



Aged Residential Care Funding Model Review

Background information to inform your feedback
Following Round One Stakeholder Forums in July 2018

Contents

Overview of the Funding Model Review

- Overview
- The review process
- Purpose of the forums and online feedback

Where are we today?

- The New Zealand Healthy Ageing Strategy
- Key trends in the NZ ARC sector
- Key projections for the NZ ARC sector
- What do we mean by ‘funding model’?
- Components of the existing ARC funding model
- Issues most commonly identified by stakeholders

Where do we want to be?

- Case study: Australia
- Case study: Ontario
- How should NZ think about assessing needs and allocating resources?
- How should NZ think about funding the components of residential care?
- How should NZ think about short and long stay care?
- How should NZ think about coordination of care?
- How should NZ think about who pays, how much and for what?

Online feedback

3

4

5

6

7

8

9 – 10

11 – 12

13

14 – 15

16 – 17

18

19

20

21

22

23

24

25

26



Overview of the Funding Model Review

Overview

District Health Boards and the Ministry of Health have commissioned Ernst & Young to carry out a Review of the Funding Model in Aged Residential Care.

Scope:

- Examine the strengths and weaknesses of the existing Aged Residential Care (ARC) funding model.
- Facilitate a transparent process for selecting a preferred funding model, and a transition plan.
- Consider the alignment between ARC policy and funding settings and those of other health and social services.

The Review is expected to be completed by December 2018.

The following information was prepared by Ernst & Young and presented for discussion at Stakeholder Forums in July 2018.

Particular areas Ernst & Young have been asked to consider:

- the role of interRAI;
- separation of accommodation and care;
- the efficacy of existing policy settings for primary care, pharmacy and palliative care – as they relate to ARC.

We are keeping an open mind about the extent of change to the funding model for ARC: small tweaks through to fundamental redesign.

The Review process

Ernst & Young are undertaking the Review in three stages:

1. Problem definition.
2. Understanding the current model.
3. Identifying and analysing options.

Key parts of the Review:

- Consumer engagement – 47 interviews with ARC residents, families and older people have been completed across the country.
- Provider site visits – 22 sites from Kaitaia to Invercargill. These involve a wide range of provider types, with the first tranche of visits nearing completion.
- Scan of international models for funding ARC, with two in-depth case studies (Australia and Ontario).
- Analysis of interRAI data, provider resourcing, and financial information.
- Survey that all providers have been invited to take part in.
- Stakeholder forums (July and October), in each of the four DHB regions.

Purpose of the forums and online feedback

- Four forums were held in Auckland, Cambridge, Wellington and Christchurch, with a total of 120 participants. This document is derived from content presented to participants during the forums. It contains background content and specific questions that we are asking you to provide feedback on.
- We want to hear from you about issues with the existing approach to funding ARC, their relative importance, discuss what a funding model for ARC should try to achieve, and how the funding model may need to change.
- The forums had a range of participants from providers, DHB representatives, clinical representatives, and consumer group representatives. We're seeking online feedback from a similar range of people.

Where are we today?

Key trends in the NZ ARC sector

Life expectancy is increasing but people are spending more time in dependence

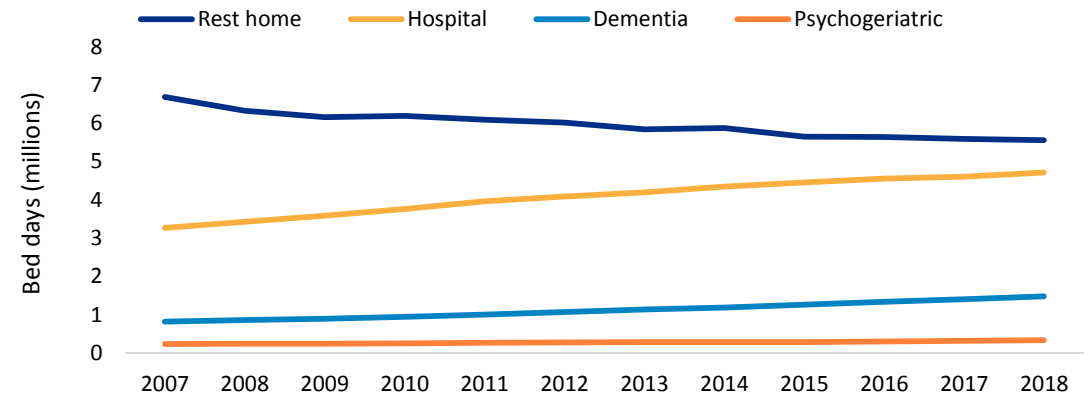
Women* are living longer
+3.5 years (+4%)

Dependency is increasing
+9% of time
dependent

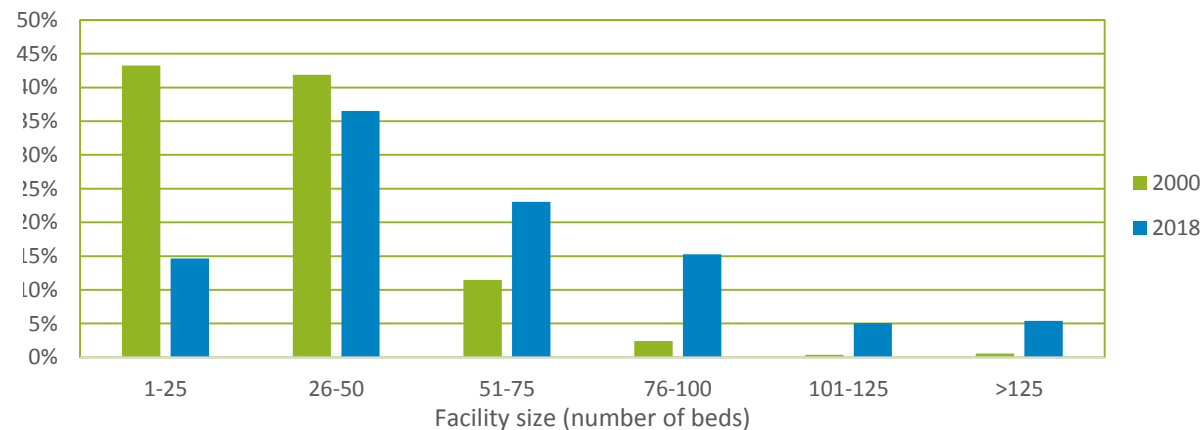
*Women 1996-2013

Maori men spend a
greater proportion of
their life dependent than
non-Maori men

Rest home bed-days have been decreasing while hospital and dementia bed-days have been increasing



