



Choice Not Chance for Older New Zealanders

Aged Care Discussion Paper by Jo Goodhew MP

NATIONAL PARTY ASSOCIATE HEALTH SPOKESWOMAN

National
www.national.org.nz





Our population is ageing. In the future, growing numbers of older people will make increasing demands on aged-care providers. And, although caring for older New Zealanders will always be a core public service, we need to make sure we can continue to provide people with the choice of high-quality care they need.

Our ability to do this will depend on two things: how prosperous we are as a country, and how well we use our resources.

Wealthier countries can afford to pay for better aged-care services, through both public funding and private contributions. Policies that will help build a more prosperous future for New Zealand are at the heart of National's vision.

At the same time, we must get the most out of our existing resources. That means investing in aged-care services as wisely and effectively as we can, and making sure we have the right structures and processes in place.

That's why we have prepared this discussion paper. Your feedback on this paper will help us address the key issues the aged-care sector faces, and provide a better future for older New Zealanders and their families.

Yours sincerely

John Key
NATIONAL PARTY LEADER

Choice Not Chance for Older New Zealanders

CONTENTS

	Introduction	
1	Our Themes	4
2	Aged Care in New Zealand	5
3	Residential Care	8
4	Home-based Care	10
5	Informal Care	12
6	Workforce Development	13
7	Ensuring Consistency	14
8	Coordination of Care	15
9	Quality of Care	17
	Feedback form	18



Published in 2007 by The Office of the Leader of the
Opposition. Written by Jo Goodhew.

Cover photo by John Boyer.

All rights reserved. © Copyright 2007

1. Our Themes

National has consulted widely among older people, their families, and care providers to learn how we can improve aged care in New Zealand.

National believes that New Zealanders who require care in their older years should have a choice of high-quality services that meet their needs. With an ageing population, it is vital we explore how this choice can best be delivered.

We have developed five principles, or themes, that frame our beliefs about what New Zealanders should expect from aged care. These were presented at the Health Care Providers Conference in 2006:

Theme 1: Independence and choice, so users of aged-care services have a choice of providers who meet national standards of care.

Theme 2: Provision of a continuum of care to ensure that access to health and social-care services, including respite care, is seamless.

Theme 3: Sustainable funding partnerships, to improve our capacity to meet the growth in demand for aged-care services.

Theme 4: Provision of a trained and skilled workforce to ensure the delivery of safe, quality care.

Theme 5: New technologies to deal with aged-care issues in the decades ahead.

Consulting older New Zealanders

National has consulted widely to prepare options for a future of quality care for New Zealand's older people. We held 15 aged-care forums throughout the country, and invited people involved in every aspect of aged care to participate. National's health team also met with many other New Zealanders with an interest in the care and support of older people.

In the forums, we explored the validity of our five themes by listening to the wider concerns expressed by **older people**, their **families** and their **care providers**. Many stories were shared by those who attended and these gave us a great deal of insight into the sector.

In particular, we asked the participants to share their beliefs and experiences about what currently works well in aged care, what is not working so well, and what changes they would like to see.

Older people told us they have difficulty navigating the myriad of services. They want to remain independent for as long as possible, and they want to 'know' their caregivers, not have them change all the time.

They told us it is important to have a choice of care providers offering assured, safe, and high-quality care. They want to know where they can turn when they don't feel safe or have concerns about their care. They are anxious about the transition from hospital back to their homes or to a community facility.

Families are also concerned about these issues. They worry about the pressure of caring for loved ones at home and how this impacts on their own health, particularly because of difficulties accessing respite care. Families also have concerns that they are not adequately trained to be caregivers.

Care providers are worried about their workforce turnover, the high compliance costs of auditing, and their reliance on government subsidies. They don't like having to renegotiate their contracts annually so they can receive increases in funding from DHBs. They also don't like the 'silo' approach to funding that makes it difficult to supply a continuum of care across the ongoing needs of older people.

We have used our themes and the concerns raised by the forum participants to develop a number of proposals to improve aged care in New Zealand. These proposals are outlined in this document.



