THE NEW ZEALAND HOME HEALTH SECTOR

MAKING THE MOST OF HOME SUPPORT SERVICES

The New Zealand Home Health Association Inc – March 2011

Contents

Note:
For the purposes of this paper, homecare and home support refer to home assistance and home health services. These terms have been used interchangeably, as have community support worker and homecarer, which refer to the unregulated work force providing these services.

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The New Zealand Home Health Association Inc is the national body representing providers of home health care services

Making the Most of Home Support Services

Executive summary

Home is the preferred place for people living with a disability, health or injury-related condition, and for older members of our community. Home support enables choice, independent living, self-management, control and restorative care. Home support that is respectful of, responsive to and guided by client preferences, needs and values enables people to remain where they are most comfortable.

Over the last 10 years the home support sector has experienced considerable changes:

- Client numbers have increased, mainly due to changes in eligibility for those over 65 and a shift in referral by DHBs from residential care to home-based care.
- The provider pool has changed, there is now a wider range of providers ('not for profit', social enterprise, private, franchise, family-based and client-managed care).
- More clients getting home support have higher health needs than in the past (because more are remaining at home rather than shifting into residential care facilities).
- Home-based care is being used to support post acute care recovery and rehabilitation, and chronic disease management.
- Models of home and community care have been designed that require delivery by qualified support workers and registered nurses, increased quality standards, greater clinical and operational governance, assessment competencies and allied health provision.

Home support organisations have built expertise in assisting people to manage chronic conditions, working in coordinated teams on specific health issues, managing specific health projects, and managing district nursing services.

These providers are now a superb resource that the Government can use to meet strategic and economic goals outlined in health and social policy (Ryall, 2007, National Health Board 2010), in localised District Health Board (DHB) District Annual Plans, the Accident Compensation Corporation (ACC) Statement of Strategic Intent and the Ministry of Health Disability Support Services Strategy (MOH 2001).

The economic benefits of home based service provision have been researched, and clearly greater benefit can be derived from services that are targeted, properly resourced and integrated with other health and social services. At the moment providers are 'dabbling' in areas such as nursing, chronic care, palliative care, allied health and assessments. With sufficient investment providers see a future where they can offer a broader range of services in the community, acting as a bridge between primary and community care, and reducing demand on secondary care and specialist services.

To date, the investment in this sector has proceeded reactively with little strategic intent. There have been (and still are) few controls on quality of service. Multiple funding and contracting arrangements have resulted in inconsistencies in service delivery and pricing arrangements.

Flexible contracting and open communication between key stakeholders will allow the best health gains and outcomes to be achieved from the combined resources of the sector. But, for example, where contract requirements (training, clinical oversight) are added without resourcing or informed consultation, the viability and potential of the service is threatened.

Providers have to be able to offer the home support workforce better pay and conditions of work so that they can improve staff retention and realise the benefits of a satisfied, trained and experienced workforce.

The government offers a person-centred, integrated vision of healthcare services, one in which more service provision takes place in the community and as close to home as possible. Home and community service models such as home support are a key component to achieving the government's vision. The sector capacity and capability that has been developed is positioned and ready to play its part.

Recommendations

Quality

1. We recommend that the Home and Community Support Sector Standard be the minimum mandatory standard for provision of HCSS services.
2. We recommend that minimum training requirements in home-based care, relative to the service provided and the service model in place be established.
3. We recommend that agreed registered nurse to non-regulated support worker ratios for complex care be established.
4. We recommend the standardisation of service specifications and purchasing frameworks for common services.
5. We recommend that the government fund research to clarify the supervision standards necessary for the safe delivery of the range of services provided in the home and community.

Effectiveness

6. We recommend that home support services be integrated more fully into other primary and community models through:
    a. Inclusion of providers in strategic planning and change processes relevant to home support.
    b. inclusion of home support providers in interdisciplinary and clinical advisory teams.
7. We recommend that the government support workforce capacity development through:
    a. service modelling that will more effectively attract, train, use, reward and retain staff.
    b. contracts that recognise the cost of clinical oversight, and the cost of training.
    c. specialised training for coordinators and care managers.
8. We recommend that the government support research into and further development of technologies that:
    a) generate and coordinate key information about individual clients and client groups; and
    b) enable people to live independently, with support/monitoring
9. We recommend that the Director of the National Health Board leads a national review to address the issues of a) inconsistency of auditing and b) potential for collaborative funder action to reduce the audit compliance burden.

