An age-old problem

Despite funding to ease rest-home staffing shortages, the sums don't add up to provide the levels of care that soaring numbers of frail older people will need. by RUTH NICHOL • photograph by STEPHEN ROBINSON

It's been more than 10 years since a new resident drove their own car to Bryant House rest home and dementia care in Napier. Owner and manager Greg Pritchard says it used to be common for residents at the 33-bed aged residential care facility to still be driving. These days, though, many of them would find it difficult to drive a motorised scooter, let alone a car.

"The acuity levels have increased exponentially to the point where, if someone comes into rest-home care they can often not walk or look after themselves independently, and they are likely to have a degree of dementia. That's why they can't live at home – they're not safe," says Pritchard, who has run Bryant House with his wife, Susan, for 15 years.

The main reason for the change is that people move into aged care later than they used to. New Zealand's "ageing in place" policy, introduced in 2002, means older people are staying at home for longer. In 1988, the median age at which New Zealanders entered aged care was 79. By 2021, that had risen to 85. Those extra six years means they are more likely to be suffering from the health conditions associated with ageing, such as loss of mobility, cognitive decline, and difficulties with everyday activities such as getting dressed.

More complex needs require more complex care, which is more expensive to provide. Almost all aged residential care is delivered by private organisations – both for-profit and not-for-profit – through contracts with Te Whatu Ora Health New Zealand. Pritchard says the amount of funding they get is making it harder and harder to fulfil the obligations of their contracts.

"The incremental increases we've had are around 2% a year, but some years we've had almost nothing. It's not just our current government; successive governments have failed to address this issue."

The number of people aged over 80 is expected to almost quadruple, to more than 730,000, by 2051.

He's not the only one finding it difficult to make ends meet. Work carried out by the New Zealand Aged Care Association 18 months ago found that the sector as a whole was underfunded by around $425 million.

"That's about running your business; it's about the cost of consumables; it's about inflation; it's about capital costs," says the association's chief executive, Simon Wallace. The association represents 93% of the country's 659 aged residential care facilities, which between them oversee almost 41,000 beds. Of those, just over half are provided by large, publicly listed or private companies, most of which also own retirement villages. The rest are owned by smaller private companies and individual private operators, or not-for-profit charitable organisations.

1100 BEDS CLOSED

The cost-of-living crisis has put aged-care providers under even more financial pressure, with the cost of everything from food to incontinence products going up.

Jo O'Neill, chief executive of Presbyterian Support Otago, says the cost of all their contracts has increased in the past two years. "The provision of personal protective equipment, laundry, food – every contract has gone up by more than 9% in the past two years, and some have gone up by more than 40%," says O'Neill. "But our income to provide those services has not changed."

Her organisation, a registered charity, runs nine aged residential care facilities in the Otago region. It's one of many forced to close aged-care beds in the past few years due to growing staff shortages that, by September 2022, had seen the loss of about 1000 nurses and 1100 beds – mostly hospital and psychogeriatric beds, which need to be staffed by registered nurses 24 hours a day.

That has made it much harder for older people to find

Bryant House owners Greg and Susan Pritchard: catering to increasingly complex needs.

Paying the price

A rest-home bed will cost you upwards of $66,000 a year if you have assets such as a house.

To qualify for aged residential care, you must first have a needs test to determine whether you need care and at what level – rest home, hospital, dementia or psychogeriatric. These are carried out by needs assessment service co-ordination agencies throughout the country.

If you are found to need long-term care, Work and Income New Zealand then carries out a financial means assessment to see whether you qualify for the residential care subsidy. This calculates your assets and income, and looks at such things as how much money you have given family members in the previous five years.

Owning your own home is probably the biggest barrier to receiving the residential care subsidy, which Te Whatu Ora pays to the aged-care facilities it has contracts with. If you live alone and your house is worth more than $256,554, you won't qualify for the subsidy. There is more leeway around the value of your house if your partner is still living there.

Most people with assets of less than $256,554 do qualify for the full subsidy – $1271.68 to $2241.30 a week on average, depending on the level of care.