Jo Goodhew MP congratulating Margaret McIsaac on her 100th birthday.

2. Aged Care in New Zealand

Aged care is a core health service, but our ageing population will place increasing demands on it

As our population ages, a growing number of older people will require more care. This will put greater pressure on care providers and increase demand on health funding.

In the 2006 census, there were 495,600 New Zealanders over 65 years of age - around 12% of the population. By 2031, the number of people living in New Zealand over 65 is projected to increase to about 1.08 million, or 22% of the population.

The greatest population increase is projected for those who are 85 years or older. See Figure 2.

Society and the state must plan for the care and support that our ageing population will require.

Increasing numbers of older people will impact on the way we deliver health and social resources. Changing work and retirement practices may modify fundamental lifestyles and where older people are located. This will lead to changes in health and disability support service needs, family structures, and the relative wealth and wellbeing of retired people.

Current funding

Public funding for aged care is provided as **health services** and **disability support services**.

Health services for older people include public expenditure on general practice, community health, pharmaceuticals, laboratory tests, and hospital-based services. Older people are higher users of publicly funded health services. In 2005/06 the estimated per capita public expenditure on health¹ was:

- \$1,361 for people under the age of 15
- \$1,628 for people aged 15-64
- \$6,729 for people aged 65-74

Disability Support Services (DSS) for older people include:

- Needs Assessment and Service Coordination (NASC)
- Assessment, Treatment and Rehabilitation services (AT&R)
- A range of home-based care services
- Long-term residential and medical/geriatric hospital care

¹ The Treasury, 2007

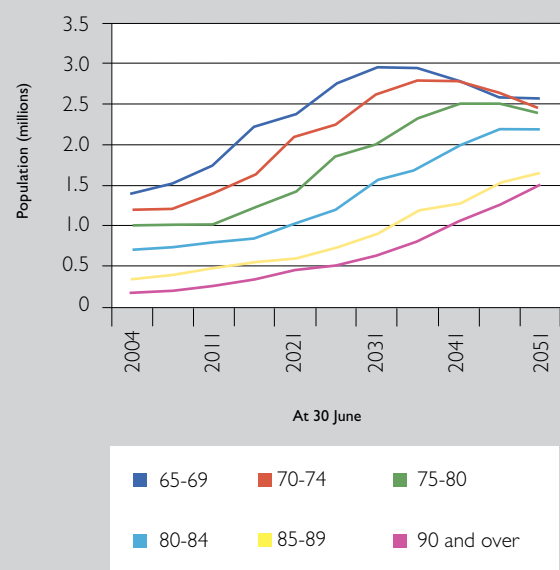
Figure 1

Projected New Zealand Population by Age Range from June 30 2004 to June 30 2051



Figure 2

Projected New Zealand Population over 65 years of Age by Age Range from 30 June 2004 to 30 June 2051



The Ministry of Health estimates that around 69% of DSS funding is used by people over 65 years of age. Females incur per capita costs of \$8,460 and males \$5,476.

Most older people require DSS funding at some stage. DSS funding for people aged 65 years and over is more than \$1 billion per year. Access to disability support services, the numbers involved, and government expenditure is described in figure 3 (overleaf).

A core health service

National believes the care of older people is a core health service. We will support New Zealanders who wish to age at home, or who choose to enter a residential facility which is home-like and meets their needs for care.

When the level of care required exceeds that available in the home, every endeavour will be made to secure the appropriate level of care within the older person's local community, close to relatives and other support people.

The present funding system is not meeting the demand for carers. As a result, some older people suddenly find themselves without the care they have come to rely on, or find themselves on waiting lists, despite being independently assessed as needing care or assistance.