Facilities have increased in size
(number of beds)



Key trends in the NZ ARC sector *cont'd*

Nearly all new investment is by group providers, with most charging premiums

~60%

Charge extra fees

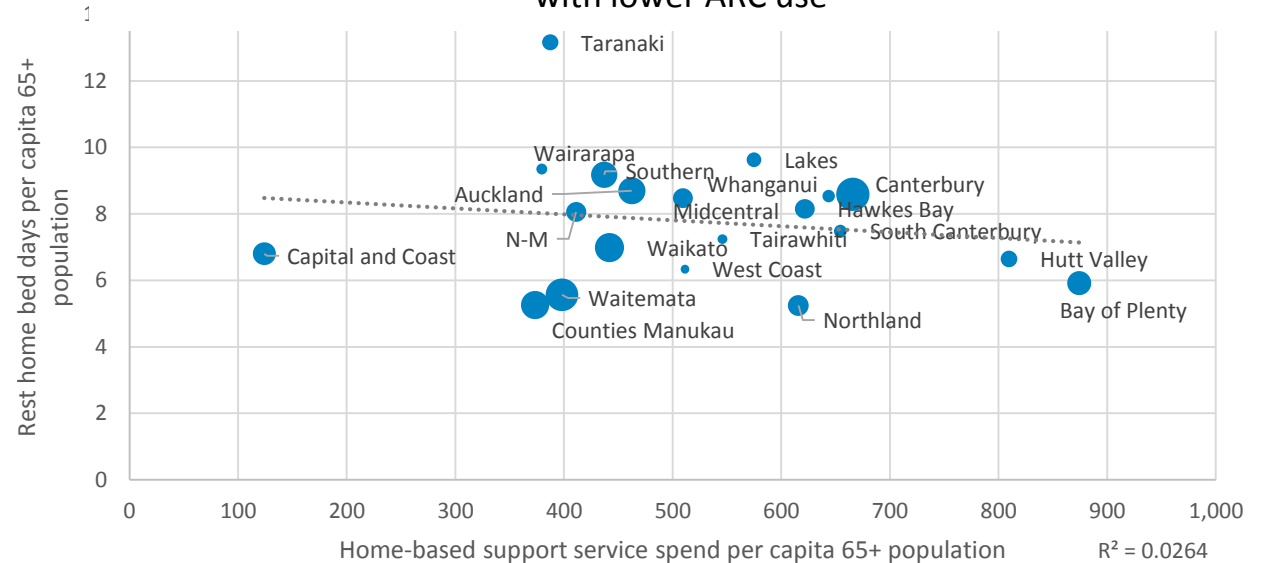
100%

Of new facilities charge extra fees

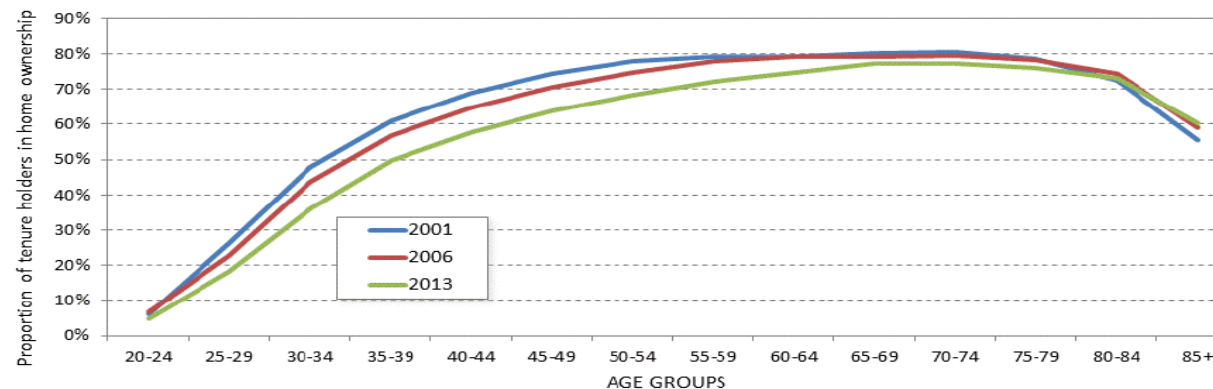
~63%

Of residents at a facility with extra charges, pay for premium services

Investments in home based care show some relationship with lower ARC use



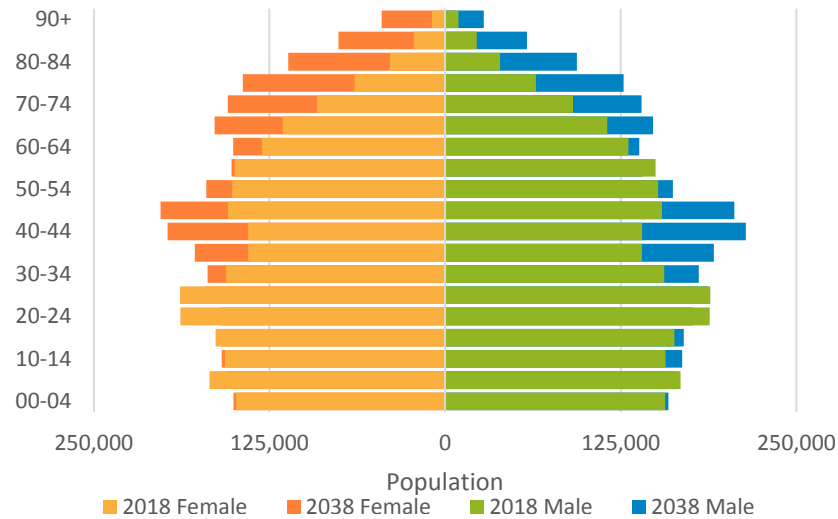
Home ownership is falling for nearly all older age groups (Census figures)



