Home & Community Health Association

Briefing for Incoming Ministers

December 2020

Contents

Overview of HCHA and the sector

The Home and Community Health Association (HCHA) was established in 1993 and represents providers of home and community health services in New Zealand.

More than 101,000 elderly and vulnerable New Zealanders live independently in their own homes due to the expert care and support they receive from our members' 17,000 nurses and support workers.

Approximately 70% of these patients are aged 65 years and older. Without this care and support, these people would be forced to go into care.

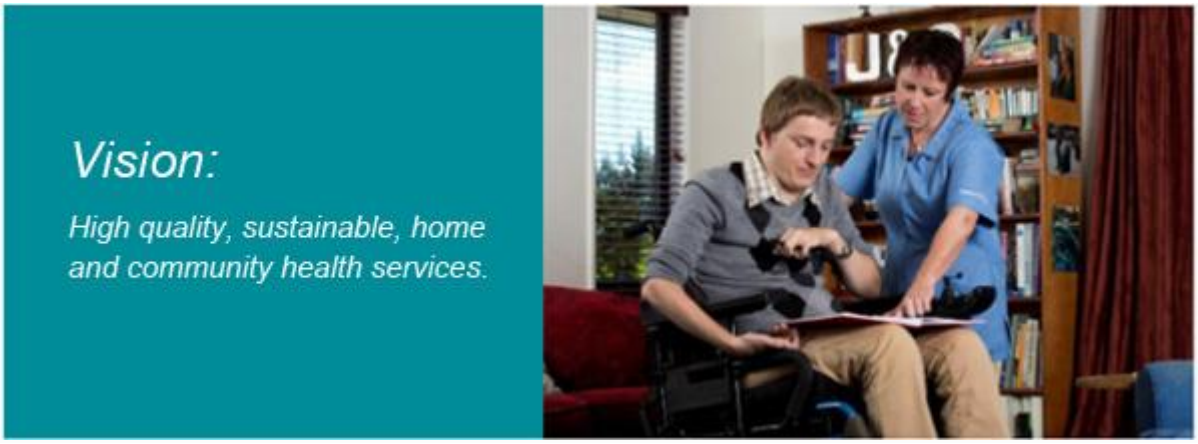
The support the sector provides, via 55 organisations, includes personal care, palliative care, household support, carer support and nursing care. These services are funded by District Health Boards, the Ministry of Health and the Accident Compensation Corporation.

However, this essential home care and support patients rely on is at risk due to:

- Insufficient funding to meet all the costs of providing care.
- Different funding models ranging from Fee for Service to bulk funding.
- No national plan or standardisation of service specifications or funding across 20 DHB's, the Ministry of Health and ACC.
- Regional variations in service and funding levels.

These issues are significantly impacting the sector's ability to deliver the care patients need and creates significant variation in equity of access, equity of service, and quality of service delivery. A lot of it comes down to where patients live.

This is leading to increased admissions to aged care facilities and hospitals which is at odds with the aims of our health sector and the purpose of home support services.



How HCHA can work with Government

We believe that there is a significant opportunity for the Government and HCHA to work together following the Health and Disability Review. We are committed to working with Government and to improve outcomes for the people we care for, their family, friends, and their community, and deliver better value for money for the government.

Specifically:

1. The Health and Disability Review noted "*that HCSS has an important role to play as part of enabling older people to live well and independently in their own homes, and it has been included in the guaranteed minimum services recommended for each locality. However, there are a wide range of issues associated with the current model that go beyond the scope of this report. Defining models of care for older people and addressing issues of sector sustainability and service consistency in HCSS needs specific attention, looking across disability support services, aged residential care, and services funded through ACC"*.

   HCHA would welcome the opportunity to work with Government to develop a more partnership and integrated approach to the Home and Community Support Sector (HCSS) that could bring significant benefits and cost savings to the wider health sector. This opportunity is detailed in the recent EY Report - *Recognising the Contribution of the Home and Community Support Sector to New Zealand, November 2019* http://www.hcha.org.nz/assets/EY-Report/2019-11-27-Recognising-the-contribution-of-the-Home-and-Community-HCHA-FINAL.pdf.

2. The Health and Disability Review noted "*Focus groups with kaumātua, for example, have highlighted a preference to live at home with whānau caring for them. However, barriers exist within the current system – from a lack of training and information for whānau carers, to assessment processes, to a lack of options for home-based support for the very frail or for people needing end-of-life care"*.

   HCHA would welcome the opportunity to work with Government to assist to develop more appropriate home-based options for Māori.