Value

10. We recommend that the government co-sponsor research to:
    a. analyse the current and projected future needs of the home support client base;
    b. measure benefits of home support models in the New Zealand context;
    c. measure the cost and risk of servicing higher levels of need.

Quality

The client should receive service of the same quality and safety no matter where or by whom the service is provided. The public and government should have assurance that the standard of home and community support across New Zealand is consistent.

- Minimum mandatory standard
- Consistent audit requirements
- Minimum qualifications

A minimum mandatory standard

There are certainly challenges in maintaining consistency and quality when a service is delivered without direct supervision, by a non-regulated support worker to a potentially vulnerable client. This is a contextual reality of home support, around which many providers have built expertise.

Despite the challenges, clients should expect the same quality of care that is legally required of comparable service providers. In the residential sector (aged care, disability, mental health etc), providers must be certificated against the Health and Disability Standards. This is not the case in home support.

There is a voluntary standard – the Home and Community Support Sector Standard (HCSSS) (NZS 8158), which covers service user rights, organisational management and activities supporting good service and safe and appropriate delivery of home support. Of the approximately 125 providers of home support in New Zealand, NZHHA knows of 50 that are certificated to that standard. The majority of providers have not met any benchmark before and whilst providing services.

The New Zealand Home Health Association strongly advocates for the mandating of the Home and Community Support Sector Standard, and has set the Standard as a requirement for membership of the Association.

A mandatory standard will bring home care into line with other comparable services. It will give greater assurance to those receiving home support, and those paying for it, that there is reasonable consistency in service delivery across New Zealand. Increased transparency should incentivise high performance. It should result in more credible information for consumers about how providers are performing against the national benchmark. It should encourage providers to aim for meaningful and positive outcomes with clients. If integrated into service specifications it will strengthen provider infrastructure and will align New Zealand with international best practice.

Providers (small and large) that have been certificated to the voluntary standard for several certification rounds report that their focus has moved from compliance with the standard to continuous quality improvement - they now actively seek opportunities to review their own performance and make positive changes.

More consistency in performance auditing

Some funders (but not all) require or make reference to Standard 8158 standard in their contracts. Some (but not all) conduct internal or external contract performance audits. Some have minimal quality assurance processes in place for home support providers. ACC undertook its first ever audit of home care services in 2010 (of just 10 of the 125 ACC providers). There is much inconsistency. Some providers face no monitoring or performance auditing at all. Others (particularly national providers) that hold contracts across DHBs can face a myriad of repetitive 'provider specification quality' audits, on top of their HCSSS certification. Those providing services under individualised funding (MoH) or under non-contracted care (ACC) face no auditing. The playing field is completely uneven.

Recently some DHBs have begun to share performance audit information and to consider standardising contracts, but there is still much that can be done. The limited collaboration between purchasers places an unnecessary cost burden on providers, and makes an uneven playing field between providers and inconsistent quality for clients across New Zealand.

The New Zealand Home Health Association recommends that the Director of the National Health Board leads a national review to address the issues of a) inconsistency of auditing and b) potential for collaborative funder action to reduce the audit compliance burden.

Minimum qualifications

The NZHHA also recommends the adoption of minimum training requirements in home based care, relative to the service provided and the service model in place. This will reduce inconsistencies in service delivery (for the same service) across New Zealand, and will lift service quality. Any required training must be funded adequately.

The qualification in the sector that is most commonly achieved is Foundations (Level 2 on the NZQA framework). This qualification assists workers to understand essential concepts such as infection control, working safely, handling equipment, understanding one's role, meeting the requirements of the care plan, medication administration and consumer rights and responsibilities. This basic training is the minimum that should be expected for a worker providing personal support. For some workers, depending upon the client need and their role in supporting them the Level 3 qualification (Core Competencies) or other training in dementia, patient handling, understanding medication and disability support could also be appropriate.

