



Spreading Our Wings

A Report into the Training and Development Needs of the Health and Disability Home and Community Workforce

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complex needs
kaiāwhina
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nursing
management
educational disabilities
social
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child
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medication
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fila ola

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Careerforce

Careerforce is the industry training organisation for the health, aged care, disability, social and cleaning sectors. We commissioned this report to better understand the current and emerging needs of individuals and whānau from an employer perspective. This information, along with understanding the aspirations and experiences of those getting support, will inform the development of qualifications and training programmes and their implementation in the workplace. Careerforce and the Home and Community Health Association will work together to action the recommendations.

Home and Community Health Association / Lattice Consulting Ltd

The Home and Community Health Association (HCHA) is the peak industry body representing providers of home and community support services in the health and disability sector. The HCHA welcomed the opportunity provided by Careerforce to undertake this project and to work alongside Lattice Consulting Ltd to produce a comprehensive report. We are sure that it will be a useful resource to inform workforce development, broader workforce planning and service commissioning.

Acknowledgements

- All of the providers who so willingly gave of their time and their expertise.
- Phillipa Gaines of Lattice Consulting who wrote the main report. This involved undertaking a literature review, a stakeholder workshop, provider interviews, analysis of the results including from an online survey, and synthesis of the information into a final report.
- Julie Haggie (CEO, Home and Community Healthcare Association) who researched and wrote three background papers to this report, including much more detailed background information about the strategic context, client need and the composition of the home and community support workforce.
- Carte Blanche Ltd, who conducted an on-line survey between mid-December 2017 and mid-January 2018. Data was gathered from 24 respondents and yielded a 53% response rate from a database of 45 people who represent employers within the sector.

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Foreword

E aku nui, e aku rahi. Tēnei te mihi maioha ki a tātou.

Careerforce Te Toi Pūkenga is the industry training organisation and kaitiaki of the health, aged care, disability, social and cleaning sectors; each with their own mana that contribute to the collective hauora of Aotearoa.

As kaitiaki, we acknowledge our responsibility to support hauora through the development of qualifications and training programmes that provide 'Real' pathways to achieve tangata, whānau and community tino-rangatiratanga.

In our efforts to fulfil this vision, we commissioned this report under the karanga of our values of kotahitanga, kaitiakitanga and manaakitanga; acknowledging the need to better understand the current and emerging needs of individuals and whānau from an employer perspective.

This kete of information and taonga, along with understanding the aspirations and experiences of those getting support, will inform and guide the development of qualifications and training programmes and their implementation in the workplace.

We are humbled by the manaakitanga provided by the Association in the development of this taonga; a true reflection of the whanaungatanga and shared commitment of the Home and Community Health Association and Careerforce Te Toi Pūkenga in working together as one whānau to bring this taonga to life for the greater hauora of Aotearoa.

We acknowledge all providers who so willingly gave of their time and expertise.

Mehemea ka moemoeā ahau, ko ahau anake.

Mehemea ka moemoeā a tātou, ka taea e tātou.

If I dream, I dream alone.

If we all dream together, we can all succeed.



Gill Genet



Preface

Home support employees provide a broad range of personal, rehabilitative and facilitative services. Customers are likely to be living with fluctuating physical and possibly mental health needs, or rehabilitating at home following injury, hospital treatment or illness. They seek support that is competent and professional, flexible, and responsive to their choices and individual requirements. Providers, health workforce planners and support staff need to meet the changing needs and choices of health customers.

Workforce development includes training, but it is also about recruitment and retention, system infrastructure (including commissioning and technological solutions) and a strong organisational culture with well-designed roles and team structures. It is underpinned by research and data on which to base service planning and funding responses to population need. This resource aims to fit into that space. We have consulted closely with employers. We have also looked closely at research and data on the needs of current health users, and on projections of future needs. We hope that the report will be used by a wide range of stakeholders and that it will spark discussion, debate and further research.

This report is the outcome of collaboration by the Home and Community Health Association, Careerforce and Lattice Consulting Ltd. We are grateful to those in the sector who contributed their time and ideas, and are heartened by the energy and passion that warms the core of this sector.

He waka eke noa.



Julie Haggie



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Executive summary

This report has been commissioned by Careerforce with the aim of highlighting the change pressures in the current operating environment and the impact of those changes on the current and future training and development needs of the home and community support workforce.

The information will be used to inform workforce planning activity by both the Home and Community Health Association (HCHA), service providers, commissioners and Careerforce. It will also be used to inform a review of the *New Zealand Certificate in Health and Wellbeing* (levels 2, 3 and 4) programme content and implementation requirements.

The report has been organised into the following sections in accordance with workforce planning frameworks and in response to the questions posed by Careerforce:

| Section of the report | Related Careerforce question |
|---|--|
| The current operating environment | <ul style="list-style-type: none">What are the impacts of emerging policy, government initiatives, service design, commissioning/contract changes and technological developments on the workforce? |
| Population related change pressures & health inequities | <ul style="list-style-type: none">What are the present and new emerging client needs from an employer perspective?How do new and emerging client needs impact on service delivery and workforce capability? |
| System related change | <ul style="list-style-type: none">What are the impacts of emerging policy, government initiatives, service design, commissioning/contract changes and technological developments on the workforce? |
| Services and the changing nature of the work | <ul style="list-style-type: none">How is the current and future workforce landscape planned, recommended and/or envisaged? |
| Key themes – challenges around training | <ul style="list-style-type: none">What do employers need to support workforce capability development? |
| Key themes – learning & development needs | <ul style="list-style-type: none">How well do the current qualifications fit the employer's needs?What learning styles are best for employers? |
| Summary of recommendations | <ul style="list-style-type: none">Summary of recommendations for Careerforce, service providers and commissioners. |

Complexity is a vital consideration for the training of current and future support workers.

At present, health and disability support work is limited by existing conceptualisations and understandings of the support worker role. However, in an operating environment that is becoming increasingly complex, the future service delivery model is likely to be a much more multifaceted and collaborative one, involving a number of different stakeholders – clients, family/whānau and a range of service providers.

1. Introduction

In December 2017, the Home and Community Health Association was contracted by Careerforce to complete a workforce planning report that was focused on answering the following set of questions:

- What are the present and new emerging client needs from an employer perspective?
- What are the impacts of emerging policy, government initiatives, service design, commissioning/contract changes and technological developments on the workforce?
- What research and/or evidence is available to inform the report?
- What do employers need to support workforce capability development?
- How is the current and future workforce landscape planned, recommended and/or envisaged?
- How do new and emerging client needs impact on service delivery and workforce capability?
- How well do the current qualifications fit the employer's needs?
- What learning styles are best for employees?

The methodology that was used in the development of this report is detailed in appendix one. A mind map that summarises the key themes from both the stakeholder workshop and the provider interviews can be found in appendix two.

Where relevant, some of the graphs that were produced with the data from the on-line survey have been used in this report to reinforce the findings from other data sources - including the stakeholder workshop, provider interviews, the supporting literature and various reports/publications.

2. Strategic context

The ageing of the New Zealand population, changing ethnic composition, technological advances and changing illness and disability patterns have been identified as important factors that are driving future demand for health and disability home support workers. Some of the trends that are appearing and disappearing in the health and disability sector are highlighted in figure 1 below.

Figure 1: Appearing and disappearing trends in the health & disability sector

| ← Disappearing Appearing → | |
|--|--|
| The system | |
| Laissez faire operating environment | High accountability |
| Focused on inputs | Focused on outcomes |
| Regulations | Standards and guidelines |
| Slow to react | Nimble and agile |
| Vocational industry | Business industry |
| The work | |
| Universal coverage | Specialisation |
| Stable demand for services | Increasing demand for services |
| Significant variation in care | Use of standardised care protocols |
| Single organisations | Networks of care |
| One-size-fits-all approach | Tailored solutions |
| Limited choices for clients | Greater client choice |
| Lower client and family expectations | Higher client and family expectations |
| Single health or disability issue | More complex, co-existing & chronic conditions |
| The workforce | |
| Adjunct to the multi-disciplinary team | Part of a multi-disciplinary team |
| Low level skill set | Multi-skilled |
| Limited career prospects | Rewarding career opportunities |
| Casual labour | Guaranteed hours |
| Low pay rates | A living wage |
| Paper-based learning options | Mobile learning options |
| Digitally challenged workforce | Tech savvy workforce |
| Unregulated workforce | Para-professional workforce |

2.1 Government policy directions

These trends are highlighting the importance of a fit-for-purpose, sustainable home and community support service system. There are a number of shifts in government policy that are influencing the current and future development of a skilled and competent health and disability support workforce. They include the following:

Table 1: Key government policy directions

| Key strategic direction | Workforce implications |
|---|--|
| <i>NZ Health Strategy</i> (Ministry of Health, 2015) | <p>The Strategy was developed to help guide change in the health sector and foster the development of a more innovative, integrated and people-centred approach to healthcare. It has a population focus with more services being provided closer to home.</p> <p>In order to do this New Zealand will need to increase the number of community based workers who have the necessary skills to work both independently and as part of a virtual care network.</p> |
| <i>NZ Disability Strategy</i> (Office for Disability Issues, 2016) | <p><i>System Transformation</i> - is based on the <i>Enabling Good Lives</i> (EGL) vision and principles. The approach is designed to support disabled children and adults and their families/whānau to have greater choice and control over their personal supports and their lives.</p> <p>It is important to note that EGL represents a radical shift in service delivery. It will rely on support workers who can operate as coaches, navigators and mentors, in addition to their usual duties. These are not skills that are taught as part of the current curriculum.</p> |
| <i>Healthy Ageing Strategy</i> (Associate Minister of Health, 2016) | <p><i>The Healthy Ageing Strategy</i> is focused on supporting older people to stay in their homes for as long as they want to, and can safely do so. There is an increased focus on the prevention and rehabilitative service options for older people, emphasising short-term interventions that maximise the potential for independence.</p> <p>The Strategy focuses on enhancing the working conditions, training, roles and linkages of home and community support workers.</p> |
| <i>He Korowai Oranga: Māori Health Strategy</i> (Ministry of Health, 2014) | <p><i>New Zealand's Māori Health Strategy, He Korowai Oranga</i> sets the overarching framework that guides the health and disability sector to achieve the best health outcomes for Māori.</p> <p>It is acknowledged that Māori are under-represented in the health and disability workforce, holding back both Māori provider development and improvements in mainstream service delivery to Māori. Extending workforce development initiatives, such as targeted culturally appropriate training programmes is therefore vital.</p> <p>Support workers should be able to recognise and value whānau who are supporting Māori clients.</p> |
| <i>Kaiāwhina Workforce Action Plan</i> (Careerforce & Health Workforce New Zealand, 2015) | <p>This action plan is a living document that is focused on the development of the health and disability kaiāwhina/non-regulated workforce.</p> |

NB: Please refer to *Background Paper Two* (page 72), which summarises the impacts of current and emerging legislation, legal challenges, funding pressures, commissioning/contract changes, strategies and technological developments.

3. The current operating environment

The current operating environment is characterised by change on a number of fronts including increased demand, increased costs and major shifts in employment legislation. It was notable that it was not possible to discuss staff training requirements with any of the employers who were interviewed as part of this project without first talking about the impact of the *Care and Support Workers (Pay Equity) Settlement Act (2017)*.

3.1 Major legislative changes

Over the last four years there have been a number of major legislative changes that have affected the employment conditions of the health and disability support workforce.

In September, 2014 the *Home and Community Support (Payment for Travel Between Clients) Settlement Act* was approved by Cabinet and came into effect in July 2015. It consisted of two parts - 'Part A' concerned the payment for in-between travel. 'Part B' included a review of the HCSS sector and the introduction of 'regularisation' as defined below:

- a) the majority of workers on guaranteed hours
- b) training to level 3 to meet the needs of the population
- c) recognition of training in wages
- d) a casemix/caseload mechanism to ensure safe workloads and safe staffing.

The *Guaranteed Hours Funding Framework* came into effect on 1 April 2017 and was quickly followed by the implementation of the *Care and Support Workers (Pay Equity) Settlement Act* on 1 July 2017. The provisions of the *Pay Equity* legislation means that all existing care and support workers moved onto the new pay scale on 1 July 2017, either at the step that recognised their qualifications or their length of service with their employer, whichever was the most advantageous to the employee.

The minimum pay rates and progression for home support workers employed after 1 July 2017 is slightly different to the current workforce, in that it is staged over a six year period. The Act now requires employers to provide support to enable workers covered by the settlement to reach the following level on the NZ Qualifications Authority *Health and Wellbeing Certificate* (or its equivalent) within the following time periods:

- Level 2 NZ Certificate – within 12 months of employment,
- Level 3 NZ Certificate – within 3 years of employment,
- Level 4 NZ Certificate – within 6 years of employment.

Workforce implications:

The Pay Equity legislation has generated a disincentive for many current employees who are able to progress towards a Level 4 pay rate based on tenure and not on qualifications. Providers also noted the uncertainty of ongoing funding for pay equity.

3.2 Qualification equivalencies

For a qualification to be considered 'equivalent' to a Level, 2, 3 or 4 *New Zealand Certificate in Health and Wellbeing*, it must be assessed and approved by Careerforce. However, employers consider that some of the qualifications that have been assessed by Careerforce as being 'equivalent' are of dubious practical value. There is now a mismatch between the staff who are qualified to sector Level 4 qualifications and those who have progressed to this level on the basis of 'equivalent' qualifications. An equally serious mismatch has been generated with higher than anticipated numbers of staff receiving higher pay rates, without sufficient complex care work for them to do.

Workforce development implications

The impact of legislative change is already being felt by employers, with most service providers reporting slower rates of staff turnover and some providers reporting a higher level of interest from

prospective staff. However, many providers also stated that it was still very much 'early days' and that the full impact is not yet known.

It is important to note that whilst all service providers expressed a strong level of support for upskilling the support workforce and paying staff a fair wage, they were united in their concern about the perverse incentives that have been created by the *Pay Equity* legislation. In particular, there are major concerns about the projected increase in the numbers of level 4 staff on the basis of tenure, irrespective of such considerations as staff aptitude and/or interest, client case-mix (i.e. client need) and the financial viability of the whole model. The strong message from providers is that the projected increase is both unwarranted and financially unsustainable.

3.3 Lack of funding coupled with fragmented funding arrangements

Home and Community Support Services (HCSS) are not delivered under a national contract. Funding arrangements currently vary between the 22 funders (Ministry of Health, Accident Compensation Corporation and the 20 District Health Boards). Funding for the same services vary considerably, which makes it difficult for providers to reliably forecast their income.

The unpredictable nature of funding has an impact on providers' ability to cover operational overheads, maintain service standards and adequately pay their workforce. An unreliable source of income limits provider's ability to fund staff skill development and improve their pay and working conditions, which in turn makes it difficult to maintain service standards and retain staff. Multiple funding arrangements also results in significant administrative burden for both funders and providers, who must maintain multiple record keeping and reporting processes (Fernhill Solutions, 2017, p5).

Working Group One provider and union representatives support a recommendation for a national-level agreement between DHBs and providers to identify standards and a national pricing structure, as well as a recommendation for the adoption of local alliancing relationships to enable flexibility to take account of local population needs and integration with other services for the benefit of the client.

Advice to the Director-General's Reference Group for In-Between Travel. 2015.

A number of service providers reported problems with poorly aligned incentives that discourage them from integrating services across the system of care. A few service providers expressed frustration about the length of time that it was taking to develop and implement alternative models of care, especially in the aged care sector. This was particularly the case where new models were not being considered in conjunction with a careful appraisal of the direct and indirect costs to the providers, as well as the implications for workforce development.

Workforce development implications

It is very difficult for service providers to plan for future workforce development when the legislated changes have not been adequately funded and the ongoing sustainability issues in the sector are so significant.

3.4 Specified minimum staff qualifications in provider contracts

Increasingly DHB's and the ACC have specified minimum staff qualifications in any new contracts, which is further driving demand for staff training.

Workforce development implications

Ongoing demand for staff training targeting levels 3 and 4 - dependant on clusters of client need, particularly the numbers of people with very complex requirements.

Service contracts should specify the workforce skills that are required to meet the needs of specific client groups.