3. We value the current engagement with the MoH/DHB/Provider/Union Joint Working Group, seeking national service specifications, standard approaches to contracting and commissioning, sustainable funding, and a coherent workforce development strategy. We will continue to contribute constructively in an endeavour to gain a consistent national approach to service delivery and funding.

   We do note our concern at the consistent frustration to this process due to DHB's preoccupation with their perception of individual independence. DHB's appear to wish to make independent and unsupported financial decisions regarding HCSS, despite the fact that costs are largely consistent across the country, due to approximately 75% of all HCSS costs being legislated minimum wage and travel entitlements. Also, despite clear evidence of the economic benefits of HCSS services, the sector is frustrated that the Aged Residential Care sector appear to receive consistently higher contract uplifts than HCSS.

4. The Health and Disability Review commented on the HCSS that – *"These services have been delivered by a semi-trained workforce with low wages, low qualification levels and poor working conditions. Despite recent regulatory changes that include in-between-travel, pay equity for care and support workers and provisions for guaranteed hours, workers are still faced with irregular hours and a lack of job security. In addition, the current system is complex and bureaucratic, as different top-up rates exist for travel times, guaranteed hours and pay equity."*

They further noted that *"Commissioning and contracting policies should be used to encourage more secure employment, particularly for the workforces involved in home-based care and other outreach services"* and that *"Simulating this scenario for home and community support services shows that costs and expected gains from moving to secure salaried contracts may be offset, and therefore may not substantially increase costs for the sector".*

HCHA would welcome the opportunity to work with Government to assist to develop a more appropriately trained and secure HCSS workforce, in conjunction with a more partnership and integrated overall approach to the Home and Community Support Sector.

5. HCHA will continue its participation and contribution to a range of working parties and reference groups that advance the governments' work programmes and priorities in relation to aged and disability policies and services. We value these opportunities to offer the wide range of skills, knowledge and expertise that exists within our membership.
6. HCHA appreciates and looks forward to the opportunity for regular engagement and discussion with Ministers whose portfolios cover various aspects of aged, disability and ACC related policy and services.

Priorities for Incoming Ministers

HCSS providers can have a greater impact on personal and population health outcomes of older New Zealanders, as well the financial sustainability of the health system. This will require the development of strategic partnerships with health and disability system leaders, and increased resourcing through a more effective nationwide funding model.

HCHA would advocate to Ministers that the next steps and recommendations should be considered as part of a comprehensive HCSS review:

1. Recognise the full extent of the role that HCSS could play in homecare for people with complex clinical needs and multiple long-term conditions, and the benefit this has on moderating hospital and residential care demand and improving financial sustainability
2. Better understand how equity of access and unwarranted variation can be addressed, aligned with the findings of the ARC Funding Model Review
3. Align national reimbursement, risk-sharing, and cost-sharing arrangements to leverage the full extent of benefits that HCSS can offer
4. Invest in building partnerships between key system stakeholders, and building horizontal leadership to improve the influence of HCSS across the health and social care sectors

5

Establish and invest in a clear approach to leveraging opportunities offered by emerging technology

Background and Supporting Information

Home and Community Support (HCSS) providers currently deliver essential home-based health and disability services to over 101,000 vulnerable New Zealanders utilising a workforce of 17,000 support workers.

However, the current system, as starkly outlined by the Health and Disability Review Panel, is too complicated and in need of a more integrated approach to services within the community.

The benefits that can accrue from a more flexible and integrated approach to service delivery was demonstrated by the Home and Community response to COVID-19. This whole of Government response not only delivered for those in need at a critical time but also illustrated that change need not take years to accomplish and that a more partnership-based and integrated approach could bring significant benefits.

The need for change in the sector is becoming more urgent. The number of people aged 65 and over is expected to double between 2011 and 2036. By the late 2030s, people aged 65 and over will comprise almost one-quarter of New Zealand's population, meaning that many more people will be living with multiple long-term conditions. And wanting to remain in their own homes and close to family.

Most people are still interacting with the health system through a traditional episodic model of care. This approach will not provide the care needed for the ageing population and the ensuing increased demand on community-based services.

Home and Community Support Sector (HCSS) providers are critical to meeting this demand. The sector is already delivering care that is increasingly clinically complex and supports the management of chronic diseases. The opportunity to grow HCSS' role in delivering clinical care will require a sustained focus on digital technology (e.g., point of care testing; remote monitoring), training and clinical supervision to equip the non-regulated workforce to contribute to delivery of care in the community.