Figure 3

Disability Support Services in New Zealand, Access and Utilization and Government Expenditure (2004)

DSS Service	Access	Number of people in care	Government expenditure
Needs Assessment and Service Coordination	Needs assessment		\$30 million
Assessment Treatment & Rehabilitation	Needs assessment		\$148 million
Home Based Support			\$168 million
· Household management (mainly Household cleaning)	Needs assessment and income tested	50,513	
· Personal care	Needs assessment based only	19,157	
Carer Support	Needs Assessment		\$65 million
Respite care	Needs assessment		\$24 million
Environmental Support	Needs assessment		\$91 million
Residential care (Under 65 years of age)	Needs assessment	7,000 residents	\$298 million
Residential care (over 65 years of age)	Needs assessment and income tested	25,234	\$589 million
Dementia care – residential	Needs assessment and income tested	3,368	
Long stay psycho-geriatric hospital care	Needs assessment	1,068	
Long stay geriatric/ medical hospital care	Needs assessment	16,541	

Source: Ministry of Health OIA, August 2005

Note: 2004 is the latest year that figures have been released. This table does not include the total amount paid privately by patients and their families who fail to meet the income and asset-testing criteria, or any additional co-payments charged by providers of these services.

3. Residential Care

Growth in demand for residential care requires a focus on sustainable funding.

The greatest amount of disability support funding for older people is spent on residential care. Access to residential care is via an assessment-of-need process, and income and asset testing for a government subsidy. Residents are required to meet the nationally described "High or Very High levels" of assessed need.

The current average age of entry into residential care is in the mid-80s and the average length of stay in residential care is seven and a half months¹.

DHBs now manage the funding of all disability support services for older people and allocate and contract with certified providers of rest-home, dementia and long stay hospital (LSH) beds. Contracted rates vary between Territorial Licensing Authority (TLA) regions and range as follows²:

- **Rest-homes** from \$93.98 to \$103.29 per day
- **Dementia care** from \$117.81 to \$127.81 per day
- **Long Stay Hospital** from \$160.87 to \$171.97 per day

The nature of the residential-care market has changed significantly since the 1980s and early 1990s. Services have consolidated with the entry of a number of larger operators, and the growth of retirement villages has been dramatic.

More recently, a number of church-based residential providers have put their facilities up for sale and are withdrawing from residential care, either for philosophical reasons such as "people prefer to stay in their own home", or because of financial pressures. Some 10% of residential care beds are owned by large listed companies.³ A number of other large providers are unlisted.

The Ministry of Health (2006)⁴ reports that there are 33, 899 residential care beds. This includes:

- 20,790 rest-home beds
- 2,501 dementia beds
- 9,907 hospital level beds
- 701 psychogeriatric beds

The average residential-care facility⁵ has 53 beds, and 70% of facilities have fewer than 60 beds. In 2006, 42,500 older New Zealanders received residential care subsidies.⁶

Current government strategy favours 'ageing in place', in the form of home-based care in order to remain at home for as long as possible. The success or failure of this strategy will impact on the number of residential care beds required in the future.

Total residential-care bed days in 2006⁷ were 9,307,037. Some predictions suggest that by 2021, 18,000,000 bed days will be required, assuming 5.5% of people over the age of 65⁸ will be using them.

Figure 4

Residential bed days			
Residential Care type	2006	2005	2004
Rest Home	4,860,042	4,435,972	4,239,123
Dementia Unit	880,010	811,102	824,855
Continuing Care Hospital	3,352,027	3,161,214	2,869,878
Psychogeriatric	214,958	193,530	176,181
Total	9,307,037	8,601,818	8,110,046

Source: Parliamentary Question 1722 and 12863

Recent legislative changes have allowed providers to charge residents for services that are additional to the contracted services paid by government subsidy.

An increasing number of people are choosing to live in private retirement villages, and many of these villages offer short-term and longer-term residential care as an integrated part of their operations. In many cases, on-site residential facilities are one of the reasons older people choose to live in such an environment. The increasing number of residential-care beds being built in retirement villages is helping reduce pressure on dedicated residential care facilities.