4. Workforce planning framework

This report outlines a number of forces and drivers for change that are impacting on the health and disability home and community support workforce in New Zealand.

4.1 The five domains of workforce development

Workforce development is a whole-of-system approach to developing a workforce. Whilst this report is predominately focused on the learning needs of the home support workforce, it is acknowledged that this learning component is situated within an overarching framework that has the following five components, all of which are closely inter-related (infrastructure; organisational development; recruitment and retention; information, research and evaluation; learning and development).

Table 2: The five domains of workforce development

| Area | Goal |
|------------------------------------|---|
| Infrastructure | National and regional coordination to develop an efficient and integrated workforce. |
| Organisational development | Service providers have the organisational culture and systems with which to attract and grow their workforce. Care is integrated across settings to better service people's needs, along with the development of well-designed roles and team structures. |
| Recruitment & retention | Recruitment & retention strategies result in the increased capacity and capability of the workforce. |
| Information, research & evaluation | Information is available to support workforce planning - including access to training and the reconfiguration of services to suit the needs of the population. |
| Learning & development | The training of the workforce is aligned to service and population needs. The workforce needs to have clearly articulated training pathways, and training that builds capability for working in multi-disciplinary teams and providing culturally appropriate care. |

Source: Ministry of Health (2017).

For example, it is not possible to think about the learning and development needs of staff without also considering the organisational environment that staff work within. It was clear from provider interviews that some organisations offer support staff a higher level of pastoral care than others. Those that do offer pastoral care consider that it is beneficial for both staff and the organisation – as evidenced by good retention rates and high levels of staff engagement in training and development opportunities. However, the provision of pastoral care also incurs costs. In an operating environment that was described as being 'a *high risk and low margin business*', such an approach might be considered to be an optional extra.

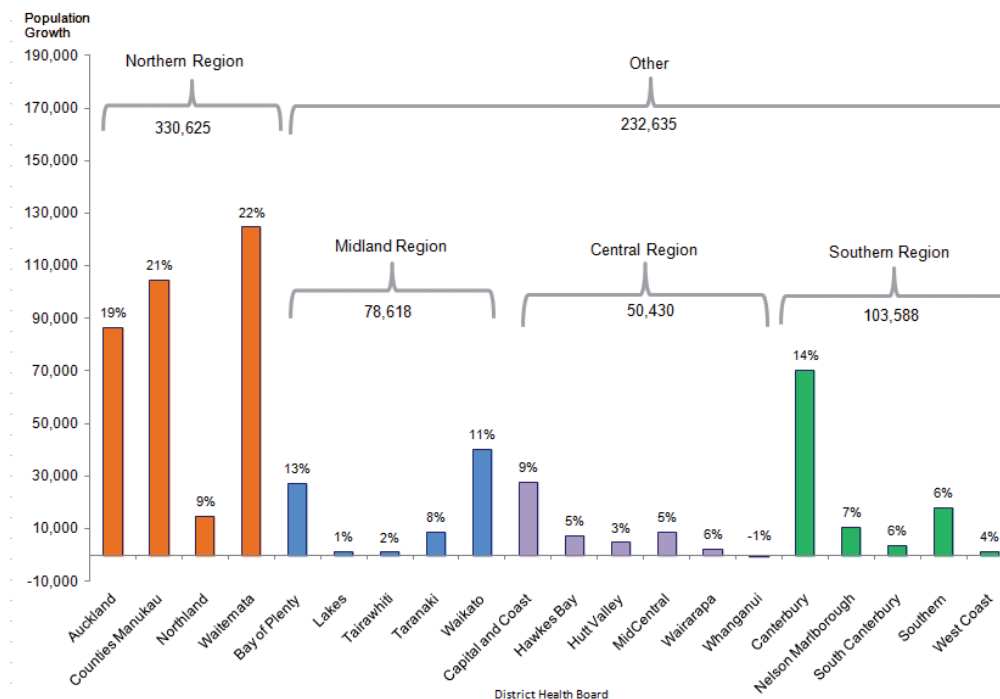
Providers might also employ staff who are dispersed over a wide geographical area, so it is very difficult to bring them together into one central location without causing major disruptions to service delivery.

It is also not possible to think about embedded staff training programmes (including the apprenticeship programme), without also considering the impact on the service provider in terms of the organisational infrastructure that is required to support this programme. Whilst the evidence supports on-the-job training, it needs to be acknowledged that many providers are not in a position to increase their investment in either learning and development roles or infrastructure.

5. Population-related change pressures

The demographics of New Zealand are changing. Firstly, the distribution of the population is changing with the urban centres growing and the provincial parts of the country shrinking. Secondly, there is a growing number of older people compared to younger people, with the ensuing health provision implications for these older people. A third consideration is the increase in migration, which is broadening the ethnic diversity of New Zealand, with the urban centres experiencing the most growth.

Figure 3: Projected population changes 2013-2026 by District Health Board



Source: Statistics NZ Annual Population Update 2014, prepared for the Ministry of Health. Chart concept National Health Board (2010) Trends in Service Design and New Models of Care: A Review.

Fast Facts:

- The growth of the population will continue to be focused on the main urban centres.
- There will be demographic differences across New Zealand, with many provincial areas experiencing a reduction in birth rates and the loss of younger people, with a proportional increase in the older population.
- Older adults will make up an increasingly large proportion of the general population over the next 30–50 years.

5.1 Population receiving home support services

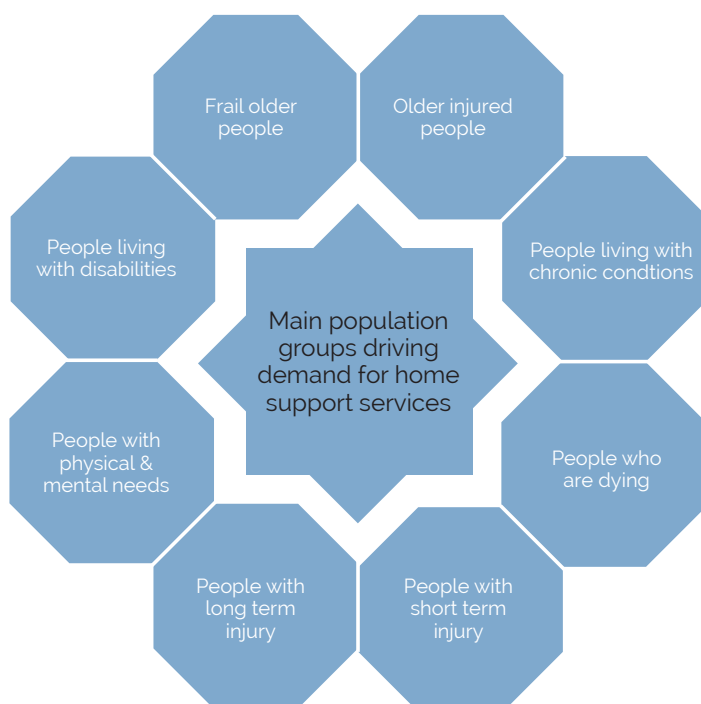
In 2017, over 55,000 people received home and community support services (see table 3), with over 80 percent being older people aged 65 years and over.

Table 3: Number of people who received home support services in 2017

| Population receiving home support services in 2017 | Number seen |
|---|-------------|
| Frail older people 65 years and over (https://www.oag.govt.nz/2014/home-based-support-services). | 75,000 |
| ACC - People living with an injury (Review of Home and Community Support Services. 2014. Advice to the Director-General's Reference Group for In-Between Travel. Working Group 1 Report). | 19,100 |
| Home support for disabled people under 65 years (Ministry of Health). | 7,900 |
| Individualised funding for disabled people (Ministry of Health). | 2,477 |
| Enhanced individualised funding for disabled people (Ministry of Health). | 399 |
| Number of people under 65 requiring home support due to them living with chronic condition(s). | Unknown |

In keeping with the changes in the general population, the demographics of people who will need home support services in the future are also changing. The main population groups that are supporting the demand for home support services are as follows:

Figure 4: Population groups supporting the demand for home support services



It is important to note that clients often span more than one of these categories because of their multiple needs.

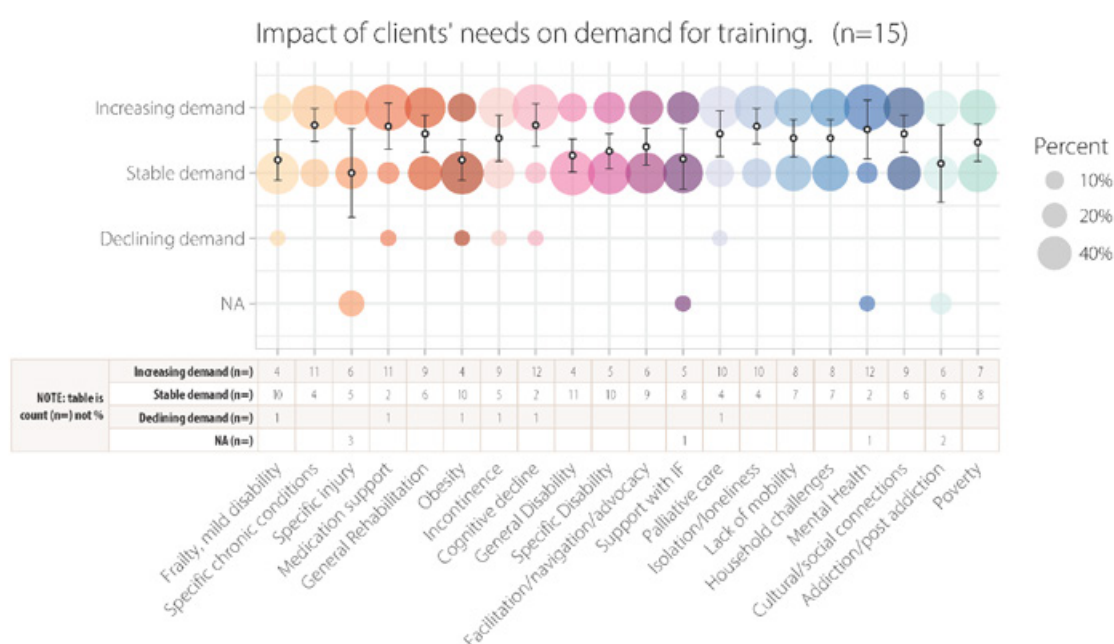
Workforce training needs based on client demand

The results of the on-line survey indicate that there is a need for increased staff training (based on client demand) in the following areas (see figure 5):

- specific chronic conditions
- medication support,
- cognitive decline/dementia,
- palliative care,
- mental health and addiction problems,
- challenging behaviours and;
- the impact of social isolation on people's wellbeing.

Whilst this is a comparatively short list, it must be emphasised that the issues represent a significant increase in complexity and demand for services.

Figure 5: Training needs based on client demand



Source: Carte Blanche (2018). Home & Community Providers Workforce Planning Survey.

What is not included in the above diagram is the client specific training to all staff who need it in order to work more effectively with specific clients.

For example, bowel management was cited by more than one provider as an example of a skill that can be theoretically taught, but in practice requires staff to implement a bowel management programme that is tailored to each client's unique bowel type. This may require a more senior staff member to work alongside the support worker and the client until such time as the support worker is able to deliver this service on their own. Bowel management also appeared in the list of competencies that employers considered to be important for staff training, but which are not covered in the current qualification. The complete list of emerging needs that are not covered in the current curriculum is captured in table 4.

Table 4: Other emerging client needs that are not already covered (N=12)

| Verbatim responses about emerging client needs that are NOT covered in the current qualification training | |
|--|---|
| Bowel care. | Palliative care. |
| First aid. | In-depth spinal cord injury. |
| Donning and removal of support stockings. | Specific clinical competencies (TED, particular medications, etc.). |
| Practical dementia based case in a community setting. | Checking on client's needs – not assuming (that care will) be (automatically) extended. |
| Workplace literacy and communication/reporting skills are the main areas that led into participating in level 2 and level 3 as additional support. | |

Source: Carte Blanche (2018). Home & Community Providers Workforce Planning Survey.

5.2 Increasing complexity

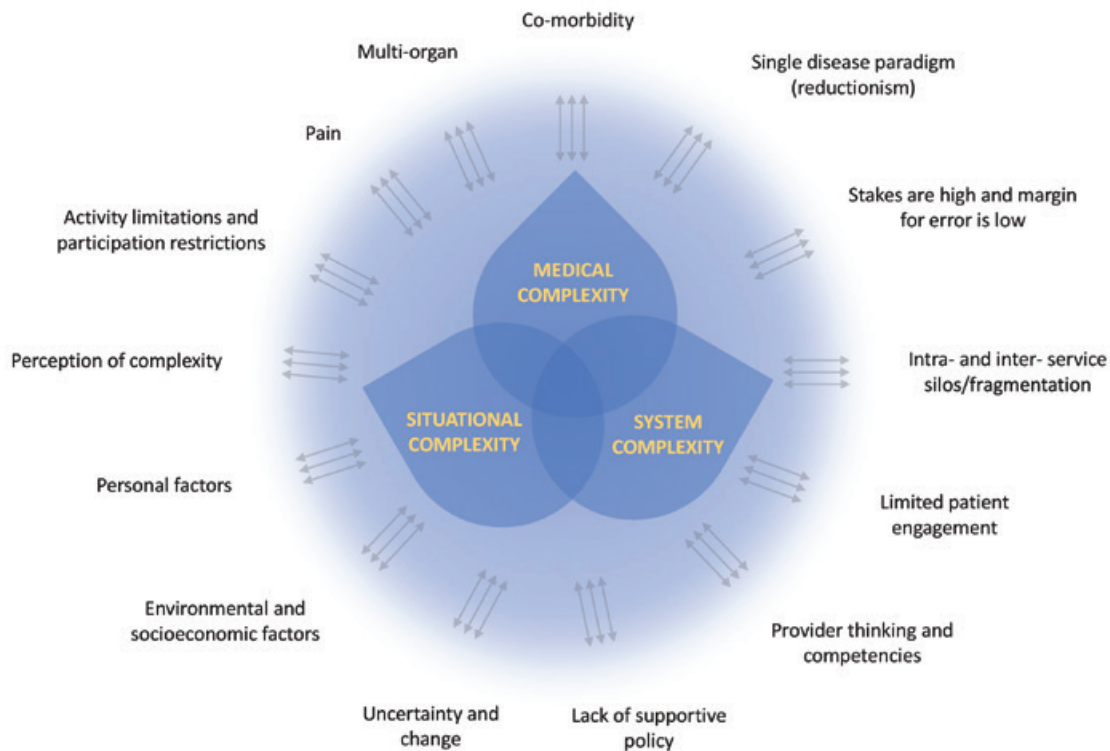
There is a risk that the list of emerging client needs produced by providers is translated into a training programme that simply deals with them as singular conditions that require a singular response. However, the reality is that clients with co-existing, multiple conditions are now the norm rather than the exception in health & disability services (Starfield, 2006).

Complexity has a profound effect on healthcare and outcomes. It is characterised by multiple dimensions, including co-occurring or multifaceted medical conditions, age, frailty, socio-economic realities, culture, environment, behaviour and systems factors.

Kuipers et al. (2011).

The implications for curriculum development include the importance of advocating holistic approaches to service delivery (Kuipers et al, 2011) that take into consideration the physical and mental conditions (medical), the situational and the system factors that are associated with healthcare complexity (see figure 6).

Figure 6: Factors associated with healthcare complexity



Source: Kuipers et al. (2011). Complexity in healthcare.

Kuipers et al. (2011) have outlined three potential elements of a response to increased complexity in health care.

- Learning oriented responses** - the importance of reflective practice, as well as case-based and experiential learning for staff. Training focused on teams and equipping for capability are emphasised.
- Collaboration-oriented responses** to health care complexity emphasise the importance of inter-professional/ workforce collaboration and collaborative teams (sometimes called communities of practice) to developing an adequate whole-of-system response.
- Care-oriented responses** emphasise the importance of integrated or coordinated care and the importance of fostering informed and active clients.