However, even if you are what is known as a "maximum contributor", you don't have to pay the full amount for all four levels of care: you pay the full amount for rest-home care, an average of $1271.68 a week, while for the other three levels of care, Te Whatu Ora pays the cost of rest-home care and you pay the difference. There's a limit to how much this can be, with the cost ranging from $1246.28 to $1349.60 a week depending on where you live. Providers get the same amount whether or not the individual is subsidised. This is increasingly being topped up with supplements paid by people in premium rooms.

About 38% of residents in care homes are maximum contributors. That means they pay up to $70,000 a year for their care and accommodation. With premium accommodation add-ons, the amount they pay can exceed $100,000 a year.

GETTY IMAGES

THE FOUR LEVELS OF AGED RESIDENTIAL CARE

REST HOME For people who can get about on their own but who need help with things such as personal care and day-to-day activities. Some with dementia can be safely supported in a rest home.

HOSPITAL For those with a significant disability, medical concerns and possible cognitive decline requiring continual oversight by registered nurses. Most need the assistance of two people to move about.

DEMENTIA For those who need a secure home, usually due to safety concerns for themselves or others.

PSYCHOGERIATRIC For people with a mental health or dementia disorder who need a high level of nursing care, a secure environment and staff skilled in managing challenging behaviour.

SOURCE: ELDERNET.CO.NZ

care. Some have ended up staying at home longer than was good for them. Others have spent unnecessarily long periods in public hospitals – this is known as bed blocking because it prevents other people getting the hospital care they need.

The closures mean some older people have had to move to another care home. Among them were the residents of the 24-bed Lindsay psychogeriatric unit at

> **"Many facilities just can't remain financially stable with what they're obligated to provide in their contract."**

Ross Home in Dunedin, one of the facilities run by Presbyterian Support Otago. The Lindsay unit officially closed on November 7, by which time the 15 residents still living there had all been moved to alternative psychogeriatric facilities – some of them in different cities.

RESCUE PACKAGE

Like other organisations forced to close beds, Presbyterian Support Otago laid the blame for the staff shortages that led to the unit's closure on two things: low salaries for registered nurses working in aged-care facilities compared with their public hospital colleagues, and tight post-Covid-19 immigration settings. The latter have made it difficult to attract the overseas-trained nurses (particularly from the Philippines and India) businesses have historically relied on.

The sector has complained long and loud about both issues, and shortly before Christmas, the government appeared to listen. On November 28, it announced a $200 million-a-year pay-parity funding package to help registered nurses working in the community, including those in aged-care homes, who have been earning up to $20,000 less than public hospital nurses. This is believed to have driven staff turnover of around 50%, with many aged-care nurses leaving for hospital jobs. As a result, the number of nurses working in aged care has fallen from about 5000 to 4000.

On December 12 came a second announcement – this time, that overseas-trained nurses would join other medical professionals on the "straight to residence" pathway known as the Green List, rather than having

Presbyterian Support's Jo O"Neill: service costs have increased; income hasn't.

SHARRON BENNETT

to wait two years before getting New Zealand residency. It's expected this will make us more attractive to overseas nurses.

Both moves have been welcomed in the sector. "We're over the moon," said O'Neill after the funding announcement, though she says the details of the package have yet to be worked through.

She hopes that as long as the two changes have the desired result – more nurses working in aged care – it will eventually be possible to reopen the Lindsay unit. But that won't happen immediately.

"When you're dealing with specialist levels of care, it's not a case of just bringing staff in and having people on the floor. It's about making sure they've had the training and support – you need the right people in the right place to deliver the right care."

MORE COMPLEX NEEDS

As welcome as these changes are, they won't solve the long-term challenges facing aged residential care – how we provide and pay for the growing number of frail older people who will need care in the future.

Aged residential care facilities provide care at four different levels – rest home, hospital, dementia and psychogeriatric. Most people (84%) receive either rest-home or hospital care. Those who qualify for rest-home care have fewer complex needs and don't require such intensive support. Those in hospital care, on the other hand, are in much poorer health. Most need help from two people to move about, and they must be continually monitored by a registered nurse.

"A whole level of older people who require care will never be able to access it, because they simply can't afford it."

The association's annual data shows the proportion needing rest home care fell from 49% in March 2014 to 42.7% in September 2021. Anecdotal evidence suggests that those qualifying for rest-home care are often closer to needing hospital care than previously. "In the past, people were younger, they were more mobile," says Simon Wallace. "But now they've got a range of conditions – we call them co-morbidities – that they wouldn't have had a decade ago."

