

## Working Paper 2014-2

# Turning silver to gold: Policies for an ageing population

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## The Retirement Policy and Research Centre

The Retirement Policy and Research Centre is pleased to publish this Working Paper providing an estimate of the total costs to the Government of aged care services and support in 2013, 2017 and 2022.

In New Zealand, the population aged 65+ is projected to almost double from 635,200 in 2013 to 1,100,000 before 2030. Those aged 85+ are expected to increase from around 74,000 in 2013 to over 144,000 by 2030. Similar demographic change is occurring across the developed world, and exerting pressure on labour market, health, pension and retirement policies and budgets.

In New Zealand, the current systems of funding the provision of services and support for those aged 65+ will be a considerable pressure point on Government spending as their numbers grow rapidly over the next 20 years: the baby-boomers have begun to retire.

The paper compiles the public policy-driven state costs of services and support for those aged 65+ and suggests possible policy options that could be applied in the future to 'turn Silver to Gold': to anticipate increasing numbers of older citizens with enthusiasm or at least equanimity rather than dread.

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# Turning silver to gold: Policies for an ageing population

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## Executive summary

The demographic change often referred to as 'the silver tsunami' is testing labour market, health, pension and retirement policies across the developed world. In New Zealand, the population aged 65+ is projected to almost double before 2030, from 635,200 in 2013 to 1,100,000, and those aged 85+ will increase from around 74,000 to over 144,000. This Working Paper provides an estimate of the total policy-driven state costs of aged care services and support, including health care, in 2013, 2017 and 2022. Funding the provision of services and support will exert increasing pressure on the rest of the population as the proportion aged 65+ grows rapidly over the next 15 to 20 years before plateauing. The paper does not cover the projections post-2032 when the large baby boom cohorts begin to enter into the more expensive 85+ age group.

Current government policies around support of the population aged 65+ are expressed in various Acts. Information about the financial and other support and services available, and the qualifying conditions and requirements for accessing them, is provided on the Ministry of Social Development's websites, including that of Work and Income.

In addition to New Zealand Superannuation (NZS), which is expected to increase from a before-tax \$10 billion a year to \$20 billion a year by 2031 (in current dollars), the vast array of specifically 'aged' services and support (only some of which are means-tested) include in-home care, Rest Home and Hospital subsidies, and subsidised prescription costs. These are in addition to universal access to free hospital-based health and accident care; means-tested and needs-tested income support; and other grants and allowances.

The underpinning assumption here is that, although the population mix is changing quite dramatically, all relevant policies will remain unchanged. Possible and likely changes to expectations; technology; labour demand and supply; and other endogenous and exogenous impacts on costs of support and service provision over time are noted, but are not included in the future cost estimates. For example, we assume that wage rates in the sector will continue to stagnate although in-home care demand and expenditure will continue to rise.

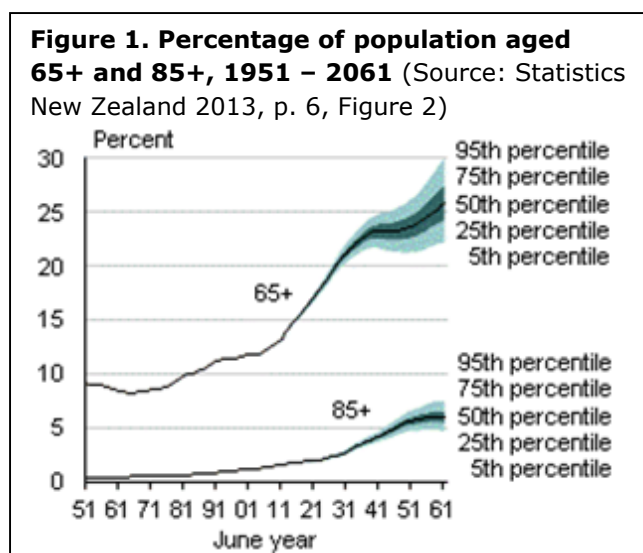
In 2012/13, those aged 65+, comprising 14% of the population, accounted for 33% of the \$14 billion Health budget. The total costs of residential care, other services and support and NZS for 2012/3 were around \$13 billion. By 2017, under medium projections, that figure of total Government costs of aged care services will approach \$15 billion, and by 2022 it will reach almost \$17 billion. These projections are in real 2013 dollars and make no allowance for increases in costs such as improved real wages in this sector.

Affordability of this array of services and support to the aged will be challenged by a diminishing proportion of the population contributing to economic output. The increasing cost of increasing numbers of elderly is the source of the 'silver tsunami' metaphor, signalling the threat this demographic change holds for the working-age population. The paper closes with suggestions of possible policy options that could be applied in the future to 'turn silver to gold', so the older population is recognized as a *taonga* rather than a threat. Such policies would also strengthen the younger population's confidence in intergenerational equity: that when they age, they will enjoy the level of physical and financial support provided for the aged of today.

## Introduction

*Population ageing has major implications for the way in which programmes designed to support older people are funded. While social security and means-tested social assistance programmes for long-term care protect the living standards of the poorest, middle income groups face under-appreciated risks, such as outliving their capital or needing expensive long-term care. (St John, Dale and Ashton 2012, p. 55)*

In New Zealand, the number of people aged 65+ doubled between 1980 and 2012 (Bascand 2012), and is likely to double again by 2036, reaching between 1,440,000 and 1,660,000 by 2061 (Statistics New Zealand 2012c). Changes to demography, longevity and costs of aged-care service provision in the next decades will substantially increase the



total costs of New Zealand's ageing population from an already large base. 'Aged care' is used throughout as a general term to cover all forms of in-home, residential and financial support for those aged 65+.

This almost doubling of the 65+ population will almost double the cost of New Zealand Superannuation (NZS). Compared with 14% in 2012, by 2036 Statistics New Zealand expects between 21% and 24% of New Zealanders will be aged 65+; and by 2061, that percentage is expected to reach between 22% and 30% (Figure 1). As a percentage of GDP,

the Treasury's long-term fiscal projections show the before-tax cost of NZS rising from 4.3% in 2010 to 6.4% in 2030 (Table 1).

**Table 1. Projected Government Expenditure as % of GDP** (Source: New Zealand Treasury 2013, p. 4)

% of nominal GDP	2010	2020	2030	2040	2050	2060
Healthcare	6.8	6.8	7.7	8.9	9.9	10.8
NZ Super	4.3	5.1	6.4	7.1	7.2	7.9
Education	6.1	5.3	5.2	5.2	5.1	5.2
Law and order	1.7	1.4	1.4	1.4	1.4	1.4
Welfare (excluding NZ Super)	6.7	4.8	4.4	4.2	4.0	3.8
Other	6.5	5.6	5.7	5.8	5.9	6.1
Debt-financing costs	1.2	1.8	2.5	4.2	7.1	11.7
<b>Total government expenses</b>	<b>33.4</b>	<b>30.8</b>	<b>33.4</b>	<b>36.9</b>	<b>40.6</b>	<b>46.8</b>
Tax revenue	26.5	28.9	29.0	29.0	29.0	29.0
Other revenue	3.2	3.0	3.2	3.2	3.3	3.6
<b>Total government revenue</b>	<b>29.7</b>	<b>31.9</b>	<b>32.2</b>	<b>32.2</b>	<b>32.3</b>	<b>32.6</b>
Expenses less revenue	3.6	-1.1	1.2	4.6	8.3	14.3
<b>Net government debt</b>	<b>13.9</b>	<b>27.4</b>	<b>37.1</b>	<b>67.2</b>	<b>118.9</b>	<b>198.3</b>

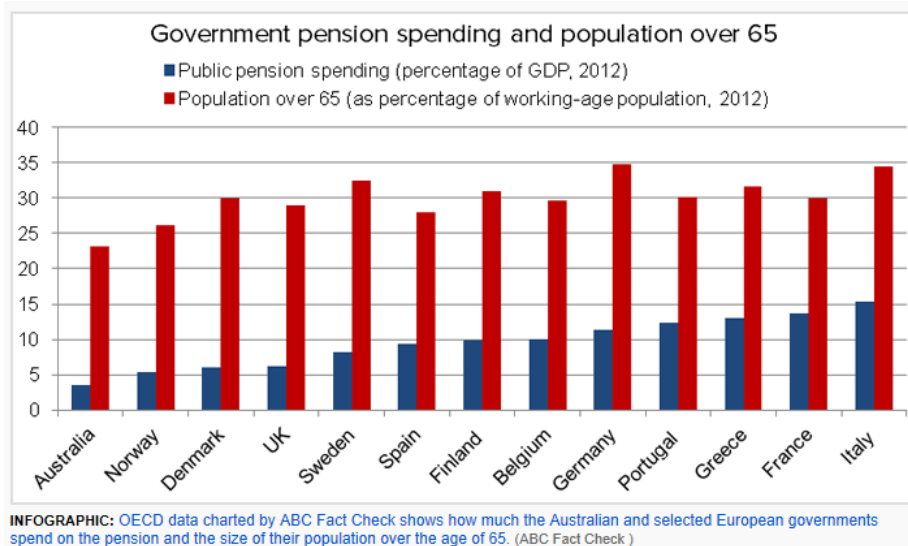
Demographic change is not confined to New Zealand, and in fact New Zealand sits around the middle of developed nations, as shown in Table 2.

Country	Female	Male	Total 65+	%	Total population
New Zealand	327,900	277,900	605,800	13.9%	4,362,000 (2012)
Australia	1,476,615	1,210,499	3,010,000	13.0%	21,000,000 (2006)
France	6,155,767	4,403,248	10,559,015	16.4%	65,822,000 (2011)
Germany	9,701,551	7,004,805	16,706,356	20.3%	81,859,000 (2011)
Japan	15,800,000	11,600,000	27,400,000	23.1%	128,057,000 (2010)
UK	5,458,235	4,027,721	9,485,956	15.7%	63,100,000 (2011)
US	22,571,696	16,901,232	39,472,928	12.8%	308,746,000 (2010)

(Source: Dale, St John and Hanna 2012)

In 2012, Australia's public spending on the age pension was 3.5% of GDP, and many Organisation for Economic Co-operation and Development (OECD) countries spend a significantly higher percentage of GDP on age pensions (Figure 2): Italy spends 15%, France 14%, Belgium 10%, Sweden 8% and the US 6% (OECD 2013). The fiscal cost of NZS in net terms, ignoring GST, is relatively low in international terms, at around 4.1% of GDP today rising to just over 6.6% in 2050.<sup>2</sup> While this appears to be a modest increase (see RPRC's *Pension Briefing 2013-6* (2013)) as Table 1 shows, there are associated fiscal pressures from an ageing population, including healthcare costs, that make this picture less benign (The Treasury 2013).

**Figure 2. Government pension spending and population over 65<sup>3</sup>**



In New Zealand, Government expenditure on aged care services and support, including in-home care, Rest Home and Hospital Subsidies and other services, are reported under different Government Budget allocations including Health, and Social Development. Such services and support are reported separately from Government expenditure on the universal age pension, NZS.