Table 5: Population-related change pressures

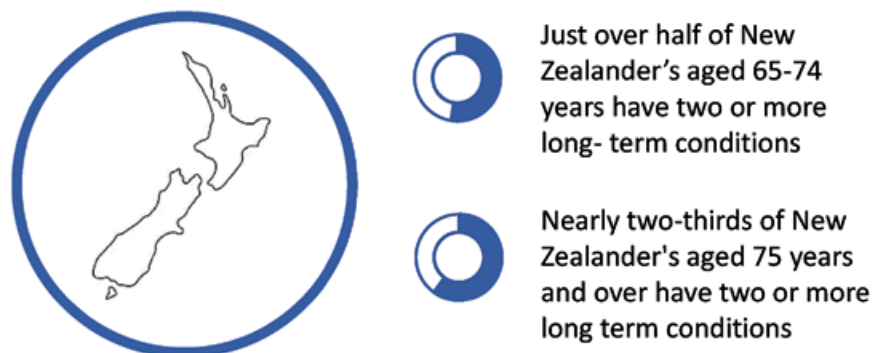
| Population changes | Workforce implications |
|---|--|
| Ageing population | <p>The population aged 65+ years is projected to double to between 1.3 and 1.5 million (21-26%) by 2046 (Statistics NZ, 2017).</p> <p>The number of people aged 85 years and older will more than triple, from about 83,000 in 2016, to between 270,000 and 320,000 in the next 30 years (Statistics NZ, 2017).</p> <p>The demand for home-based services is expected to grow as the proportion of New Zealanders aged 65 and over increases.</p> |
| More older people living on their own, in their own homes | <p>Based on current statistics, an estimated 75% of people aged 85 years and over will be living in their own homes.</p> <p>This might mean that increasing numbers of informal carers will be supporting and caring for older family and whānau members alongside formal support services.</p> |
| Loneliness and social isolation | <p>Whilst loneliness decreases with age (Statistics NZ, 2013), a recent NZ study found that one in five older frail people identify as feeling lonely (Jamieson et al., 2018). This study also found that ethnic identification and living arrangements are also significantly associated with the likelihood of loneliness for those having an InterRAI-HC assessment.</p> <p>Loneliness can be as harmful for people's health as smoking 15 cigarettes a day (Holt-Lunstad, 2015). If someone is socially isolated, they are more at risk of depression and anxiety, as well as some chronic conditions such as pain, which can become worse.</p> <p>There are four main types of interventions: (1) Developing social skills, (2) giving social support, (3) developing opportunities for social interaction, and (4) recognizing maladaptive social cognition. (Mushtaq, R. et al., 2014). Efforts by support workers to help reduce the negative impacts of loneliness will require a nuanced approach - including the identification of people who might be feeling lonely, working with other team members to develop culturally appropriate strategies to help people overcome their feelings of loneliness - including the identification of any natural supports and other NGOs that can provide help.</p> |
| Chronic long term conditions and multiple morbidities | <p>Higher rates and greater complexity of long-term conditions and multiple morbidities (Ministry of Health, 2016) will continue to fuel the demand for home and community support services. It will also increase the complexity of the work.</p> |
| Urban and regional spread | <p>New Zealand is a top-heavy country, with Auckland projected to be home to almost 40 percent of the country's total population in 2038 compared with 34 percent in 2013 (statistics NZ).</p> <p>While the NZ population overall continues to grow, a large proportion of towns and communities in rural or peripheral areas will exhibit stagnation or decline in their populations (Cochrane & Mare, 2017). This will see a tightening of the labour market in rural/provincial areas of New Zealand, particularly as people start to retire.</p> |

| Population changes | Workforce implications |
|--|---|
| <p>Mental health and addiction is everyone's business</p> | <p>It is common for people to have co-existing long-term physical and mental health and/or addiction problems. Evidence demonstrates that people with a long-term condition are two or three times more likely to develop mental ill-health. People with two or more long-term conditions are seven times more likely to experience depression (Chapman, Perry & Strine, 2005). The combination of physical and mental illness is more disabling than either problem occurring on its own (Oakley Browne, Wells & Scott, 2006).</p> <p>Increasingly the home and community support workforce will need to be able to identify and support people who have co-existing problems. This means that all front-line support workers will need to have some basic 'first aid' training in mental health and addiction issues.</p> |
| <p>Ethnic diversity</p> | <p>The entire country is projected to have increasing ethnic diversity over the next two decades. Statistics NZ has projected that New Zealand's 'European or Other' ethnic group will drop from 75 percent of the New Zealand's total population in 2013 to about 66 percent in 2038.</p> <p>Whilst the population aged 65+ is projected to increase for all four broad ethnic groups, significant differentials in size and share will remain. The European ethnic group will provide the majority of the numerical increase, projected to increase from 637,500 in 2018 to 913,800 in 2033. However, the fastest growth in the population aged 65+ years is projected for the Asian ethnic group with an increase from 59,500 in 2018 to 164,100 in 2033.</p> <p>The support workforce will need to appropriately reflect and cater to the growing ethnic diversity of the population. This might involve recruiting new migrants into the workforce, possibly using non-traditional recruitment pathways, such as social media.</p> |

5.3 Ageing and long term health conditions

Older people commonly have more than one long-term condition, and a person with multiple long-term conditions is more likely to experience physical impairment (Figure 7).

Figure 7: Ageing and long term health conditions



Source: NZ Productivity Commission (2015). More effective social services.

Dementia is among the most important causes of disability in older people, and severe dementia has the highest disability weight of all ageing-related diseases (Jorm, 2001).

The changing pattern of disease among the aged is expected to increase the proportion of frail older people who have more complex care needs. Specific analysis of age-related diseases indicates that the New Zealand health sector can expect increased demand from cardiovascular diseases, cancers, strokes, diabetes mellitus, chronic obstructive pulmonary diseases, osteoporotic fractures and musculoskeletal diseases. International evidence indicates that visual and auditory limitations, while not fatal, are also likely to increase and drive the demand for support services as the population ages (Cornwall & Davey, 2004).

5.4 Disability trends

According to the Disability Survey (Statistics NZ, 2013) an estimated 24 percent of people living in New Zealand were identified as disabled. The likelihood of having a disability increases with age, with 59% of people 65 years and older reporting a disability. Nearly 20 percent of those aged 65 years and older had disabilities which severely restricted their activities.

About half of all disabled people reported living with limitations arising from more than one

impairment type. Forty-seven percent of disabled people indicated that they were limited by a single impairment type, while the remaining 53 percent were limited by more than one impairment type.

For adults, multiple impairment increases with age. Forty-two percent of adults aged 15 to 44 years reported being limited by more than one impairment type, compared with 63 percent of older adults (65 or over). Forty-eight percent of children had multiple impairments.

Physical impairment is the most common main limitation for disabled people. For an estimated 43 percent of the disabled population, physical limitation was either their only impairment, or was more limiting than the other impairments with which they were living.

Approximately 10 percent of people with a disability have an unmet need for some kind of service or assistance.

6. Health inequities

Over the past quarter century New Zealand has achieved one of the fastest rates of decline in health loss from all causes combined amongst high-income countries. Yet, within New Zealand, serious inequalities in health outcomes persist between different sub-groups of the population (Ministry of Health, 2016). Health inequalities are also greater for those in more deprived socioeconomic groups.

One of the biggest challenges for the health and disability system is to improve its performance with regard to improved health outcomes for Māori.

Māori and disability

The New Zealand Household Disability Survey (2014) indicated that disability was a significant issue for Māori, with close to one in five Māori reporting they had a disability. Māori disabled make up approximately 5,400 (16%) of people who access the Ministry of Health-funded disability support services.

As a group, Māori disabled are predominantly youthful, with over a third (37.8%) under 15 years of age and 49% aged under 25 years. Māori disabled mainly have intellectual disability (50.9%) or physical disability (32.2%), and some Māori disabled have significant support needs, with 23% having very high levels of need. Due to the higher susceptibility of Māori to disabling health conditions as they age, the incidence of disability is expected to increase.

As at June 2011, almost two-thirds (64%) of disability support services funding from the Ministry of Health for Māori disabled was allocated to residential care, followed by home support (19.7%) and day programmes (5.2%).

Older Māori

Older Māori have poorer health outcomes and a higher burden of chronic illness than older non-Māori and are more likely to be exposed to risk factors for poor health (Ministry of Health, 2011).

The LiLAC study (Kerse et al., 2017) estimates that by 2026, the Māori population aged 80+ years is projected to increase by 190 percent, to just under 12,000 people. Given that older Māori are significantly less likely to be living in residential care than non-Māori, it is estimated that the need for home support services for older Māori will significantly increase over time.

Māori access to palliative care services

Cormack et al. (2005) noted anecdotal reports of differential utilisation of palliative care services by Māori and a belief that late referral of Māori to palliative care resulted in reduced access to equipment and support services.

7. System-related change pressures

As previously indicated, there are a number of system-related change pressures that are generating changes in the workforce. These are as follows:

Table 6: System-related change pressures

| System-related changes | Workforce implications |
|---|---|
| Financial constraints | <p>Increases in funding are not keeping up with rising costs.</p> <p>One provider reported that, after meeting all other staff-related costs associated with pay equity, the funding to support the organisations training infrastructure was now reduced to 50 cents per support worker. This situation is not sustainable and does not auger well for a workforce development strategy that relies on staff being able to learn on-the-job.</p> |
| Skill mix | <p>Many DHBs have shifted their focus from simple household support to more personal care in line with a restorative and person-centred approach to home-based care. Broadly speaking, all staff perform both sets of tasks to varying degrees, with a greater emphasis on household management tasks by those staff who have attained a level 2 qualification and a greater emphasis on sub-clinical tasks by those staff who have attained a level 4 qualification.</p> <p>In the future, providers might choose to utilise their level 4 staff in a much more targeted way. It is possible that the scope of practice of a few selected support staff will expand, so that they are effectively operating as healthcare assistants under the supervision of clinically trained staff. This will be dependent on funding being available to employ health professionals and on service delivery models that are more integrative.</p> |
| Restorative and rehabilitative care for older people | <p>There is an increased focus on restorative and rehabilitative services for older people in their own homes.</p> <p>This shift relies on a significant increase in both staff and service options that are focused on short-term and rehabilitative care. It also requires a change in the core competencies of the workforce – i.e. support workers may be more used to offering clients a home support service rather than a restorative and rehabilitative service.</p> |
| Socioeconomic deprivation and the social determinants of health | <p>People living in more socioeconomically deprived areas have poorer health and report a greater unmet need for health care after adjusting for age, sex and ethnic differences. (Ministry of Health, 2016a).</p> <p>Support workers are not trained to consider the needs of their clients within a wider social context.</p> |

| System-related changes | Workforce implications |
|---|---|
| Move toward more integrated service provision | <p>Increasingly, support workers will be expected to operate in a more integrated way as part of virtual teams. However, they will be doing so in an operating environment that does not fully support and promote 'networked care'.</p> <p>Service providers report a lack of cohesion and consistency across the sector driven, in part, by the different funding and contracting frameworks that are utilised by different funders.</p> <p>Support workers will need to be able to operate across internal and external team/organisational boundaries, irrespective of wider systemic issues.</p> |
| Self-directed care | <p>The gradual introduction of 'person-centred' care and support arrangements are intended to enhance the potential for people to influence the type of the services that they receive. It is noted that the sector offers qualified support for this approach on the understanding that it will work well for some clients in some situations, but that it will not work for everyone.</p> <p>Self-directed care may increase the number of support workers who decide to operate as independent contractors - in which case the worker's qualification(s) will become even more important as they will be the main way that clients make judgements about the prospective worker's level of competency.</p> |
| Case mix funding model | <p>The majority of DHBs pay providers on the basis of a 'fee-for-service' model (where the provider is paid for the number of hours it delivers).</p> <p>The Deloitte report (2015) states that funding risks for DHBs and providers are distributed more appropriately under a case-mix model, whereby the workforce has the flexibility to vary either the tasks or the number of hours to reflect a client's changing needs, without a further NASC assessment.</p> <p>Nationally agreed minimum safety and service standards and worker competency criteria can also be established for each case-mix category. A case mix approach may also encourage support workers to work with clients to maintain or regain a higher level of independence.</p> <p>NB: <i>It is noted that ACC is currently working with Auckland University to develop a casemix funding model.</i></p> |
| Impact of pay equity on the demand for training | <p>The pay equity settlement parties agreed to create incentives to help care and support workers gain formal qualifications. The Act now requires employers to provide all reasonably practicable support to enable workers covered by the settlement to reach the following level on the NZ Qualifications Authority <i>Health and Wellbeing Certificate</i> (or its equivalent) within defined time periods. For this reason, many employer's efforts will be focused on supporting their staff to attain the level 2 <i>NZ Certificate</i> in the first instance.</p> <p>In addition, some growth can also be expected in level 3. At least one provider reported that it was 'easier' to fast-track their workforce towards level 3 rather than bothering with level 2.</p> |

| System-related changes | Workforce implications |
|--|--|
| Level 4 support workers – same pay rate but undertaking very different tasks of different complexity | <p>Under pay equity provisions, all support workers who attain a level 4 qualification will be paid the same hourly rate, irrespective of the type of tasks that they perform. For some providers this has created some discrepancies between staff who currently undertake very different roles.</p> <p>Whilst this issue will be resolved over time as organisations improve the fit between the client case mix and the staff skill mix, but is currently an inflexible structural problem.</p> |

8. Services and the changing nature of the work

Home and community work encompasses a wide variety of services that are designed to help people live at home. These services are funded by the Ministry of Health, District Health Boards and the Accident Compensation Corporation (ACC). They typically include household management and/or personal care tasks, but increasingly they also include more advanced and specialist care (eg, palliative care, dementia, spinal and brain injuries, etc.).

Whilst the different funding streams target specific sub-groups of the population, support staff interact, on a day-to-day basis, with a wide range of clients who have very diverse needs. As such, the day-to-day work of a home support worker is agnostic to the source of funding. The nature of the work is also changing rapidly in response to a number of factors - outlined in table 7 below.