1 Ministry of Health OIA, April 2007. AL0S 229 days

2 Prices as at June 2007

3 Parliamentary Question 8181 (2007)

4 Parliamentary Question 963 (2007)

5 Information from Health Care Providers New Zealand, August 2007

6 Ministry of Health OIA, April 2007

7 Parliamentary Question 1722 (2007)

8 HealthCare Providers New Zealand Briefing (2006)

Palliative care

Care for older New Zealanders who are dying is provided through hospices or palliative-care-funded beds, within residential-care facilities. People with a terminal illness are now more likely to receive the hospital-level care from a hospice (or sometimes an aged-care provider), rather than be admitted to a public hospital. Additionally, hospices around the country are providing increasing amounts of support for those people who wish to die at home.

A growing number of DHBs are negotiating agreements for residential-care facilities to provide palliative-care services. This palliative care is usually provided for longer periods of time than short-term hospice care.

Funding of palliative care services is provided by:

- DHBs through population based funding
- Hospice organisations raising funds and bequests etc.

About 50% of hospice funding comes from DHBs. Many residential care providers believe there should be a specific level of funding assigned for palliative-care services within the residential-care setting. This funding would cover the particular skills and equipment needed for palliative-care.⁹

Options for sustainable funding

Modelling of demand for residential care in the future suggests that, even with growing numbers of older people receiving care at home, there will need to be increasing investment in residential care-beds.

The National Party will consider providing government-owned surplus land as a contribution to public-private partnerships (PPP). This will help reduce the cost of building facilities and improve the economics of providing government-subsidised residential-care beds for older people. This will be particularly important where smaller facilities are required to meet the needs of the community.

We recognise that businesses, whether providing home-based or residential-care services, need some certainty of funding. Many providers tell us they could provide improved services if they had greater certainty of future funding.

Multi-year funding agreements, incorporating an agreed increase in funding each year, would give providers greater certainty of funding and improve their ability to deliver services.

PROPOSAL

The use of Public Private Partnerships and improved multi-year funding arrangements with DHBs can provide certainty and lower compliance costs for the aged-care sector.

⁹ Author's, interview with industry leader

4. Home-based Care

Simplifying funding streams and using new technology can improve home-based care.

At present, resources to help older people remain in their own home are provided as follows:

- **Household management** (which is income tested and needs assessed).
- **Personal care** (which is assessed on needs only).
- **Night-sitting services** (also called sleepover), a mixture of personal care and household tasks where there is facility for the caregiver to sleep.

Older people assessed as needing **household management** receive an average of two hours a week. This includes house cleaning, laundry, meal preparation, and shopping.

Those assessed as needing **personal care** receive an average of four hours a week. This encompasses tasks such as showering, dressing, and grooming.

Respite day-care for carers looking after relatives at home is supplied to 1,504 carers a week on a day-release basis. This does not cover the residential form of respite where the relative is cared for in a residential setting and the carer gets total respite.

Other key services that provide support in the home include:

- Environmental support (such as hearing aids)
- Wheelchairs
- Housing modifications

The latter two services are accessed by need and there is usually a waiting time.

There are limited intensive home-based care packages, combined with intensive rehabilitation or restorative services, undertaken in the home, or in a short-stay facility, to enable people to stay in their own home. There are some trials under way that model a restorative approach to care in the community. The significance of the costs and benefits of these trials is yet to be established.

Home-based care providers face a number of issues. Low unemployment and wages make it hard to find caregivers to work weekends and evenings. There are high workforce turnover rates, and the work is perceived to be of low status.

Quality and safety is jeopardised by low levels of training



and monitoring. Home-based carers are also distanced from members of the wider health-care team.

Funding streams

During consultation, it was apparent that older people who receive care in their own homes have a multitude of needs that cannot be easily divided into the current funding silos of home management, personal care, and night-sitting services.

National believes there may be improved service delivery by bringing together all the home-based services - home management, personal care, and night-sitting - into one funding stream. This would be called 'support-at-home payment'. These different silos of funding currently total \$168 million.

Bringing together these services will also be compatible with providing home-based services that are restorative or rehabilitative. The restorative or rehabilitative model looks for ways to return older people to the levels of independence they previously enjoyed.