The two largest areas of Crown expenditure for the 2012/13 financial year were Social Security and Welfare at \$26.3 billion, and Health at \$14.5 billion (New Zealand Treasury 2013a).<sup>4</sup> Of the former, \$10.24 billion funded NZS; and \$4.8 billion provided the other welfare payments (e.g. then-named Domestic Purposes, Unemployment, Sickness, and Invalid Benefits). The remaining \$12 billion of the Social Security and Welfare allocation

<sup>2</sup> To find the actual cost of NZS, the gross cost in principle should be adjusted for both income tax and GST. Otherwise a tax shift, such as the GST/income tax shift in 2010, can make the net cost of NZS look greater than it actually is.

<sup>3</sup> Source: <http://www.abc.net.au/news/2014-02-03/kevin-andrews--makes-unfounded-welfare-claim/5215798>. The chart ignores the cost of tax incentives for private pensions. New Zealand's cost of public pensions as a percentage of GDP is lower than Australia's.

<sup>4</sup> Education at \$13.4 billion was the third largest area of Crown expenditure.

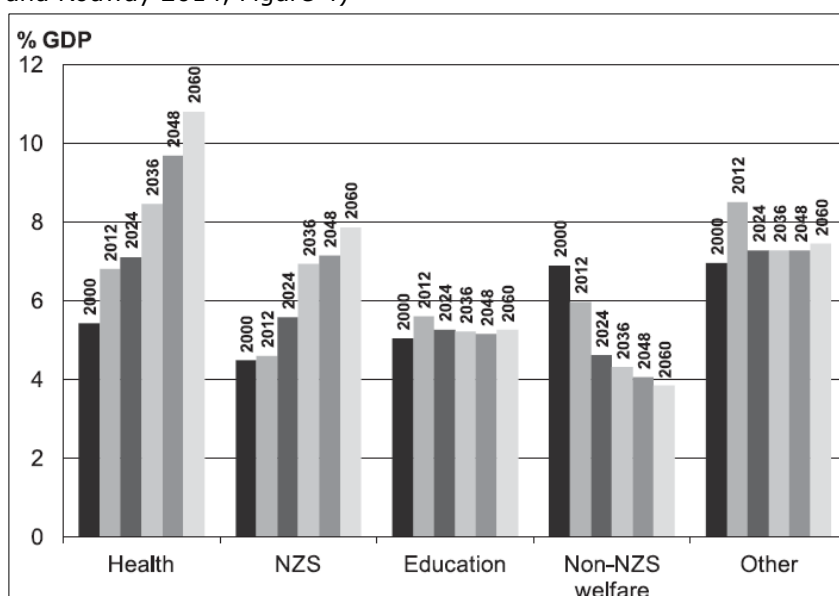
funded Working for Families tax credits, as well as social assistance accessed by some aged 65+, such as the Accommodation Supplement.

“Government-financed health spending as a percentage of GDP in New Zealand ... increased from 3.1% in 1950 to 6.9% in 2011” (Blakely, Atkinson, Kvizhinadze, Nghiem, McLeod and Wilson 2014). As Table 1 shows, that increase is predicted to continue apace.

Although comprising only 13.9% of the total population, the 65+ group absorbed between 33%<sup>5</sup> and nearly 36%<sup>6</sup> of total Crown Health expenditure. Within the 65+ age group, the number of people aged 85+ is also expected to increase significantly, from one in eight people aged 65+ in 2012 to about one in four by 2061. Ministry of Health (MoH) data indicate that per capita health expenditure is nearly twice the all-age average in the 65 to 69 age group, and nearly eight times the all-age average in the 85+ age group.<sup>7</sup> However, in addition to demographic (recipient) and non-demographic volume growth, the increasing Government Health spend is fuelled by inflation, real input price growth (mainly labour-related), and public sector productivity (Bell and Rodway 2014, p. 141).

Figure 3 compares the projections for the Government’s major expense categories, including Health, NZS, Education, Non-NZS welfare, Other and Finance costs, assuming current policies and GDP growth are maintained until 2060. Demographic change is reflected in the decreases in Education, Non-NZS welfare and Other Crown expenditure, as well as in the increases in Health and NZS.

**Figure 3. Major core Crown expenditure-to-GDP in the RHCg scenario** (Source: based on Bell and Rodway 2014, Figure 4)<sup>8</sup>



NZS contributes significantly toward residential care costs. The total real costs (government and private in 2013 terms) of residential aged care under current policy are projected to grow rapidly in the next 20 years, from \$1.82 billion in 2012/3 to \$2.02 billion

<sup>5</sup> See <http://www.treasury.govt.nz/government/longterm/externalpanel/pdfs/ltfep-s1-06.pdf>.

<sup>6</sup> “Based on current funding formulas and population trends, the Ministry of Health estimates that \$4.678 billion, or 35.8 per cent, of health spending goes to services for people over the age of 65.” at <http://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/corporate/bims/office-for-senior-citizens-2012.pdf>, p. 14.

<sup>7</sup> This report does not include the projections post 2032 when the large baby boom cohorts enter the more expensive 85+ age group.

<sup>8</sup> In the Resume Historic Cost Growth (RHCg) scenario, the trend growth parameters are derived from historical averages or current policy settings, and from the underlying demographic projections (Bell and Rodway, p. 141).

in 2017, \$2.43 billion in 2022, reaching \$3.49 billion by 2032. In addition, a plethora of other government-funded or subsidised care services and support provided to those aged 65+ is also likely to double within the next 20 years.

The total combined cost of residential care and other services for 2012/3 was around \$2.67 billion (including GST), of which the Government-funded component was \$2.45 billion. By 2017, under medium projections, the Government cost of aged care services will reach at least \$2.8 billion, and by 2022 will exceed \$3.3 billion. The projections, in real 2013 dollars, make no allowance for cost increases such as improved real wages in the sector. The assumption underlying the estimated future costs is that all 65+ care and support policies will remain unchanged, although the population mix changes quite dramatically. Thus we assume, for example, home care demand and expenditure will continue to rise, while wage rates in the sector will continue to stagnate.

The paper assesses total Government expenditure on aged care services and support in 2013, using information from the Treasury, the MoH, Statistics New Zealand, the New Zealand Aged Care Association, the Retirement Village Association, and other sources. Drawing on past agreements between service providers and the MoH and District Health Boards (DHBs), Statistics New Zealand's projections of population ageing and increasing longevity, and estimates of future demand for institutional services and support from the MoH's 'Aged Care demand model' (Health Partners Consulting Group 2013), Government expenditure on aged care services and support in 2017 and 2022 is estimated. Somewhat unrealistically, the projections of costs in this paper assume that costs only increase by the rate of inflation.

The paper then explores past policies, and possible future policies around aged care and support, including an increased contribution to care costs from the old themselves as methods for 'turning silver into gold'. It is noted that in 2010, only 138,658 people aged 65+ (23%) were covered by health insurance (Ministry of Health 2012a, p. 53). Private pensions and annuities that spread the risks of longevity are uncommon (St John, Dale et al. 2012), and in 2012 only 3 annuities were sold (Neilson 2012).

New Zealand's system of funding age pensions and healthcare (and welfare) out of current taxation intertwines the issues of demographic change, future affordability of current aged support policies, and intergenerational equity. As defined by Woods (2011, p. 171), the central function of the concept of intergenerational equity is of "increasing time-horizons of decision-making in order to take into account the interests of future generations". While it not possible to imagine the wants or needs of future taxpayers, it can safely be assumed that they would not want to be worse-off than current taxpayers, and would want a similar level of support in retirement as enjoyed by current retirees. Consideration of fairness across the generations, or fairness in the intertemporal distribution of assets and rights, could and should be a political, economic and moral imperative.

### ***Complicating factors***

Given the impact of technology on other parts of the economy and society, changes in aged care and support are likely to be significant. Medical and technological advances such as devices enabling remote- and self- monitoring of medical conditions, are contributing to increasing longevity, and to sustaining independent living for the aged, or 'ageing in place' (Dale and St John 2011). The future relationship between age, health needs and advances in medical technology cannot be readily predicted (Cornwall and Davey 2004, p. 9). The possible health improvements and/or budgetary effects of such medical and technological advances have not been incorporated in the calculations of this research.



Although the aged care sector is profitable for investors (Gibson 2014), current low pay rates are neither attractive to workers, nor do they give sufficient recognition to the skills required (Robinson 2012).

*The Department of Labour estimates that the number of paid caregivers needs to almost treble from the current 17,900 in 2006 to 48,200 in 2036 in order to meet the needs of the projected number of disabled older people requiring a high level of support... the current pathway is not sustainable. (Ministry of Business Innovation & Employment 2009, p. 3)*

The possible impact of the Living Wage movement, and significant increases to rates of pay in the aged care sector, have not been included in this analysis. An associated set of factors also excluded from the analysis and only given passing mention is the ageing of caregivers, who are overrepresented in the older age groups (40 years and over) (Ministry of Business Innovation & Employment 2009, p. 3).

It is noteworthy that the 2013 Census shows the health care and social assistance industry expanded 19.6% since 2006 and replaced manufacturing as the most common industry.

*In 2013, 1 in 10 employed people (191,694 people) worked in the health care and social assistance industry, which includes hospitals and medical care, residential care services, child care, and other social services. (Statistics New Zealand 2014b)*

Increased demand for care workers will continue. The question is whether sufficient labour supply will be forthcoming at current real rates of pay.

## **Ageing populations**

The share of the population aged over 80 years in the OECD member countries increased from less than 1% in 1950 to around 4% in 2010, and is expected to reach nearly 10% by 2050 (OECD 2011). In addition to the enlarged burden of pension costs, a further consequence of increasing longevity is that total healthcare expenditure in OECD countries has climbed faster than gross domestic product (GDP), and could double by 2040 (World Economic Forum 2013). Also, globally, longer lives mean the number of people living with Alzheimer's disease and other dementia is expected to almost double to 65 million by 2030 (World Economic Forum 2013), with a consequent impact on care and support costs.

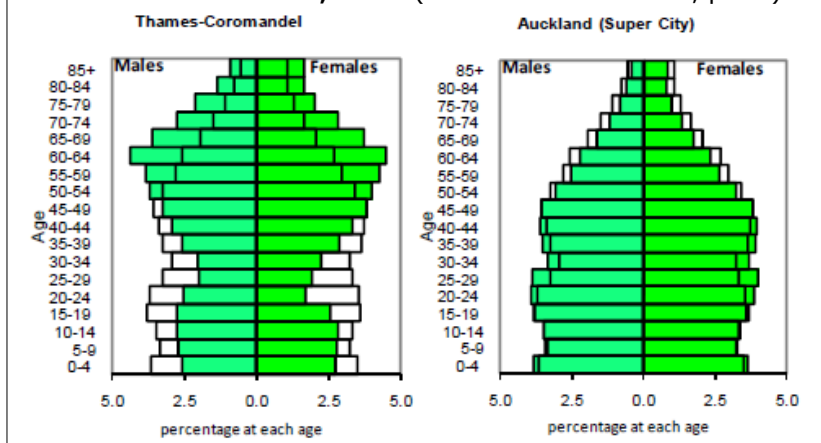
Jackson (2011) explains the 'four dimensions' of population ageing: numerical ageing is the absolute increase in the numbers of elderly; structural ageing refers to the increase in the proportion of the population that is old; natural decline means having more deaths than births and typically occurs between ten and twenty years after a population has more elderly than children; and absolute decline follows where there is insufficient 'replacement' migration to offset the lost births and increased deaths. While different countries are experiencing different degrees of these four dimensions of ageing, population ageing globally is pervasive, profound, and enduring. In New Zealand:

*With New Zealand's current birth rate being the highest in the developed world, it is unlikely that future rates will greatly (if at all) exceed current levels. Moreover, ... future birth numbers depend not only on birth rates per woman, but also on the size of the reproductive age cohort. Across the next 12 years (and beyond), much will depend on the extent to which the current 15-24 year old cohort is retained, or travels and returns to, New Zealand. (Jackson 2011, p. 7)*

The uneven geographical distribution of the aged population will add complexity to demographic change. For example, while Auckland arguably has the best facilities and

support for aged care, it has the lowest regional proportion of superannuitants at 10.5% compared to the New Zealand average of 13.9% (Jackson 2012, p. 28).