Table 7: The changing nature of the work

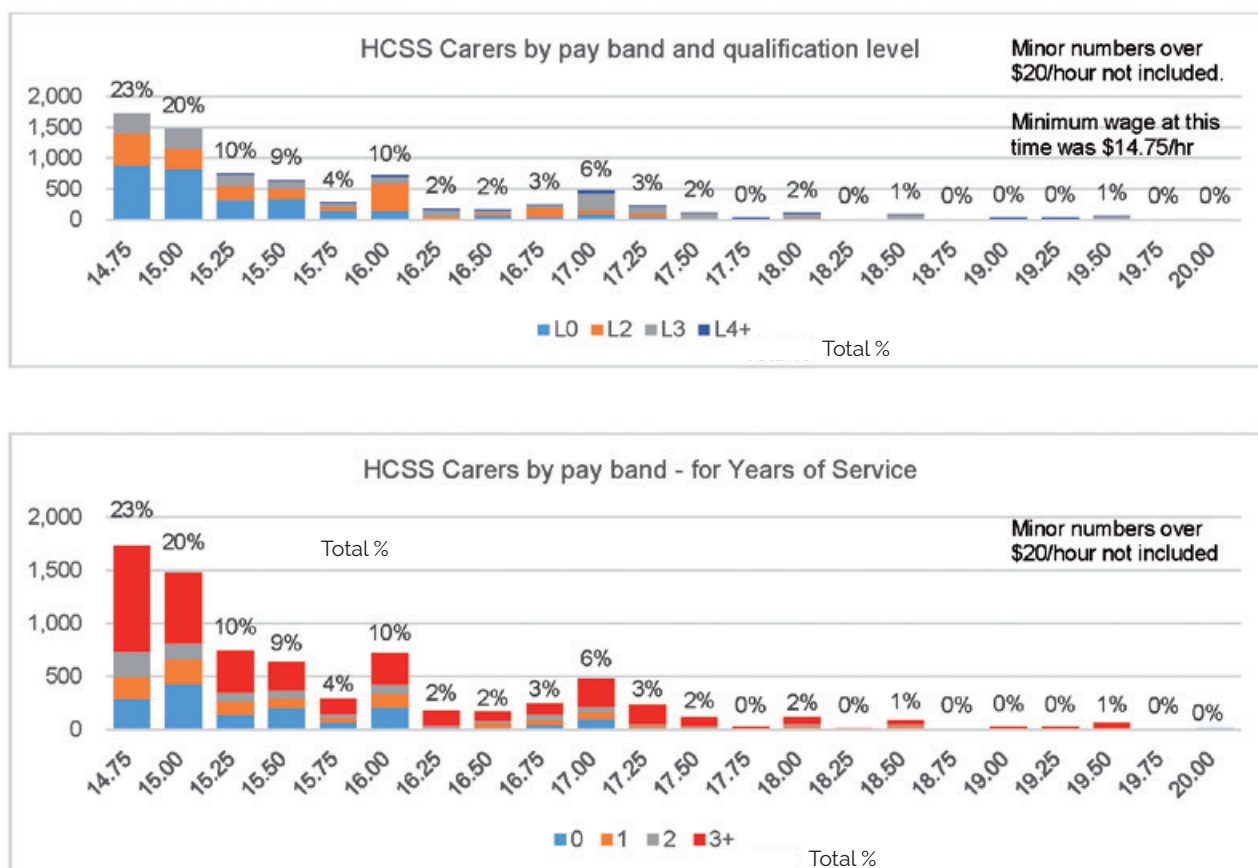
| Work-related changes | Workforce implications |
|---|---|
| Increasing client and family/whānau expectations | <p>Clients want more information, choice and control based on their experience of engaging with other industries in other parts of their lives (eg, retail sector). This has meant that the health and disability sector as had to become more person-focused and pay closer attention to providing a good client experience as part of their service.</p> <p>This means training staff so that they are able to work in a much more participatory way with clients.</p> |
| Increasing level of complexity | <p>As the proportion of clients with complex conditions increases, so will the demand for a workforce that has the requisite level of skill and competence to deal with client needs in a holistic way.</p> |
| Individualised care packages | <p>Client as the employer, provider as an agent, with the potential for a much greater variety of support workers.</p> <p>With regards to older people, the NZ Productivity Commission (2015) noted that more client choice is generally better, but that it needs to be accompanied by systems that provide guidance and information for older people exercising choice, that help guard against abuse.</p> |
| Increasing use of standardised care assessment protocols (ie, CAPs in InterRAI) | <p>Standardised assessment protocols require the workforce to be proficient in using electronic records to both record client-related assessment information and then use the results to inform their practice.</p> |
| Shift towards more restorative approaches | <p>The restorative care model changes the nature and role of home and community support workers. Many workers in this sector currently undertake simple duties (eg, cleaning) on behalf of their clients as part of a 'domestic assistance' role. Under the restorative care model, workers are also required to become facilitators and coaches to assist the client to be as independent as possible.</p> <p>In addition to training in these skills, this shift will require a change in support worker values and attitudes (Deloitte, 2015).</p> |

| Work-related changes | Workforce implications |
|---|--|
| Rehabilitative services | A shift in the model of care has also seen an increase in the number of short term or transition rehabilitation services that are being delivered at home post hospital event or injury. |
| Technological impacts | <p>Technological tools will become increasingly important as a way of enabling people to exercise greater choice and control over their daily lives and to stay in their own homes for as long as they wish. However, the pace at which clients adopt both assistive and mainstream technology will vary.</p> <p>The workforce will need to become more technologically literate in order to support clients to use assistive technology and to access the services that they need on-line.</p> <p>Support workers will also need to be comfortable using digital devices to record their client's health status, report to their organisation and engage in training opportunities.</p> |
| Growth of on-line platforms that disrupt traditional employment opportunities | <p>Digital platforms will offer some clients a mechanism to select and employ the support worker that they want without having to use an intermediary, such as a traditional home care service provider.</p> <p>The impact on support workers that choose to be employed in this way is that they will either have to become adept at operating as a self-employed contractor who is administratively and technologically proficient or they will need to sign themselves up with an organisation that can look after the legal and administrative aspects of the contracting process on their behalf. Either way a trusted qualification becomes important as it is the primary means by which a member of the public will assess someone's competency.</p> |
| Increasing numbers of health and disability clients who are struggling with their mental health and/or addiction issues | <p>Mental health and addiction problems are common, but the siloed funding arrangements for the provision of mental health and addiction services has meant that other service areas have not fully considered their role with a client who is developing a mental illness (such as depression, anxiety, or substance misuse), or who is in a mental health crisis.</p> <p>Similar to other first responders, the health and disability home and community support workforce need the skills and confidence to identify and respond appropriately to those clients who are struggling with their mental health.</p> |
| Increased demand for palliative care services | <p>Populations with high health needs, such as those with high prevalence of chronic and co- morbidities will require support and caregivers both formal and informal whom are able to provide palliative or end of life care.</p> <p>Providers have identified palliative care as an emerging training need for support staff.</p> |

9. The home and community support workforce

The pay equity data shows that there are just over 16,300 support workers employed in DHB and MoH contracted home support services in New Zealand (additional uncounted employees in ACC only and private services). The distribution of workers by pay band, qualification level and years of service are captured in the following graphs taken from a NZ Treasury (2017) cabinet paper.

Figure 8: HCSS carers by pay band, qualifications and years of service



Source: NZ Treasury (2017). Cabinet paper.

NB: The information about pay bands was collated before the Pay Equity Settlement and before the qualification equivalency process.

Given that the initial focus of the *Pay Equity legislation* (2017) is on all support workers attaining at least a level 2 NZ Certificate in Health and Wellbeing within the first 12 months of employment, it is clear that the initial demand for training will be focused on level 2.

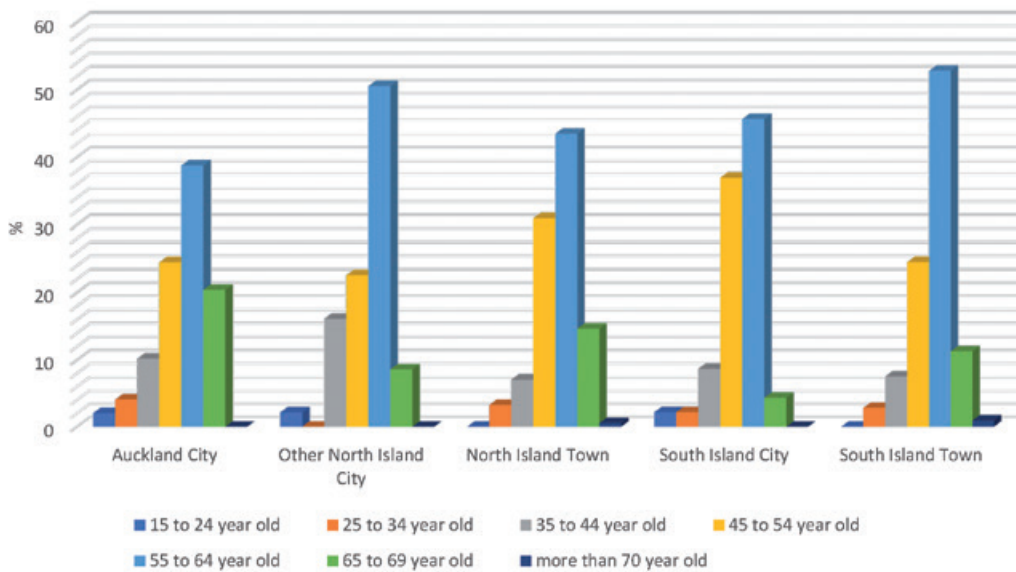
However, given provider comments about the relevancy of level 2, it is also expected that there will be some growth in level 3 because some providers will simply choose to skip level 2 and fast-track their workforce towards the higher grade qualification.

Demographic profile of the workforce

A Ministry of Health *HCSS workforce survey* was completed in March 2015 (linked to the In-Between Travel Settlement). The survey comprises data received from 33 service providers (42% representation response), covering 11,288 support workers. It confirms that the HCSS workforce is female dominated (91%), has wide and varied ethnicities (28% European), and has an older age profile (54% are aged between 45 and 64 years of age) compared to the total New Zealand labour force.

Figure 9 below shows that, in all locations, the largest age group of home and community aged care workers is in the 55-64 age bracket. The data also indicates that Auckland appears to have a broader spread of workers in each age band than other parts of New Zealand.

Figure 9: Age distribution of home & community aged care workers across New Zealand locations (N=478)



Source: Ravenswood & Douglas (2016).

The evidence suggests that over the next 40 years there will be difficulties in securing an adequate supply of personnel with the necessary skills to support the delivery of home support services, particularly for aged care.

Changes in the level and composition of demand for home support services, along with the challenges arising from an 'aged induced' tightening of the labour market over coming years, has meant that some employers are already considering new recruitment strategies designed to attract younger people into the workforce.

Please refer to the supplementary information paper for more detailed information about the current composition of the support workforce.

Workforce implications

Table 8: Workforce-related changes and the implications

| Workforce-related changes | Workforce implications |
|---|--|
| Ageing workforce | Over coming decades, the sector will need to replace a growing number of retiring workers. This will place a premium on attracting new workers and retaining existing workers. |
| Rural/urban distribution | There are significant differences in regional/urban age distribution which will impact on the availability of staff in the future –ie, less personnel will be available in the regions. |
| Ethnic composition and English as a second language (ESOL) | Given the projected changes to the ethnic profile of the country, training programmes will need to be made more accessible to students/support staff whose first language is not English. |
| Imposed employment and training conditions | As previously mentioned, not all current support staff want training and the <i>Pay Equity legislation</i> (2017) has created no incentives for them to do so. In addition, some may not necessarily have the aptitude to engage in further study at this stage in their career. |
| Changes to the core skill set in response to increased complexity | <p>As mentioned previously, Kuipers et al. (2011) have outlined three potential elements of a response to increased complexity in health care that have implications for workforce training. They are:</p> <p>Learning oriented responses - the importance of reflective practice, as well as case-based and experiential learning for staff. Training focused on teams and equipping for capability are emphasised.</p> <p>Collaboration-oriented responses to health care complexity emphasise the importance of inter-professional/workforce collaboration and collaborative teams (sometimes called communities of practice) to developing an adequate response.</p> <p>Care-oriented responses emphasise the importance of integrated or coordinated care and the importance of fostering informed and active clients.</p> <p>In addition, the shift towards a more restorative service involves a shift in the values and attitudes of staff (ie, more enabling and less paternalistic).</p> |
| Literacy issues | Increased literacy and ESOL problems impact on people's capacity to engage in training opportunities and to do the work. Whilst there are some support options available to both staff and to employers, this is an area that could be developed further. |
| Highly qualified immigrant workers and the impact of the equivalency process on employers | The problems with the 'equivalency' process are most strongly felt by those employers that are taking on highly skilled immigrants who have a related health or social sector qualification (which attract a higher pay rate), but who lack the necessary core skills to be an effective support worker. This creates unfair discrepancies between support staff, which are difficult for employers to manage. |

| Workforce-related changes | Workforce implications |
|-----------------------------------|--|
| Rural and/or isolated workforce | <p>Those organisations that have a widely dispersed workforce find it almost impossible to bring a large number of their support workers together in a central location for class-room style training and/or peer support sessions.</p> <p>One provider talked about the use of technology to help assess the skills of support workers who are working in geographically remote areas.</p> <p>Two providers talked about the development of small teams (comprised of nurses and support workers) who would be responsible for all clients within a designated geographical area. To some extent this approach reflects aspects of the highly successful Buurtzorg model that is operating in the Netherlands.</p> <p>One provider, covering a wide geographic area, already uses a team-based model. The teams are self-managing (eg, sort out their own rosters, etc.) and act as their own supportive learning unit with input from a human resources manager who is located at 'home base'.</p> <p>These are all examples of innovative approaches to training and supporting staff at a distance.</p> |
| Changes to recruitment strategies | <p>The formation of a career pathway that is supported by fairer pay rates is starting to make support work a more attractive proposition to a wider group of prospective workers.</p> <p>Some of the providers who were interviewed talked about the possibility of being able to attract slightly different cohorts of people to support work – eg, more men, younger people (including some school leavers) and mothers who were interested in returning to the workforce.</p> <p>Whilst public advertising remained the most popular avenue for sourcing future employees, other avenues included pre-employment courses, overseas staff and high school students (Carte Blanche, 2018). Only one provider talked about the use of social media, particularly when reaching out to specific ethnic groups.</p> <p>Other providers thought that young people who had just left school lacked the necessary level of maturity to be a good support worker. A couple of providers also reported that some younger people lacked the basic household management skills to do the job (eg, they did not know how to clean properly or how to make a bed). This skill deficit presents an interesting challenge to both employers and training providers who might otherwise reasonably assume that anyone who wants to be a support worker comes to the job already equipped with some basic life skills.</p> |

10. Key themes – the challenges around training

The following key themes related to support worker training are prioritised based on how frequently they were mentioned by stakeholders. Please refer to appendix 2 for a high level summary of all the issues.

1 Cost of training

When asked to identify the main hindrances to workforce capability development, all providers talked about the direct and indirect costs of staff training as being the single most pressing challenge for employers (particularly in a funding constrained operating environment). One provider mentioned that they were able to access the disability funding grants from Te Pou o te Whakaaro Nui, which was helpful, but this was the exception rather than the norm.

NB: *The Government has introduced a Fees Free Industry Training scheme that came into effect on 1 January 2018, which will enable employers across the health and wellbeing sector to upskill eligible employees at no cost to the organisation. However, the scheme is focused on school leavers, and it has quite a few restrictions, so most home and community support staff are unlikely to ever be eligible for this.*

2 Literacy issues

The second most commonly identified challenge was poor literacy and numeracy.

The Tertiary Education Commission (TEC) has created an assessment tool to measure and improve the literacy and numeracy skills of adult learners in New Zealand. Any support worker who is enrolled in a foundation level course (ie, level 2) has to complete this assessment at the start and end of their study. There is no pass or fail for the assessment, but neither is there any guarantee of support to help them address any literacy issues that might have been identified.

In 2014 the TEC commissioned Heathrose Research Ltd to evaluate the extent to which this approach had improved the literacy and numeracy skills of trainees. The researchers found that whilst there was anecdotal evidence from employers that trainees' skills were improving, the Industry Training Organisations (ITOs) were more circumspect because the delivery model that they worked within did not allow for deliberate acts of teaching. In addition, the ITOs pointed out that explicit literacy and numeracy was not included in their learning materials because it added to the size of the learning package and was off-putting for trainees.

Whilst the intention is for prospective support staff to gain access to learning opportunities that might help strengthen their literacy and numeracy skills, in practice this is highly variable. In some cases providers are in a position to offer internal training and support (eg, Vision West Community Trust) but other providers have to rely on the availability of an external training programme. Careerforce should examine this issue with a view to offering providers/staff more options/support, especially given the push for support workers to attain at least a level 2 qualification.

Provider example:

One provider estimated that a third of the organisation's level 2 support workforce are struggling with literacy problems. Whilst there is a free literacy programme that is available to this particular group of workers, there is still a cost to the organisation in terms of enabling these staff to take time off work to attend their study programme, dealing with the associated changes to rosters, back-filling their position with other staff, managing the disruption to clients and dealing with various other administrative tasks - particularly in the context of guaranteed hours.

3 English as a second language (ESOL)

There is a growing multicultural support workforce where English is not the first language. Some providers reported that staff with ESOL issues had problems with the *NZ Certificate* training material because it was written in a way that made the material inaccessible to them. They suggested that it be redone in a more user friendly way – ie, less wordy and in common English.

4 Technological challenges

The low levels of literacy impede people's capacity to use Careerforce's on-line learning platform - *MyPath*. Whilst technology promises to revolutionise healthcare, the associated digital skills are not yet equitably distributed throughout the support workforce. This will change over the next decade as digital competency becomes commonplace. However, in the meantime, the lack of technological skills acts a further impediment for those support workers who might otherwise possess the right personality, values and attitudes for the work, but who are not very proficient with a computer or a smart phone. For this reason, providers were very keen to retain paper-based training options for some of their support staff.

In addition, a number of providers reported that the Careerforce on-line learning platform *MyPath* was prone to timing out and that it was a bit 'clunky' to use. The performance of the platform needs to be improved, including some allowances for an element of customisation by employers so that it is a better fit with their organisational processes.

11. Key themes – learning and development needs

11.1 Employer satisfaction with the current qualifications

This section of the report needs to be read in conjunction with other provider feedback about the emerging needs of clients (see 5.0 Population-Related Change Pressures).