PROPOSAL

National will explore combining home-based services into a 'support-at-home payment' to simplify the service and provide improved flexibility for older people.

Telecare options

We believe that developments in technology, such as telecare and pharmaceutical case management, will enhance and extend the timeframe for home-based care.

For example, personal alarms are becoming increasingly sophisticated. At present, some alarms can sense when a person has fallen and do not need to be activated by the wearer.

Developments in a 'restorative and rehabilitative' approach to home-based care will fit well with the use of technology to improve independence and safety for older people in their homes.

Developing technologies, such as personal electronic health records and interactive information sharing between health professionals and patients, may help provide access to care and improve safety for people who are isolated from their communities or live in rural areas.

Companies in New Zealand and overseas are developing technologies to deliver healthcare at a distance from health professionals. This is most likely to be used for day-to-day management of chronic conditions, such as diabetes.

Though not all people with chronic conditions have access to internet-based technology, this form of access to healthcare advice will be an advantage to those for whom mobility and isolation from healthcare professionals is an issue.^{1,2}

PROPOSAL

National will explore the use of technology to increase access to healthcare information and advice for those who have limited mobility or who are isolated from healthcare professionals. The use of these technologies will enhance independence and security for many older New Zealanders.

1 <http://www.healthit.org.nz/>

2 <http://info.doctorglobal.com/>

5. Informal Care

Informal caregivers need greater support and better access to respite care.

The burden of care at home often falls on informal caregivers who are relatives. Caring for a dependent older person is a constant job and can be very stressful. Support for carers, particularly in the community, is a scarce resource. Much of the work that informal caregivers do is unsung, unpaid, and unsupported.

The National Health Committee estimates that up to 5.4% of New Zealanders provide some informal caregiving in their own home and 5.9% provide it outside their home. It reports that caregivers often have poorer physical health and use more medication than other New Zealanders, and suffer increased rates of depression and anxiety.¹

The committee suggests that support for informal caregivers could include:

- Respite care
- Improved relationships and better communication with formal services
- Quality information
- Practical assistance
- Emotional support

In the case of a family member who leaves paid employment to undertake an informal caregiver role, that person can receive financial assistance equivalent to the DPB.

A National Caregivers Strategy is currently being developed by the Ministry of Social Development, Carers New Zealand and the New Zealand Carers Alliance, but will not be launched until 2008. We will review this strategy when it is released, but our consultations suggest that caregivers prefer training that helps them care for their loved ones at home, and support in their role, rather than payment.

National believes that through appropriate recognition of the needs of informal caregivers, the health and wellbeing of this vital part of the aged-care workforce can be improved.

Respite care

During our consultations, many informal caregivers (usually family members, but not always) told us they had reached 'breaking point' because they could not readily or regularly

access respite care.

As a result, when an older person goes into residential care for respite, they often do so with trepidation and reluctance. They fear that their caregiver may decide they can no longer cope with having them at home.

In addition, rest-homes report that respite patients, because of their unfamiliarity with the staff and their anxiety about the situation, often find it very hard to settle. Their health tends to suffer accordingly.

We believe it is essential that informal caregivers have reasonable access to respite care, both in residential facilities and, where workforce constraints allow, at home. Overstretching informal caregivers can have a negative impact on our health system because the health of both the carer and the older person can suffer.

Planned access to residential respite care would be beneficial to the health of informal caregivers. This may ultimately mean that elderly can be cared for at home for longer, thus delaying entry to longer-term residential care.

Some DHBs already support the funding of dedicated respite beds, but the majority do not. Workforce development will be required to enhance the availability of home-based respite.

PROPOSAL

National will require DHBs to contract for the provision of dedicated respite residential care-beds.

¹ Informal Caregivers Literature Review, July 2007

6. Workforce Development

Enhancing the skills of our professional aged-care workforce will help increase job satisfaction, reduce turnover, and boost quality of care.