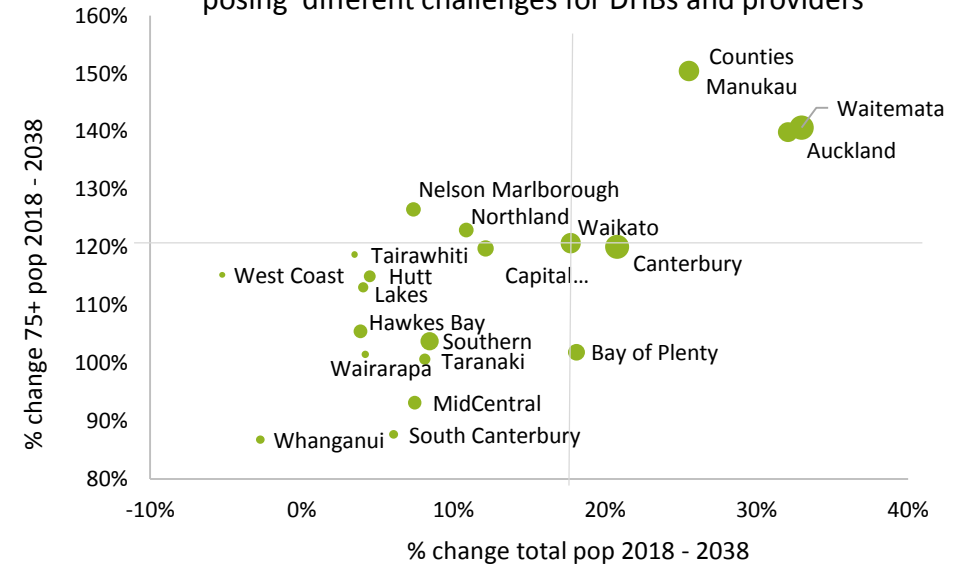
+5% for 85+ year olds (60%)
 0% for 80-84 year olds (73%)
 -3% for 75-79 year olds (76%)
 -4% for 70-74 year olds (77%)
 -3% for 65-69 year olds (77%)
 -5% for 60-64 year olds (75%)
 -7% for 55-59 year olds (72%)

Key projections for the NZ ARC sector

Over the next 20 years the number of people aged 85+ will triple, to 207,000 people

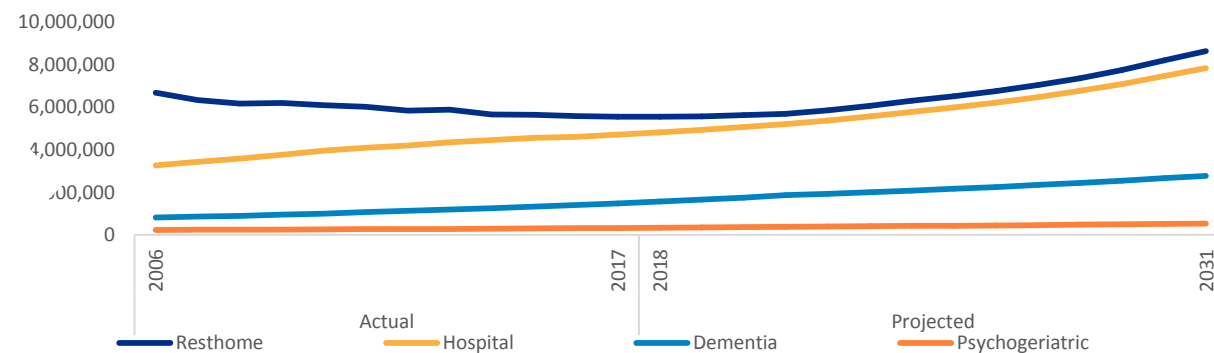


Population growth and ageing will vary across NZ, posing different challenges for DHBs and providers



Based on recent trends and expected demographic changes, ARC bed-days are projected to increase over the next decade