The following table summarises provider responses to the on-line survey questions that specifically asked them about how well the current qualifications met their needs.

Table 9: Summary of satisfaction level with NZ Certification qualification

| | No | Somewhat | Yes | Total responses |
|---------|----|----------|-----|-----------------|
| Level 2 | 3 | 4 | 7 | 14 |
| Level 3 | 2 | 7 | 5 | 14 |
| Level 4 | 4 | 4 | 4 | 12 |

Source: Carte Blanche (2018). *Home & Community Providers Workforce Planning Survey*.

Level 2

Employers described level 2 as a basic orientation programme and, as such, they were reasonably happy with it, apart from a few comments about its relevancy. In many cases organisations had embedded it into their own induction programme for staff.

However, as part of the on-line survey a few participants did question the value of the level 2 qualification and were of the opinion that the level 3 qualification was more desirable. Nothing is known about the characteristics of these particular respondents, so it is difficult to draw any conclusions from these remarks.

The majority of provider feedback related to levels 3 and 4.

Level 3

Many providers complained about the inflexibility of the level 3 curriculum, but on closer examination it would appear that Careerforce does enable providers to mix and match the learning modules to suit the needs of each organisation. In one case a provider has worked with Careerforce to completely change the mix of modules for all three levels of the *NZ Certificate in Health and Wellbeing*. The end result is not perfect, but it was described by the provider as being 'good enough'.

Of greater concern was a statement to the effect that '*some of the unit standards were wrong and have not been updated for some time*'. There was no additional information specifying which standards the respondent thought were suspect, but given that the unit standards and the training materials are closely intertwined, it might be a good idea for Careerforce to explore this issue further to establish what (if any) unit standards require attention.

Some providers wanted more micro-learning opportunities for staff that were directly applicable to the needs of their current clients. For example, there was a sense that some of the more practical skills (eg, use of multiple hoist types, bowel cares, etc.) were missing from the level 3 programme.

Level 4

In addition to the problems experienced at level 3, it appears that the biggest problem with the level 4 qualification is the length of time that it takes to complete the qualification (70 credits). However, one provider specifically noted the value of the *New Zealand Certificate in Health and Wellbeing (Level 4) Advanced Support*, which they wanted to retain as they considered it to be very useful.

Some providers speculated about the development of a shorter, more modularised approach to staff training at level 4 (eg. micro-credentialing). The New Zealand Qualifications Authority is of the view that micro-credentials have the potential to offer a range of lifelong learning options, as people seek to develop their skills over the course of multiple careers. The other benefits are that they (a) support learners to participate in a way that suits their individual needs and circumstances and (b) employers get increased access to 'just-in-time' training and relevant skills that reflect their organisation's unique requirements.

Micro-credential pilot projects (NZQA)

It is noted that the New Zealand Qualifications Authority (NZQA) is undertaking micro-credential pilot projects with three organisations (not including health and disability providers) from 1 August 2017 to 30 June 2018. These pilots will enable NZQA to better understand the role micro-credentials could play in New Zealand's education, training and qualification system of the future.

A variation of micro-credentialing already occurs in nursing, whereby the endorsement of someone's nursing registration identifies them as being someone who has additional qualifications and specific expertise in a certain area and who meets the requirements of the relevant registration standard. The problem with trying to apply this model to the support workforce is that support workers are not regulated and do not have any registration standards. It is debatable about whether or not micro-credentialing for support workers would actually work in practice without this sort of professional infrastructure. Further research of the risks and benefits is required.

Possible development of new senior support worker role - level 4 plus

The issue of micro-credentialing leads to a discussion about the possible development of a senior level 4 support worker. The notion of a more advanced role was put to providers as part of the interview process and was generally well received. In other jurisdictions, such as the United Kingdom, these staff typically work in the space between the registered health professional and other support staff. They are recognised as having the skills and expertise to take on some of the clinical tasks and responsibilities usually associated with nursing staff, as well as operating as team leaders, assessors, coaches and mentors for less experienced support workers.

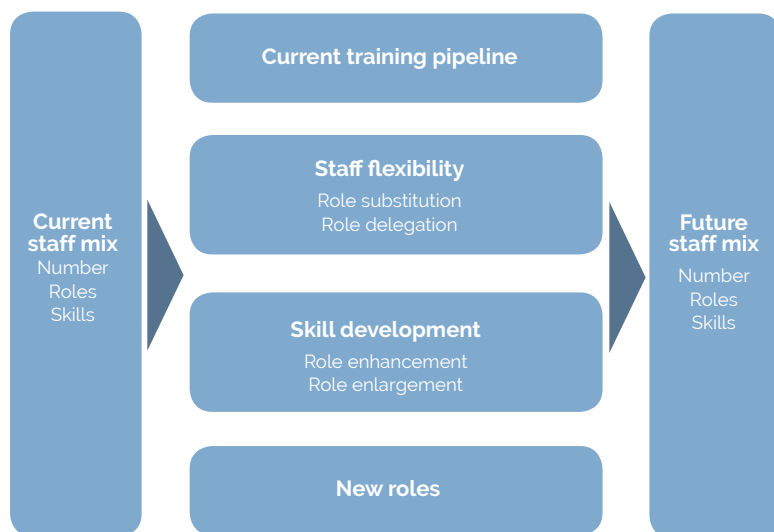
In many cases, organisations already have this arrangement in place based on individual staff aptitude and organisational requirements. However, there is no particular training for it, other than the supplementary training/support that the provider may offer the staff members that they have selected for this role.

The number of level 4 support staff in this senior role is very small, so any training and development would need to be considered in terms of the cost/benefits. However, the provision of some training modules (perhaps as endorsements) for these workers would not only help to upskill them but also offer them more formal recognition of their more advanced role – thereby validating it. Potentially, this role could also form part of a pathway into a clinical training programme for those staff that were keen to continue developing their skills in this direction.

One of the issues to resolve as part of enhancing the senior support worker role is the possible lack of role clarity (Davis, 2011, p. 78). Any changes to what support workers do on a day-to-day basis has the potential to create some uncertainty about task responsibility, particularly with regard to the current roles and responsibilities of registered nursing staff who work within a very clearly defined scope of practice. A change in the current training pipeline (see figure 10) that serves to enhance the support worker role will inevitably

impact on the role of other workers. Any knock-on effects will require careful consideration and management – possibly involving the Nursing Council of New Zealand in the first instance.

Figure 10: The training pipeline



Source: Imison, C. et al. (2016). *Reshaping the workforce to deliver the care patients need*.

Essential knowledge, skills and attitudes

In 2008, the Ministry of Health led the development of a framework that described the essential knowledge, skills and attitudes that were required to work in mental health and addiction services, irrespective of context, role, discipline or position. The aim was to embed the framework in services to help improve the capability of the workforce, thereby improving the quality of service delivery. It was also intended to influence education and training.

In 2017/18 Te Pou o te Whakaaro Nui led a refresh of the *Lets Get Real* framework in order to bring it up to date with current practice and service provision. The refreshed version will have the potential to be applied more broadly than mental health and addiction services to include anyone who is working in a health setting.

As the right skills, values and attitudes are fundamental to creating effective partnerships with clients, the HCSS sector might like to consider the possible application of the *Lets Get Real* (Ministry of Health, 2008) framework to both staff performance management metrics at a provider level and national qualification development at a national level.

Office coordinator roles

Many service providers talked about the critical role of the office coordinator. Basically this role provides administrative support to front-line workers to ensure the effective and efficient operation of the organisation. The role requires someone who can interact with clients and support workers in a calm and respectful way and, at the same time, be very capable in a number of other areas (eg, manage the staff rosters, work with the organisation's financial and human resources systems, and provide other client-facing reception tasks that might form part of the job description). The job sounds very similar to that of an air traffic controller and carries with it about the same amount of stress.

A few support workers are now in office coordinator roles but, in the main, these roles are filled by people who have a strong administrative background who may (or may not) also have a background in the health and disability sector.

The training needs that providers identified for this particular role are as follows:

- Organisational skills/time management
- Communication skills
- Level 3 or 4 health qualification/background computer/digital skills/cultural competencies
- Customer service
- Leadership
- Negotiation skills
- Personal awareness
- Stress management
- Risk management
- Critical thinking skills
- Qualification in business/administration?
- How to motivate, manage, engage support workers over the phone
- HR skills and an understanding of the support worker role.

Source: *Carte Blanche (2018)*. Home & Community Providers Workforce Planning Survey.

The training needs for some of the other roles (eg, managers, clinical staff, finance, HR, etc) were also collected as part of the on-line survey, but no-one referred to these roles during the course of the interviews, possibly because they were more focused on the immediate training needs of support workers and the staff who interact the most with the support workers (ie, office coordinators).

11.2 What learning styles are best for staff and employers?

The findings from the on-line provider survey indicate that the vast majority of providers utilise their own in-house training programmes and Careerforce materials to train their own support staff.

The demand for different learning styles was very evident from the provider interviews, with the emphasis being on flexibility and mobility. This includes different methods of delivering the training, with a shift away from classroom-based training to a more mobile model that is tailored to the needs of individual students.

It is important to note that there is still a need for paper-based learning, particularly for staff who are digitally challenged. However, increasingly the shift is towards technological developments that enable support workers, workplace assessors and learning & development managers to easily connect and communicate across space and time. This will, reasonably quickly, become the norm.

Providers are already starting to experiment with technological developments that might generate efficiencies in the workplace. It is inevitable that on-the-job training and assessment processes and packages will be swept up in this wave of digital reform.

What is harder to predict is the role that the client will play in this revolution of health care. On the basis that clients want to exercise more control over the services that they have in their lives, they will also want to play a more active role in assessing the quality of those services. This may be as simple as completing an on-line customer experience survey or it could be the equivalent of submitting information to a version of *Trip Advisor* that is developed for health and disability support services sometime in the future.

Workplace assessors

With regard to workplace assessors, at least one organisation reported that they could not identify anyone who wanted to undertake this role. It is not clear to what extent this is a problem across the country.

It is noted that there is no single model for 'on-the-job' assessment. Rather ITOs should adapt a principles-based approach to suit the needs of their trainees, employers and the various industries.

Apprenticeship model

The Apprenticeship model for level 4 *NZ Certificate in Health and Wellbeing* was recently introduced by Careerforce. The model has been very successful in other settings and in other jurisdictions (Heathrose, 2009) and health and disability providers are cautiously optimistic about being able to access this training option for their support workforce.

12. Summary of recommendations

The legislative changes that have come into effect over the last four years have been very challenging for employers, but they are making the industry more attractive to prospective support workers, mainly because of the increased pay rates, the guaranteed hours and the formation of a potential career path.

The following summary of recommendations is based on comments that have been made throughout the body of this report and have been compiled here for easy reference purposes.

| 1 | Recommendations for Careerforce |
|------|--|
| 1.1 | Review the curriculum – Review the modules in the curriculum so that they include those areas that providers have indicated are missing in the current training qualification programme. |
| 1.2 | Review the training module(s) relating to cultural competency – the increasing ethnic diversity of New Zealanders means that support workers will need to improve their cultural competency. |
| 1.3 | Advance literacy and numeracy – The Tertiary Education Commission (TEC) expects Industry Training Organisations like Careerforce to strengthen and extend opportunities for adults to improve their literacy, language and numeracy skills within the training provision of specific industry-related skills. For this reason it is recommended that Careerforce investigates what additional options/support it can offer students/employers should literacy issues be identified in the first assessment. |
| 1.4 | Develop kaupapa Māori workforce training material – In the interests of efficiency and cultural responsiveness, consider developing a kaupapa Māori version of the generic training material for the <i>NZ Certificate in Health & Wellbeing</i> , particularly for level 2. |
| 1.5 | Improve the performance of the Careerforce on-line learning platform – Given the reliance on digital training options, it is critical that the on-line learning platform is easier for both students and employers to use. |
| 1.6 | Promote the flexibility of the current curriculum and improve the level of responsiveness to individual provider needs – Work with providers to establish the best mix of training modules for individual organisations. Jointly monitor on a regular basis and modify accordingly. |
| 1.7 | Research the benefits and risks of micro-credentialing – Providers want access to more 'just-in-time' training modules that are more closely aligned with current client needs, which can be completed within a shorter timeframe and which are cost effective. Micro-credentialing might be a possible solution. |
| 1.8 | Support the development of senior support workers (level 4) – Provide mini-training modules, perhaps as endorsements for senior support workers, which would not only help to upskill them, but also offer them some formal recognition of their more advanced role. |
| 1.9 | Review the administration of the Apprenticeship model – Assess the level of responsiveness within Careerforce to provider inquiries about the Apprenticeship model. Monitor its uptake and effectiveness over time, and evaluate the fit of the model with HCSS sector needs. |
| 1.10 | Strengthen workforce core skills, values & attitudes – Careerforce to consider the possible application of the <i>Let's Get Real</i> framework (Ministry of Health, 2008) to national qualification development for the support workforce. |

| 2 | Recommendations for service providers |
|-----|---|
| 2.1 | Profile your client groups - Actively use available information from client care plans and assessments to build up a picture of the needs of your client groups in order to more closely match workforce deployment, training, recruitment and policies to meet those needs. |
| 2.2 | Engage in workforce planning - Ensure that your organisation's workforce forecasting takes into account staff retirements, anticipated shifts in qualification and tenure, and local workforce availability. |
| 2.3 | Improve the cultural competency of your staff - Ensure you have training for new staff on ethnic diversity and cultural competency. Consider developing some information for clients on working with a support worker who is from a different cultural background to them. |
| 2.4 | Develop or strengthen your digital strategy. |
| 2.5 | Build stronger alliances with other local health care providers, which could include sharing workforce training opportunities. |
| 2.6 | Strengthen workforce core skills, values & attitudes – service providers to consider the possible application of the <i>Let's Get Real</i> framework (Ministry of Health, 2008) to staff performance management metrics. |

| 3 | Recommendations for service commissioners |
|-----|---|
| 3.1 | Consider future workforce requirements using a workforce planning model |
| 3.2 | Commission research to fill critical information gaps for workforce planning purposes. |
| 3.3 | Focus on service outcomes |
| 3.4 | Act cohesively and promote service integration across the continuum of care |
| 3.5 | Address systemic workforce development issues |
| 3.6 | Develop new approaches to commissioning and contracting - For example, if some of the funding agencies (eg, ACC) introduce a casemix funding model, it is likely that worker competency criteria will need to be established for each case-mix category. It should not be assumed that the current levels of certification will meet the new commissioning requirements. |

Appendix 1: Methodology

A mixed methods approach was used in the development of this report. The project was conducted in five overlapping stages.

Stage One: Literature review

Given the limited scope of the project, the purpose of the literature review was not to undertake a comprehensive analysis of the literature but to identify some of the supporting evidence for any emerging trends.

Stage Two: Stakeholder workshop

Thirty eight people from 20 member organisations attended a HCHA leadership workshop that was held in Wellington on 12 December 2017.

Stage Three: On-line survey

Carte Blanche Ltd conducted an on-line survey between mid-December 2017 and mid-January 2018. Data was gathered from 24 respondents and yielded a 53% response rate from a database of 45 people who represent employers within the sector. Due to the small sample size the results cannot be said to be statistically sound, but they are indicative of key themes and trends and, as such, have been included in this report alongside information from other data sources.

Stage Four: Provider interviews

In addition, key informant interviews were undertaken with twelve self-selected service providers ranging in size from small to very large. These semi-structured interviews were approximately 60 minutes long and, where possible, were digitally recorded (ie, in those cases where there was minimal background noise). These recordings were a means of supplementing the interviewer's notes and were deleted when the final report was accepted.

Information from the interviews provided a range of perspectives about the changing needs of the client population, the associated impact on the workforce and what industry might need from workforce training in the future.

Stage Five: Analysis and reporting:

A qualitative analysis was completed using an inductive approach that allowed the findings to emerge from the frequent, dominant or significant themes in the raw data.

The high level findings were shared with key informants in the form of a draft report to ensure that they accurately reflected the views of the sector. The feedback informed the development of the final report.

Supplementary information papers

In addition to the final report, Julie Haggie (CEO, Home and Community Health Association) wrote three supplementary papers containing background information about:

(a) the strategic context, (b) client need and (c) the composition of the home and community support workforce.

