Submission to:
The Ministry of Health
Health of Older People
Policy Business Unit

on:
Premium-only Aged Residential Care Facilities and Stand-down Provisions for Mixed Facilities

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The Retirement Policy and Research Centre

The Retirement Policy and Research Centre (RPRC) of the University of Auckland specialises in the economic and public policy issues of demographic change including public and private provision of retirement income (New Zealand Superannuation, and e.g. KiwiSaver, respectively), and both the accumulation and decumulation phases of retirement provision. Access to and provision of long-term care for the aged is a vital aspect of the decumulation phase of retirement.

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Summary of the RPRC's Submission

a) We strongly disagree with the proposals for premium-only facilities.

The current system is provision via contracts between District Health Boards and primarily private providers for standard care and accommodation, at a guaranteed price (the Age Related Residential Care Agreement price). Every facility must contribute to the base level of provision needed to meet the anticipated number of places/beds in the particular District Health Board catchment area.

If some facities are exempt from the requirement to contribute to this pool of standard care beds and instead offer 'premium-only' facilities, a segmented market is created.

This proposed change will divide the sector, put enormous pressure on the facilities that are ***not*** premium-only, and will put the standard level of provision at risk. It will also increase the risk of a shortage of beds in some regions where larger numbers of poorer elderly reside.

b) We strongly disagree with a "stand-down" in mixed facilities.

The stand-down policy enables a provider to charge a new resident a daily fee for up to four weeks, over and above the resthome subsidy, in order to secure standard care and accommodation at that facility. As the Discussion document states "Most facilities have some vacant beds most of the time" (page 8).

c) We support maintaining the status quo, where every facility contributes to adequate provision of standard residential aged care in each area *except that* we support the introduction of a requirement for a resident to give a minimum of four weeks notice before ceasing to receive, and pay for, additional services.

The Submission:

The background

Around 31,000 people are in long-term aged residential care: 17,000 in rest homes, 2,900 in dementia units, 10,500 in long-stay hospitals and 750 in psycho-geriatric facilities. District Health Boards (DHBs) currently pay around $910 million a year to subsidise aged residential care residents. The residents themselves pay around $730 million for contracted care as a result of income and asset testing. (Discussion document, page 2)

The cap on personal contributions for long-term aged residential care in 2012 was $812.45 - $892.73 per week (up from $786 - $864 in 2011) depending on the region,[1] although the cost of hospital-level care can exceed $1,500 a week.

> *Currently aged residential care providers can charge some of their residents extra for services that are additional to those stipulated by DHBs. For example, many providers charge extra for larger rooms (premium rooms). However, all providers must give their residents an option to not pay extra, and hence they must have some rooms at the standard contract rate.*
>
> *The discussion document outlines a proposal to allow some providers to charge all their residents extra, and only accept residents who are willing to pay extra. The proposal includes safeguards to ensure a sufficient supply of rooms without an extra charge. It also outlines a proposal for situations where a resident who will not pay extra wants to enter a mixed facility (one with standard charge and additional charge rooms) but the facility has only extra charge rooms vacant*.[2]

The proposals for premium-only facilities

> *Providers want the ability to accept only those residents who are willing and able to pay an additional charge for services additional to those stipulated by DHBs. The current contract between DHBs and aged residential care operators prohibits this.* (Discussion document, page 1)

The current contract terms protect the elderly who are unable or unwilling to purchase additional services. The proposed changes are likely to compromise services for the poorer elderly.

> *DHBs are concerned that:*
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> *a residents will not have enough choice of standard rooms, and*
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> *b [introduction of premium-only facilities] would increase the costs of aged residential care.* (Discussion document, page 3)

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[1] See http://www.health.govt.nz/our-work/life-stages/health-older-people/long-term-residential-care/maximum-contribution: The maximum contribution is set by the Director-General of Health through a notice in the New Zealand Gazette under the Social Security Act 1964 and varies between Territorial Local Authority regions. Gazette Notice – Maximum contributions in each region from 1 July 2012 (Word, 110 KB).

[2] From Ministry of Health website: http://www.health.govt.nz/publication/premium-only-aged-residential-care-facilities-and-stand-down-provisions-mixed-facilities-discussion.

Contract prices paid by DHBs to providers are reviewed annually. The cap on fees prevents providers from cost-shifting by increasing the price charged to non-subsidised (i.e. private) patients (Ministry of Health 2007). However, residents can still be charged for services 'outside the contract specifications', including, for example, superior rooms, special equipment, transport to outside services or functions, and specialist care.

The introduction of premium-only facilities may encourage providers not to service lower-socioeconomic areas where residents are less able to afford extra charges, or rural areas with less potential to offset operating losses through property development.

The premium-only model proposal states that DHBs must allow for 10% to 20% of beds in their district in each service category[3] to be in premium-only facilities, with permission granted for a maximum of 10 years (Discussion document, page 5).

The protections proposed for residents are weak and would be almost impossible to monitor: "*Providers of premium-only facilities are not permitted to evict residents from premium-only facilities on grounds of ceasing to pay a premium*." And "*When a facility changes to be premium-only, any resident who was not paying an additional charge cannot be forced to pay one, or be evicted for not paying one*."

'Safeguards to ensure a sufficient supply of rooms without an extra charge'

The only safeguard evident in the proposal is the limit of 10% to 20% of premium-only facilities in each DHB district.

This limit confers economic advantage on those granted premium-only status at the expense of the mixed-facilities in each district. Provision of Standard care is likely to be compromised.

"Stand-down" in mixed facilities

Currently, mixed facilities must accept a client wanting a standard room, even if they only have premium rooms available.

The proposed stand-down policy enables a provider to charge a new resident a daily fee for up to four weeks, over and above the subsidy, in order to secure standard care and accommodation at that facility. As the Discussion document states "Most facilities have some vacant beds most of the time" (page 8).

Adequate provision of standard residential aged care in each area

> *The differing views between providers and DHBs is likely to result in litigation as some providers try to charge all of their residents extra and some DHBs resist that development. The Government wants to avoid the issue being decided in the courts through costly, uncertain and disruptive litigation.* (Discussion document, page 1)

We note that "a 2009 survey showed that 44% of facilities charged some of their residents extra,… and 3% of facilities charge all residents a premium" (Discussion

[3] The service categories are rest home, dementia, hospital and psychogeriatric.

document, page 2). The latter group of providers are known to be not complying with all the terms of the DHB contract. The likelihood of litigation thus appears to be overstated.

For the reasonable protection of the provider, we support the introduction of a requirement for a resident to give a minimum of four weeks notice before ceasing to receive, and pay for, additional services.