled by NZACA, Ministry of Health

Figure 7 shows the number of aged residential care beds as a proportion of the population aged 85+ by DHB region for March 2022. The DHB regions are ranked by the deprivation index so that the DHB region with the population aged 85+ with the greatest level of deprivation is on the left of the graph. The straight horizontal lines represent the nationwide averages. One estimate of the use of late-life care by the population aged 85+ in New Zealand suggested that it could be as high as 66% (Broad et al. 2015). This may be falling, partly because the number of people aged 85+ is increasing while the number of aged residential care beds has not increased at the same rate. If 66% is a high estimate, the availability of beds is nevertheless considerably lower.

There is considerable variation between DHBs. There is not an obvious relationship between the number of aged residential care beds in a DHB region and the relative level of deprivation. Four regions appear to have a significant shortfall: Hawke's Bay; Bay of Plenty; South Canterbury; and Nelson Marlborough. Of those, both the Bay of Plenty and Nelson Marlborough have had some decline in non-ORA bed numbers, and occupancy rates are

higher. Hawke's Bay, Bay of Plenty and Nelson Marlborough also have proportionately higher populations aged 65+.

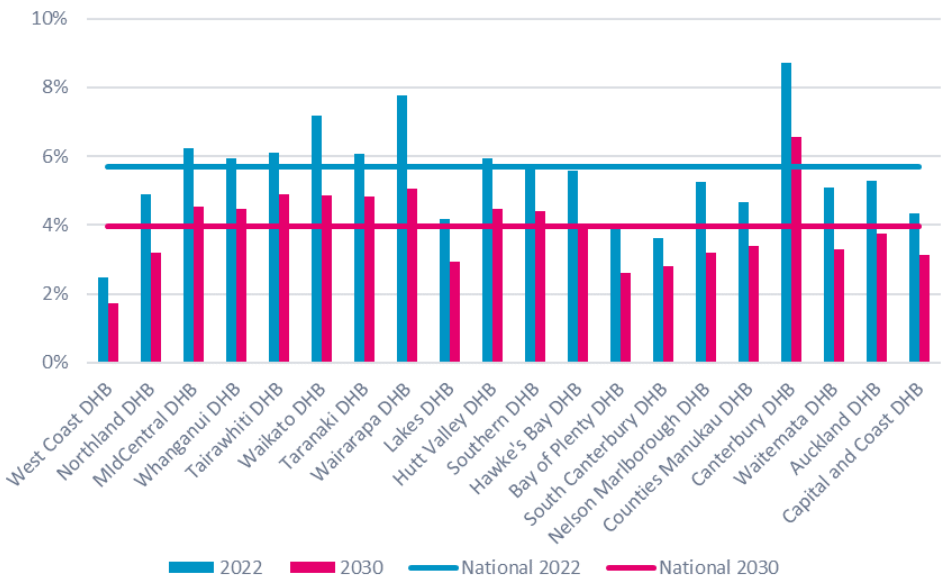
Figure 8 maps all non-ORA aged residential care beds against the population aged 85+ in 2022 and 2030. We have assumed that there is no new investment in aged residential care facilities and beds over this period and that there is no significant reduction in beds. The impact is to reduce the coverage from 40% to 29% at a national level, with significant variation between the regions.

To maintain coverage at the national level of 40%, the number of non-ORA beds would need to increase from 36,402 in 2022 to 52,224 in 2030, or by 43%. Some of this difference is likely to be met by ORA beds, but Broad has noted these are unlikely to be available to those individuals who cannot pay for the ORA for residential care.