These supplementary papers could be used to generate further discussion about the gaps in the information as well as the depth, breadth and structure of the current qualifications and training.

Limitations and benefits of the approach

The main limitation of the approach is that the key themes are based on a relatively small number of people who participated in the following sector engagement opportunities - stakeholder workshop (38 people from 20 organisations), the on-line survey (24 people) and the provider interviews (20 people from 12 organisations).

However, the themes are considered to be an accurate gauge of sentiment within the sector and they were reinforced by information from other data sources (eg. the supporting literature, Ministry of Health reports, InterRAI reports, etc.).

Information gaps

Gaps in the information were identified on the basis that there was a poor quality body of evidence to support any conclusions. 'Poor quality' was defined as either being insufficient data or the information was not specific enough for our purposes. The main gaps included the following:

Table 10: Identified information gaps for strategic workforce planning purposes

| Gaps | Area of uncertainty |
|---|--|
| Profiling the current workforce Lack of a detailed profile of the current home and community support workforce | <p>AUT have conducted an analysis of the age and location of the aged care workforce, which indicates that the home and community sector has an ageing workforce in most parts of the country (apart from the North Island metropolitan areas). A much broader range of ages is found in the residential aged care workforce.</p> <p>This finding should be influencing recruitment and retention strategies, particularly in those parts of the country (eg. rural) where there is not much growth and the general population is also ageing.</p> <p>NB: There is no equivalent information for the rest of the health and disability sector.</p> |
| InterRAI assessments Incomplete information | <p>There is considerable variation across New Zealand in terms of the frequency of InterRAI assessment for people living at home with support. This makes it very difficult to compare and monitor the health or support outcomes of older people receiving home support at a regional or national level.</p> |
| Projected need for home-based services Lack of projections about the need for home and community support services in the future, particularly for people with disabilities | <p>The Disability Survey (Statistics NZ, 2013) identified that 24 percent of people living in New Zealand are disabled. Disability now accounts for over half of the total health loss experienced by the population as a whole and this proportion is expected to increase over time (NZ Burden of Disease Study, 2013). However, there is very little information about the current utilisation of disability support services in NZ and the need for future services - based on disability client profiles and trends. This is essential information for workforce planning purposes.</p> |
| Mental health & addiction The impact of the increasing need for mental health and addiction support for clients where co-existing problems are a consideration | <p>Mental health problems are common. However, whilst there is an increasing body of knowledge on the impact of mental health and addiction problems on a person's physical wellbeing, there is a lack of recognition that physical illness and disability carries with it a much higher risk of mental distress.</p> |

| Gaps | Area of uncertainty |
|--|---|
| <p>Visioning future services and future workforce</p> <p>Lack of workforce modelling to help identify and describe the future home and community support workforce</p> | <p>Although population-based workforce projections indicate that an increase in the overall size of the home and community support workforce will be required, there is limited modelling of the nature of this increase under a number of different scenarios.</p> <p>The lack of workforce modelling makes it almost impossible to identify the numbers, skill mix and the associated characteristics of the future home and community support workforce.</p> |

Ethics

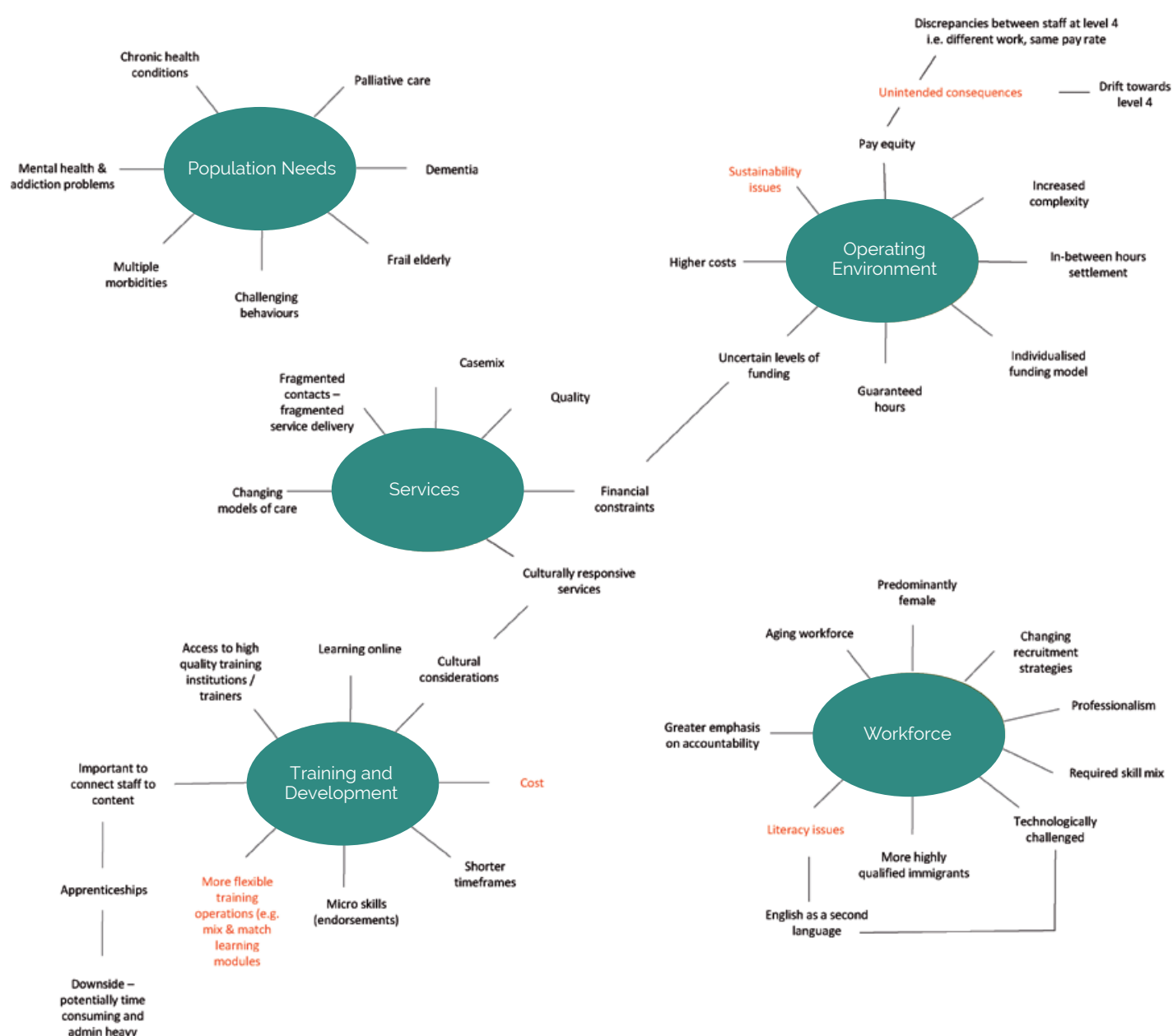
Provider participation in this project was at the discretion of the individuals and their employing organisations. All twelve providers/employers who were interviewed nominated themselves. They all received information before their interview, which briefly outlined the purpose of the project as well as listing the questions of interest. Everyone that was interviewed was also given the opportunity to review and comment on the content of the draft report.

All information that was provided by interviewees is confidential to Lattice Consulting Ltd and has not been reported in any way as to allow individuals to be identified.

Appendix 2: Mind map of stakeholder feedback

The mind map in figure 11 offers a high level summary of the key themes and sub-themes from the stakeholder feedback. The issues highlighted in red reflect the most commonly expressed hindrances to workforce capability development.

Figure 11: Summary of stakeholder feedback



Background papers

one, two and three

HCHA has based these background papers on information received or obtained, on the basis that such information is accurate and complete. For the most part we are reliant on information and data gathered by others.

These papers may display labelling from the original source of the table, graph or diagram used.

The information contained in these papers has not been reviewed.

Background paper one:

Present and emerging client needs, relevant to workforce development, HCHA scan, April 2018

Background paper two:

Summary of impacts of current and emerging legislation and legal challenges, funding pressures, commissioning/contract changes, strategies and technology developments, through the lens of workforce planning and development, April 2018

Background paper three:

Present and emerging workforce statistics, supply HCHA scan, April 2018

Background paper one:

Present and emerging client needs relevant to workforce development, HCHA Scan, April 2018

We have scanned for information relevant to the needs of home support client groups, and of the current workforce and future supply¹. We mainly focus on the next 3-5 years for the purposes of the specific project, however we take a longer view where that seems appropriate. We have used interRAI assessment data² and research on that data. We have used the LiLAC study and publicly available research and statistical information. When scanning we have tried to look at the features of current client groups; trends in change and growth or decline; areas where there is potential for HCHA services to add value; and gaps.

Disclaimer: *There are limited sources of information on the home and community support workforce. HCHA has based this background paper on information received or obtained, on the basis that such information is accurate and complete. For the most part we are reliant on information and data gathered by others. The information contained in this report has not been reviewed.*



¹For some client groups/conditions there is a large amount of research available (eg health of older people), others less so. This is a scan and not a full literature review, so not all research is included.

²Noting that interRAI data is based on self-reported needs assessment.

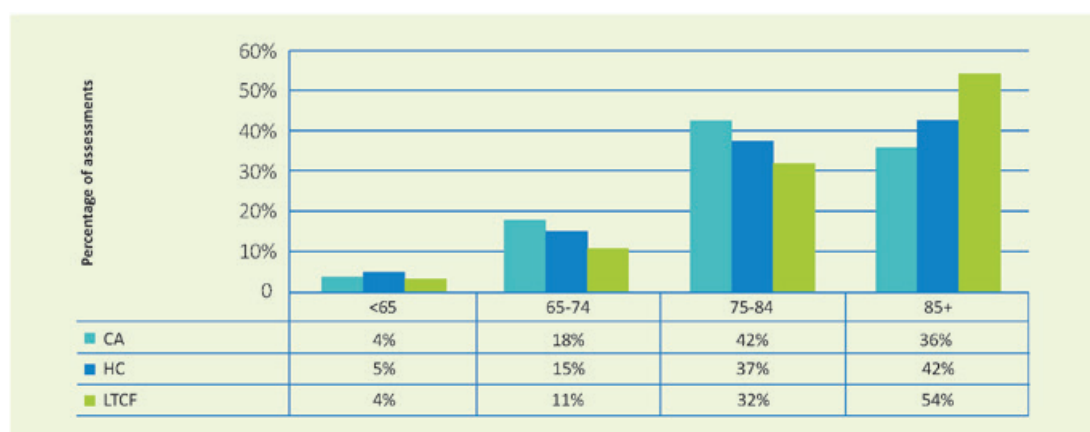
1. The older client population – frail older people

1.1 Age, ethnicity, gender and population growth

1.1.1 Age

Just under 80% of older people who had an InterRAI home care assessment in 2015/16 were over 75 years of age³. The graph below is copied from an interRAI Annual Report.

Figure 18: Percentage of assessments by age and type and age group, 2015/16



1.1.2 Ethnicity

In 2015/16 interRAI data the older home support client population is substantially European – overall around 87%⁴. Close to 7% of home support recipients overall are Maori, another four percent are Pacific and around 3% are of Asian descent.⁵ The table following of interRAI-HC assessments 2012-2014 shows the proportionate difference between European, Maori and Pacific users of the service as they age.

³ National interRAI Data Analysis Annual report 2015/16, page 26

⁴ 35% of current older New Zealanders were born elsewhere, so 'European' is a broad term.

⁵ National interRAI Data Analysis Annual report 2015/16, page 27

The table below is an extract from a 2016 epidemiological profile. It shows sex and ethnic distributions of the interRAI-HC cohort aged 65+ years (45,418 people) and the New Zealand population (NZ Popn) aged 65+ years usually resident at the 2014 Census (607,035 people) stratified by 10-year age bands.⁶

Table 2

| | 65–74 years | | | | 75–84 years | | | | 85–94 years | |
|------------------------------|-------------|--------|---------------------|--------|-------------|--------|---------------------|--------|-------------|--------|
| | interRAI-HC | | NZ pop ^a | | interRAI-HC | | NZ pop ^a | | interRAI-HC | |
| | n | (%) | n | (%) | n | (%) | n | (%) | n | (%) |
| Sex^a | | | | | | | | | | |
| Males | 3,256 | (43.9) | 167,565 | (48.4) | 7,364 | (40.1) | 85,128 | (45.4) | 6,316 | (35.2) |
| Ethnicity^b | | | | | | | | | | |
| Māori | 879 | (11.8) | 22,188 | (6.7) | 1,033 | (5.6) | 8,505 | (4.7) | 338 | (1.9) |
| Pacific | 489 | (6.6) | 9,225 | (2.8) | 670 | (3.7) | 3,693 | (2.1) | 269 | (1.5) |
| Asian | 232 | (3.1) | 17,847 | (5.4) | 501 | (2.7) | 7,596 | (4.2) | 260 | (1.4) |
| European/Other | 5,821 | (78.4) | 280,596 | (85.1) | 16,147 | (88.0) | 159,570 | (89.0) | 17,092 | (95.2) |

a: 2 observations missing in the interRAI-HC for people aged 65–74 years;

b: In the 2013 Census, 16,275 people aged 65–74 years had unstated ethnicity; 8,220 people aged 75–84 years had unstated ethnicity; people aged 95+ years had unstated ethnicity.

More work is needed to project future ethnic diversity of older home support clients.

1.1.3 Gender and living arrangements

65% of older New Zealanders who receive home support are women. This is consistent with the higher proportion of females in the general population over 85. Close to half of home care clients are living alone, a third are living with a spouse or partner and no other. 10% live with their child (but not spouse/partner) 7% live with non-relatives, 5.8% have other living arrangements. Not surprisingly female home care clients are more likely to be living alone compared to males.^{7,8}

⁶Schluter, P. J., Ahuriri-Driscoll, A., Anderson, T. J., Beere, P., Brown, J., Dalrymple-Alford, J., David, T., Davidson, A., Gillon, D. A., Hirdes, J., Keeling, S., Kingham, S., Lacey, C., Menclova, A. K., Millar, N., Mor, V. and Jamieson, H. A. (2016), Comprehensive clinical assessment of home-based older persons within New Zealand: an epidemiological profile of a national cross-section. Australian and New Zealand Journal of Public Health, 40: 349–355. doi:10.1111/1753-6405.12525

⁷National interRAI Data Analysis Annual Report 2015/16, page 27

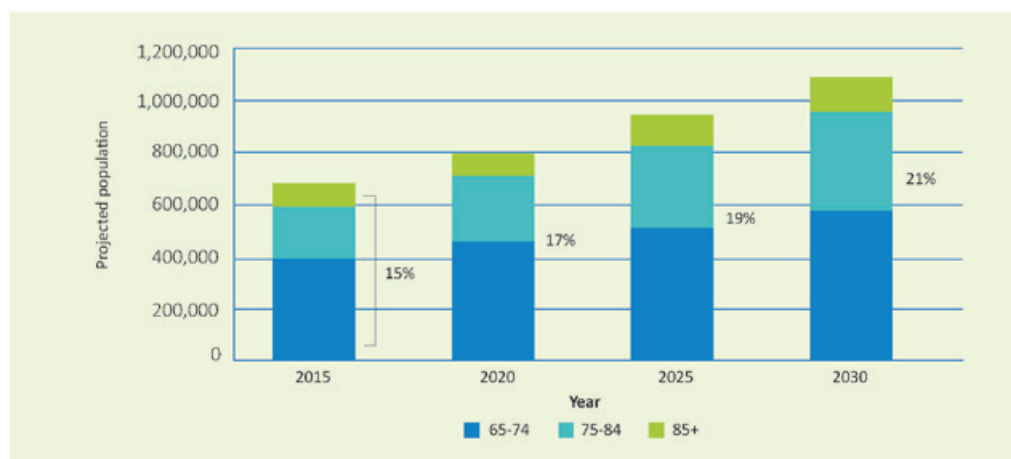
⁸P. Schluter et al., 'Comprehensive clinical assessment of home-based older persons within New Zealand: an epidemiological profile of a national cross-section, p. 352.