**Figure 4. Age-Sex Structure, Selected New Zealand Territorial Authorities, 2010** (Source: Jackson 2011, p. 15)



However, while growth is projected in the Auckland region for all age groups, the population aged 65+ is anticipated to grow both numerically: doubling between 2011 and 2031; and structurally: from 10.5% in 2011 to 16.6% by 2031 (Jackson 2012, p. 47).

More dramatically, as shown in Figure 4, in

Territorial Authorities like Thames-Coromandel, in 2011, immigration of older retirees is adding to both increased numbers and proportions at older ages, resulting in fewer than 6 people at labour market entry age (15-24 years) for every 10 in the retirement zone (55-64 years), compared with 13.2 for every 10 at national level (Jackson 2011, p. 14).

**Figure 5. Population by broad age group 1951- 2061: numerical ageing**

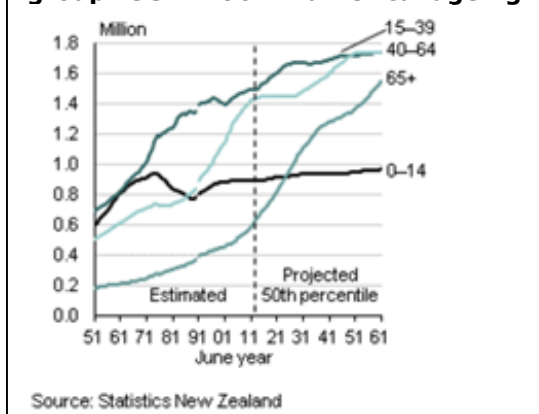
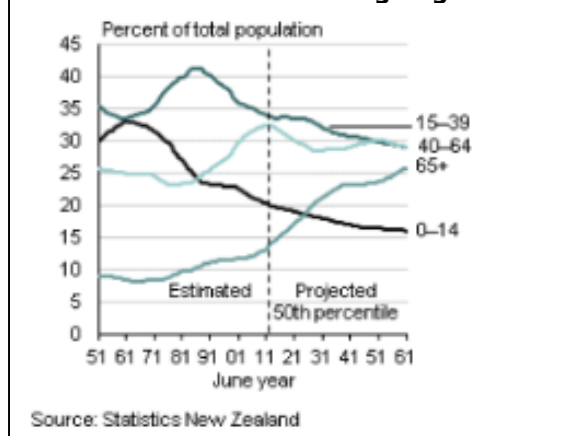


Figure 5 shows numerical ageing in StatsNZ's (2012b) projections. By the late 2020s, those aged 65+ in New Zealand will outnumber those aged 0-14 years, and will exceed 1 million, up from 605,800 in 2012. Alarmingly, Jackson (2011, p. 21) predicts that by 2016, more than 30% of Territorial Authorities will have more elderly than children, and by 2021, those aged 65+ will outnumber children in more than 50% of Territorial Authorities.

Demonstrating structural ageing, StatsNZ's "data on demand" tables<sup>9</sup> conservatively suggest that those aged 65+ will increase from 13.9% of the population in 2013 to 15.5% by 2017, and by 2022 will comprise 17.1% of the total population (Figure 6). The enduring structural increase in the 65+ population will have a profound effect on the number of people in the workforce (aged 15 and over) compared to the number over age 65, as Bell and Rodway (2014, p. 144) emphasise.

New Zealand's funding policy for NZS and public health, including in-home care and other aged services and support, is pay-as-you-go (PAYGO). The basis of the perceived threat of the ageing population, and the source of the 'silver tsunami' metaphor, lies in the prospect of a decreasing proportion of working-age

**Figure 6. Age distribution of population 1951 - 2061: structural ageing**

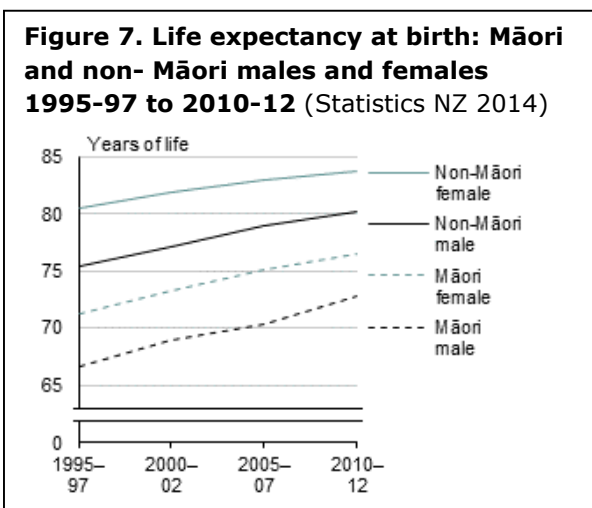


<sup>9</sup> See: <http://nzdotstat.stats.govt.nz/wbos/Index.aspx?DataSetCode=TABLECODE2303#>

citizens confronted by an ever-growing tax burden required to fund the support and care of the increasing numbers of the aged.

### **Ethnic aspects of ageing**

It is important to note the stark contrast between the youthful Māori population with 50% aged less than 23 years, and the ageing European-origin population with a 2006 median age of 38 years. Māori account for 21% of all 0-14 year olds, and Pasifika comprise approximately another 11% (Jackson 2011, pp. 17-8).<sup>10</sup>



Māori comprised 7% of the total population aged 65+ in 2006, however the Ministry of Health (2011) reports that ageing for Māori is faster than non-Māori (Figure 7). In 2012 approximately 5,000 Māori were aged 80+, a 50% increase in number from 2002 (Statistics New Zealand 2012a). Although the gap is decreasing, life expectancy at birth is 76.5 years for Māori females and 72.8 years for Māori males, compared with 83.7 years for non-Māori females and 80.2 years for non-Māori males (Statistics New Zealand 2014).

A regional health report found “25.1% of Māori aged 50 years or above lived in the most deprived areas by comparison to 6.6% for non-Māori” (Central Region District Health Boards 2011, p. 12). It follows that:

*Māori over the age of 50 have poorer health outcomes and a higher burden of chronic illness than non-Māori of the same age, and their need for health and support services sets in at an earlier age, although their use of care facilities is lower than for the population overall.* (Central Region District Health Boards 2011, p. 12)

For Māori, Pacific and Asian populations, median ages will increase, with the Pacific population having the lowest median, now and in the future. “Māori, Pacific and Asian people are expected to represent an increasing proportion of all age groups over the next 20 years”, an increase most marked in the 65+ age group for the Māori and Asian populations (Cornwall and Davey 2004, p. 4).

The 2013 Census showed the total population comprising 75.6% European/New Zealander, 14.9% Māori, 7.4% Pacific peoples, and 11.8% Asian. StatsNZ projects life expectancy at birth by 2026 to increase for the European/New Zealander to 82.2 years for males and 85.4 years for females, for the Māori population to 75.4 years for males and 79.2 years for females, for the Pacific population to 77.0 years for males and 80.4 years for females, and the Asian population are expected to continue as the most long-lived on average at 86.6 years for males and 89.7 years for females (Statistics New Zealand 2014).

### **The ‘old’ elderly: increasing longevity**

Between 2011 and 2031, the largest growth in the numbers of the younger ‘aged’ population, aged 65 to 74 years, will occur as the baby boomers move into the 65+ age group (Jackson 2011). From 2031, baby boomers enter late retirement, contributing to the large growth in number of those aged 85+. The reduction in older age mortality is now

<sup>10</sup> The youthful Maori and Pasifika populations suffer relative economic disadvantage. In light of the ageing of the population there is a persuasive argument for an active investment in their health and education.

responsible for increases in life expectancy, and projections released by StatsNZ in 2012 forecast (median mortality assumption) life expectancy for males rising to 84.3 years in 2036 and 88.1 years in 2061, and for females, the projected increase is to 87.3 years (2036) and 90.5 years (2061) (Woodward and Blakely 2014). However, Woodward and Blakely (2014) suggest that, if the improvements in mortality rates continue in the future, period life expectancy will continue to under-estimate actual survival probabilities.

While New Zealanders reaching age 65 around 1950 lived, on average, another 14 years, those reaching age 65 in 2013 can expect to live, on average, another 22 years (Statistics New Zealand 2013b, p. 10). Based on the 2006 census and median mortality assumptions, the population aged 85+ is expected to increase from 73,400 in 2011 to 94,680 by 2022 (Health Partners Consulting Group 2013). By 2061, about one in four people aged 65+ will be 85+, compared with one in eight in 2012 (Statistics New Zealand 2014). This older group has shown a strong but declining gender imbalance:

*In 2011 the number of females aged 85+ (47,300) was more than double the number of males aged 85+ (21,500). In comparison, in 1981 the number of females aged 85+ (15,500) was almost triple the number of males (5,800). While the number of both males and females has increased significantly over the 30-year period, the changing proportion reflects male longevity increasing more than female longevity. (Bascand 2011)*

Improving longevity shows no signs of levelling off. Projections of future numbers are made for a range of assumptions for low mortality to high mortality outcomes. Based on past projections, improvements in longevity have been consistently under-estimated (Jackson 2012).

Table 3 compares the projected future aged population out to 2036 under low and high mortality assumptions. While the differences in 2036 are small in the 65-74 and 75-84 age groups (3.2% and 8.4% respectively), in 2036 the number of people aged 85+ will be 32% larger under the low mortality assumption than under the high mortality assumption (235,900 versus 178,700). Given the vast difference between these growth assumptions in the 85+ age group, "care must be taken not to underestimate the actual growth in this population" (Ministry of Business Innovation & Employment 2009, p. 13).

**Table 3. Effects of different mortality assumptions on growth of future aged population, 2006-2036** (Statistics New Zealand 2006a)

Year	Age 65-74		
	Low	High	% difference between population
2006	275,700	275,700	
2016	397,400	393,900	0.9%
2026	513,100	502,500	2.1%
2036	581,700	563,800	3.2%
<b>Age 75-84</b>			
2006	177,800	177,800	
2016	217,100	211,900	2.5%
2026	328,500	310,600	5.8%
2036	436,600	402,700	8.4%
<b>Age 85+</b>			
2006	58,200	58,200	
2016	93,200	85,800	8.6%
2026	139,700	115,100	21.4%
2036	235,900	178,700	32.0%

## Changing demand for aged care and support

Regardless of age at death, more than a quarter of all acute health care costs occur in the last year of life (Wanless 2001; Cornwall and Davey 2004). Nevertheless, a 2004 report for the Ministry of Health states:

*Data on service provision is far from perfect, but hospitalisation statistics indicate that older people ... in acute and sub-acute care in New Zealand ...accounted for ... just over half of all bed-days. Similarly, nine of the main diseases and conditions affecting older people accounted for ... nearly two-thirds of bed-days in the population as a whole....*

*Ministry of Health data also indicate that per capita health expenditure in New Zealand starts to increase exponentially around the age of 50, so that it is nearly twice the all-age average in the 65 to 69 age group and nearly eight times the all-age average in the 85 and over age group. (NZIER 2004, p. ii)*

In addition to public hospital care, for those aged 65+ who need support but not 24-hour nursing/medical services, New Zealand legislation provides for in-home support, as well rest homes. For those requiring 24-hour nursing and/or medical care, long-term care private hospitals are provided (Connolly, Broad, Boyd, Kerse and Gott 2013).