Some providers encourage their workers to undertake training and some providers contribute towards training costs, but the situation nationally is inconsistent. Even if they support staff training, providers face several barriers: training is not currently funded through contracts, there is a high turnover of largely part-time staff in this sector (increasing the cost of training and limiting its long-term benefit) and poor literacy can also be a barrier.

One of the main reasons why providers struggle to train and retain qualified staff is that they can offer little incentive. Under current contract rates providers cannot compete with industries such as the residential sector, hospitals and fast food outlets. Community support workers earn between 13–30 percent less than healthcare assistants or nurse aides working in a public hospital. They often have higher qualifications than hospital aides and work mostly unsupervised. Support workers generally earn around $13-$14.50 per hour and have no guaranteed hours of work.

There is no funding for non-contact time such as writing reports, performance appraisal and training, nor for penal rates or other benefits received by DHB or other medical agency staff.

Staff are not fully reimbursed for travel time between clients or for mileage.

Service models are now being developed that require Foundations 2 or Core Competency training. It is vital that adequate recognition is given in any service planning, to the whole cost of training staff.

A community support worker's day

Kay is a 53-year-old community support worker (CSW). She has several regular clients but she works as many hours as she can get because her hours are not guaranteed. If the client is absent and she cannot be rostered to another client, she does not get paid. She gets different hourly rates and travel payments depending on who has purchased the service. Her average is $14.30 gross per hour.

Kay drives to her first client at 6.00 am to assist him to shower himself, take his medication and eat. She also checks his fridge and cupboards to see what food he might need. She spends an hour with each morning client, all of whom are over 80 and live with conditions such as dementia, diabetes and arthritis. She provides a catheter change for one serious injury client. Tonight, she will 'sleep over' at the home of a client whose family pay privately for respite care.

Kay is an experienced CSW and recognises problems such as skin infections, poor diet, dehydration and temperature changes. In these cases, she informs her case co-ordinator who will advise the family or doctor. Kay forms bonds with her clients – for several, she is the only regular visitor. She has almost completed her National Certificate in Community Support Services (Level 3).

Effectiveness

The client should receive a safe level of service, and should benefit from the services they receive. Best value should be gained from public funding, this can be facilitated through trust and cooperation, evidence-based research, and nationally consistent service standards for similar services.

- Recognising and agreeing on the services that can be provided safely in the home
- Improving outcomes for clients
- Recognising the costs of providing quality service
- Applying consistent service requirements
- Building the workforce

Recognising and agreeing on the services that can be provided safely in the home

Traditionally, home support providers delivered either domestic support services for clients (ranging from general housework to shopping and meal preparation), to personal support (e.g. showering, assistance with dressing and eating). Over the last 7-10 years we have seen an increase in both breadth and depth of care provided to people in their homes. Demand has grown and a greater percentage of clients have higher levels of need. Table 1 demonstrates the range of support needs now provided to people living at home.

Age	Diagnoses	Intervention by community support worker	Hrs per week
69	Multiple sclerosis	Passive limb exercises daily, transfers, mobility assistance, personal care, medication administration.	10
80	Spinal multiple sclerosis, depression	Personal care, carer respite, mobility assistance, medication prompting.	35
71	Cognitive impairment, dysphasic CVA	Medication assistance, personal care.	12
11	Learning difficulties and physical health needs	Challenging behavior modification, personal care, sleepovers, behavioral management, peg feeding.	34
55	Tetraplegic	Bowel management, medication administration, wound care, grade 4 pressure ulcers, PC, hoist, catheter.	112
26	Spina bifida	Daily personal care, medication management, toileting.	45

Source: Healthcare of New Zealand.