1.1.4 Growth in older population

The National InterRAI Data Analysis Annual report 2015/16 says:

"Figure 17 shows that by 2030, the number of people aged 85 years and over will increase from 80,100 to 137,000 (a 71 percent increase) while the number of people aged 75-84 will increase from 204,000 to 382,500 (an 88 percent increase). This trend is likely to put increasing pressure on the demand for services to care for older people."⁹

Figure 17: Population growth in New Zealand in the older age groups, 2015-2030



Source: Statistics New Zealand. Projections are 'medium' 2015/16 population projections according to assumptions specified by the Ministry of Health, using the 2013 base (2014 update).

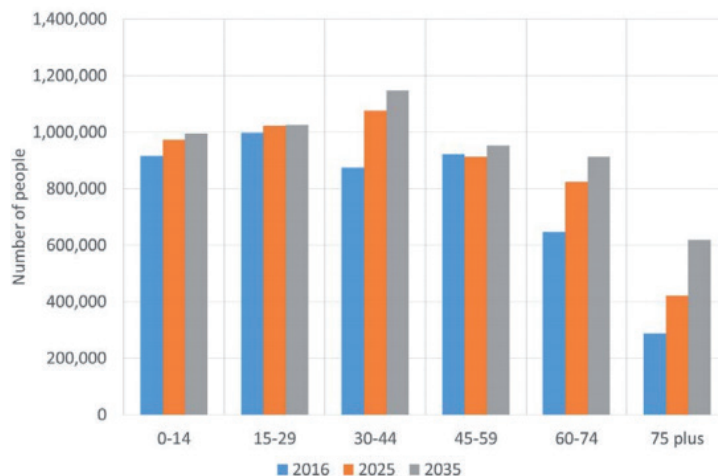
1.1.5 Growth in specific regions

"In terms of absolute numbers, the highest increases in people aged 75 years and over are expected in the three Auckland region DHBs as well as Canterbury, Waikato and Southern. Some of the smaller DHBs are forecast to serve a relatively high percentage of older people by 2035: notably Hawkes Bay, Nelson Marlborough, Northland, South Canterbury, Wairarapa, West Coast and Whanganui."¹⁰

⁹ National interRAI Data Analysis Annual Report 2015/16. Page 25

¹⁰ District Health Board Financial Performance to 2016 and 2017 Plans, page 17

Figure 9: Actual and forecast New Zealand population by age band



1.2 Care needs of older people – range of care, frequency of care and growth in demand

1.2.1 Current care needs

Approximately 75,000 people over 65 are currently receiving home support services¹¹. The level of care ranges from simple functional supports such as laundry and housework, to personal care visits for people with very low mobility or high cognitive challenges. The LiLAC study looked at current care needs for older people and made projections of these care needs. They used four categories based on frequency of need: 'independent' (not needing support), 'long interval' support (needing weekly support), 'short interval' care (needing daily support with activities of daily living) and 'critical interval' care (needing help with activities of daily living more than daily).¹²

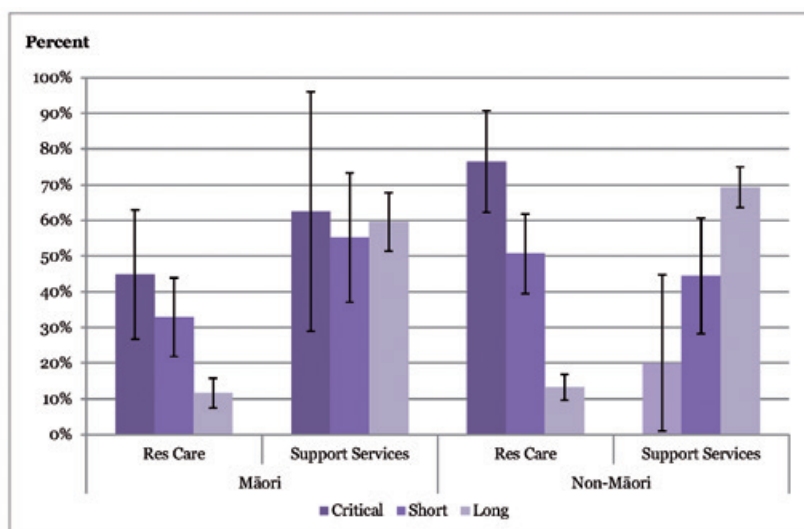
A LiLAC study graph (Figure 2 following) shows current care provision. Critical short and long-term care are occurring in both residential and community services¹³:

¹¹ Appendix E: Home-Based services for older people, Productivity Commission. <https://www.productivity.govt.nz/sites/default/files/social-services-final-report-appendix-e.pdf>, page 1

¹² Intervals of care need: need for care and support in advanced age, LiLACS NZ, University of Auckland

¹³ Intervals of care need: need for care and support in advanced age, LiLACS NZ, page 11

Figure 2: Proportion of LiLACS NZ participants with each intervals of care need and their receipt of support services and receipt of support services and residential care



Source: LiLACS NZ

Note: *Res Care - living in residential care at the time of the baseline interview

1.2.2 Growth projections

The same LiLAC study predicts growth projections from 2010 to 2026 – Figure 4¹⁴. LiLAC researchers have projected that:

“...the number of non-Māori needing long interval care is estimated to increase by 74% from 50,605 in 2010 to 93,161 people in 2026. The number of non-Māori needing short interval care is likely to increase by 75 percent (an increase from 9,481 in 2010 to 16,546 in 2026). The number of non-Māori needing critical interval care will increase by 74% by 2026, corresponding to an increase of 5,728 people. Even if there are changes in the proportions of those categorised as needing each level of care, these estimates present challenges to health planners, communities, whānau and family and older people themselves in contemplating the increase in absolute numbers of people.”¹⁵

1.2.3 Projections for Māori

For Maori, the LiLAC study projected that:

“In 2010 the NZ Māori population aged 80+ comprised just under 4,000 people. By 2026, the Māori population aged 80+ is projected to increase by 190 percent, to just under 12,000 people. The proportions of the LiLACS NZ sample with each interval of care need were extrapolated onto the estimated population groups for the NZ Māori population aged 80+. This extrapolation was adjusted for gender and age differences in the population. Using the current LiLACS NZ proportion of people who were independent, we found that the number of Māori aged 80+ who are likely to be independent in 2026 will increase by 174 percent from 2010 figures, corresponding to an increase of 2,907 people. Figure 3 shows these projections. Of Māori aged 80+ in 2026, 195 percent more Māori than in 2010 will have ‘long’ and ‘short’ interval care needs. This corresponds to an increase of 3,175 and 805 people respectively. By 2026, 772 more Māori aged 80+ will have a ‘critical’ interval of care need than in 2010, a 242 percent increase. Numbers of people in both the critical and short interval of care needs are small, which increases the uncertainty of the projection.”¹⁶

¹⁴ Intervals of care need: need for care and support in advanced age, LiLACS NZ, page 13

¹⁵ Intervals of care need: need for care and support in advanced age, LiLACS NZ, page 12

¹⁶ Intervals of care need: need for care and support in advanced age, LiLACS NZ, page 12

1.3 Chronic conditions, co-morbidities and general health of older people

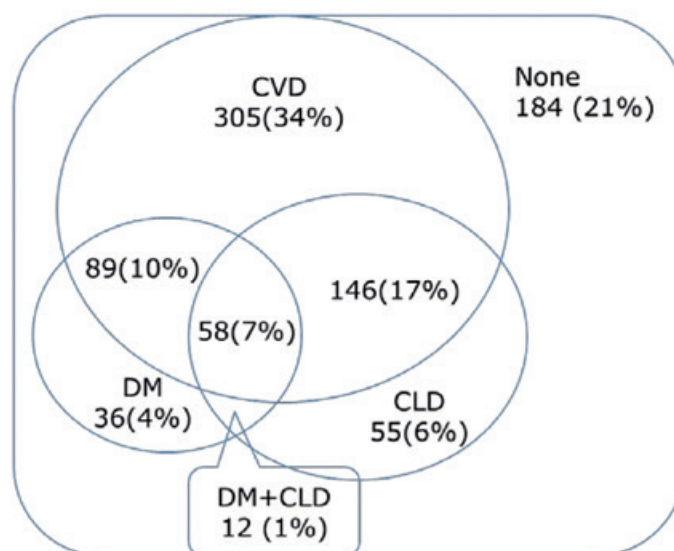
1.3.1 Comorbidities

Multimorbidity is ubiquitous in advanced age, with 93 percent of LiLACS participants having two or more diagnosed health conditions¹⁷.

1.3.2 The LiLAC study

(Figure 1-1 below) shows the overlap between cardiovascular disease, chronic lung disease and diabetes within its wave 1 cohort,¹⁸

Figure 1-1 : Overlap between the conditions of cardiovascular disease, chronic lung disease and diabetes mellitus, Wave 1



Source: LiLACS NZ

Note. CVD = Cardiovascular disease, CLD = chronic lung disease, DM = Diabetes mellitus

1.3.3 Main chronic conditions

The top chronic conditions of older people currently receiving home support services are coronary heart disease (32%), diabetes (32%) and stroke/CVA (18%).¹⁹

1.3.4

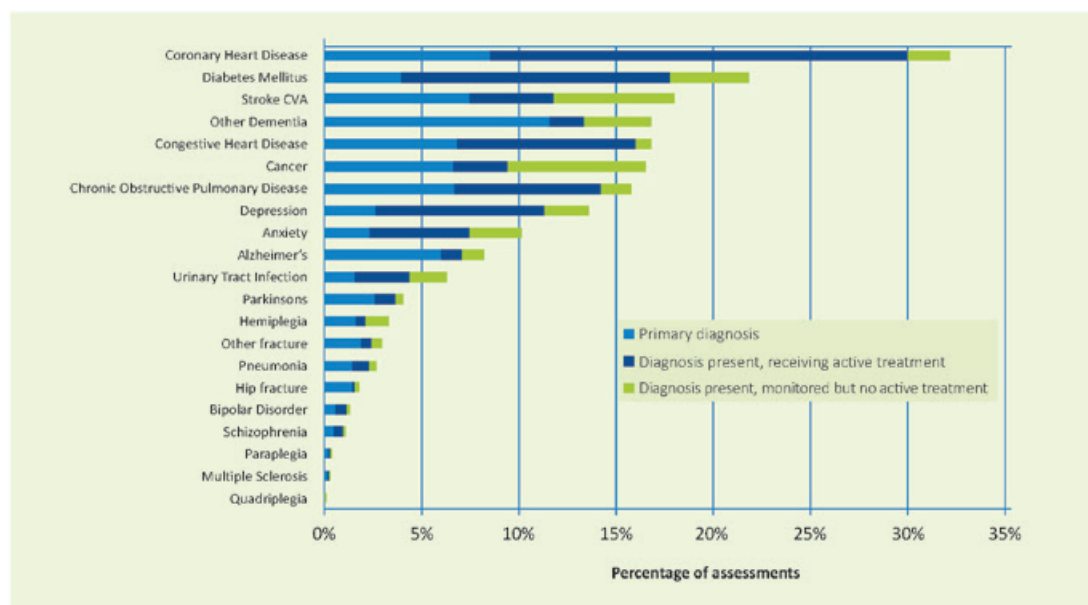
(Figure 23) from interRAI 2015/16 report shows the diseases reported from home care clients who were assessed in 2015/16:

¹⁷ Dementia Supplementary Findings from LiLACS NZ for Section Five, 'Service Use and Common Health Conditions' in the report 'Health, Independence and Caregiving in Advanced Age, page 9

¹⁸ Dementia Supplementary Findings from LiLACS NZ for Section Five, 'Service Use and Common Health Conditions' in the report 'Health, Independence and Caregiving in Advanced Age, page 11

¹⁹ interRAI Annual Report 2016/17, page 10

Figure 23 : Diseases reported by the Home Care clients, 2015/16



That report noted that "Home Care clients are more likely to report coronary heart disease, diabetes, cancer and chronic obstructive pulmonary disease as their primary diagnosis compared to Long Term Care Facility (LTCF) residents."²⁰

1.3.5 Cardiovascular disease

Cardiovascular disease (CVD) is the most frequent cause of mortality in advanced age, associated with 89 percent of deaths among older (65+) non-Māori and 59 percent among older Māori. New Zealand's rates of hospitalisation from CVD are high.

1.3.6 A projection of the LiLAC study is that:

"CVD and DM are common in advanced age and have significant morbidity and mortality effects. Twenty percent of Māori and 10 percent of non-Māori had both conditions. Having CVD on its own was associated with the highest current interval of care need for Maori but not for non-Māori. If the current proportions remain the same, projections to 2026 for these health conditions suggest that CVD, in particular, is likely to be present for a substantial number of people aged over 80 years of age. The number of older Māori and non-Māori with CVD and/or DM diagnoses is projected to increase by up to 200 and 75 percent respectively.

*However, despite these potentially increasing needs, international trends in dependency suggest that more recent cohorts of older people generally appear to have better levels of function than earlier cohorts. It seems clear that with resource-intensive physical activity interventions, there is a potential for recovery in function over time even in advanced age."*²¹

²⁰ National interRAI Data Analysis Annual Report 2015/16, page 30

²¹ Intervals of care need: need for care and support in advanced age: LiLACS NZ page 19

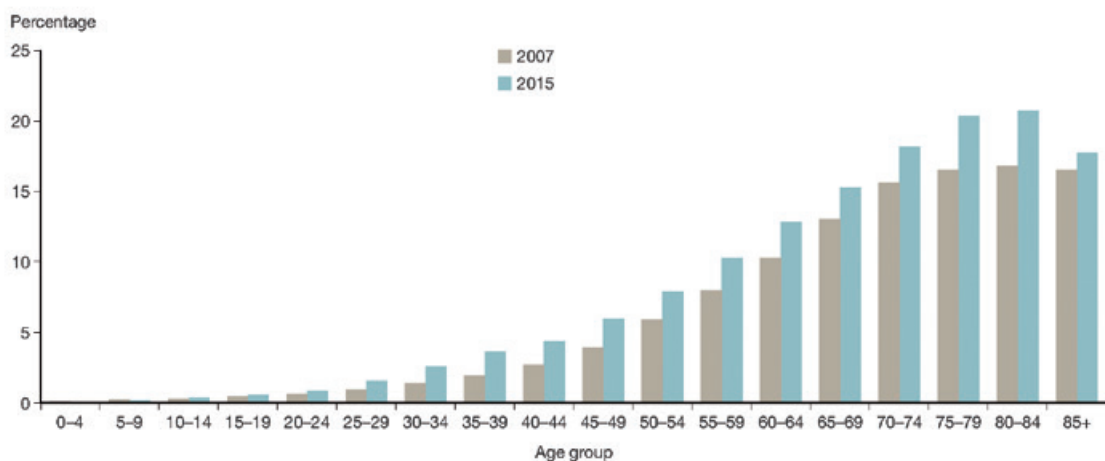
1.3.7 Stroke

There are an estimated 60,000 stroke survivors in New Zealand. Many are disabled and need significant daily support. However, stroke recovery can continue throughout life.²² Cerebrovascular disease was the third leading cause of death in the total population in 2006, after cancer and ischaemic heart disease. Māori females had the highest age-standardised mortality rate of the four groups in 2006, followed by Māori males. The calculated Māori male age-standardised rate was 6.6 percent higher than the non-Māori male rate in 2006, and the calculated Māori female rate was 34.3 percent higher than the non-Māori female rate²³.

1.3.8 Diabetes

The following graph (Figure 31) taken from the 'Health and Independence Report 2016' shows the growing number of people living with diabetes at each age group.²⁴

Figure 31 : Proportion of the population with diabetes, 2007 and 2015, by age group



Source: Virtual Diabetes Register

The Health and Independence report also notes that:

"Diabetes is a major cause of serious but largely preventable conditions including renal failure, working-age adult blindness and lower limb amputations, and is a substantial contributor to premature stroke and cardiovascular disease. A focus on addressing diabetes over the last ten years has begun to yield signs of improvement. Figure 32 shows that on a per capita, age-adjusted basis, health loss from diabetes declined between 2005 and 2015, even though the prevalence of diabetes increased over that time. This reflects earlier diagnosis and better management of this condition."²⁵

The LiLAC study indicated that DM is significantly more prevalent in older Māori than non-Māori with 28 percent of Māori having DM (includes Type I and Type II).²⁶

²² Ministry of Health, Health Survey. Retrieved from Stroke foundation <https://www.stroke.org.nz/stroke-facts-and-fallacies>

²³ <https://www.health.govt.nz/publication/mortality-and-demographic-data-2006>

²⁴ Ministry of Health. 2017. Health and Independence Report 2016. The Director-General of Health's Annual Report on the State of Public Health. Wellington: Ministry of Health, page 41.