The need for hospital-level care is not inevitable: "Each subsequent generation is becoming healthier, as a result of both lifestyle factors and advances in medical technology." (Cornwall and Davey 2004) A Treasury report on a survey of older people notes that "changes in health status are not always to a lower status", for example, 27% of those reporting their health status as "good" reported an improvement to very good in the next wave of the survey, and "54% of those reporting excellent health remained in excellent health in the following wave" (Gorman, Scobie and Towers 2012, p. 28).

However, according to the Ministry of Health's Annual Report (2013a), despite improvements in both health expectancy and life expectancy at birth:

*the increase in health expectancy has not kept pace with that in life expectancy. This means that we can expect to live longer, but some of that extra time will be lived in poor health. While life expectancy and health expectancy are expected to increase between 2006 and 2016, projections show that, on average, about 40% of the additional life years gained over this time will be lived in poor health. This expansion of morbidity suggests that long-term disabling conditions will become increasingly important drivers of health expenditure. (Ministry of Health 2013a, p. 154; Ministry of Health 2013c)<sup>11</sup>*

When OECD countries' institutional care usage is compared, New Zealand usage is high (5.9%), exceeded only by Norway (6%), Sweden (7.9%) and Switzerland (7%), but over time the assessment criteria have been tightened, and the proportion of those over 65 in institutional care has decreased in most OECD countries (Grant Thornton 2010, p. 86). In Auckland the age-adjusted population proportion in rest home care has decreased while the proportion in hospital level care has stayed steady. Thus absolute numbers in residential care beds have stayed roughly steady over 20 years, but with an increase in dependency levels (Boyd, Broad, Kerse, Foster, von Randow, Lay-Yee, Chelimo, Whitehead and Connolly 2011). As the use of rest home care has declined, the use of home support services has increased (New Zealand Home Health Association 2011).

### ***Trends in disability over decades***

There is some hope that later cohorts of people are healthier than earlier ones. An examination of serial cross-sectional studies in England show that there may have been a 3.4% decline in the proportion of people with assisted daily living (ADL) limitations and up to a 1% reduction in self-care (Martin, Schoeni, Andreski and Jagger 2012). The improvements were not noted in those with lower socioeconomic status, thus the impact of improvement on government expenditure may be blunted.

Trends in disability-free life expectancy vary throughout Europe (Jagger, Gillies, Cambois, Oyen, Nusselder, Robine and EHLEIS team 2009). In Denmark there is clear evidence that mortality in old age is decreasing (Jacobsen, Oksuzyan, Engberg, Jeune, Vaupel and Christensen 2008); for example women reaching 100 years of age in 2005 were more

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<sup>11</sup> Woodward and Blakely (2014, p. 218) contest this claim by the Ministry of Health and assert: "As life expectancy increases, so too will healthy life expectancy".

independent than their counterparts born 10 years earlier (Engberg, Christensen, Andersen-Ranberg, Vaupel and Jeune 2008). Trends in disability are reducing in Japan where from 1992 to 2002 the proportion of people aged 65+ with any ADL deficit reduced from 16% to 14% corresponding to a 16% reduction in the number of people with disability (Schoeni, Liang, Bennett, Sugisawa, Fukaya and Kobayashi 2006).

Cognition may also be improving. The Cognitive Function in Ageing Studies (CFAS I, 1989-94 and CFAS II, 2008-2011) show an overall decrease in the age-standardised rate of dementia by 1.8% (Matthews, Arthur, Barnes, Bond, Jagger, Robinson, Brayne and on behalf of the Medical Research Council Cognitive Function and Ageing Collaboration 2013).

Analysis of information from the New Zealand disability and health surveys from 1981 to 1996 suggested that moderate level disability may have increased and major level disability decreased slightly over 15 years (Graham, Blakely, Davis, Sporle and Pearce 2004). However, the 2013 Disability Survey (Statistics New Zealand 2014a) identified 24% of the New Zealand population as disabled, a total of 1.1 million people. The increase from the 2001 rate of 20% is partly explained by our ageing population.

*People aged 65 or over were much more likely to be disabled (59%) than adults under 65 years (21%) or children under 15 years (11%). Māori and Pacific people had higher-than-average disability rates, after adjusting for differences in ethnic population age profiles. For adults, physical limitations were the most common type of impairment....64% of disabled adults were physically impaired. (Statistics New Zealand 2014a)*

In summary, there may be some increase in healthy life expectancy, however the large increase in the absolute numbers of people in advanced age will offset any decrease in dependency. Thus our estimates, based on current levels of disability, may be an overestimate, but not by any more than a few percentage points.

## **Means-tested Residential Care Subsidy**

The means-tested Residential Care Subsidy (RCS) provides financial assistance towards the cost of their care for people in long-term aged residential care in a rest home or hospital. People eligible for the subsidy pay their NZS income (less certain exempt amounts including a weekly allowance) for their care. Access to the RCS requires an assessment by the Needs Assessment and Service Coordination service (NASC) in addition to an asset- and income-test (St John, Dale et al. 2012). Residents not eligible for the subsidy pay for the cost of their care up to a maximum weekly contribution, which is set and Gazetted annually (see Appendix 1).

The resident's DHB pays the difference between what the resident pays and the contracted cost of their care. Different rates apply in different Territorial Local Authorities, ranging in 2013 from \$819.70 in Otorohanga District to \$900.69 in Auckland City (New Zealand Gazette 2013).<sup>12</sup> The rate is set at the most recent, nationally agreed, rest home contract price applying to residential care facilities in each territorial local authority region.

### **Asset-test for Rest Home Subsidy<sup>13</sup>**

Policy changes mean that since 1 July 2012, the asset threshold to qualify for a RHS has increased by the CPI on 1 July each year, instead of the previous annual increase of

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<sup>12</sup> In October 2014, these rates were increased by the respective District Health Boards to \$869.26 in Otorohanga and \$955.29 in Auckland (New Zealand Gazette 2014).

<sup>13</sup> See <http://www.health.govt.nz/our-work/life-stages/health-older-people/long-term-residential-care/residential-care-subsidy/changes-residential-care-subsidy-asset-threshold>.

\$10,000. From 1 July 2013, the asset threshold increased from \$213,297 to \$215,132 for single people or a couple where both are in care. A couple, where only one is in long term care, can choose either the asset threshold of \$215,132 (from 1 July 2013) or the alternative asset threshold of \$117,811 (from 1 July 2013) where the family home, car and a pre-paid funeral of up to \$10,000 are exempt assets. In 2013, around 9,000 people aged 65+ paid the maximum contribution:

*MOH estimates that currently around 5,000 residents are paying the full cost of their rest home care, and another 4,000 are paying at the capped rest home rate for higher cost forms of residential care. Residential care costs about \$1,550 million a year (ex GST) with DHBs paying approximately \$890 million a year. Of the balance about \$450 million is recovered from client contributions (including from NZ Superannuation) for those in subsidised care, and \$210 million was contributed by fully private payments. (Preston 2013, p. 12)*

In 2012, around 31,000 people were 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” (Ministry of Health 2012b, p. 2). All residents of long-stay hospitals are likely to be in receipt of a subsidy as these facilities charge more than the maximum contribution. In 2011, it was estimated that about 1.1% of the New Zealand population, about 48,000 people, had dementia (Deloitte Access Economics 2012). Over the coming years, as rapid population ageing begins, “health loss due to dementia is likely to increase” (Ministry of Health 2013a, p. 174; Ministry of Health 2013b).

In 2012/13, of those aged 85+, about 18,300 or one in four lived in residential care. As shown in Table 4, although the proportion of the population aged 85+ in care has reduced over the past five years, the numbers in aged residential care continue to rise due to the growing size of the population aged 85+ years (Ministry of Health 2013a, p. 156).

**Table 4. Percentage and number people aged 85 years and older living in aged residential care, 2006/07–2012/13** (Source: Ministry of Health 2013a, p. 156, Table 3.2)

Year	People aged 85+ years living in aged residential care		Estimated population aged 85+ years
	Percentage	Number	Number
2006/07	28.7	16,707	58,155
2007/08	27.1	16,445	60,576
2008/09	26.4	16,647	63,122
2009/10	26.1	17,195	65,802
2010/11	25.6	17,576	68,622
2011/12	25.2	18,069	71,590
2012/13	24.8	18,319	74,000

Note: 2012/13 data are an estimate. (DHB Shared Services Website 2013)

## Other state-funded or subsidised aged care services and support

*Ministry of Health Disability Support Services, district health boards (DHBs) and Accident Compensation Corporation (ACC) usually contract other professional organisations to provide home support services. These other organisations are also called ‘providers’. Most home support service contracts are moving away from fixed tasks and hours to a more flexible approach, working with you to maintain or improve your independence.<sup>14</sup>*

Once assessed for need and eligibility by the NASC team, specific assistance is set out between the consumer and the provider in an agreed ‘home support plan’. The two types of Home Support assistance are Personal care (showering etc.), and Household management (shopping, cleaning etc.). Personal care is provided at DHB expense on the

<sup>14</sup> See <http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/support-services-older-people/what-you-can-expect-home-support-services>.

basis of assessed need; and the Community Services Card acts as an indirect income test to determine access to free household management assistance (Preston 2013, p. 10). Income limits in 2014 (for those without children) are \$27,150 per year gross for a single person living alone, and \$40,590 for a couple.<sup>15</sup> The average amount of Home Support hours a person receives is close to 2 hours a week, and around 10% of the 65+ population receive some element of Home Support at an annual cost of around \$250 million (Preston 2013, p. 10). Use of and expenditure on home support has been increasing as fewer people are admitted to rest homes. This trend seems likely to continue into the future with "Ageing in place" policies (Ramage 2006).

In the May 2013 Budget, the Government announced *New Funding for Home Support*<sup>16</sup> of \$20 million over 4 years. The Health Minister announced that DHBs (such as the Whanganui DHB) that pay prices that are "below average" will increase their contract payment to providers, and other DHBs will spend the money on those older people living at home with higher and more complex needs. The home support sector will welcome this additional money but it is a tiny amount to address another large issue – how to raise the wages and improve the conditions of home support workers who must support the increasing number of older people needing this service.

General Practitioner (GP) visit costs for those aged 65+ are usually a combination of a direct charge to the patient, a fee-for-service, and a state subsidy by capitation payments: population-based compensation through a Primary Health Organisation (PHO). Health status can be addressed by a High User Health Card (HUHC) (see Table 7, below). All New Zealand residents who are enrolled with a PHO are eligible for the Vote Health PHO capitation subsidies, including those aged 65+. "Most older people (around 95%) are enrolled in a PHO which provides general practice and nurse services." (Preston 2013, p. 7) The level of enrolment in PHOs for those in residential care is the lowest of any population group. GPs can charge a General Medical Services subsidy on a fee-for-service basis, plus a payment from the resident, and a contribution from the care home. The type and amount of payment arrangements varies throughout New Zealand. GP and specialist charges may also be covered by ACC.