As District Health Board (DHB) spending on home-based support services has increased, Aged Residential Care bed days per capita of the 75+ population have decreased. This does not necessarily mean that greater DHB investment in HCSS directly contributes to fewer bed days (as it is on a 75+ per capita basis), but it could well be a significant causative factor.

The shift from hospital care to home or community care has been happening for the last decade. This change is gathering momentum as the population ages, and complex long-term conditions become more prevalent. Advancements in skills and technology facilitate the transition. Unfortunately, in reality, little has been done to understand what is actually required to sustain effective home and community based clinical care and support services. The role of HCCS is increasingly supported by international and New Zealand evidence which recognises the importance of person-centred care coordination in supporting ageing in place and avoiding unplanned presentations to acute hospitals. There is unwarranted variation in New Zealand's approach to commissioning of home and community services, that raises concern for equity of access to care, and the quality and sustainability of services.

The variability may be driven by a mix of different approaches by the various funders (ACC, DHBs, and the Ministry of Health), fiscal pressure and cost saving being prioritised over investment, commissioning maturity and risk-sharing practices together with health sector fragmentation.

The Home and Community Health Association engaged EY to illustrate the impact that the Home and Community Support Sector currently has on financial and quality dimensions of care in the New Zealand health system, and to identify the greater contribution that HCSS could make to meeting the increasing demands of a growing and ageing population. This report illustrates the case for greater investment in the home support sector to enable a person-centred and coordinated care supporting older people to stay in their own homes longer, an increasingly important part of health system strategy. To illustrate the opportunity for HCSS, the EY report describes a future model of coordinated care, integrated across health and social care settings with HCSS at its core. It also presents a perspective on the role of HCSS within this future model, including the importance of aligning delivery and funding.

However, there are some core enablers of the system that need to be in place for HCSS to provide greater person-centred care and support, to provide a model that wraps services around older people and their needs, improves individual choice, and provides a care coordinator to form a relationship with the older person with complex needs. Core enablers need to allow services to be delivered consistently and effectively, while also being flexible in responding to patients and their needs. Nationwide adoption of a case mix funding model that would individualise care, reduce risk, improve system effectiveness, and increase cost-efficiency and reduce inequities.

Investment in building collaborative relationships between key system stakeholders will be essential. In particular, strengthening trust between the leaders of DHBs and HCSS providers. Supporting older people to stay in their homes and their communities for longer not only improves person-centred and coordinated care, but also has a positive financial return. The impact of an improved model of care offering the opportunity for savings across three distinct patient journeys is illustrated in the EY report. This impact can be extended by leveraging the use of technology in an environment where clients expect greater participation in their own health care and support. An improved model of care with HCSS interventions would reduce secondary care usage (improving both patient satisfaction and cost to the system) by supporting older people to live in home and community settings with multiple long-term conditions. Increased spending across primary and community services can be offset by savings through reducing ED attendance, hospital readmissions and bed-days in acute and residential facilities.

The effectiveness of HCSS is already proven by local initiatives that are already demonstrating the impact of patient-centred and coordinated care. The success of such examples should be recognised and celebrated. Most importantly, the success of these programmes should be leveraged through the deliberate spread of innovation across New Zealand. The opportunity to identify and remove the barriers to spread and adoption of these innovations should be seriously considered in the Government's response to the Health and Disability System Review Panel Report.

Waikato DHB's START programme has demonstrated a range of measurable benefits, including a decrease in overall acute hospital length of stay, reduction in readmissions and improved rehabilitation outcomes. Extrapolation of the results of this programme to the New Zealand population suggests the potential to save up to 16,190 bed-days - $16.8m.

Canterbury DHB's CREST programme has also produced measurable benefits, including, decrease in overall hospital length of stay and no subsequent increase in readmissions to hospital.

HCSS provider organisations

Around 48 NGOs and private providers, including 16 iwi providers provide HCSS services throughout New Zealand. 20 organisations have left the service since 2015 through purchase, service review, or financial pressure.

DHB Contracts have shifted from NFP to privately owned companies, which now manage around 70% volume.

The Home and Community Health Association's objectives are to:

- provide leadership and advocacy for the home and community health sector
- establish, promote and recognise high standards for the conduct of home and community health services
- address members' educational and information needs
- provide a united voice for the Association's membership, to government and the public
- maintain links and provide opportunities for the development of the sector
- develop home and community health services that reflect the Association's obligations under the Treaty of Waitangi

The Workforce

HCHA and Careerforce undertook a comprehensive review of the training and development needs of the health and disability workforce in 2018. The Report, *Spreading our Wings*, outlines the changes required in the workforce to meet the rapidly changing needs of the client population.