Source: ARC Demand Planner
Past-five year trend scenario
All funders



Key projections for the NZ ARC sector *cont'd*

Population ageing will result in more deaths per year in NZ from 2026

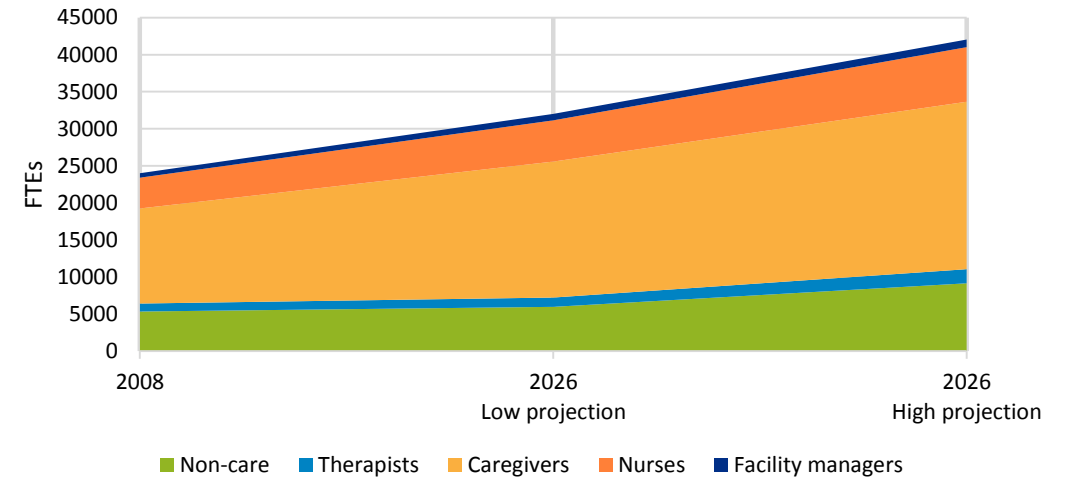
48%

Projected increased in number of deaths in NZ, 2016-2038

84%

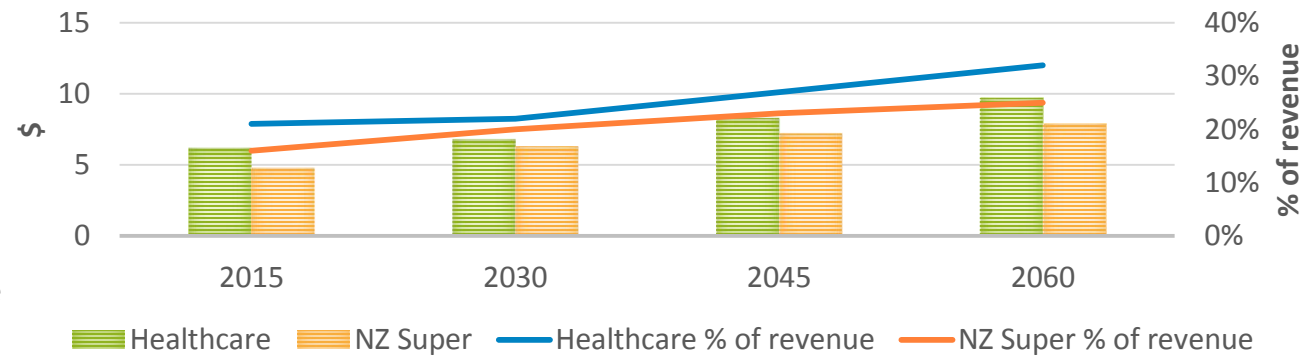
Projected increase in deaths that will occur in ARC, 2016-2038

The total workforce needed for ARC by 2026 is projected to be between 32,000 and 42,000 FTEs
(note that these projections were developed by Grant Thornton eight years ago).



Spending on health care is projected to increase

Source: Treasury (2016)
Government health expenditure excluding ACC



What do we mean by ‘funding model’?

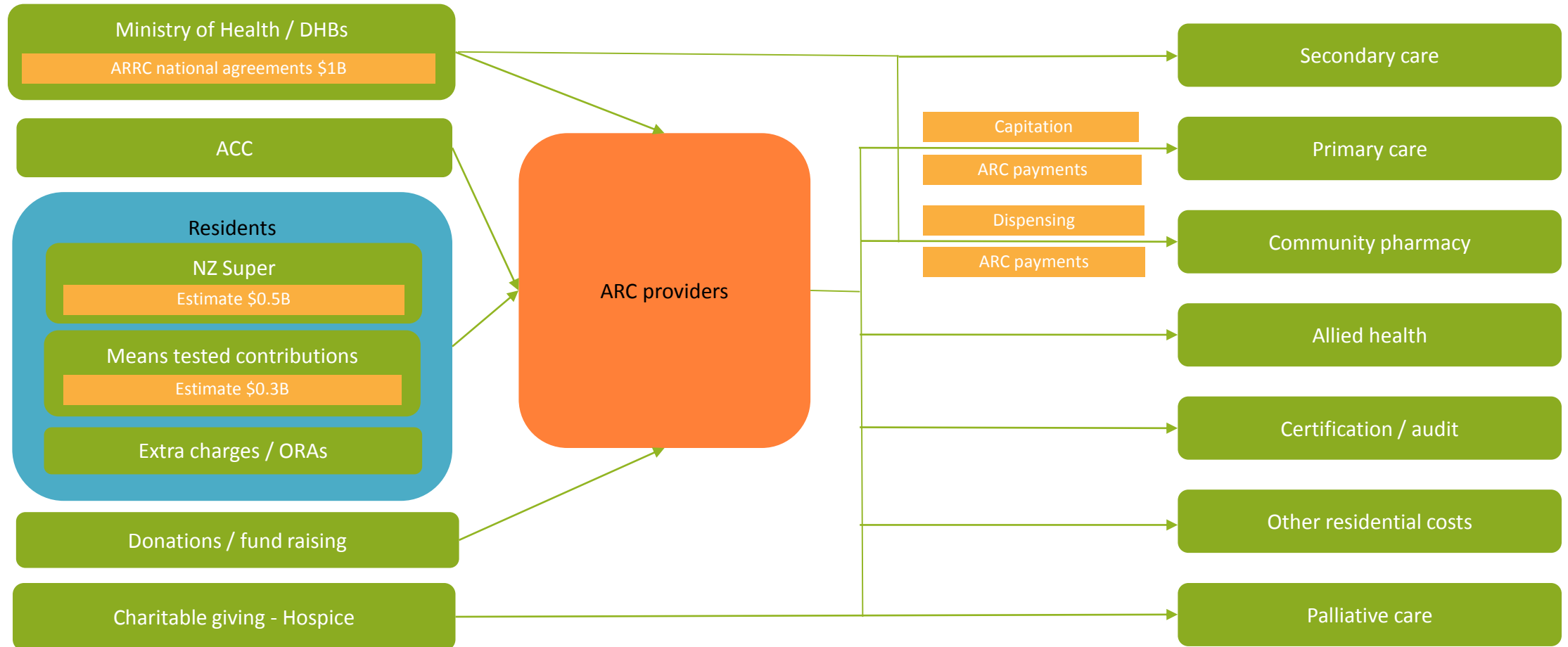
- A funding model is a means to allocate financial resources to enable human, physical and technological resources to be deployed to meet defined objectives.
- A funding model allocates financial resources based on:
 - units of purchase;
 - prices for units of purchase;
 - arrangements for payment for units of purchase.
- A funding model is enabled by contractual arrangements that specify a service's:
 - scope;
 - objectives;
 - purchase units;
 - prices;
 - terms and conditions.

Funding models influence how consumers, funders and providers behave through the incentives they create.

Components of the existing ARC funding model

- Resident choice of facility, and provider choice of resident.
- Needs-based allocation to one of four levels of care (rest home, dementia, continuing care ('hospital') and psychogeriatric).
- National price for each level of care, with small adjustments based on geographic location of facility ('TLA price').
- Demand driven ('uncapped' budget).
- Subsidised, top-up model. Each resident must contribute to the cost of their care up to a maximum amount, with the remainder of costs being subsidised by DHBs. The subsidy is universal for hospital, dementia and psychogeriatric. It covers the incremental change in contract price between these levels of care and rest home level care.
- Nearly all residents make a contribution towards the cost of their care, with the level of contribution based on an income and asset testing regime.
- Payment is based on a fee-for service model using a bed-day as a unit of service.
- Bed-day price includes accommodation, care delivered by provider staff, equipment needs, availability of on-site amenities and purchasing of other defined health services required for resident care needs (e.g. primary medical care).
- Minimum staffing levels as per national agreements, and 'safe' staffing guidelines.
- There are some targeted funding streams that providers can access to assist with managing costs associated with some types of care (e.g. high cost wound dressings, bariatric care equipment).
- Flexibility for providers to:
 - charge extra fees to residents, with some rules;
 - operate a range of business models including retirement living arrangements and ARC.
- Flexibility for DHBs to provide local solutions to support appropriate access and quality of care (e.g. respite care and other short term care; quality improvement programmes).
- Quality and safety managed through:
 - certification;
 - audit;
 - consumer/family choice;
 - DHB performance management.