A further range of partially or fully government-funded services and support that are available for older people includes outpatient care (which may be curative or rehabilitative), basic medical and diagnostic services, and dental and/or other specialised care. Government expenditure is incurred with medical goods dispensed to outpatients and inpatients, including pharmaceuticals and other medical non-durables, therapeutic appliances and medical durables (Ministry of Health 2012a). Community medical care provided by government sources includes (as well as the GP and pharmaceutical subsidies) laboratory and radiology costs.<sup>17</sup>

Also impacting on government spending is a respite allowance for 28 days of residential care stay for carer relief, with eligibility assessed by the NASC service contracted to the local DHB.

*... in Hawkes Bay DHB the long term rate to look after the elderly at rest home level is \$107 per day but the respite rate is only \$99 per day and in MidCentral DHB the long term subsidy rate for hospital care is \$181.46 but the respite hospital rate is only \$168.52. (NZ Aged Care Association 2013)*

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<sup>15</sup> See: <http://www.workandincome.govt.nz/individuals/brochures/community-services-card.html#Lowtomiddleincomefamilies5>.

<sup>16</sup> See <http://www.beehive.govt.nz/release/health-receives-largest-budget-increase>.

<sup>17</sup> There are also private costs for older people that are not covered by government sources, including, as well as unsubsidised residential care and GP payments: physiotherapy, dental, audiology and optometry costs.



The Carer Support Subsidy is funded by the Ministry of Health to assist the unpaid, full-time carer of a disabled person to take a break from caring for that person. The Supported Living Payment (SLP),<sup>18</sup> paid through the Ministry of Social Development, is available to those caring full-time for someone at home who would otherwise need hospital-level or residential care (or the equivalent) who is not a husband, wife or partner.

*In some circumstances a household member may receive a Domestic Purposes Benefit for the Care of a Sick and Infirm person. At June 2012 MSD statistics indicate this income tested benefit was being paid in respect of care of 3,926 persons identified as being aged 65 plus. (Preston 2013, p. 11)*

An income-tested Disability Allowance up to \$60.54 a week may also apply. Free day care may be available for people with a diagnosis of dementia or Alzheimer's (Seniorline 2013). The incidence of disability increases with age, and is a crucial factor in the need for care. In the 2006 Household Disability Survey, 32% of those aged 65-74 years, 51% aged 75-84 and 71% aged 85+ reported some form of disability; and the 85+ age group "is projected to increase by 3.5 times over the next three decades from 18,800 in 2006 to 66,800 in 2036" (Ministry of Business Innovation & Employment 2009, p. 14). Most adults living in residential care facilities reported having multiple disabilities (94%) and high support needs (82%) (Statistics New Zealand 2006). Those aged 65+ who are not in residential care may qualify for the weekly Special Disability Allowance of \$37.76 when their partner is in residential care. Also, available to those in residential care, is the annual clothing allowance of \$267.43.

In-home care and support services (for all those who are eligible, not just those aged 65+) are funded from Vote Health. In 2012/3, DHBs spent approximately \$269 million on home support services, a \$48 million increase on 2008/09, and purchased over 10 million hours of home support services (Ministry of Health 2013a, p. 18).

*According to recent statistics from the Health Minister around 75,000 people receive home support at some time each year – and around 15,000 people come on, and 15,000 go off home support each year. As more and more people choose to stay in their homes longer, the quality of in-home services becomes a growing and important issue where, according to the Health and Disability Commissioner, there "is no formal supervision or external regulation". (New Zealand Labour & Green party of Aotearoa New Zealand in conjunction with Grey Power New Zealand 2010, p. 21)*

Other fully or partially government-funded assistance for the aged supports housing, transport and mobility, personal security, and communication and social connection (Preston 2013). These benefits can include: state rental housing and local government pensioner housing; the Accommodation Supplement; Housing New Zealand Income Related Rents subsidy; the Living Alone Payment;<sup>19</sup> the Total Mobility Scheme; health-funded support equipment including hearing and other aids; and local rates rebate and deferral schemes.

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<sup>18</sup> The SLP replaced the Domestic Purposes Benefit: Care of Sick/Infirm on 15 July 2013. See <http://www.workandincome.govt.nz/individuals/a-z-benefits/domestic-purposes-benefit-care-of-sick-or-infirm.html>.

<sup>19</sup> "On the 5 April 2013, the Social Assistance (Living Alone Payment) Amendment Bill received Royal Assent. From September 2013, the separate Living Alone Payment will be replaced by a single living alone rate of NZS/VP. The total amount of assistance payable to a single superannuitant who is living alone will not change." (Ministry of Social Development 2013a, p. 11)

**Table 5. Supplementary assistance provided to people aged 65 and over\*** (Ministry of Social Development, 2013a, Table 11)

Supplement type	As at end March 2007			As at end March 2010			As at end March 2013		
	Number of recipients	Proportion of total population 65+*	Average weekly payment	Number of recipients	Proportion of total population 65+*	Average weekly payment	Number of recipients	Proportion of total population 65+*	Average weekly payment
Accommodation Supplement	25,694	5.1%	\$49	30,314	5.5%	\$54	35,045	5.6%	\$58
Disability Allowance	122,471	24.4%	\$25	129,743	23.6%	\$26	129,123	20.7%	\$25
Temporary Additional Support	315	0.06%	\$48	2,246	0.4%	\$56	3,253	0.5%	\$55
Special Benefit	1,292	0.26%	\$40	670	0.12%	\$48	383	0.1%	\$64

\* Total population aged 65 and over receiving NZS/VP or other main benefit

At March 2013, as shown in Table 5, 35,000 over-65s (5.6% of the total aged 65+) were receiving assistance with housing costs at an average of \$54 per week via the Accommodation Supplement, while 129,000 (nearly 21%) were in receipt of the Disability Allowance at an average of \$25 per week (Ministry of Social Development 2013a, p. 17). The Temporary Additional Support allowance is available for up to 13 weeks to meet essential living costs (Ministry of Social Development 2013b). Much of this additional assistance is income-tested, and requires assessment by the NASC service contracted to each DHB. Table 6 shows state expenditure on this assistance to NZS recipients.

Accommodation Supplement	\$88,098,000
Disability Allowance	\$171,847,000
Temporary Additional Support	\$8,322,000
Special Benefit	\$1,247,000
<b>Total</b>	<b>\$269,514,000</b>

The Special Needs Grant, a one-off non-repayable payment to help with urgent and necessary costs such as food, bedding and emergency medical care; and home insulation funding (not exclusively available to those aged 65+) are not included here. Those aged 65+ have an additional benefit, through the SuperGold card, for free off-peak transport funded by local government. This cost is also excluded from the following calculations. A further comparatively small Government cost through the Ministry of Social Development is Age Concern's provision of elder abuse prevention programmes.

## Actual and estimated total costs of government-funded aged services and support

As noted above, at the 2006 census (data is not yet available from the 2013 Census), 5.4% of people aged 65+ were in residential aged care. This comprised 1% of those aged 65-74 years, 5.6% of those aged 75-84 years and 21% of those aged 85+ (Statistics New Zealand 2007). In 2008, an estimated 32% of rest home residents were paying the full cost of their care (Grant Thornton 2010, p. 76). By 2013, the Ministry of Health estimated that of around 9,000 people aged 65+ paying privately for residential care, approximately 5,000 were paying the full cost of their care, and another 4,000 were paying at the capped rate for higher cost forms of residential care. In 2013, about 22,000 people aged 65+ were fully state-subsidised (in addition to their NZS contribution).

Of the \$1,550 million (ex GST) in residential care costs in 2013, DHBs paid approximately \$890 million. Of the balance, about \$450 million was recovered from client contributions via NZS, and an additional \$210 million was contributed by private payments (Preston 2013, p. 12).

In Table 7, the projected bed-days are taken from the DHB Shared Health Services ARC model (Health Partners Consulting Group 2013). Total costs per bed-day are derived from the New Zealand Gazette (2013)<sup>20</sup> and the New Zealand Aged Care Association (2013) Report, and are GST inclusive. The average contract-bed-day price is \$119.70 (\$837.90 per week) for rest homes and \$215.00 daily, or \$1,505.00 per week for hospital-level care, including psycho-geriatric and dementia care (NZ Aged Care Association 2013).

<b>Medium projections</b>											
	2012/13			2016/17			2021/22			2031/32	
	cost per bedday	beddays	cost per annum	beddays	cost per annum	beddays	cost per annum	beddays	cost per annum	beddays	cost per annum
Resthome	\$119.7	5,836,531	\$698,632,761	5,388,022	\$644,946,247	6,531,789	\$781,855,110	9,314,524	\$1,114,948,516		
Hospital	\$182	4,075,281	\$741,701,142	4,955,353	\$901,874,266	5,992,691	\$1,090,669,757	8,664,675	\$1,576,970,763		
Psychogeriatric	\$182	268,419	\$48,852,258	311,049	\$56,610,971	371,481	\$67,609,506	505,267	\$91,958,512		
Dementia	\$182	1,101,741	\$200,516,862	1,364,915	\$248,414,510	1,632,560	\$297,125,927	2,322,304	\$422,659,331		
<b>Total</b>		<b>11,281,972</b>	<b>\$1,689,703,023</b>	<b>12,019,339</b>	<b>\$1,851,845,994</b>	<b>14,528,521</b>	<b>\$2,237,260,300</b>	<b>20,806,769</b>	<b>\$3,206,537,122</b>		
<b>Low projections</b>											
	cost per bedday	beddays	cost per annum	beddays	cost per annum	beddays	cost per annum	beddays	cost per annum	beddays	cost per annum
Resthome	\$119.7	5,809,702	\$695,421,281	5,266,072	\$630,348,856	6,189,513	\$740,884,757	8,342,016	\$998,539,259		
Hospital	\$182	4,057,158	\$738,402,813	4,846,353	\$882,036,195	5,683,655	\$1,034,425,232	7,768,044	\$1,413,783,933		
Psychogeriatric	\$182	267,196	\$48,629,619	304,070	\$55,340,699	353,353	\$64,310,168	455,791	\$82,954,041		
Dementia	\$182	1,096,661	\$199,592,262	1,334,044	\$242,796,059	1,548,266	\$281,784,449	2,079,022	\$378,381,950		
<b>Total</b>		<b>11,230,716</b>	<b>\$1,682,045,975</b>	<b>11,750,539</b>	<b>\$1,810,521,809</b>	<b>13,774,787</b>	<b>\$2,121,404,605</b>	<b>18,644,872</b>	<b>\$2,873,659,184</b>		
<b>High projections</b>											
	cost per bedday	beddays	cost per annum	beddays	cost per annum	beddays	cost per annum	beddays	cost per annum	beddays	cost per annum
Resthome	\$119.7	5,877,082	\$703,486,705	5,575,263	\$667,358,933	7,049,062	\$843,772,754	10,673,543	\$1,277,623,150		
Hospital	\$182	4,103,781	\$746,888,066	5,131,351	\$933,905,833	6,478,306	\$1,179,051,734	9,943,153	\$1,809,653,820		
Psychogeriatric	\$182	269,936	\$49,128,294	319,691	\$58,183,731	393,741	\$71,660,894	566,686	\$103,136,836		
Dementia	\$182	1,109,016	\$201,840,836	1,410,765	\$256,759,157	1,752,161	\$318,893,318	2,653,042	\$482,853,718		
<b>Total</b>		<b>11,359,814</b>	<b>\$1,701,343,901</b>	<b>12,437,069</b>	<b>\$1,916,207,654</b>	<b>15,673,271</b>	<b>\$2,413,378,699</b>	<b>23,836,425</b>	<b>\$3,673,267,523</b>		

Population projections are based on increases to the 65+ population set out in Table 8.