Figure 8 All non-ORA ARC beds as % of 85+ population, 2022 and 2030

Source: TAS ARC Quarterly Reporting Survey compiled by NZACA, Ministry of Health

Figure 9 Dementia beds as % of 85+ population, 2022 and 2030



Source: TAS ARC Quarterly Reporting Survey compiled by NZACA, Ministry of Health

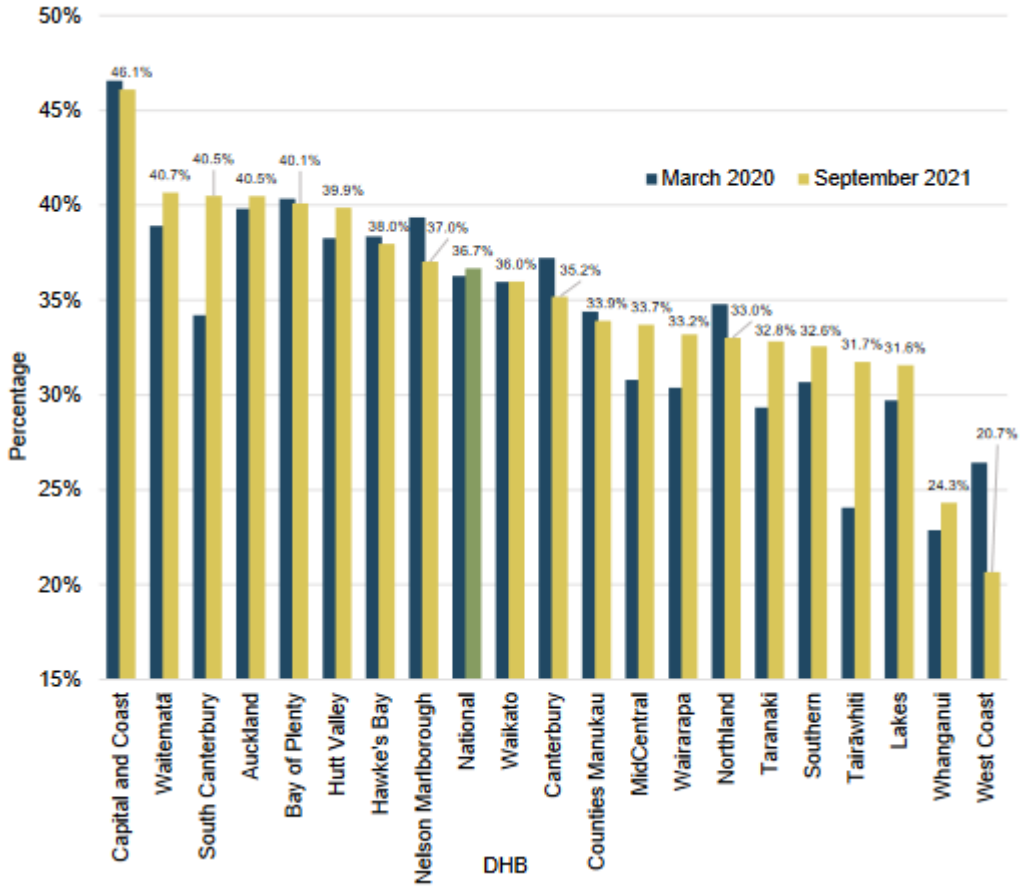
There is a greater variation in the availability of dementia care beds. West Coast and Northland have fewer dementia beds, but availability is not consistent across the DHB regions. The expected rise in the need for dementia care means that there is a need for increased investment in the provision of dementia care facilities, which are generally outside the scope of an ORA for residential care.

At 30 September 2021, 63% of long-term aged residential care residents received a residential care subsidy (Reid 2022, 23). Residents in dementia or rest home care are more likely to be non-subsidised.

The DHBs have had four output classes: prevention; early detection and management; intensive assessment and treatment; and rehabilitation and support. Services for older people, including access to aged residential care, are included in rehabilitation and support. Although these output classes are universal, each DHB has determined its outcome measures to reflect its community's needs. This means there is no transparency on how the DHBs approach the provision of long-term care across the continuum in their communities.

For example, Tairāwhiti District Health Board (TDHB) had an objective of increasing the ratio of long-term home support clients over people in residential care. It provides data on the share of the population aged 65+ that receive some funding for aged residential care and those that receive home-based support services. In the year ended June 2021, TDHB reported that of the population aged 65+, approximately 6% received funding for aged residential care and about 9% for home-based support services. This has been the same for the past five years (Tairāwhiti District Health 2021, 37). A quick review of some other DHB reports indicates that their choice of impact measures does not provide this information.

Figure 10 Long term ARC residents who are non-subsidised by DHB



Source: Reid (2022, 25)

9 Implications

Older people enter aged residential care via two routes:

1. They are assessed as meeting the criteria for aged residential care following a Needs Assessment; or
2. They choose to enter aged residential care independent of the needs assessment process and will be financially independent.