Competencies required of the 30-40,000 community support workers working in the home health sector include:

<u>Aged care and chronic condition care</u>

- Personal support – assisting with showering, dressing, feeding, ensuring sufficient food is in the house and is safe to eat
- Noticing changes in client health/wellbeing and cognitive or physical ability and reporting those
- Medication – supporting clients by prompting and assisting
- Administering eye drops
- Blood glucose monitoring
- Management of hyper and hypo glycaemia in diabetics
- Diabetic medication

<u>Disability care</u>

- Urinary catheter care
- Manual bowel evacuation
- Nasogastric tube insertion
- Intermittent catheterisation
- Urodome management
- Suppository and enema administration
- Nebuliser administration
- Peg care
- Suctioning upper airways
- Tracheotomy care

The gradual shift of basic clinical activity from registered nurses to an unregulated workforce has required providers to develop more sophisticated quality assurance and clinical governance processes and structures. Home and community support providers have also had to expand their co-ordinator and clinical staffing roles. These roles are pivotal to the maintenance of a service that can meet the needs of the client (within contractual boundaries) and support and monitor workers.

Some providers employ registered nurses, but there are no nationally agreed supervisory ratios of registered nurse to support worker. There is an urgent need for consideration, at senior policy levels, of safe supervisory levels. Without this, clinical risk is transferred to the provider and in some cases to the carers themselves.

Improving outcomes for clients

The changes in demand and need have challenged provider and purchaser thinking and activity towards new models of care that will offer greater benefits to the client whilst being flexible enough to enable more efficient and effective use of the government dollar. Packages of care, bulk funding, case mix, multi-disciplinary, rehabilitative and restorative models are now more common.

The move towards client-centred care philosophies and models - as reflected in government policy such as Ageing in Place and the NZ Disability Strategy - is a good fit with home care, as providers have expertise and experience working with these concepts. This capacity is a resource to the government as it moves towards implementation of 'better, sooner, more convenient' and other features of health service redesign (prevention, self-management and home-based services (National Health Board Trends in Service Redesign, 2010).

Achieving best value from this service is more likely to occur if providers are involved in strategic and operational discussions about service modelling, service design and outcomes.

Research is also needed that will analyse the current and projected future needs of home and community support clients, so that providers and planners can consider the best ways of supporting those needs.

Recognising the costs of providing quality service

Providers do not expect the government to keep them 'in business'. However, a review of the fee for service contracts is needed so that increasing need for clinical oversight and other aspects of provider capacity to deliver the services required, are recognised and accounted for.

Providers have invested heavily in information technology to manage multiple contracting arrangements, rostering and caseloads. The introduction of the assessment system InterRAI-HC into the New Zealand health system offers some providers the opportunity to assess client need and deliver the most appropriate service; however, again, investment is needed to support new electronic tools and shared records. This is not an add-on for providers, but essential to any integrated or multi-disciplinary care models.

In addition, technology that is currently available must be fully utilised to generate vital information about the individual client and client groups.

Consistency in, access to, and purchasing of, services

Home support is not a specialised service, it is accessible in name across New Zealand, and yet there is inconsistency between funders about how it is described and purchased. From DHB region to region, for example, what is provided and how it is provided varies. Even eligibility, for basic homecare support varies between regions. Providers working across regions and with the MoH and ACC operate multiple contracting and billing arrangements – there is enormous waste in financial and administrative compliance costs.

A commonsense approach must be taken to reduce this unnecessary burden and to move towards a nationally consistent service. NZHHA recommends consistent home support 'service specifications' and nationally agreed models of care.

The variations between individual DHBs, the Ministry of Health and ACC as to how services are purchased, provided and funded reflects keenly in the hourly rate paid to providers. Table 3 demonstrates the disparity across and between the public sector funders in their purchasing behaviours.

Table 3: Funder home support rates 2010

Funder	Domestic care $	Personal care $
Northland DHB	21.58	23.77
Waitemata DHB	24.58	26.73-32.99
Auckland DHB	Bulk funding	
Counties Manukau DHB	24.44	26.73-32.99
Waikato DHB	25.02	27.66
Bay of Plenty DHB	23.25	24.99
Lakes DHB	22.17	23.89
Tairawhiti DHB	21.80	24.05-27.01

Taranaki DHB	23.88	25.97
Hawkes Bay DHB	20.73	23.77
Whanganui DHB	20.23	22.03
Mid Central DHB	20.50	22.41
Wairarapa DHB	21.99	24.39
Capital & Coast DHB	25.44*	28.54*
Hutt Valley DHB	21.50	24.55
Nelson-Marl DHB	22.80	26.80
West Coast DHB	22.47	26.20
Canterbury DHB	23.41	25.42
South Canterbury DHB	23.50-24.30	25.50-26.30
Southern	21.15-23.40	24.23-26.28
MOH	23.25	25.00
ACC	23.25	24.99

*The Capital & Coast DHB contract rate is inclusive of the requirement for nursing oversight. CCDHB also purchase units for community care and complex care rather than domestic care and personal care. These roughly equate to domestic care and personal care although each can contain both DC & PC components.