<b>Medium projections</b>				
	2012/13	2016/17	2021/22	2031/32
	599,788	690,150	810,370	1,075,610
% Change		15.07%	17.42%	32.73%
# Change		90,362	230,810	496,050
<b>Low projections</b>				
	591,511	670,580	772,740	985,310
% Change		13.37%	15.23%	27.51%
# Change		79,069	230,810	496,050
<b>High projections</b>				
	605,492	707,580	845,190	1,166,370
% Change		16.86%	19.45%	38.00%
# Change		102,088	230,810	496,050

The maximum contribution paid by the resident who does not qualify for the Rest Home Subsidy is the rest home rate, whether they receive rest home or hospital level care. To avoid double-counting, note that the costs shown in Tables 7 and 8 include the contribution of NZS paid directly to the provider, and private costs paid by those whose assets and/or income exclude them from qualifying for a Rest Home Subsidy. The additional fees for services people can choose to

<sup>20</sup> See Appendix and <http://www.health.govt.nz/our-work/life-stages/health-older-people/long-term-residential-care/maximum-contribution>.

pay, covering 'premium' add-ons, for example, a view, a private bathroom, are excluded from the analysis.

The total costs of long-term care in 2017, 2022 and 2032 are projected assuming that the bed-day cost increases with the CPI, so that the figures are in real 2013 dollars.

The numbers of bed-days include respite care, although such care is usually funded at a slightly lower rate. Although high and low projections are provided for the 65+ population, the focus here is primarily on Statistics New Zealand's medium projections, which show New Zealand's population aged 65+ almost doubling in 20 years, from 599,788 in 2012 to 1,075,610 by 2032.

While the number of bed-days in rest home care reduce from 5,836,531 in 2012 to 5,388,022 in 2017, this fall is more than offset by the increase in hospital numbers (including psychogeriatric and dementia) from 5,445,441 in 2012 to 6,631,317 in 2017.

Total costs (public and private, inclusive of GST) of residential aged care rise from \$1.82 billion in 2012/3 to \$2.01 billion in 2017, and \$2.44 billion in 2022. Between 2012/3 and 2032, total costs of residential care almost double to \$3.49 billion.

Table 9 sets out the numbers of bed-days required for those aged 85+, drawn from the ARC Demand Model (2013) medium projections. It is this population that will experience the most growth in the years after 2032 and provide increased pressure on required bed-days. As in Table 7, prices are from the New Zealand Aged Care Association and the 2013 Gazetted maximum charges. This doubling of the population aged 85+ over the next 20 years is reflected in the doubling of the cost of their residential care.

<b>Medium projections</b>									
	2012/13		2016/17		2021/22		2031/32		
	cost per bedday	beddays	cost per annum	beddays	cost per annum	beddays	cost per annum	beddays	cost per annum
Resthome	\$119.7	3,556,891	\$425,759,808	3,286,890	\$393,440,692	3,823,571	\$457,681,442	5,730,846	\$685,982,313
Hospital	\$182	2,483,755	\$452,043,447	3,112,368	\$566,450,889	3,598,297	\$654,889,973	5,464,030	\$994,453,434
Psychogeriatric	\$182	97,872	\$17,812,624	107,205	\$19,511,289	120,361	\$21,905,704	174,642	\$31,784,818
Dementia	\$182	547,760	\$99,692,410	705,352	\$128,374,006	798,921	\$145,403,547	1,204,619	\$219,240,649
<b>Total</b>		<b>6,686,278</b>	<b>\$995,308,289</b>	<b>7,211,814</b>	<b>\$1,107,776,877</b>	<b>8,341,149</b>	<b>\$1,279,880,666</b>	<b>12,574,137</b>	<b>\$1,931,461,215</b>
Population 85+		74,000		84760		94680		144200	
% Change				14.54%		11.70%		52.30%	
# Change				10760		230810		496050	

Table 10 (derived from ARC Demand Model 2013), shows private and public contributions to the cost of residential aged care in 2013, 2017, 2022 and 2032. The MoH and DHB component includes NZS contributions from those accessing the Rest Home Subsidy.<sup>21</sup>

As shown in Table 10, under medium projections for those aged 65+, the contribution from the MSD, MoH and local DHB, including client contributions of NZS for those qualifying for the Rest Home Subsidy, is 87% in 2012/3. About \$210 million or 13% was contributed by fully private payments. The Demand Model predicts the private component declining slightly from 13% in 2013 to 11% by 2017, possibly due to the way the asset test operates.

<sup>21</sup> As noted above, Preston (2013, p. 12) reports annual total cost of residential care as \$1,550 million ex. GST. Allowing for GST at 15% on the DHB subsidy of \$890 million, this corresponds to the costs shown in Table 4.

<b>Med projections 65+</b>	<b>2012/13</b>		<b>2016/17</b>		<b>2021/22</b>		<b>2031/32</b>	
Private	13%	\$230,693,777	11%	\$219,823,866	11%	\$266,668,049	11%	\$382,810,877
MSD, MoH and DHB	87%	\$1,593,493,519	89%	\$1,795,548,780	88%	\$2,168,351,053	88%	\$3,109,660,505
<b>Total</b>		<b>\$1,824,187,296</b>		<b>\$2,015,372,646</b>		<b>\$2,435,019,102</b>		<b>\$3,492,471,382</b>
<b>Low projections 65+</b>								
		<b>2012/13</b>	<b>2016/17</b>		<b>2021/22</b>		<b>2031/32</b>	
Private	13%	\$229,662,804	11%	\$214,979,617	11%	\$252,957,178	11%	\$343,613,143
MSD, MoH and DHB	87%	\$1,586,269,396	89%	\$1,755,471,832	89%	\$2,056,008,047	89%	\$2,786,391,480
<b>Total</b>		<b>\$1,815,932,200</b>		<b>\$1,970,451,449</b>		<b>\$2,308,965,225</b>		<b>\$3,130,004,623</b>
<b>High projections 65+</b>								
		<b>2012/13</b>	<b>2016/17</b>		<b>2021/22</b>		<b>2031/32</b>	
Private	13%	\$232,297,122	11%	\$227,447,968	11%	\$287,775,506	14%	\$438,120,903
MSD, MoH and DHB	87%	\$1,604,471,538	89%	\$1,858,094,260	89%	\$2,339,387,300	86%	\$2,691,883,719
<b>Total</b>		<b>\$1,836,768,660</b>		<b>\$2,085,542,228</b>		<b>\$2,627,162,806</b>		<b>\$3,130,004,622</b>
<b>Med projections 85+</b>								
		<b>2012/13</b>	<b>2016/17</b>		<b>2021/22</b>		<b>2031/32</b>	
Private	13%	\$140,395,228	11%	\$133,590,391	11%	\$159,773,594	11%	\$233,646,600
MSD, MoH and DHB	87%	\$936,876,982	89%	\$1,076,894,614	89%	\$1,238,850,858	89%	\$1,878,127,600
<b>Total</b>		<b>\$1,077,272,210</b>		<b>\$1,210,485,005</b>		<b>\$1,398,624,452</b>		<b>\$2,111,774,200</b>

As discussed above, in addition to residential care for those aged 65+, the Government funds or subsidises many other services, including GP visits and in-home care and support. Table 11 only indicates the current and likely future impact of the major costs spread across Health, Housing and Social Development Budget allocations.

<b>Item:</b>	<b>Numbers 65+ affected</b>	<b>Weekly cost 2012</b>	<b>Annual cost 2012</b>	<b>Numbers 65+ affected (est.) 2017</b>	<b>Annual cost (est.) 2017</b>	<b>Numbers 65+ affected (est.) 2022</b>	<b>Annual cost (est.) 2022</b>
PHO capitation subsidy	575,510	\$3.91	\$117,012,693	662,239	\$134,646,506	777,601	\$158,101,927
High Use Health Card (HUHC)	107,962	\$8.10	\$874,491	124,227	\$1,006,239	145,867	\$1,181,520
Ministry of Social Development Disability Allowance per week (average)	129,042	\$30.00	\$201,305,520	148,489	\$231,642,262	174,355	\$271,994,344
In-home care and support services (including Meals-on-wheels)	60,000	\$80.00	\$249,600,000	69,042	\$287,214,720	81,069	\$337,247,524
Accommodation Supplement	35,386	\$58.00	\$89,542,024	39,986	\$120,597,776	45,184	\$136,274,944
Financial Assistance (Statistical Report 2012)	29,689	\$8.10	\$12,600,000	37,910	\$15,967,692	42,839	\$18,043,787
HNZ Income Related Rents subsidy	13,128	\$182.27	\$124,427,709	15,106	\$143,178,965	17,738	\$168,120,741
Temporary Additional Support	3,253	\$55.00	\$9,303,580	3,741	\$10,699,117	4,392	\$12,560,931
Special Benefit	383	\$64.00	\$1,274,624	440	\$1,465,818	516	\$1,719,112
Other main benefits (MSD 2013a Table 9)	7,829	\$233.59	\$95,096,357	9,003	\$10,936,081	10,569	\$12,806,032
MSD Supported Living Allowance	3,926	\$335.18	\$68,427,667	4,518	\$78,739,717	5,305	\$92,456,176
Elder Abuse programmes			\$1,700,000		\$1,955,000		\$2,295,170
<b>Total</b>			<b>\$971,164,666</b>		<b>\$1,038,049,893</b>		<b>\$1,212,802,207</b>
Population growth estimates from Table 8. Some discrepancies between data sources.							

It is difficult to find statistical information on the High Use Health Card (HUHC), however, Motu research in 2009 reported the comparatively high proportion of those aged 65+ visiting a GP in 2002/03: "76% of 15-44 year-olds ..., compared with 83% of 45-64 year olds and 94% of individuals aged 65 years and over", and also note that "in 1996,... possibly as few as 20% of those eligible had an HUHC" (Cumming, Stillman and Poland 2009, pp. 8 - 18). More recently, the 2013 Health Survey found 90% of all adults over 65 had visited a GP in the last 12 months, and more than 50% had visited a practice nurse (Ministry of Health 2014). Based on these statistics, in Table 11 we estimate that of 90% of those aged 65+, 20% have an HUHC.

As the population aged 65+ increases as a proportion of the total population, costs in these areas are also predicted to increase, from a minimum of \$845 million in 2012 to at

least \$1.14 billion over the next ten years. Data is drawn from various sources, including the Office for Senior Citizens (2013).