The deteriorating affordability of ARC services matters because the ageing population will require care over the coming decades. Without access to ARC services, the burden of care will fall on whānau or families and other parts of the healthcare system.

This analysis has focused on the needs of those less likely to be financially independent and more likely to be in group 1. A shift to ARC beds that are classified as premium (with additional charges) or ORA would impact that group directly.

A person who is assessed as needing ARC can choose not to enter ARC. This is most likely if they have whānau or other family support and access to respite support. Older people who do not have whānau or other family support do not have similar options.

Whānau and other family support tend to fall on women, whether looking after their partners or other family members. This may mean that women are unable to participate in the workforce while they are care givers, which both reduces their income and their economic contribution. Because women tend to live longer than men, they are more likely to access ARC if they do not have whānau or family support for end-of-life care (Dale and St John 2022, 5).

Other options are hospice support, which is not set up for end-of-life care for older people, or possibly inpatient hospital care. The New Zealand public hospital system has very limited facilities for older people care. Only 0.4% of aged care beds were DHB-owned in September 2021 (Reid 2022, 10). The public hospital system relies on the availability of beds in the aged care industry to take older people who cannot live independently or need palliative end-of-life care. There is anecdotal reporting that there are older people in hospital who cannot move into ARC because the care facilities cannot take new residents because of the shortage of registered nurses (Gordon 2022).

The population aged 65+ is increasing in part because older people are also living longer. At the same time, many of these people are healthier and living more active lives. The rising population of older people will not necessarily translate directly into a proportionate increase in demand for aged care beds. But the increase in the number of people aged 85+ implies demand will increase.

The public health system is dependent on the aged residential care providers to meet current demand and any projected increase. Currently, there is no incentive to invest in the sector to meet the needs of those with limited means to pay. And those willing to pay want better facilities than mandated by the current system.

For most people, access to aged residential care is not a desire or even a priority until they need it, either directly or because whānau or family can no longer manage the older person's needs at home.

The demographic information suggests the most acute needs for ARC services will be in Nelson, Marlborough, Bay of Plenty and Hawke's Bay. However, people in these regions are more likely to be able to afford private sector services. Once we overlay considerations for deprivation across the regions, we find that the West Coast, Northland, Mid-Central, Whanganui and Tairāwhiti are most likely to be left further behind as the ageing population grows over the coming decades and the system continues to shift towards user pays.

10 Caveats around data interpretation

The data on the use of residential aged care as reported to TAS is reportedly inconsistent[5] from quarter to quarter, perhaps reflecting the interchangeability in classifications between rest home and hospital care, reflected in the designation of some beds as dual use. There is

[5] Email correspondence with NZACA.

considerable anecdotal information across the aged care sector that is not directly supported by the data.

The data as it stands can support a range of interpretations. At face value, it appears that there is currently not a shortage of aged residential care beds in New Zealand, especially as occupancy rates are not increasing markedly

This macro view undoubtedly masks some underlying issues. In April 2022, the NZACA members asked its members to identify unoccupied beds that are not operational, at least in part because of the shortage of registered nurses. Excluding these from the number of non-ORA beds suggests that occupancy rates for non-ORA beds are close to 100% in some regions and that facilities are managing the staffing issue by not taking new residents (McDougall 2022a). In particular, the current classification of needs is not a good guide to the level of care required and future needs. The increase in ORA beds points to a greater focus on accommodation over improving care outcomes.

11 Other issues for consideration

This review of the equity issues facing aged residential care has highlighted several issues facing the sector, and there is a lack of consensus on the role of aged residential care and its place in the wider provision of health outcomes.

There is a widely expressed view that many people do not want to enter aged residential care, preferring to die at home among their community. Supporting these people is a priority within the current health strategy, but there is still a need for some aged residential care to provide respite support, palliative end-of-life care[6] and long-term care for those with needs that cannot be easily supported in the community, such as dementia.

Current models of long-term care, including aged residential care, are based on the European medical framework. These do not necessarily integrate Māori, Pacific or Asian people's end-of-life practices into the model of care.

The current definition of a 'standard bed' is vague. It has a meaning that does not recognise that this is an older person's home for the term of their residence. Access to an ensuite bathroom is currently defined as a premium cost, under the ARRC contract, although it helps meet infection control requirements as well as supporting the resident's dignity. The standards are also out of line with other guidelines in the health sector, such as from the ACC on moving and handling of people (ACC n.d.).