The workforce involved in disability support is predominantly made up of semi-skilled female workers. There are no minimum entry criteria and the work is not regulated. The work also has a high annual turnover, reported to be as much as 40% in the area of home support. There is a large casual-work component (those who work under 20 hours).¹

The high turnover in the disability support workforce is undermining the safety, quality, and sustainability of aged-care services. However, many loyal and hard-working caregivers and nurses have stuck with the sector through tough times.

One way to increase morale in the sector is to provide improved training for carers. This will allow them to complete qualifications that are appropriate to their caregiving roles, and then be remunerated for the skills they have acquired. Training should be relevant for both the home-based and residential-care sectors, and it should be portable. This would minimise costs to the employer and employee.

Caregivers and nurses should have recognisable career pathways and training opportunities that support their development. This should help reduce turnover in the workforce and reduce costs.

Earlier this year, DHBs demanded that aged-care employers promote collective bargaining agreements with their staff. This is compulsory unionism by stealth. National believes aged-care workers deserve the freedom to decide if they are union members or not. They should be allowed to negotiate for themselves, as individuals, if they choose.

Aged-care workers are caring for some of the most vulnerable people in our communities. Labour's plan to force them into unions will affect only one group – the elderly.

PROPOSALS

National will work with the sector to establish an aged-care sector-specific Industry Training Organisation (ITO) to oversee independent providers of training.

National will remove Labour's de facto compulsory unionism requirements for aged-care workers.

Supporting Volunteers

Many organisations give valuable support to older people and the wider community, such as:

- Age Concern
- Stroke Club
- St John
- Citizens Advice
- Alzheimer's Society
- Volunteer drivers.

Without support from the voluntary sector, DHBs would have to provide many of these services. It is therefore imperative that voluntary organisations working in the sector remain viable.

National has already announced a package aimed at assisting community support organisations. For more information, see our policy on **Turbo-charging Community Groups**.

¹ Disability Support Workforce Development, Easterbrook-Smith, March 2003

7. Ensuring Consistency

Standards of care for older people should be consistent across the country.

Older people want to have choices as they age. They value their independence. They want to know that the care they need will be available and that they can choose their provider.

It is important to every New Zealander requiring healthcare that they can form continuing relationships with their health professionals. Older people should not have to continually change provider as their needs evolve.

Across New Zealand's 21 District Health Boards (DHBs) there is duplication of processes and associated bureaucracies. This 'silo' approach creates unnecessary cost and compliance for the providers of aged care and confusion for many older people and their families.

DHBs should share more services. National believes that cooperation between DHBs can improve responsiveness to the changing needs of our ageing population.

An example of the lack of consistency between DHBs was revealed to the Health Select Committee when it heard the Petition of Rural Women New Zealand on aged-care services. The committee was told there are as many variations on how travel payments are made to carers, as there are DHBs.

Aged-care services vary depending on where older people live. Currently, metropolitan areas have choices available in residential-care settings, but limited choice in home-based care services. The more rural the area, the more limited the choices.

During consultation, we were told that there are some parts of the country with empty rest-home beds, while an hour away in a neighbouring DHB there are long waiting lists.

National believes DHBs should plan their services by projecting future demand for publicly funded aged care and report on how they will meet this demand. Older New Zealanders will have more certainty about their future if standards of care, assessment of care needs, and contractual processes are nationally consistent.

PROPOSAL

National will require DHBs to collaborate on developing standards of care, assessment of care needs, and contractual processes that are nationally consistent.



8. Coordination of Care

Quality of care and the choices available to older people can be improved with better coordination between DHBs, care providers, general practice, and specialists.

Improving the continuum of care

In a Ministry of Health review¹ it was acknowledged that "... the continuum-of-care model must be developed further – in homes, residential, AT&R, primary" (referring to Assessment Treatment and Rehabilitation and primary care).

During consultation, we heard from older people and their families that juggling organisations to arrange a package of care causes stress and uncertainty. People should be able to access seamless care along a continuum of need and they should have choice, without having to continually change providers.

National believes that improved service coordination is vital to this, but there is also a need for development away from 'silos' of providers to widen the choice of care.