The total costs of residential care (Table 10), other services and support (Table 11) and NZS for 2012/3 are around \$13 billion (Table 12). By 2017, under medium projections, that figure of total Government costs of aged care services will approach \$15 billion, and by 2022 it will reach almost \$17 billion. Table 12 consolidates the actual and estimated costs (\$2013) for aged care and support services for 2012, 2017, and 2022.

<b>Table 12. Combined costs of Aged Services and Support (65+)</b>			
	<b>2012/3</b>	<b>2016/7</b>	<b>2021/2</b>
Residential Aged Care: MSD, MoH & DHB (medium projections)	\$1,593,493,519	\$1,795,548,780	\$2,168,351,053
Other Services and Support	\$971,164,666	\$1,038,049,893	\$1,212,802,207
New Zealand Superannuation (estimate)	\$10,400,000,000	\$11,700,000,000	\$13,279,000,000
<b>Total (rough estimate)</b>	<b>\$12,964,658,185</b>	<b>\$14,533,598,673</b>	<b>\$16,660,153,260</b>

Based on population estimates, by 2032 the 2012/3 real costs of residential and in-home care, health, and other services for those aged 65+ will approximately double, and from 2032 onwards these costs will grow even more rapidly as the babyboomers enter the 85+ age group. These estimates do not take into consideration possible policy changes or likely changes to the existing wage structure in the sector, and are likely to be an underestimate.

## **Budget 2014 initiatives for the aged**

The 2014 Budget revealed no changes to 'silver' policies, apart from some small measures of increased support. In advance of the Budget announcements on 15 May, the Senior Citizens Minister announced an additional \$170,000 for two new specialist Elder Abuse and Neglect Prevention (EANP) services, adding to the existing 24 Government-funded EANP services (\$1.6 million annually). Age Concern New Zealand is already funded to deliver 19 of these, and provides training and coordination for all services (Goodhew 2014).

The current record spending on health of \$15.6 billion (Ryall 2014) is at best an increase in nominal terms. Labour's Health spokesperson calculated a 2.3% cut in real terms for health (Brown 2014). Apart from the very welcome \$90 million to make GP visits and prescriptions free for children aged under 13 from 1 July 2015; the "extra funding" of about \$320 million to DHBs for "cost pressures and new initiatives" includes \$96 million over four years for in-home support (\$24 million per year, about 10% of home support expenditure); and an extra \$112.1 million for disability support services, some of which will go to the aged, to meet rising needs and costs (Ryall 2014).

A further \$40 million over 4 years for "support for elderly people including people with dementia" was announced (Ryall 2014), of which some may top up the DHB cost of the 1% funding increase offered to residential aged care providers. The Treasury's (2014, p. 71) *Budget Fiscal and Economic Update* reports an unquantified risk relating to "caregiver employment conditions" including the several cases and funding claims in the disability support and aged care sectors around the Minimum Wage Act and Equal Pay Act.

The small injection of funding (\$30 million over 3 years) to the Social Housing Fund is welcome but inadequate. An extra \$16 million over 4 years goes to rural and Māori housing to build capacity, fund housing improvements and repairs, and build in remote and rural areas (Community Housing 2014). The \$80 million from the asset sales programme proceeds going to MSD is to *administer* social housing: reviewing tenancies, managing social housing providers and the waiting list, and investigating frauds and recovering debt, and will not deliver a single new housing unit (Satherley 2014).

However, it is possible that some of the social housing funding will support the increasing numbers aged 65+ who are not home-owners into options such as Abbeyfield.<sup>22</sup> The 2013 Census results showed that home ownership in New Zealand is decreasing: in 2013 35.2% of dwellings were rented, and 60% of dwellings were owned or partly owned by the usual resident(s) compared with 73.8% owned in 1991. However, the Census data on home ownership are unfortunately incomplete, and we have no ownership information about 20.7% of all dwellings (Retirement Policy and Research Centre 2013). If the apparent trend of reducing percentages of home ownership eventuates, there will be fewer homeowners in the later waves of retiring babyboomers, so they will have less accumulated assets to contribute to the costs of their retirement. Lack of affordable housing and a shortage of care-givers could be the triggers for crisis among the ageing population by 2020.

## Turning Silver to Gold

The notion of an ageing population conjures up fears of increasing numbers of frail elderly dependent on provision of their pay-as-you-go pensions, as well as their care and support, to be provided and funded by decreasing numbers of young workers. This is the source of the 'silver tsunami' metaphor, an unstoppable surge of grey-headed women and men, consuming or destroying everything in their path. A different image can be conjured, 'turning silver to gold', if their potential for contribution to the community and the economy is considered.

The most frequent response to demographic change is to increase the qualifying age for the age pension, a change already underway in the UK,<sup>23</sup> Australia<sup>24</sup> and the US.<sup>25</sup> Some developed countries, including Australia, means-test age-pension payments. New Zealand does not, although from 1985 to 1998 a surcharge was used to recover NZS from high earners. In the last few decades, New Zealand has become far more generous to retirees with high incomes, and needs a research-led debate to determine the future size and shape of NZS. Susan St John, co-director of the RPRC, writes:

*... there is a strong case for a greater degree of targeting. Universal provision of benefits usually goes hand in hand with progressive taxation. Reductions in the top tax rate since NZS was first introduced make it much more generous today to the top end than in the past. If a means test is to be implemented, doing it through the tax system may be the simplest and the least contentious. It is suggested NZS may be progressively removed through a carefully designed tax scale for superannuitants so that there is minimal impact on lower income retirees. In doing so it may be more equitable than a blanket raising of the age or reduction in the level of NZS. (St John 2013, p. 24)*

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<sup>22</sup> See: <http://www.abbeyfield.co.nz/>.

<sup>23</sup> See: <https://www.gov.uk/government/policies/reviewing-the-state-pension-age>.

<sup>24</sup> See: <http://www.smh.com.au/federal-politics/political-news/retirement-age-rise-to-70-by-2035-joe-hockey-announces-20140502-zr318.html>.

<sup>25</sup> See: <http://www.socialsecurity.gov/retire2/agereduction.htm>.

### **Workplace policies**

The strongest response to demographic change in New Zealand appears to be coming from the ageing population themselves. This country has one of the highest rates in the OECD of participation in the paid workforce for those over age 65, as shown in Table 13.

**Table 13. Some comparisons of labour force participation rates of older workers in 2010** (RPRC, 2014, Table 1)<sup>26</sup>

	<b>Age 55-64</b>	<b>Age 65 plus</b>
New Zealand	75.9%	17.0%
Australia	62.6%	10.7%
United States	64.9%	17.3%
United Kingdom	59.7%	8.6%

While the high rate of labour-force participation by those aged 65+ is not new in New Zealand, it has increased dramatically over the 27 years from 1986 to 2013 (Table 14). Also, in 2013, of the 22.5% of all those over age 65 still in the workforce, more than half were working full-time (defined by Statistics New Zealand as 30 or more hours a week), and the remainder were working at least one hour a week for pay (Retirement Policy and Research Centre 2014, p. 1).

**Table 14. New Zealand's labour force participation rates age 65+, 1986-2013** (RPRC, 2014, Table 2)

<b>Census year</b>	<b>Population age 65 &amp; over</b>	<b>Participation rate</b>			
		<b>All</b>		<b>Males</b>	<b>Females</b>
		<b>Rate</b>	<b>Number</b>		
1986	342,111	6.4%	21,895	11.2%	2.9%
1991	379,767	6.0%	22,786	10.3%	2.8%
1996	422,667	9.2%	38,885	14.4%	5.2%
2001	450,423	11.6%	52,249	17.5%	7.0%
2006	495,603	17.1%	84,748	23.9%	11.6%
2013	607,032	22.5%	129,516	29.3%	16.7%

Explanations for this increased participation range from changes to the qualifying age for NZS (from age 60 to 65 between 1992 and 2001); dropping the income-test (the 'surcharge') in 1998, so that there was no longer a financial penalty on earning extra income; to the Department of Labour's (2007) factors including better health and the recognition among older people of the benefits of keeping active; and the increased share of work that is knowledge- and skill-intensive rather than being manually intensive. A further critical factor for these high rates of labour-force participation among those aged 65+, and perhaps one of the greatest steps toward taking away the notion of 'threat' from the ageing population, is the Human Rights Act 1993 that prevents the adoption of a compulsory retirement age.

Gains in life expectancy do not constitute gains in quality of life unless they are associated with health, interpersonal relationships, and an ability to maintain a productive social role, for example, volunteer work, family care giving, or labour-market participation (O'Reilly and Caro 1994). In addition to paid employment, data from the 2006 Census shows that about 15% of those aged 65+ were involved directly in voluntary work through clubs, societies and churches. The value of this contribution, using 2011 dollars, is estimated to rise from \$5–6 billion in 2011 to over \$22 billion in 2051 (Ministry of Social Development 2011). The high participation rate of those aged 65+ makes a significant and growing contribution to GDP and thus to the tax base from which NZS, health, and other costs are funded. The projected after-tax income available to older people for expenditure is

<sup>26</sup> Note that the US state pension age was increased to 66 years in 2009 which will influence the numbers aged 65+ still in paid work. See <http://www.ssa.gov/retire2/retirechart.htm>.



expected to rise from about \$11 billion in 2011 (\$2011) to over \$45 billion by 2051 (Ministry of Social Development 2011).

However, prejudicial attitudes and discriminatory practices still limit the opportunities for older people to make substantial contributions, particularly in workplace settings. Few companies incorporate effective strategies for retaining older workers, and there has been little improvement in the last two decades. O'Reilly and Caro (1994, p. 43) report the dearth of strategies such as "job-sharing, flexible hours, job redesign, retraining, job transfer, phased retirement, part-time employment, and internal skills banks". Twenty years later, a report compiled by the NZ Work Research Institute and the Equal Employment Opportunities Trust: *Managing an Ageing Workforce* (Bentley 2015, p. 10), notes that less than 25% of the organisations they surveyed had an effective age strategy.

While the well-being of seniors depends to a great extent on their ability to play a role in the labour market when they choose to do so (Bellaby 2006), policy or institutional changes to improve opportunities for older women or minorities don't and won't make up for a lifetime of discrimination. Bentley (2015) offers a strong warning regarding the lack of preparedness for the ageing workforce:

*Findings from our recent New Zealand diversity surveys suggest that while many New Zealand organisations regard the ageing workforce as an important priority, most organisations have neither a policy nor programmes and initiatives in place to address the issue. This ties in with observations from other research conducted here and elsewhere highlighting concerns around negative stereotypes within organisations regarding older workers and a potential lack of preparedness for engaging an ageing workforce positively and productively. (Bentley 2015, p. 1)*

Moreover:

*Worryingly, a recent survey suggested that many HR directors and business leaders acknowledged a 'silent tipping point', usually 50 to 60 years of age, beyond which workers are viewed as less attractive by an organisation. (Bentley 2015, P. 2)*

Such negative attitudes to older workers are likely to disadvantage the older workers, the organisation, and its clients. While negative myths and stereotypes abound, the available evidence tells a different story (Bentley 2015). Older workers are often the holders of Institutional knowledge, and have the skills to mentor younger workers.