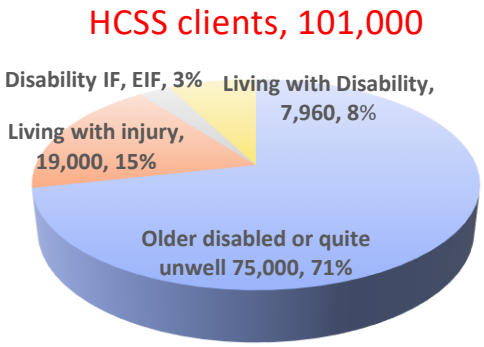
The current HCSS support worker workforce consists of 17,000 Kaiāwhina: 93% women, 82% Pakeha. This Kaiāwhina workforce has an ageing profile, with 12% over 65, 55% over 55 and very low numbers under 34.

In addition, the HCSS sector also employs over 400 nurses in addition to physiotherapists, coordinators, trainers & educators, quality staff and managers.

To effect the changes in the workforce, required to meet the identified changing client needs, will require substantial additional investment in training. HCHA note the recent Health and Disability Report comments that despite recent adjustments for pay equity, travel and guaranteed hours that "*workers are still faced with irregular hours and a lack of job security".* This is acknowledged but addressing this issue is challenging without fundamental changes to model of service, funding approach and the current sustainability issues of the sector.

The people we support

Every client has different needs. All live with disability injury or illness, some need short term assistance, others lifelong support. Some have family to help, others are isolated. Services range from laundry to life-sustaining care. A large proportion of clients are older New Zealanders, but we also support younger people. Clients receive services after a needs assessment and are allocated care. Older people received about 9.5 million hours of support in 2015-16 through Home & Community Support Services (HCSS).



Sources: MoH 2017, DHB ProdComm Report 2015, ACC DGRG report.
Note: Disability IF, EIF = IF 2,477, EIF 399

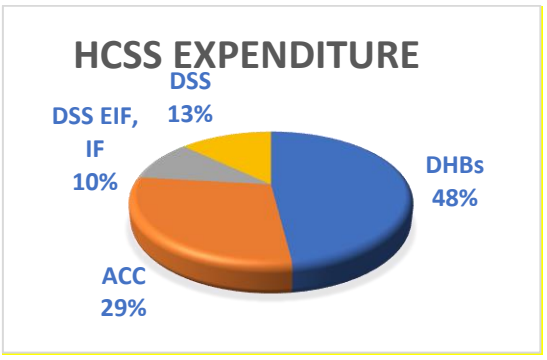
Those that identify as Māori constitute 16.5% of the New Zealand population, and Pacific Peoples 7.4%. However, those receiving home-based services are markedly less than these proportions at Māori 7% and Pacific Peoples 4%. This is markedly higher than those receiving Aged Residential Care, Māori 4.7% and Pacific Peoples 2.3%. However, as identified in the Health and Disability Review, "focus groups with kaumātua, for example, have highlighted a preference to live at home", and the discrepancy in percentages receiving services indicate issues of equity of service that needs to be addressed.

How well are the people we support?

41% are older than 85 years, and 58% are living with chronic conditions. A quarter have moderate or severe cognitive impairment, and 56% are at risk of hospital or residential care admission. 22% feel lonely. 22% report informal carer stress such as feelings of distress, anger, or depression. 7% are Māori and 4% are Pacific Peoples. *Source: National interRAI Data Analysis Annual Report 2015/16*

What does it cost?

For service users there is no fee to pay. Means testing for older people restricts household support to those with a community services card. Funding flows along three streams: DHBs for over 65 and chronic conditions support, MOH DSS for under 65 disability support / Individualised funding (IF) and Enhanced Individualised Funding (EIF), and ACC for injury.



Sources: DHBs Written Question 14293 (2016 figures); ACC 2016/17 year spend, Service review presentation 2017; MoH direct 2017

The HCSS sector is under significant financial pressure

The Health and Disability System Review (2020), Director Generals' Reference Group Report (2015) and the Sapere Independent Report on implementation of guaranteed hours (2018), together with numerous Ministry of Health working groups, have all highlighted some of the issues and challenges that are impacting on the HCSS providers' financial sustainability, and therefore on their ability to respond to the needs of people, and to be innovative in the way in which they design and deliver supports:

Overall, analysis shows that provider sustainability is becoming critical. There has been a consolidation of the provider market, generally resulting in larger providers taking over small, often unsustainable providers; further material consolidation is unlikely as the larger providers no longer find this approach viable.