New Zealanders are spending their retirement years in an increasingly wide range of accommodation. Some choose to stay at home for longer. Some choose to live in shared accommodation with joint facilities, housekeepers, and cooks, such as Abbeyfield houses. A rapidly growing number – around 25,000 – live in private retirement villages.

Aged-care provision needs to allow for this increasing diversity of living arrangements. For example, Aged Residential Care (ARC) providers are not allowed to contract to provide publicly funded home-based services to people who live in retirement villages. Nor are rest-homes permitted to deliver publicly funded home-based care to people outside their facility.

PROPOSAL

National will support people having a wider choice of providers to care for them through the continuum of their health needs.

Coordination of services

Priority should be given to identifying 'best practice' coordination of care and multi-disciplinary services to the elderly.

¹ Ministry of Health Review December 2006

During consultation, we heard of older people receiving care from several different providers at home at the same time. Older people and their families were confused about where to turn for services like respite care, safety aids for their homes, and other services.

To reduce the confusion and, at times, duplication of services, there needs to be a more collaborative approach to providing community-based services for older people. We believe there should be a model for coordinating services that is consistent across New Zealand.

Services should be delivered to the elderly by multi-disciplinary teams. These teams should be able to access the elderly in their own homes, work with general practice, and provide specialist back-up to residential-care providers.

Members of these teams would include:

- Needs Assessment Service Coordination (NASC) services
- Pharmacy and pharmaceutical services
- General practice team members
- Mental health care providers
- Occupational therapy
- Physiotherapy
- Specialist nursing services (e.g. diabetes or cardiac care nurses)
- Palliative care
- Podiatry
- Oral health professionals.

At present, there is not enough collaboration between these providers, except in a few areas where a 'one-stop-shop' philosophy has been adopted.

PROPOSAL

National will incentivise a 'one-stop-shop' or multi-disciplinary team approach for the care of older people. This approach will be in the primary care setting and should encompass a full range of health professionals.

Discharge planning

During consultation, we heard many horror stories about older people being discharged from hospital or sent home from emergency departments before adequate planning had been undertaken for their return to the community.

One example was an elderly lady who had a 'turn'. After being assessed in the emergency department and deemed fit to go home, she was discharged in the middle of the evening. When she asked who would unlock the door for her and turn on her heater, she was advised to ask the taxi driver to do it!

We also heard reports of patients being discharged without the aids they required, such as walking frames, and without the medications they needed and with no way of accessing a pharmacy.

Though all DHBs claim to be 'working on' discharge-planning protocols, we believe there has been inadequate work in this area. Some DHBs have a 'departure lounge', which might include armchairs, without nursing supervision but with assistance available from St John Friends of the Emergency

Department. This is preferable to putting elderly people at risk as our examples indicate.

Planned discharge for older people from hospital or the emergency department should be a smooth pathway where people can be assured that their immediate needs will be met.

PROPOSAL

National will require DHBs to work collaboratively with the providers of care services to older people to ensure that when they are discharged from hospital or sent home from the emergency department they have adequate support in the community.



9. Quality of Care

Auditing methods need to be improved to reduce compliance costs and ensure that older people get the quality of care they need.

Recent media reports on the quality of aged care and reports of elder abuse are deeply worrying. Age Concern has stated that “many [older people and their families] are discouraged because they have previously raised concern about quality of care with management but feel nothing has happened to improve the care and stop the abuse”¹.

There are also widespread reports of abuse of older people when they are in their own home in the care of family members.

Elder-abuse stories leave New Zealanders feeling unsure about their safety in their vulnerable older years. There are currently 26 publicly-funded (mainly part-time) positions dealing with elder-abuse issues², but the situations in which elder abuse occurs are often complex and time consuming to address.

During consultation, strong views were expressed that there should be greater awareness of how people can seek assistance when elder abuse is suspected. Currently, DHBs can audit a rest-home facility if an issue is raised with them. Equally, a complaint can be laid with the Health and Disability Commission.