Improving workplace policies to suit an ageing workforce will become increasingly important as the numbers of workers aged 65+ increase significantly over the next 40 years. StatsNZ's median projections indicate that the labour force of 2.4 million in 2012 will increase to 3.0 million in 2036 and 3.3 million in 2061, and of that, those aged 65+ (130,000 in 2012) will increase to 370,000 in 2036 and 460,000 in 2061. This means the proportion of the labour force aged 65+ (5% in 2012) will increase to 12% in 2036 and 14% in 2061. The proportion of the 65+ population in the labour force will increase from 21% in 2012 to about 30% from the mid-2020s (Statistics New Zealand 2012).

Australia has similar demographic change to New Zealand, but appears to confront the issue rather than deny it.<sup>27</sup> For example, initiatives taken by the Australian Government in the 2012-2013 budget focussed on encouraging both employees and employers to embrace the new older worker and workplace. For example, under the "Silver Service employment program" initiative, \$26 million would, in designated areas or industries,

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<sup>27</sup> It is important to note, however, that "Australia's mature age [labour force] participation rate is below that of comparable countries — including the United States, United Kingdom, Canada and New Zealand" (Australian Government 2010, p. 14)

“provide tailored, practical help for job seekers aged 55 and over”, to assist them with job-readiness (Australian Government 2012). In addition, the Government pledged to:

*... work with industry through the National Workforce Development Fund to prioritise the up-skilling and reskilling of mature age workers and will provide an additional \$35 million for this purpose. The Government's \$41 million response to the final report of the Advisory Panel of the Economic Potential of Senior Australians includes \$10 million for new Jobs Bonuses to help tackle age discrimination and encourage businesses to employ older Australians. The new \$1,000 Jobs Bonus will be introduced for employers who recruit and retain a mature age jobseeker for three months. This initiative will be coupled with a \$15.6 million extension of the successful Corporate Champions program to provide support to employers who wish to promote mature aged employment at their workplace. (Australian Government 2012)*

### **Beyond the workplace**

Of great advantage to both the aged and to those the younger population would be a range of ‘decumulation’ options, including annuities, home equity release options, and other products that would provide income security over an uncertain number of years and states of health in the retirement years. Annuities that included a long-term-care add-on would also ensure that the residential care costs of the aged would be shared amongst the aged, rather than continuing to be the burden of current tax-payers.<sup>28</sup> State involvement in some form would be required for such products to be viable.<sup>29</sup>

A ‘blue sky’ option would be ensuring towns and cities are age-friendly, and offering:

*a supportive environment that enables residents to grow older actively within their families, neighborhoods, and civil society and offers extensive opportunities for their participation in the community (Fitzgerald and Caro 2014, p. 2).*

Age-unfriendly towns, and the absence of the option to age-in-place is already evident in some tourist destinations like Wanaka and Queenstown-Lakes district. Advocates for the elderly are saying that the need for more pensioner housing in Wanaka is part of a wider problem where demand for aged care services in the town outweighs supply:

*... concerns have resurfaced ... about the lack of space at Wanaka's only rest-home, Elmslie House, which is consistently full with a waiting list several names long. An ageing population and Wanaka's popularity as a retirement destination are placing increasing pressure on Elmslie House and a new aged care facility being built next to the Aspiring Lifestyle Retirement Village is still about 18 months away. Further compounding the situation is the fact Wanaka has just five pensioner units owned by the Queenstown Lakes District Council. It owns another four units in Arrowtown, bringing the total across the district to nine, less than a tenth of the number provided by the Central Otago District Council, which owns 99 units across Central Otago. (Ibbotson 2015)*

Of course, an age-friendly community is potentially “friendly” for all and not only older people. A good example is the Matanikolo Project in South Auckland, a collaborative effort between several partners, including the Tongan Methodist Church, the Government’s Social Housing Unit (SHU), Airedale Property Trust, the Methodist Church of New Zealand, and others (Tanielu and Johnson 2014, p. 35). In February 2014, under Stage One of the Project, 22 homes with rents set at 80% of market value were opened, and 22 low-income Pacific families moved into them. The consortium has already made an application to the SHU for Stage Two of the Project to build 14 homes for Pacific elderly people.

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<sup>28</sup> For more information on decumulation, see the background papers and presentations of the RPRC’s Forum, November 2014, [Decumulating retirement savings: making the options work](#).

<sup>29</sup> For example, it could become part of the role and function of the New Zealand Superannuation Fund.

As well as encouraging cultural access and proximity, an age-friendly community option may involve encouraging the construction of retirement housing or retirement villages in close proximity to schools. This would enable reciprocity: provision by the retirees of such services as mentoring for the pupils and co-operative gardening projects; and access for the retirees to upskilling including computer literacy. The advantages to the school, the retirement village and the wider community would be multiple and could even be measurable.

Variations of this concept have been operating successfully for more than 20 years. For example, the International Association of Homes and Services for the Ageing, records how one program began in Spain when Barcelona City Council, Obra Social De Caixa Catalunya and the Universities of Barcelona, got together in 1996-1997 to test the idea of housing their students in the homes of older people. Starting with around 20 older people, it has grown to a 'fully consolidated programme across Spain, operating in 27 cities in seven autonomous communities. Similar intergenerational programs now exist in Lyons, France and Cleveland, Ohio.

A variation on this scheme is a nursing home in the Netherlands where 6 university students live rent-free alongside the 160 elderly residents, as part of a project aimed at warding off the negative effects of aging. In exchange for small, rent-free apartments, the Humanitas retirement home in Deventer requires students to spend at least 30 hours per month acting as "good neighbors". Students' activities with the older residents include watching sports, celebrating birthdays and, importantly, offering company when seniors fall ill, which helps stave off feelings of disconnectedness (Reed 2015). The students come and go as they please, as long as they follow one rule: "Do not be a nuisance to the elderly".

Other international initiatives to address ageing populations as reported by the MSD (2011, p. 29) include:

- *Australia's introduction of a work bonus in 2009 to allow working pensioners to keep more of their pension while working*
- *the United Kingdom's Opportunity Age, a broad multi-faceted approach to population ageing, identifying housing, crime and transport as issues to be addressed*
- *Finland's whole-of-government National Programme on Ageing Workers was launched in 1998 with the slogan: "Experience is a national asset". By expanding employment prospects and changing attitudes to early retirement, in five years the programme increased both older peoples' labour force participation rates and the average age of retirement*
- *France, Luxembourg and Finland each reducing implicit tax rates on continued work, making work more attractive and raising the opportunity cost of early retirement*
- *financial incentives for those who choose to claim pensions at a later age introduced in the United Kingdom, Germany, France, the United States and Spain*
- *a comprehensive programme of age-positive initiatives in the United Kingdom.*

It is worth noting that many of these initiatives would be redundant in New Zealand, given current policies. Although, based on international comparisons, we may appear to be ahead in the project to turn silver to gold, as the MSD stated (2011, p. 28):

*New Zealand has an opportunity to take action to harness the full economic potential of older people. If we do not, productivity and economic growth are likely to be constrained and our living standards may fall in relative terms.*

Extrapolating from Table 12, we can estimate that policy-driven public spending on support and services to those aged 65+ could increase by 30% by 2021 from the 2013 base. This

signals that a more reality-based, holistic, community-focussed approach to Crown expenditure is both necessary and urgent. This approach would need to include recognition of the value of our older citizens. They are a taonga, our link with history, our store of social and organisational memory, and our support for a path to a richer future for all New Zealanders.

## Appendix 1: Maximum private contribution to residential care services

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 Number 2014-go3744, Page 1857, Issue Number 65](#)<sup>30</sup> **Extract:** **Maximum Contribution Applying in Each Territorial Local Authority Region from 1 July 2014.**

... The maximum contribution is the maximum weekly amount (inclusive of GST) that a resident assessed as requiring long-term residential care (through a needs assessment and service coordination agency) is required to pay for contracted care services provided to them in the region in which their rest home or continuing care hospital is located. Contracted care services are services provided to needs-assessed people in a rest home or continuing care hospital that has a contract with a district health board. The services provided are those necessary to meet the person's assessed care needs in accordance with the agreement between the district health board and the residential care provider.

This agreement covers residents who are:

- eligible for the residential care subsidy (under section 141 of the Act); or
  - entitled to have funding paid to cover the difference between the maximum contribution and the cost of contracted care services provided to them (under section 140 of the Act).
- The maximum contribution is the same for all residents regardless of the type of contracted care services they receive.

The maximum contribution set by this notice applies from **1 July 2014** .... The daily GST exclusive contract price for rest home services has been increased by 1%, GST has been added and the result has been multiplied by seven to determine the new maximum contribution. The calculations are rounded to two decimal places at each step.

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<sup>30</sup> See: <http://www.health.govt.nz/our-work/life-stages/health-older-people/long-term-residential-care/maximum-contribution>. Information on the maximum contribution for each region (Territorial Local Authority regions in each DHB) is also available from Needs Assessment Service Coordination agencies, residential care providers, Work and Income, and the Residential Subsidy Unit of the MSD.

## Appendix 2. Overview of Vote Health 2012/13

Total Vote Health operating budget as at Budget 2013 was \$14.14 billion for the 2013/14 financial year. Source: Information Supporting The Estimates of Appropriations for Vote Health, Budget 2013 (<http://www.treasury.govt.nz/downloads/pdfs/b14-info/b14-2837340.pdf>, footnote 11, p. 7) Of this funding, more than \$11 billion is devolved to the 20 DHBs. See: [http://www.parliament.nz/resource/en-nz/50DBSCH\\_SCR5935\\_1/d60621ba4e6113cd6f5ffd3f91dfb790f9d51cd2](http://www.parliament.nz/resource/en-nz/50DBSCH_SCR5935_1/d60621ba4e6113cd6f5ffd3f91dfb790f9d51cd2)

As published in Vote Health (Ministry of Health 2012), the Minister of Health is responsible for appropriations the 2012/13 financial year totalling nearly \$14,125 million covering the following:

### **Departmental Operating Appropriations**

A total of nearly \$191 million (1.4% of the Vote) relates to the functions of the Ministry of Health for: policy advice, administering the purchase of national health services; monitoring the performance of the funders and providers of health and disability services; developing and administering legislation and regulations related to health service facilities, providers and public safety; ministerial servicing; and information services.

### **Non-Departmental Operating Appropriations**

A total of just over \$13,645 million (96.6% of the Vote) is for operating expenses to be incurred on behalf of the Crown and is intended to be spent as follows.

#### *Output Expenses*

These total nearly \$13,618 million (96.4% of the Vote) and are to fund the purchases of health services as follows:

- just over \$10,819 million (76.6% of the Vote) to fund health services from DHBs through the DHB appropriations
- nearly \$1,053 million (7.5% of the Vote) to purchase national disability support services
- just over \$800 million (5.7% of the Vote) to purchase national health services and provide clinical training for health professionals
- just over \$476 million (3.4% of the Vote) to purchase public health services
- nearly \$176 million (1.2% of the Vote) to purchase primary health care services
- just over \$145 million (1.0% of the Vote) to purchase national maternity services
- \$65 million (0.5% of the Vote) for a provision for DHB deficit support
- \$52 million (0.4% of the Vote) to manage health sector risks
- just over \$31 million (0.2% of the Vote) to fund other health and disability services.

#### *Other Expenses Incurred by the Crown*

A total of just over \$27 million (0.2% of the Vote) is for other expenses to fund provider development, legal expenses, and international health obligations including World Health Organisation (WHO) membership.

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