As EY noted in 2018, there is a need for better clarity on the model(s) of care in the aged care sector. It has been reported for some time that there is a declining need for rest home care as it is currently defined and that most people entering aged residential care now have multiple morbidities combining physical and cognitive needs. Indeed, Dale and St John refer to ARC as "end-of-life" care (page 4). The average age of residents entering aged residential care is rising, which also means that they have more acute conditions when they enter care. In turn, this means that the average cost of care is rising. The needs classification for hospital care is very wide but does not seem to reflect the increasingly complex needs of people in aged residential care and the related costs.

[6] We recognise that many would prefer to spend their last days in their own home.

Those referring people to aged residential care appear to have a financial incentive to minimise the level of care funded because it potentially reduces the base cost, increasing the availability of funding, although not the availability of beds.

Although the changing needs of older people in aged residential care is widely recognised, there is a laissez-faire approach to investing in facilities that are fit for purpose. Outside retirement villages, there has been no investment in new aged residential care facilities in recent years.

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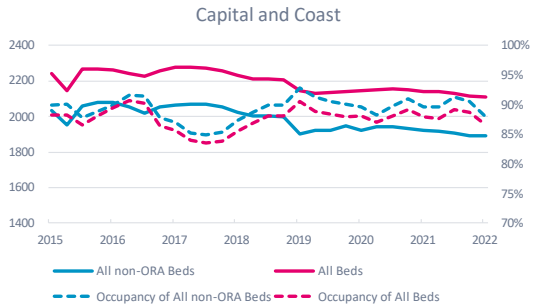
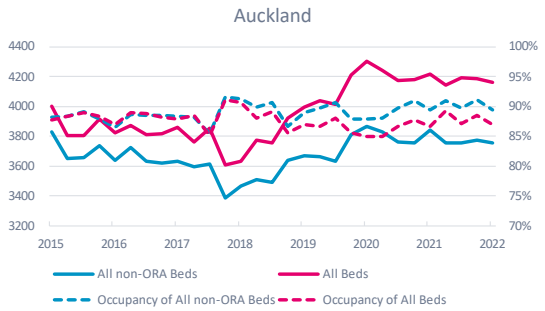
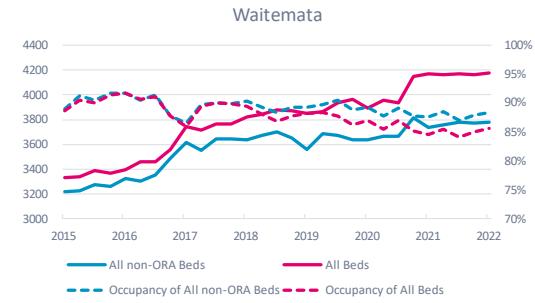
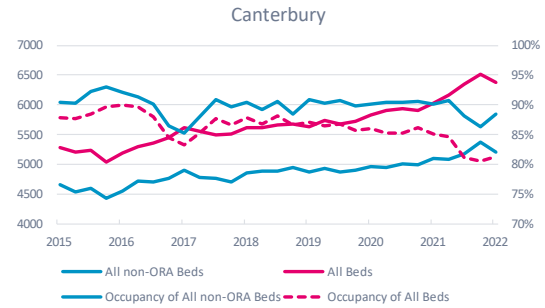
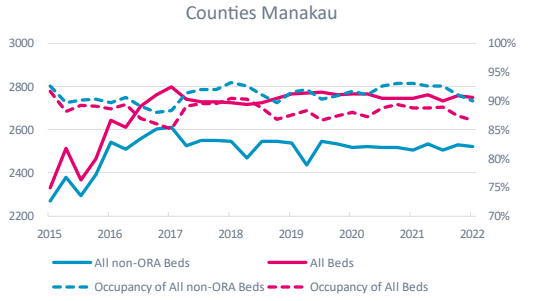
Appendix A Aged care beds and occupancy by region[7]