Components of the existing ARC funding model *cont'd*



Issues most commonly identified by stakeholders

- Through the Review process to date, Ernst & Young have compiled fourteen issues commonly identified by stakeholders in the ARC sector.
- These were identified through:
 - A review of New Zealand aged care research and information about the older population.
 - Interviews with DHBs, a range of ARC providers, health professionals, and the funding model review's Steering Group (which includes representatives from the provider industry bodies, DHBs, Ministry of Health, and consumer advocacy groups) and Project Reference Group (which includes individuals with expertise across aged care in clinical, policy and funding, interRAI, needs assessment and operational management roles).
 - The issues are outlined on the next slide. These are not in any particular order.

Issues most commonly identified by stakeholders

Needs assessment

InterRAI, and changes in needs and care levels.

Complexity of resident needs

Resourcing for residents with more complex care needs.

Social connectedness

Care models for resident social needs.

Cultural appropriateness

Availability of care models appropriate for an increasingly diverse older population.

Care quality

Variability of care quality and resident access to information about care quality.

Medical cover

Access to sufficient medical cover, in-hours and after-hours.

Medicines management & review

Resident access to medicines management and review.

Rural access

Access to beds and associated services (e.g. primary care; ambulance) in rural areas.

Resident care costs

The cost of accessing residential care, whether through resident fees or extra charges / ORAs.

Balance of provider types

Balance of for-profit and not-for-profit, and stand-alone and facilities integrated with retirement villages so residents have choice of provider and facility.

Workforce recruitment & retention

Attracting, recruiting and retaining suitably qualified and skilled people.

Capital costs

The capital investment and return required to maintain and/or expand ARC capacity.

Compliance costs

E.g. fire, health and safety.

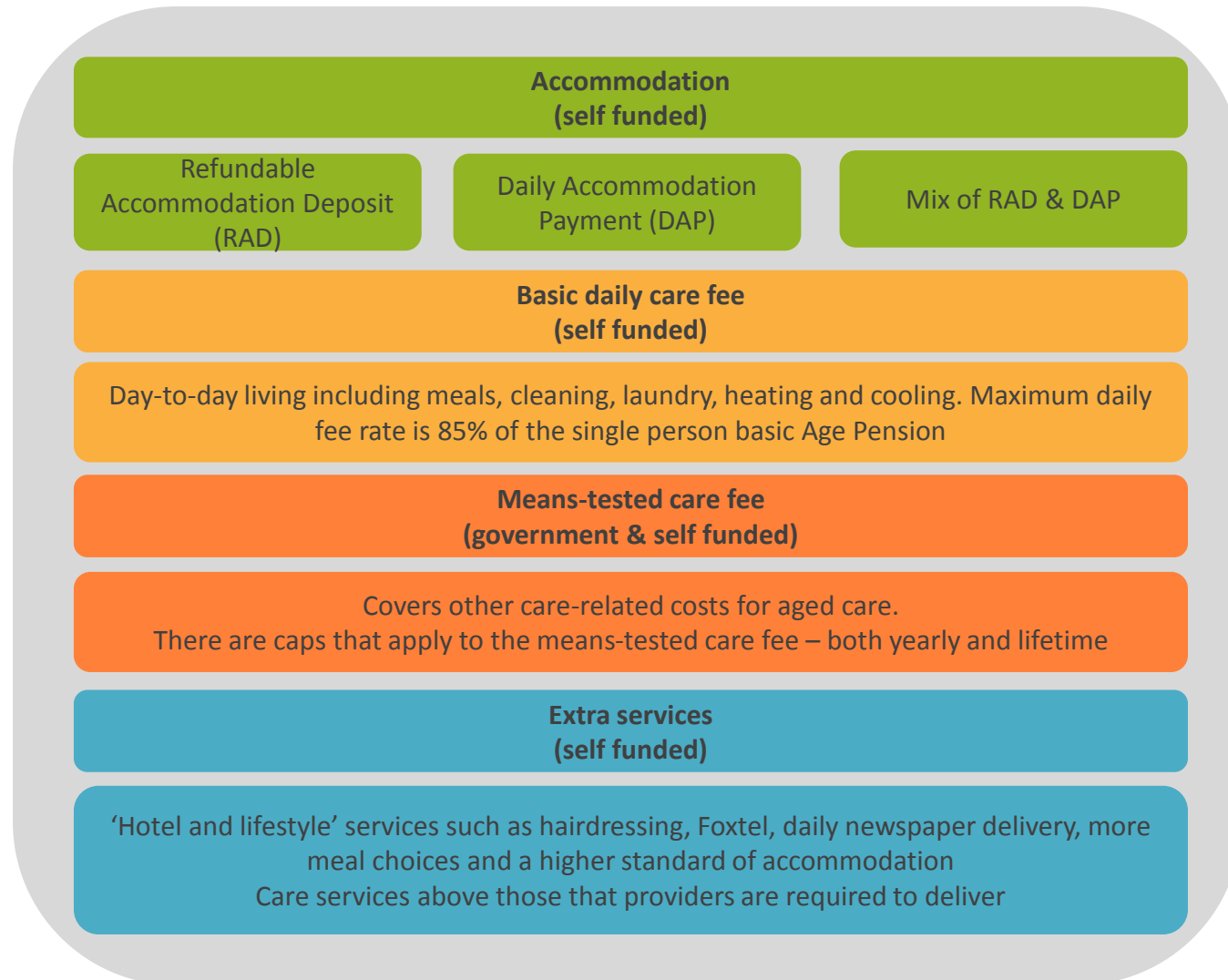
Certification and audit

The process and requirements to gain certification of facilities to provide ARC services.

Where do we want to be?