Unfortunately the response by funders to increasing demand for and increasing complexity in home support services has been to lift the eligibility bar for support; and to expect providers to manage increased volume at medium and higher levels at the same cost. Hourly contract rates have barely shifted over the last five years whilst costs of providing the service have increased considerably. In some areas providers have faced three years without any increase despite external factors such as the minimum wage rise, fuel and GST increases.

A contracting environment that enables flexibility, trust and collaboration is much more likely to lead to foster innovation and improved outcomes. The relationships between purchasers and providers is made difficult where purchasers refuse to negotiate and adopt 'a take it or leave it' stance. More positive working relationships that exist between the purchasers and secondary and primary providers in some regions are a result of the individuals involved rather than a focused policy directive.

One example of an innovative service model is the Auckland care model for clients aged over 65. The model is working towards funding on a 'case mix' basis giving homecare providers greater flexibility in the way the service is delivered. The DHB shares the risk of demand management with providers and eliminates duplication by giving them the responsibility to assess non-complex clients and apply eligibility criteria based on need.

The model aims to eliminate the duplication of assessment, reduce costs and give greater ability for providers to control their inputs to gain more effective outcomes. Concerns remain about the funding model in relation to this programme, but, if appropriately funded, this sort of service model has considerable potential for improving health outcomes.

Workforce

All providers report that there has been an increase in the clinical complexity of their client base. However, there has been little effort by government agencies or DHBs to quantify this level of complexity or project the future needs of the client base. Analysis of the current and projected future needs of home support clients is essential to enable providers to plan how best they can support those needs.

The workforce implications that relate to the increase in demand are documented, it is expected that the demand for labour in health and disability services will grow between 40 percent and 69 percent by the year 2021 (NZIER, 2004).

Providers also know that there will be insufficient staff to manage burgeoning numbers of elderly in the community and that assistive technologies, such as telemonitoring and robotics will be increasingly relied upon. Government agencies also need to be aware of and plan for the use of these technologies.

Value

Home support, if designed and delivered well, can be of economic and social value.

The economic and social value of home support have been documented in international research although not well studied in the New Zealand context.

Approximately 110,000 New Zealanders receive home support for some time each year at a total approximate cost of $591,514,126 (figures received from MoH (including DHB data) and from ACC, December 2010). This includes the purchase by Ministry of Health for disability services for around 10,500, and by ACC of $139,808,000 of home support for around 23,000 clients. Community support workers visit an estimated 25,000 elderly New Zealanders each day.[1]

As the population ages there will inevitably be increasing cost pressures. Expenditure on older people in 2002 was approximately 39 percent of total Vote Health spending. By 2021, it is projected that 17.6 percent of the population will be aged 65 and over and, based on current expenditure, will consume about 49.6 percent of total Vote Health services expenditure (MoH, Health and Independence Report 2004). The numbers of citizens over 85, those in most need and most frail and who make up the majority of NZHHA member clients, will increase from 58,000 to 116,5000 in the 20 years to 2026 (Grant Thornton NZ Ltd, 2010).

Home care providers offer support across a range of client need. The lowest is house-hold management (cleaning, shopping etc) which assists people to function semi-independently. This has been shown to be a low-cost way of preventing entry to long-term care (Cohen 2003), yet many DHBs have responded to pressure on funding by cutting low-level home support.

Providers also support many people with higher levels of need including support following hospital discharge injury-related rehabilitation and long-term injury support, support for those living with short or long term medical conditions, palliative care, support for those living at home with dementia, respite care for family carers.