The number needing care is also increasing and, over the next 30 years, they will increase even more. By 2051, the number of people aged 80 or older is expected to almost quadruple, from just under 200,000 in 2021 to more than 730,000.

At present, just over a quarter of those 85 or older are in residential care. It's possible that with a greater commitment to at-home care and better medical treatment, the percentage will drop in the next three decades. But it's clear we will need far more beds than now.

Those in the sector say the way it's funded means it's difficult for facilities to make ends meet with the number of beds they

Home, sweet home

Only a minority of older people will need rest-home care, but more could be done to support them – and their caregivers – at home.

Most older people will never need to move into aged residential care, and for those who do – particularly those assessed as needing rest-home-level care – there are alternatives.

"The idea of moving into an institution to die is quite a uniquely Western perspective on ageing and dying," says Esther Perriam, co-director of Eldernet, a comprehensive source of information and support for older people.

Traditionally, Māori families have tended to care for their kaumātua at home, but Perriam says that's starting to change. "You are beginning to see more Māori faces in facilities now."

That may be partly due the growing financial pressure facing many families today. Caring for someone at home often means at least one caregiver has to give up or cut back on the amount of paid work they do, and many households need two incomes just to survive.

However, Perriam knows from her own family's experience that with a lot of what she calls "pooling of familial resources" it's possible to care for an older person with complex health needs at home right up until they die. Her extended family did exactly that in the months before her maternal grandmother's death, aged 96, four years ago.

"By the time she died she would have been at hospital-level care. We had the support of our GP, who did home visits, and of palliative care services. We also used paid caregivers to give my parents – who moved in with my grandmother for her last two months – a break."

If taking on the care of a frail older person with complex health needs feels like too much, or the older person would prefer to be looked after by non-family members, Perriam says another possibility is taking out a reverse mortgage to pay for private care at home.

From top: Eldernet's Esther Perriam and Aged Care Commissioner Carolyn Cooper.

JOHN COSGROVE

Inaugural Aged Care Commissioner Carolyn Cooper also believes we need to change the way we view aged care. If we continue with the current system we will definitely need more and more residential care beds, she says. "But actually, I think there are other ways we could look at things, and it's not just about more beds."

That includes looking at the level of care available to keep people living safely and well at home. "I think there needs to be a much more integrated approach for older people. We need a better understanding of how people age, what really affects them as they do that, and what they need in terms of access, so we can set up the system to support that."

Cooper, who started her role in March 2022, was previously head of Bupa, a large rest home and retirement village business. She plans to release a monitoring report in the first half of this year summarising her findings from her first year in the role.

"My job is not to tell people what to do, but it's definitely to look at strategies and innovation and quality improvement and have a view on those."

have now, let alone find the capital they need – as much as $250,000 per bed – to build more.

Wallace says many older facilities are now reaching the end of their useful life, and without substantial capital investment, they are likely to eventually close. "How does the funding model build in an incentive to upgrade old care homes, to renovate them, to build bigger rooms and that sort of thing?"

LOSS-LEADER BEDS

The effect of underfunding is already limiting the number of new care beds being built. Most of the recent growth has been in retirement villages, many of which provide aged-care facilities as well as villas and apartments for independent living.

The profits these companies make from retirement villages are often used to subsidise the cost of building residential care facilities. They effectively run such facilities as a loss leader to make the villages more attractive to potential residents by providing what is known as a continuum of care. People moving into retirement villages like the security of

Two-thirds of all rooms are now non-standard, carrying premiums ranging from $35-$700 a week.

knowing they may not have to move again if their care needs increase – although the process isn't always as straightforward as it appears.

In October, retirement village operator Ryman, the country's largest provider of aged-care beds, announced it would be cutting the number of these beds at new retirement villages by up to two-thirds. That means new Ryman retirement villages will have 40-60 residential care beds rather than the 120 common at its older villages. The lower number is expected to meet the needs of village residents, but not non-residents. The reason for the cutback: it doesn't make financial sense to build more care beds than absolutely necessary. "Securing adequate aged-care funding from the government is an annual battle, and our approach reflects this view that this is likely to remain the same," a company spokesperson said.