Case study: Australia

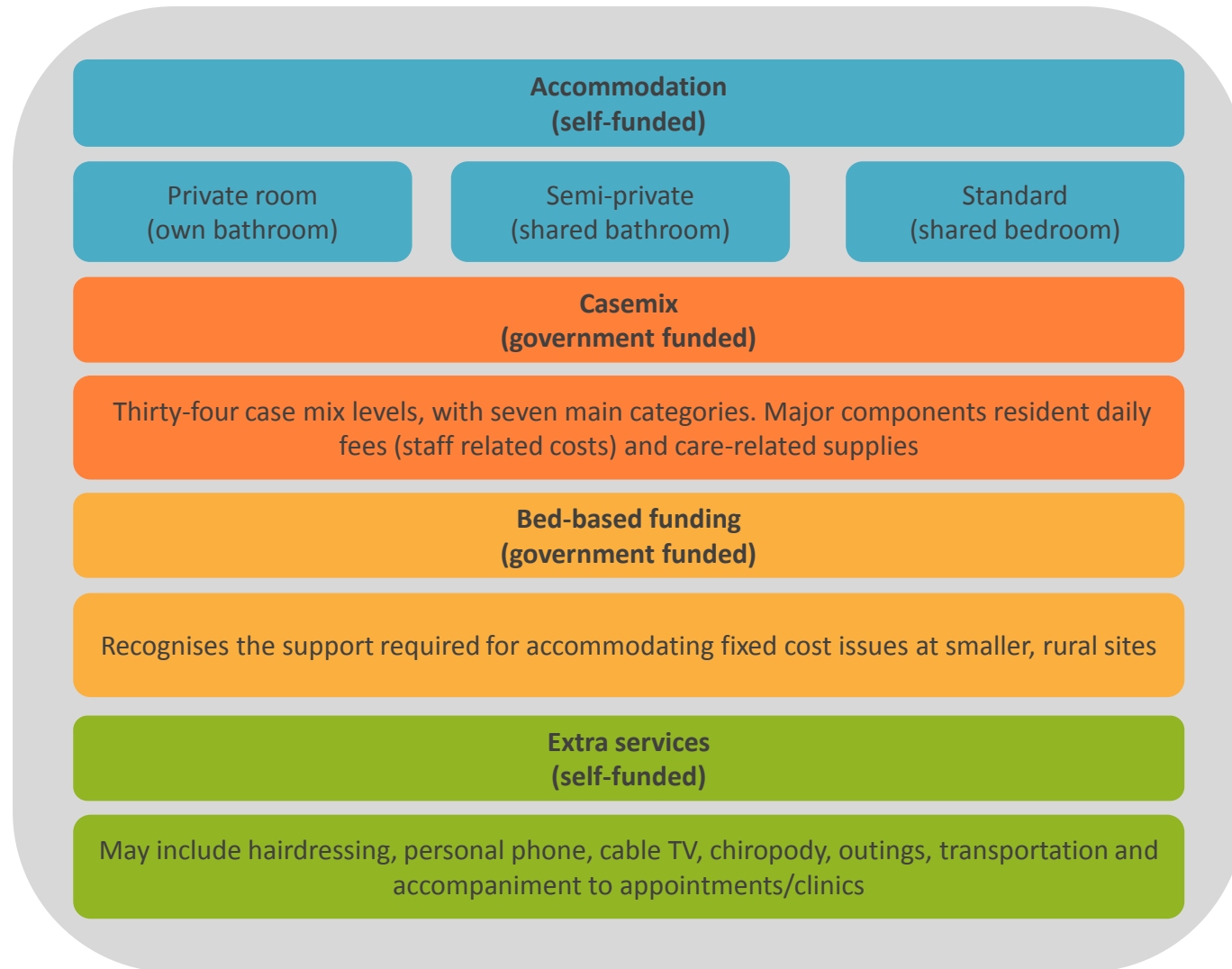
19



- Other features of note:
- Incentive payments for admitting “standard” (“subsidised”) residents.
- Incentive payments for new and majorly renovated facilities.
- Contestable process for bed supply (‘places’), for both long-term and short term restorative care, based on a target ratio of number of places available relative to the size of the 70+ population. Priority for places is given to regional, rural and remote areas and those targeting special needs groups. Some capital grants available for eligible providers.
- ‘Extra service’ status homes (for extra ‘hotel’ services) on approval of Aged Care Pricing Commissioner, which can be charged to all residents in the home, or optional additional service fees (for extra care and ‘hotel’ services).
- Regulatory mechanisms to manage accommodation and extra service resident charges.
- Home care is means-tested (as is the age pension).
- Specific funding streams for rural provision.