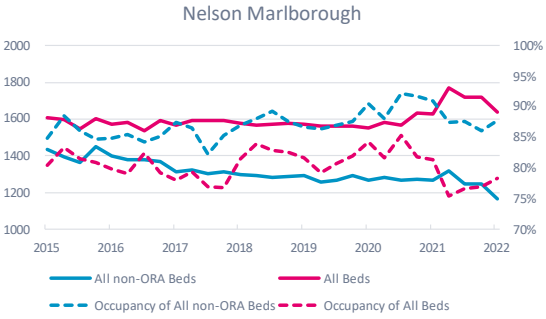






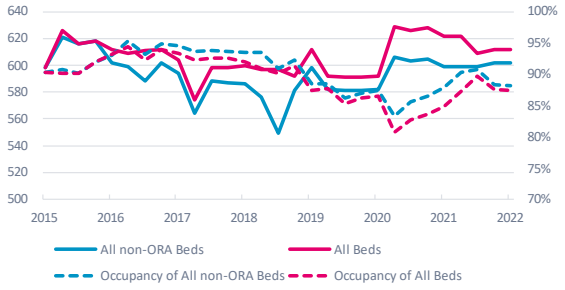






7 Source: NZACA

South Canterbury



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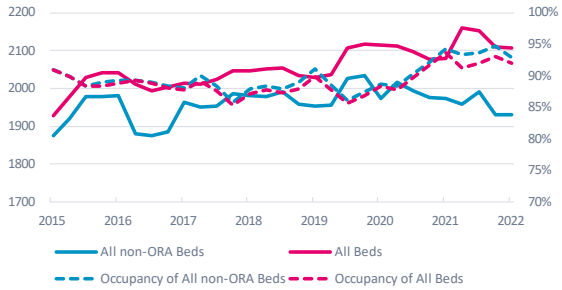
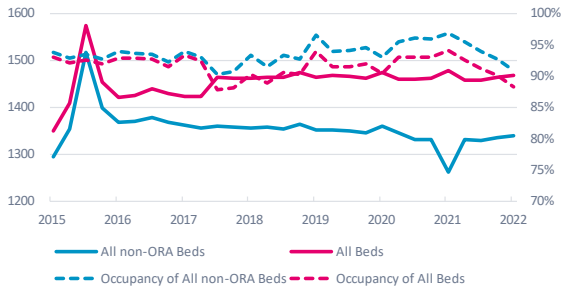


Hawke's Bay



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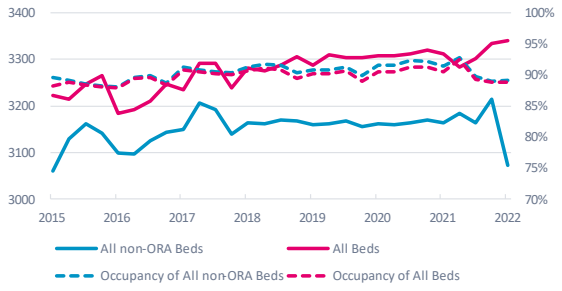

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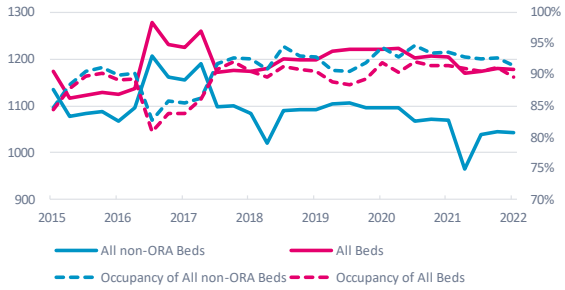

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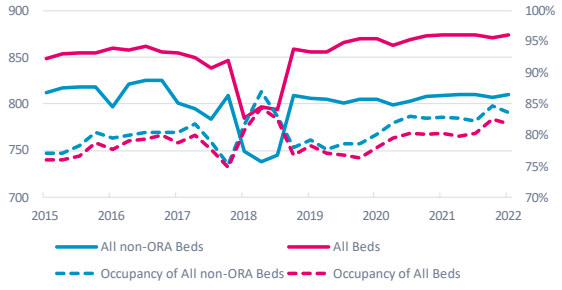