Because home support covers many types of need and is delivered (at least overseas) under a range of models, research on its effectiveness (economic, social, wellness) tends to focus on particular models or particular needs. The research that has been done suggests that innovations work most effectively for well-defined conditions or client groups. But in general, home-based interventions appear to reduce the length of stay in the acute hospital beds (Wainwright, 2003) and can reduce subsequent use of social services. (Glendinning et al, 2003). Canadian research showed that the costs of providing home and community based continuing care services (direct medical and nursing care, home-makers, adult day care and assessors) were about 20 percent to 30 percent of the costs of residential long term care for people with the same level of need (Hollander 2001, Chappell, Dlitt, Hollander, Miller & McWilliam, 2004).

Other Canadian research indicates that, if people did not have homecare, the costs of looking after them in long-term facilities would be 2.2–3.4 times more expensive. Similar savings are indicated in terms of likely increased use of secondary services if people were not receiving home-based support (Boston Consulting Group, 2010).

The challenge for government agencies is to compare the 'whole value' of available and new models of home-based support. As an example re-ablement (short-term intervention in English home support, focusing on self-care skills and self-confidence) has been associated with a significant decrease in subsequent social care service use (Glendinning et al., 2010).

The service was found to result in 60 percent less subsequent social care use than conventional homecare services. The high intervention cost of re-ablement means that the input costs are the same as conventional homecare. However re-ablement has much-improved impacts on users' health-related quality of life and (projected) reduced use of social services in the longer term. That equates to a positive investment.

[1] By comparison, the Government funds more than 34,000 people to receive care in around 715 aged residential care facilities every year at an estimated cost of over $785 million (Barton, 2010; New Zealand Labour Party, Green Party of Aotearoa New Zealand & Grey Power New Zealand, 2010; Controller and Auditor-General, 2009).

Wainwright's 2003 literature review of cost-effectiveness of home-based services revealed several common themes that are more likely to lead to the best value being gained from the services:

- **co-ordination of services** is made easier where all relevant services in the continuum of care are part of an integrated organisational structure for allocating resources among them.
- being able to shift resources among services to achieve the most cost-effective mix for the older population can only be done if we know what is being used by whom, how this has changed over time and the impact of each service upon the others. Deciding on the most cost-effective mix of services is well-near impossible without **good datasets and effective use of a common assessment tool.**
- there needs to be a **single point of entry** into the continuing care system, and standard access criteria, so that people are triaged and referred to the most appropriate service. Older people typically have ongoing needs for both health and disability support services, and a small minority have complex problems. Triage and initial assessment are best done by multi-disciplinary primary-based teams, which include needs assessment/social work skills as well as medical/nursing skills, and which have strong links to geriatric specialist services.
- **home-based services can be a cost-effective alternative** to both long-term residential care and acute hospital care – in specific situations and for specific groups of people. We need to explore in detail the interventions or service mixes that are best suited to specific groups of people or types of health problems.
- **Maintaining health and fitness -** maintaining people at their current level of functioning and preventing deterioration keeps people out of acute hospital and long-term residential care. Low-level home support, as well as various community-based services and interventions, are effective in preventing acute hospital admission and entry to long-term care.
- **Good linkage between the acute hospital and primary care** is crucial for homebased interventions to work successfully as an alternative to hospital care.
- '**Home-based' care is increasingly seen as one component of 'non-acute' care** that is linked to other components such as intermediate care, carer support and respite care and disease management activities. (Wainwright, 2003)

Social Value

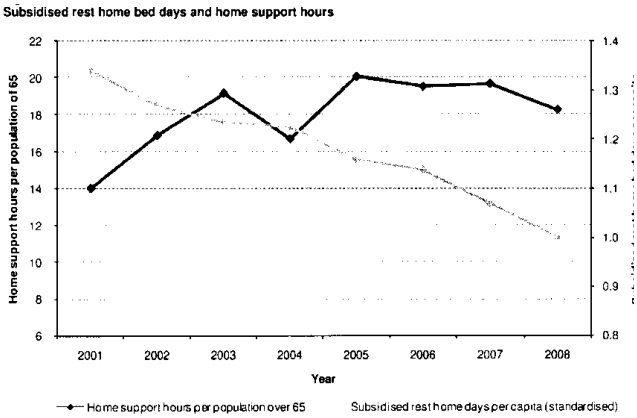
Home support providers provide services within communities (regional, cultural or need-specific). Each organisation provides services within the context of their community environment. Whether organisations are for-profit or not-for-profit (roughly 51% of NZHHA members are 'for profit' agencies), community support workers are members of their communities, and they are knowledgeable about the resources, links, facilities and relationships within their community. It is this intrinsic knowledge that adds immeasurable value to service delivery, as shown in the Canterbury earthquakes of September 2010 and February 2011 when providers were able to immediately respond to support thousands of Christchurch citizens.