Case study: Ontario

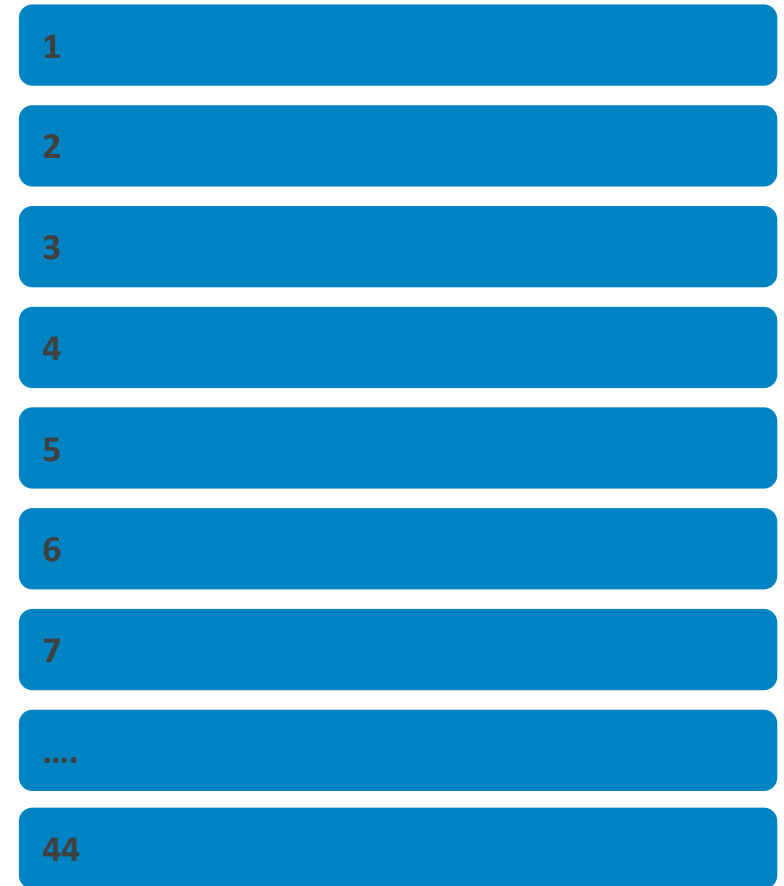
20



- Other features of note:
- Accommodation charges are regulated by the state, and accommodation subsidies are provided only for 'standard' accommodation.
- Tight control of supply through state approval processes.
- Government subsidies for construction funding can be accessed by eligible providers.
- Recognition of scale / fixed cost issues for smaller facilities, mainly in rural communities.
- Core per diem funding is broken down into four categories (nursing and personal care, program and support services, raw food and other accommodation). The nursing and personal care category is adjusted by the facility's casemix index.
- 'Wash-up' arrangements for unspent casemix ('variable') funding.
- Quality attainment premium funding pool.
- Residents access subsidies for medicines through the Ontario Drug Benefits Program and primary care is covered by the Ontario Health Insurance Plan.

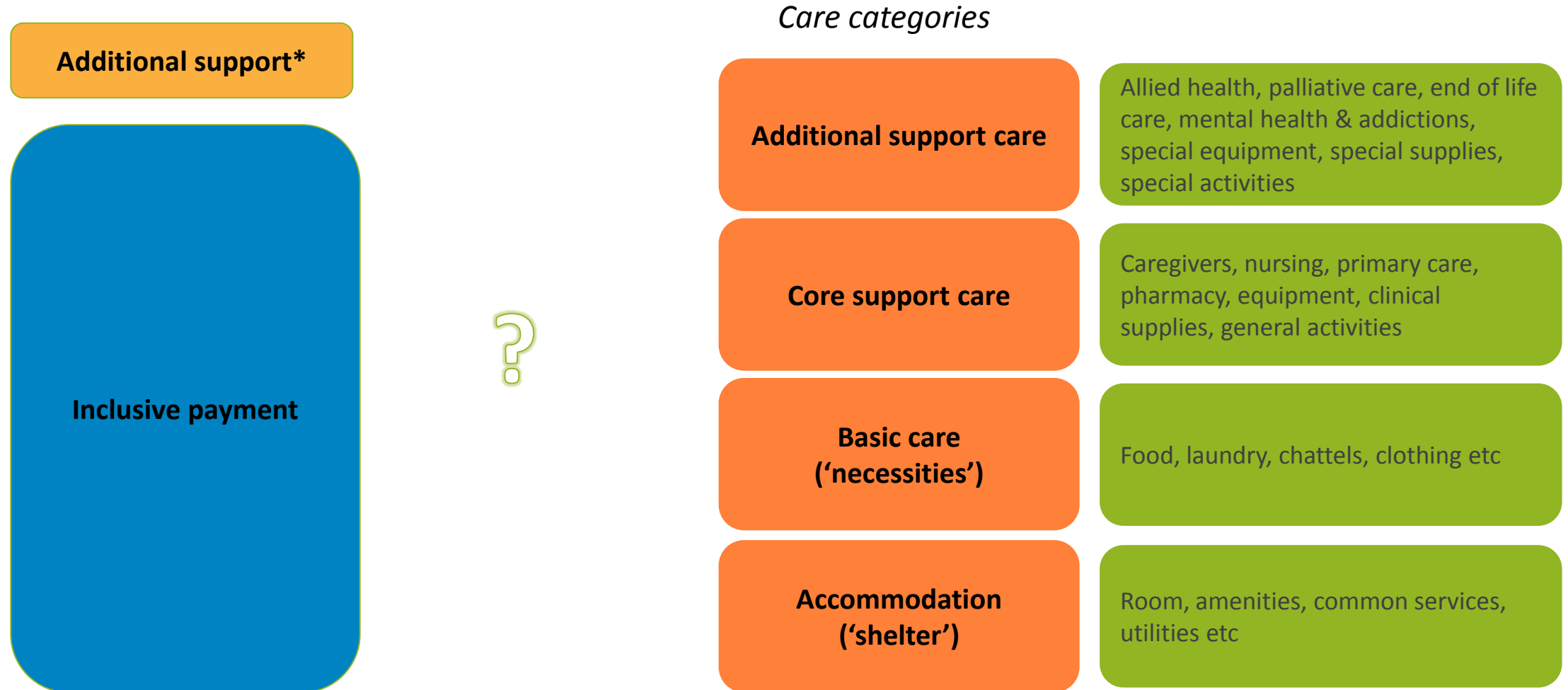
How should New Zealand think about assessing needs and allocating resources? 21

Care categories



How should New Zealand think about funding the components of residential care?