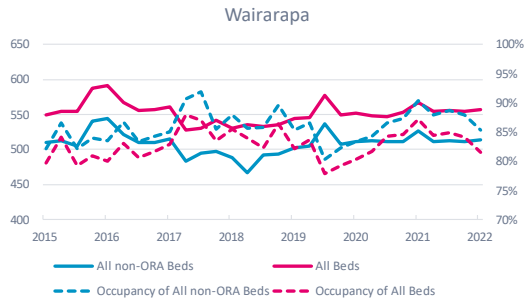
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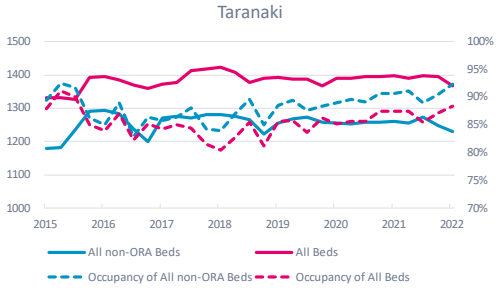
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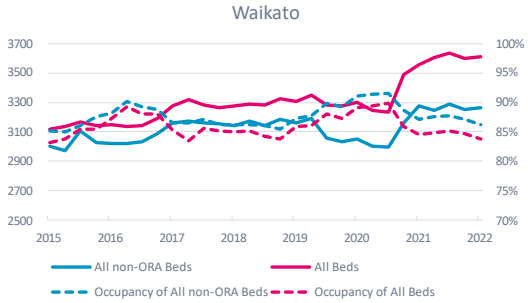
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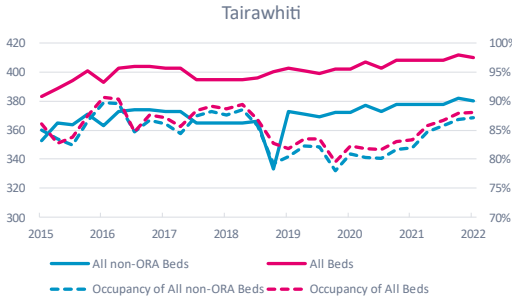
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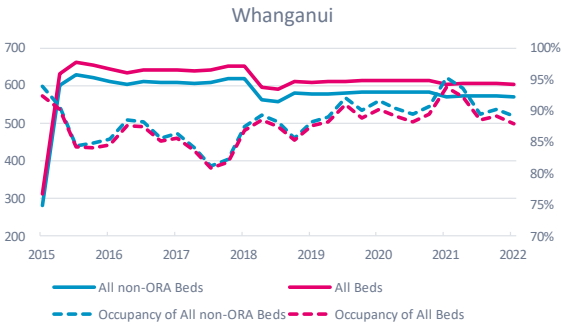
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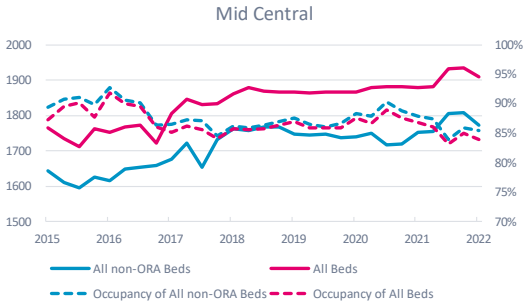
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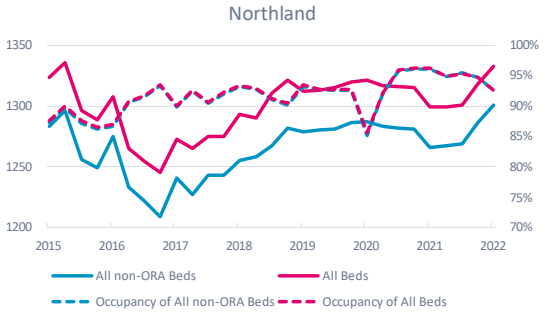
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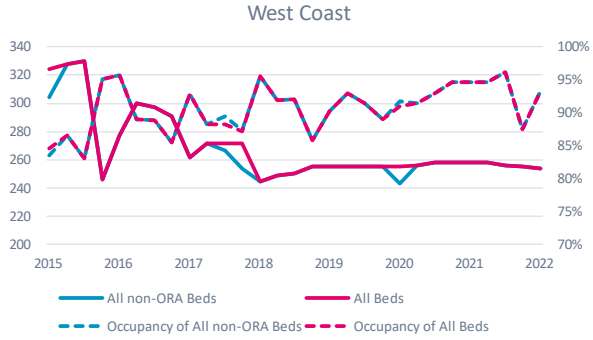
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