Many providers, being sited in the community, also offer valuable privately funded, community-funded and unfunded programmes such as:

- tai chi and day activities for people with dementia (Presbyterian Support);
- asthma and COPD support groups (Disabilities Resource Centre Trust Whakatane);
- kaumatua services co-ordinating physical activity and health promotion classes (Te Hauora Pou Heretaunga);
- free shuttle service to enable people to attend medical and treatment appointments, funded by grants and donations (Home Support North Charitable Trust, Northland)
- monthly training for practice and district health nurses in skills such as IV canulation and cast plastering (Total Care Health Services).

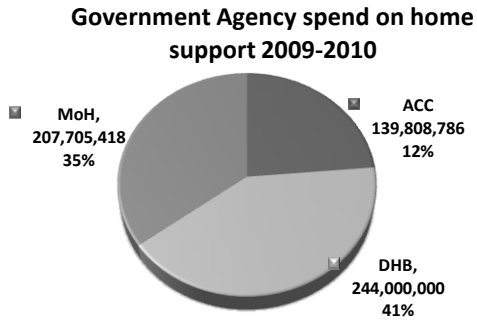
Background

Since 1993, the New Zealand home support sector has experienced significant growth (Grant Thornton, 2010, Cornwall & Davey, 2004). The increasing demand can be attributed to a number of factors, predominantly the number of available hospital beds, the reduction in funded residential placements and an increasing elderly population (Denton, Zeytinoglu, Davies & Lian, 2002).

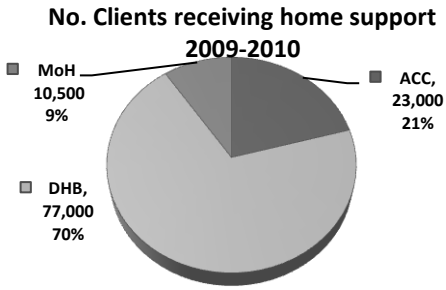


Source: Grant Thornton NZ Ltd (2010).

In 10 years time, projections are that the number of people over the age of 85 will double: an increase in the demand for home support services can also be anticipated (Canterbury District Health Board, 2003; National Health Board, 2010).



Source: MoH and ACC (2010)



Source: MoH; ACC; Grant Thornton NZ Ltd (2010).

These demographic trends will have a significant impact on the labour market, as the care of older people and those with long-term disabilities shifts from the traditional institutions to community-based home support (Ministerial Review Group, 2009).

Home and community support is purchased by ACC, the Ministry of Health and District Health Boards for short-term support (post-hospitalisation, respite care or post-injury) as well as long-term support for those with chronic disease, seriously injured, the young disabled and the frail elderly. The total Government spend on home support in 2009–2010 was $591,514,000, including $244,000,000 funding for those over 65.

Despite the increase in spending, New Zealand still spends less than most countries in the OECD on home support and spends a higher proportion of residential care than any other country in the in the OECD (OECD, 2008).

Fully funded home support services are available to people who are assessed as requiring them. Eligibility for personal and domestic care is based on the person's level of need (and income criteria in the case of domestic care) and is assessed by multi-disciplinary teams across the various funders (ACC, MOH and DHB). A significant proportion of home support users are the elderly (people over the age of 65). Public spending on healthcare is heavily weighted towards older people, and within this demographic, it is recognised that people over the age of 85 will be the major users of the service (Cornwall & Davey, 2004). However, people with chronic diseases are increasingly reliant on home support provision to maintain their independence and avoid hospital admission. In addition, home support provides support for families looking after relatives. Respite daycare for carers looking after relatives at home is supplied to approximately 1,500 (unpaid family) carers a week on a day-release basis (Goodhew, 2007).

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