BASICS AND EXTRAS

Te Whatu Ora sets the amount paid to such facilities to provide care and accommodation for each resident. The average weekly payment now ranges from $1271.68 for rest-home care to $2241.30 for psychogeriatric care.

Depending on a resident's financial circumstances and their level of care, either Te Whatu Ora pays the full amount or the resident pays a proportion of it – as much as $1349.60 a week, depending on where they live. (see "Thresholds to care", page 16).

In the 2021-22 financial year, long-term aged residential care cost Te Whatu Ora $1.33 billion excluding GST. Residents contributed another $970 million before GST.

The amounts may seem a lot – more than $116,000 per person for a year of psychogeriatric care. But, as Wallace explains, that sum has to cover not just accommodation and food but services including laundry, cleaning, continence products, doctors' visits, medication and activity programmes, on top of 24-hour care from registered nurses and healthcare assistants.

"We've been consistently arguing to government that it's just not enough. Many facilities just can't remain financially stable with what they're obligated to provide in their contract."

To help cover the shortfall, aged-care providers are increasingly charging accommodation supplements for what are known as premium rooms. These are bigger than standard rooms and they often have ensuite bathrooms and access to a balcony or garden.

Two-thirds of all aged residential care rooms provided now carry accommodation supplements, with premiums ranging from as little as $35 to more than $700 a week. It's estimated that they bring another $300 million a year into the sector.

Presbyterian Support Otago's Jo O'Neill says it's more than 10 years since a standard room was built anywhere in New Zealand. Even charitable organisations like hers have been forced to introduce accommodation charges, though they are relatively modest and apply to less than half of its beds.

She worries that we are already well on our way to creating a two-tier system where people who can afford to pay additional costs will get access to aged care when they need it, and those with few assets and no income apart from national superannuation will have very few options.

"We already have a class system in aged care. It started a long time ago, and it's going to get worse. There will be a whole level of older people who require care but who will never be able to access it, because they simply can't afford it."

The billboards used by aged care providers to highlight their concerns last year.

In Napier, Greg Pritchard has been working hard to keep Bryant House financially viable. At present, it has 16 rest-home and 17 dementia beds. All are in standard rooms. But that is about to change. Pritchard is now building a 17-bed hospital wing which will carry premium charges. He's also built the first seven of 15 villas at his neighbouring Ascot Park Retirement Village to help improve his company's cashflow. "We can't survive without doing these things," he says.

"We already have a class system in aged care. It started a long time ago, and it's going to get worse."

BENEFITS OF CARE

It can be easy to see moving into aged residential care as an unwelcome first step towards death. It's true that most people who move into care stay there until they die – the average length of stay is about 18 months. But while we all hope we won't need aged care, there's a lot of evidence that for those who do need it, it can significantly improve their quality of life.

An association analysis of recent aged care needs assessment data found those who qualify for and enter residential care do better in key areas of health and wellbeing than if they remained at home.

Carriann Hall, chief executive of CHT Healthcare, a not-for-profit organisation that has provided aged residential care for more than 60 years, agrees that it has many benefits for those who need it. She recalls a recent chat with a male resident at a CHT Healthcare facility about his motorised scooter. "The unit manager said to me quietly afterwards that when he came to us, he was nonverbal and immobile. This was two years ago, and now he's chatting and riding his scooter."

The fact is, says Hall, there's a reason some people need to be cared for by registered nurses and healthcare assistants. "These are people who have got really complex needs and they need a lot of support."

CHT Healthcare is one of 11 members of lobby group Aged Care Matters, which includes not-for-profit organisations, private providers and listed companies. In November, it ran an advertising campaign aimed at Prime Minister Jacinda Ardern and Finance Minister Grant Robertson. Using illustrations of the two of them in their 80s, it called for better funding so the sector can provide for the needs of older people both now and in the future.

Hall says Aged Care Matters wants to sit down with the government to develop long-term, sustainable solutions before it's too late. "What I really worry about is older people not being able to get into an aged-care facility, because we know what a huge impact that has on their lives. It's so important to give them every opportunity to have as good a life as possible at this time of their life." ▮