- **Despite recent significant funding boost for the sector in recent years HCSS provider organisations continue to experience critical funding shortfalls and cost pressures.**

  Recent Budgets have substantially increased funding to the HCSS sector. However, this funding has been for specific purposes (In-Between Travel, Pay Equity, Guaranteed Hours) and is essentially "money in/money out" and does not improve the financial position of organisations. This has been exacerbated by an expectation that HCSS Providers make a contribution to these costs, despite comprehensive evidence that the sector sustainability was critical. While specific funding was made for a "pass through" to support workers, Many DHB's and MoH Disability then did not give appropriate, or in some cases any, increases for non-support worker cost increases. **The reality for providers is year on year net decreases in funding.**

  If the sector does not urgently gain relief and get regular contract price uplifts, there is a significant likelihood that providers will need to make some difficult decisions about the continuation of some services, staffing levels, whether to accept new referrals and ultimately the need to exit the service.

- **The impact of the pay equity legislation, while moving us away from a minimum wage labour market, is also exacerbating long standing funding shortfalls.** While specific funding has been made available to implement the pay equity legislation for support workers this funding simply enables employers to meet their obligations to pay the new minimum pay rates required under the legislation. It is "money in/money out" and does not improve the financial position of organisations. In fact, the flow on impacts and wage relativity costs for other staff has significantly increased financial burden for providers (increased costs of between 3-5% per year). These shortfalls have amounted to net funding reductions year on year as relativity costs associated with legislated pay increases have not been addressed at all. This issue will be acutely felt in the final year of the settlement when the remuneration at each of the four levels has to be rebalanced to take account of shifts in the minimum wage.

Opportunities

Delivery of person-centred and coordinated care enabling older people to stay in their own homes longer is an increasingly important part of health system strategy. However, there are some core enablers of the system that need to be in place for HCSS to provide greater person-centred care and support:

- A model that wraps services around older people and their needs
- A model that improves individual choice, and provides a care coordinator to form a relationship with the older person with complex needs
- A consistent, flexible, and fit-for-purpose needs assessment model
- Nationwide adoption of a funding model that would individualise care, reduce risk, improve system effectiveness, and increase cost-efficiency
- A technology-enabled workforce, with access to shared electronic health records and care plans

Investment in building collaborative relationships between key system stakeholders will be essential:

A partnership approach between HCSS providers and funders will be needed to meet future demand challenges

- In particular, strengthening trust between the leaders of MoH, DHBs and HCSS providers is critical and will take deliberate and committed action

Supporting older people to stay in their homes and their communities for longer not only improves person-centred and coordinated care, but also has a positive financial return:

The impact of an improved model of care offers the opportunity for savings across people journeys. This impact can be extended by leveraging the use of technology in an environment where people expect greater participation in their own health care and support:

- An improved model of care with HCSS interventions would reduce secondary care usage (improving both client satisfaction and cost to the system) by supporting older people to live in home and community settings with multiple long-term conditions
- Increased spending across primary and community services can be offset by savings through reducing ED attendance, hospital readmissions and bed-days in acute and residential facilities
- Local initiatives are already demonstrating the impact of people-centred and coordinated care. The success of such examples should be recognised and celebrated. Most importantly, the success of these programmes should be leveraged through the deliberate spread of innovation across New Zealand.

References

Health and Disability System Review – Final Report – Pūrongo Whakamutunga. Wellington: HDSR. This report is available at www.systemreview.health.govt.nz/final-report

Recognising the Contribution of the Home and Community Support Sector to New Zealand, November 2019. This report is available at http://www.hcha.org.nz/assets/EY-Report/2019-11-27-Recognising-the-contribution-of-the-Home-and-Community-HCHA-FINAL.pdf

Spreading Our Wings, September 2018. This report is available at http://www.hcha.org.nz/assets/Uploads/Spreading-our-wings-HCHA-Report.pdf

Director Generals' Reference Group Report, August 2015. This report is available at http://www.hcha.org.nz/assets/DG-REFERENCE-GROUP-REPORT-FINAL-AUGUST-2015-1.pdf

Deloitte Financial Review Risk Analysis. This report is available at http://www.hcha.org.nz/assets/FINAL-Financial-Review-Risk-Analysis-Report-Final-13-April.pdf

Sapere Independent Report on Implementation of Guaranteed Hours, 2018. This report is available at http://www.hcha.org.nz/assets/IBT-GH-Sapere-Report-2018-1.pdf