Quality monitoring

Auditing agencies appointed by the Ministry of Health monitor the quality of aged-care providers.

Mandatory monitoring is limited to the residential-care sector. The residential-care certification regime is based on standards set under the Health and Disability Act.

Many residential-care providers believe that the audit tools used during certification and auditing processes involve duplication and are, in some cases, inconsistent.

ACC also audits residential-care facilities against three levels of quality. Their annual ACC levies are based on the level of quality achieved and demonstrated during the audit. ACC audits employ the use of ‘self-audit’ tools in the years between bi-annual audits.

No quality standards are enforced for home-based care, but sources in the sector report that up to 80% of home-based providers have adopted voluntary standards³.

National believes aged care quality standards should apply across all home-based care and residential-care options.

Duplication in auditing

Auditing is an essential tool to ensure quality of care, but audit requirements are often duplicated. Providers feel there are too many audit requirements and that these impose unnecessary costs.

During consultation, we heard from aged-care providers who purchased residential care facilities with current audit compliance and were required to jump through the audit hoops as if they were a totally new provider and facility.

We also heard of contradictory findings in audits and inconsistencies in the approach of the auditors. There was, however, wide acceptance that audits and standards are necessary.

Families occasionally question why their concerns about the standards of care are not being picked up in audits. There is a lack of understanding that the failure to meet standards of care is not addressed in routine audits, but rather in ‘issue-based’ audits.

The Wellington and Hawke’s Bay DHBs have trialled combined certification and contract audits. We believe this model should be adopted across the country.

There is also a need to streamline audit processes to reduce compliance costs. The time has come to examine how audits can best meet the need for consistently high quality-care across the country.

As a safety measure, ‘issue-based’ audits should remain. These audits are initiated when a complaint has been laid with the funder of the health service.

PROPOSAL

National will implement standardised audit tools and combine certification and DHB contract audits. National will also institute greater reliance on mid-cycle, ‘self-audit’ tools, as is currently the case with ACC audits.

¹ Press release 11 April 2006

² Either under the umbrella of Presbyterian Support or Age Concern

³ Author’s interview with industry player

FEEDBACK. Aged Care - Choice Not Chance for Older New Zealanders

The National Party Caucus wants your feedback on the proposals outlined in this paper and any other aspects of aged care that concern you. We welcome your submission. Please detach this form, fill it out, and mail it freepost to: Jo Goodhew MP, Parliament Buildings, Wellington. Alternatively, email your comments to jo.goodhew@national.org.nz

To assist your submission you may respond on this form, but you should feel free to comment more broadly if you wish.

Agree

Disagree

Residential Care

1. Public Private Partnerships and improved multi-year contracts should be encouraged to provide certainty and lower compliance costs for the aged-care sector.

Home-based Care

2. Home-based services should be combined into a 'support at home payment' to simplify the service and provide improved flexibility.
3. Technology should be used to increase access to healthcare information and advice for those who are isolated from healthcare professionals.

Informal Care

4. DHBs should contract for the provision of dedicated respite residential-care beds.

Workforce Development

5. An aged-care sector-specific Industry Training Organisation (ITO) should be established to oversee independent providers of training.
6. Labour's de facto compulsory unionism requirements for aged-care workers should be removed.

Ensuring Consistency

7. DHBs should collaborate on developing standards of care, assessment of care needs, and contractual processes that are nationally consistent.

Coordination of Care

8. People should be allowed to choose the same provider to care for them through the continuum of their health needs.
9. Funding should incentivise a 'one-stop-shop' or multi-disciplinary team approach to the care of older people.

Coordination of Care (continued)

Agree

Disagree

10. DHBs should work collaboratively with providers to ensure that when older people are discharged from hospital or the emergency department they have adequate support in the community.

Quality Monitoring

11. Standardised audit tools should be provided.

12. Certification and DHB contract audits should be combined

Other Comments

Thank you for taking the time to give us your feedback.

If you would like to be kept informed of developments in our aged-care policies, please take the time to complete the details below.

Your Details

Name: _____

Address: _____

Email: _____