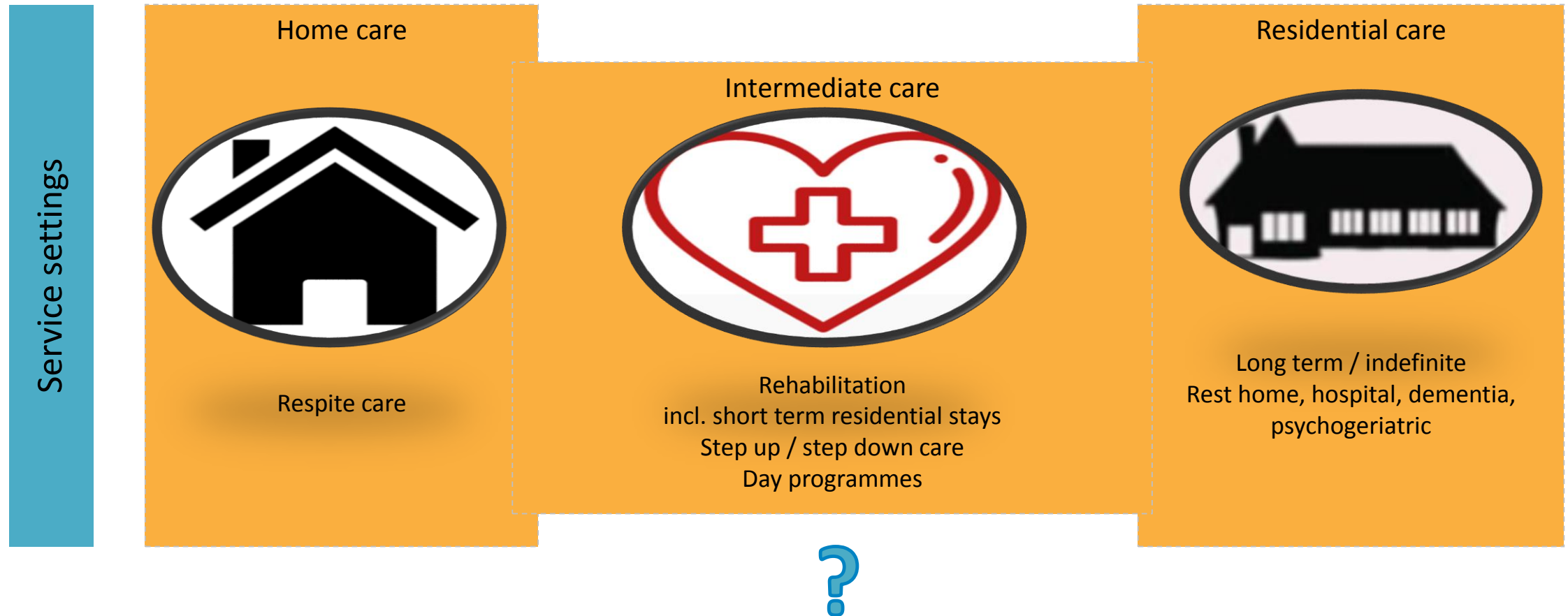
22



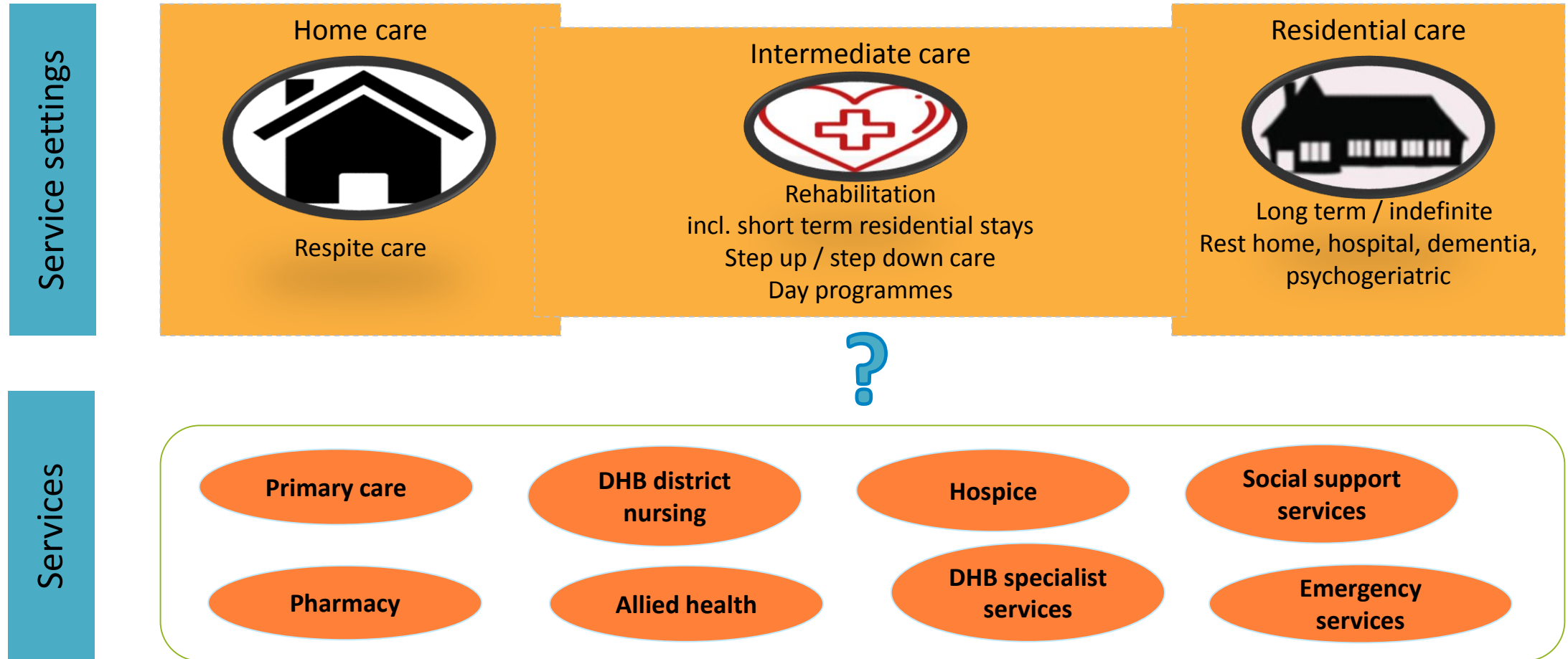
* e.g. high cost dressings; non-emergency transport

How should New Zealand think about short and long stay care?

23



How should New Zealand think about coordination of care?



How should New Zealand think about who pays, how much and for what?



***Older people with higher net worth
and those with less?***

?



Aged Residential Care Funding Model Review

Online feedback

How would you design the high-level components your preferred funding model?

Consider the following questions. How should New Zealand think about:

- assessing needs and allocating resources?
 - funding the components of residential care?
 - short and long stay care?
 - the coordination of care across settings and between services?
 - about who pays, how much and for what?
-

**Thank you
for your contribution to
the Review**

The summary of findings contained in this background information document are based on the findings of the report prepared at the request of Central Region's Technical Advisory Services ('TAS') solely for the purposes of the aged residential care funding model review ('the Review'), and is not appropriate for use for other purposes. This summary is provided for information purposes only in order to provide background context for the Review and should not be taken as providing specific advice on any issue, nor may this summary be relied upon by any party other than TAS. In carrying out our work and preparing this background information document, Ernst & Young has worked solely on the instructions and information of TAS, and has not taken into account the interests or individual circumstances of any party other than TAS. Ernst & Young does not accept any responsibility for use of the information contained in this background information document and makes no guarantee nor accept any legal liability whatsoever arising from or connected to the accuracy, reliability, currency or completeness of any material contained herein. Ernst & Young expressly disclaims all liability for any costs, loss, damage, injury or other consequence which may arise directly or indirectly from use of, or reliance on, this background information document.