²⁵ MoH, 2017, Health and Independence Report, page 42

²⁶ Intervals of care need: need for care and support in advanced age: LiLACS NZ page 14

1.3.9 Cholesterol

The prevalence of high cholesterol (medicated) increases steeply with age, and affects one in three adults aged 65 years and older.

"High blood cholesterol increases a person's risk of developing ischaemic heart disease and ischaemic stroke. High blood cholesterol accounted for about 4% of illness, disability and premature mortality in 2013 (IHME 2015). About 412,000 adults (11%) reported high cholesterol (medicated), up from 8% in 2006/07. However, there has been little or no change in the prevalence of high cholesterol (medicated) since 2011/12 (11%)."²⁷

1.3.10 Cancer

The Ministry of Health register of cancer registrations and deaths in 2011 records that:

- Cancer accounts for nearly 1/3 of all deaths in NZ.
- 57 percent of all new cancers registered in 2011 were for people aged 65 and over.
- 73 percent of all deaths from cancer in 2011 were people aged 65 and over.
- in people aged 75 years and over, the most common cancer registration and the most common cause of death from cancer was prostate cancer for men, and colorectal cancer for women.²⁸

The same report notes that despite a decline in cancer mortality and an increase in cancer survival over time, it remains an important cause of preventable mortality and illness alongside cardiovascular disease. Smoking, nutrition, obesity, alcohol and lack of exercise are significant risk factors. For Māori and people living in socioeconomically deprived areas, the burden of cancer is much higher than for the general population. In 2011 Māori had an age-standardised cancer mortality rate of 204.6 per 100,000 population, compared to 118.9 for non-Māori. Māori cancer mortality rates are dropping but at a lower rate than that for non-Māori.²⁹

While the overall risk of developing cancer in New Zealand is expected to stabilise or decline over the next decade, New Zealand has an increasing number of people who are developing cancer, mainly because of population growth and ageing.³⁰

1.3.11 Depression

Depressive symptoms were present in 35% of LiLAC participants at any one time throughout the study, although many individuals improved over time³¹. Depression did not differ by ethnic group, sex or socioeconomic deprivation.

²⁷ Annual Update of Key Results 2014/15, New Zealand Health Survey, page 21

²⁸ Ministry of Health. 2014. Cancer: New Registrations and Deaths 2011. Wellington: Ministry of Health <https://www.health.govt.nz/publication/cancer-new-registrations-and-deaths-2011>

²⁹ Ministry of Health. 2014. Cancer: New Registrations and Deaths 2011. Wellington: Ministry of Health <https://www.health.govt.nz/publication/cancer-new-registrations-and-deaths-2011>

³⁰ <https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/cancer/>

³¹ Health, Independence and Caregiving in Advanced Age Findings from LiLACS NZ, University of Auckland, page 101

1.3.12

In the LiLAC report on research findings 'Health, Independence and Caregiving in Advanced Age', depression was associated with:

- lower functional status
- higher frailty (more so for men than for women)
- poorer HRQOL
- higher health service use and cost.³²

That report also noted that depression in association with CVD contributes the most to negative outcomes.³³

1.3.13 Loneliness

Around 20% of home care clients report feeling lonely. There is considerable variation in the level of loneliness across DHB areas.³⁴ Those living alone are more likely to be lonely (29%) than those living with others (14%).

1.3.14

Amongst those living alone, 2017 research by Jamieson, Gibson et al indicates:

- significant differences in the likelihood of being lonely exist between ethnic groups.
- similar proportions of Maori are lonely whether living alone or living with others (10-11%).
- approximately four times the proportion of Pasifika were lonely living with others (13% than living alone (4%). As older Pasifika people mostly lived with others, this could be of some importance.
- in a similar way, twice the proportion of older Asian people were lonely when they lived with others (16%) than living alone (7%).
- more than twice the proportion of European/older adults were lonely when living alone (15%) than when living with others, and a higher proportion of this group lives alone.³⁵

Further Research is underway, using the interRAI data, looking to identify risk factors for entry into residential care.³⁶

1.3.15 Incontinence

Research on interRAI homecare assessments (interRAI HC) by Schluter, Arnold, Jamieson for 25,257 men and 42,032 women found that incontinence was reported by 34.3% of men and 42.6% of women. It also found that urinary incontinence is a common and significant independent risk factor for falls but not for hip fractures. It indicated that patterns are different between men and women with complex needs.³⁷

³² Health, Independence and Caregiving in Advanced Age Findings from LiLACS NZ, University of Auckland, page 19

³³ Health, Independence and Caregiving in Advanced Age Findings from LiLACS NZ, University of Auckland, page 19

³⁴ National interRAI Data Analysis Annual Report 2015/16, page 49

³⁵ Jamieson, H. A., Gibson, H. M., Abey-Nesbit, R., Ahuriri-Driscoll, A., Keeling, S., & Schluter, P. J. (2017). Profile of ethnicity, living arrangements and loneliness amongst older adults in Aotearoa New Zealand: A national cross-sectional study. *Australasian Journal on Ageing*. Advance online publication. doi: 10.1111/ajag.12496

³⁶ <https://www.ageingwellchallenge.co.nz/research/risk-factors-in-reduced-social-engagement/>

³⁷ Schluter, P. J., Arnold, E. P., & Jamieson, H. A. (2017). Falls and hip fractures associated with urinary incontinence among older men and women with complex needs: A national population study. *Neurourology & Urodynamics*. Advance online publication. doi: 10.1002/nau.23442

A second study showed a statistically significant relationship between faecal Incontinence and mortality in a large community population of older people with complex needs.³⁸

A third study showed that urinary incontinence is a risk factor for admission to aged residential care.³⁹

1.3.16 Oral health

A 2012 oral health study found that:

- Around two in five people living in their own home (43.2%) had untreated coronal decay on one or more teeth,
- the prevalence of oral ulceration was 8.2% for older adults living in residential care and 11% for those older adults residing in their own homes;
- For older adults residing in their own homes the prevalence of oral candidiasis was 5.5%.
- One in five (18.9%) living in their own home reported having difficulty cleaning their teeth.
- Cost is the main barrier to oral health services for 32% of those living at home.
- Other barriers are difficulty in accessing services (11%) and a perceived lack of problems (59.7%).
- Older adults who had seen a dental professional in the previous 12 months had better oral health over almost all of the clinical and self-reported indicators.⁴⁰

1.3.17 Nutrition

A 2013 Ministry of Health background paper on nutrition for older people notes there are many contributors to poor nutrition in older people including natural physical decline, medications or metabolic changes, isolation and socioeconomic status and access to food. The report notes that frail older people have different and more complex nutritional and physical activity needs than healthy older people, and there is an association between poor nutritional status and altered regulation of the immune system. Older people are at increased risk of foodborne illness. They may also be at greater risk of dehydration than younger adults, and may also experience poor oral health.⁴¹

³⁸ Jamieson, H. A., Schluter, P. J., Pyun, J., Arnold, T., Scrase, R., Nisbet-Abey, R., Mor, V., Deely, J. M., & Gray, L. (2017). Fecal incontinence is associated with mortality among older adults with complex needs: An observational cohort study. *American Journal of Gastroenterology*. Advance online publication. doi: 10.1038/ajg.2017.200

³⁹ Schluter, P. J., Ward, C., Arnold, E. P., Scrase, R., & Jamieson, H. A. (2017). Urinary incontinence, but not fecal incontinence, is a risk factor for admission to aged residential care of older persons in New Zealand. *Neurourology & Urodynamics*, 36(6), 1588-1595. doi: 10.1002/nau.23160

⁴⁰ Our Older People's Oral Health, Key Findings of the 2012 New Zealand Older People's Oral Health survey, CBG Health Research Ltd, 2015

⁴¹ Food and Nutrition guidelines for Older People: A background paper, MoH, 2013

1.3.18 Cognition and mobility

Schluter, P and others undertook an epidemiological profile based on the interRAI minimum data set. In their research they include extensive tables on a range of indicators reported by over 47,000 individuals. An extract from one of their tables on reported cognition and locomotion ability is copied below.⁴²

| | 65–74 years | | 75–84 years | | 85–94 years | | 95+ years | |
|---|-------------|--------|-------------|--------|-------------|--------|-----------|--------|
| | n | (%) | n | (%) | n | (%) | n | (%) |
| Cognitive skills for daily decision making ^c | | | | | | | | |
| Independent | 3,781 | (51.0) | 8,538 | (46.5) | 7,812 | (43.5) | 688 | (40.8) |
| Modified independence | 1,149 | (15.5) | 3,183 | (17.3) | 3,499 | (19.5) | 341 | (20.2) |
| Minimally impaired | 1,228 | (16.5) | 3,108 | (16.9) | 3,176 | (17.7) | 303 | (18.0) |
| Moderately impaired | 854 | (11.5) | 2,300 | (12.5) | 2,271 | (12.6) | 219 | (13.0) |
| Severely impaired | 404 | (5.4) | 1,200 | (6.5) | 1,190 | (6.6) | 131 | (7.8) |
| No discernible consciousness, coma | 5 | (0.1) | 22 | (0.1) | 10 | (0.1) | 5 | (0.3) |
| Primary mode of locomotion ^c | | | | | | | | |
| Walking, no assistive device | 3,099 | (41.8) | 6,277 | (34.2) | 3,797 | (21.1) | 163 | (9.7) |
| Walking, uses assistive device | 3,604 | (48.6) | 10,776 | (58.7) | 12,979 | (72.3) | 1,328 | (78.7) |
| Wheelchair, scooter | 478 | (6.4) | 731 | (4.0) | 545 | (3.0) | 79 | (4.7) |
| Bed-bound | 240 | (3.2) | 567 | (3.1) | 637 | (3.5) | 117 | (6.9) |

⁴²Schluter, P et al Comprehensive clinical assessment of home-based older persons within New Zealand: an epidemiological profile of a national cross-section. Australian and New Zealand Journal of Public Health, 40: 349–355.

1.3.19 Dementia and other neurodegenerative diseases

25 percent of current home support recipients had a formal diagnosis of dementia and are living with mild to moderate dementia. 35% of those clients require extensive assistance or are completely dependent, and 33% of clients with dementia have daily episodes of troubling behaviours, such as wandering or being physically or verbally abusive or resisting care. Over half of primary carers and caring family and friends report that the stress of caring for someone with dementia is overwhelming.⁴³

As the baby boomers age we can expect this proportion to increase. 18% of homecare clients with dementia and cognitive performance issues receive full time care from family or friends (more than 40 hours per week), compared to only 4% of clients without dementia.⁴⁴

Parkinson's Disease

The prevalence of Parkinson's Disease in New Zealand is expected to double over a 25-year period, to 17,500 by 2035. It is predicted to increase at a slower rate to 24,000 by 2068, due to the drop-off in prevalence and incidence in the oldest old.⁴⁵

1.3.20 Experience of chronic pain

35% of adults aged 75 years and over experience chronic pain. Rates of chronic pain have increased in all groups aged 55 years and over since 2006/07.

Rates of chronic pain are highest in Māori (23%) and European/Other (22%) adults, intermediate in Pacific adults (14%) and lowest in Asian adults (11%). After adjusting for age and sex differences, Asian adults were less likely to experience chronic pain than non-Asian adults.

Chronic pain affected 23% of adults living in the most deprived areas, compared with 17% of adults living in the least deprived areas. After adjusting for age, sex and ethnic differences, adults living in the most socioeconomically deprived areas were 1.7 times more likely to experience chronic pain than adults living in the least deprived areas.⁴⁶

1.3.21 Arthritis

Half of adults aged 75 years and over live with arthritis⁴⁷

The figure on the following page (Figure 1.3) from the Access Economics report on the Economic cost of arthritis of Arthritis Cost of New Zealand shows the raw prevalence rates for osteoarthritis (i.e. across all age groups) are lower in Māori than non-Māori men and women. This is due to the younger age distribution of Māori people. Rates for rheumatoid arthritis are broadly similar by gender across ethnic groups, while 'other' arthritis is higher in Māori men but lower in Māori women relative to non-Māori people. This may be due in part to gout, where known risk factors are ethnicity and male gender. Māori men had an increased prevalence of arthritis, after adjusting for age, compared to men overall. Pacific women and Asian men and women had a significantly lower prevalence of arthritis than overall. European/other women had a slightly higher prevalence of arthritis, mostly due to an increased prevalence of osteoarthritis⁴⁸

⁴³ interRAI Annual report 2016/17, page 13

⁴⁴ interRAI Annual Report 2016/17, page 18

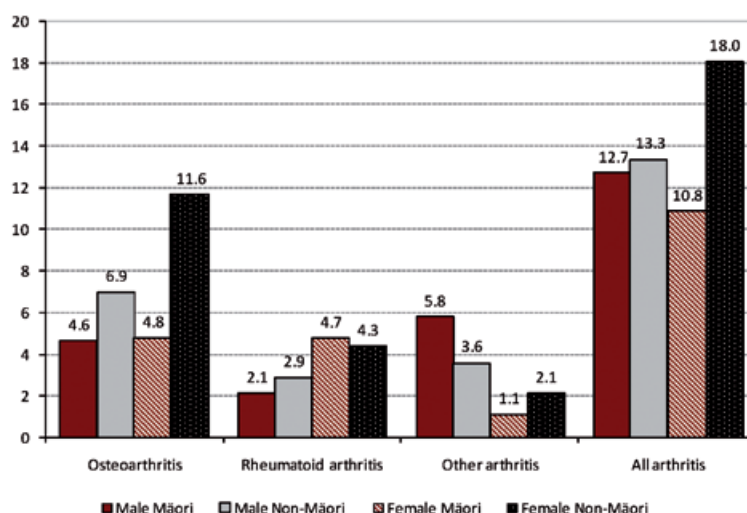
⁴⁵ Myall, D.J., Pitcher, T.L., Pearson, J.F., Dalrymple-Alford, J.C., Anderson, T.J., MacAskill, M.R. (2017). Parkinson's in the oldest old: Impact on estimates of future disease burden. *Parkinsonism and Related Disorders*. 10.1016/j.parkreldis.2017.06.018

⁴⁶ New Zealand Health Survey, Annual Data Explorer, December 2017

⁴⁷ Ministry of Health. 2017. Annual Data Explorer 2016/17: New Zealand Health Survey [Data File]. URL: <https://minhealthnz.shinyapps.io/nz-health-survey-2016-17-annual-update>

⁴⁸ Access Economics, The economic cost of arthritis in New Zealand in 2010 13 April 2010, page 8.

Figure 1.3 : Raw prevalence rates (%) by type of arthritis, New Zealand 2010



That report also comments that:

"Due to the expected demographic ageing of the New Zealand population over the next ten years, the number of people with arthritis will increase further, as more people move into the older age cohorts where arthritis is more prevalent. By 2020 around 650,333 New Zealanders will have arthritis. This is equivalent to 16.9% of the population, which is an increase of around 1.6 percentage points from the 15.2% in 2010. By 2050, the number of New Zealanders with arthritis will rise to around 780,000."⁴⁹

1.4 Functional decline

1.4.1 Improvement in functions

The LiLAC Study on 'Intervals of Care Need' stated that:

"International trends in dependency suggest that more recent cohorts of older people generally appear to have better levels of function than earlier cohorts. It seems clear that with resource-intensive physical activity interventions, there is a potential for recovery in function over time even in advanced age."⁵⁰

The LiLAC study looked at change in functional status over time:

- Most participants maintained function from one year to the next.
- Around 60% declined in function (more likely to be non-Māori men).
- Improved function was not at all uncommon (15%-18%).

The study found that Māori and women were more likely to stay the same or improve between waves of the study. Participants with low function in Wave 1 were more likely to have died by Wave 4. Mortality was also predicted by older age, being Māori or being male but, not predicted by socioeconomic deprivation. Neither physical nor mental HRQOL (Health Related Quality of Life) decreased as functional status decreased. More than 1/3 of people had fallen in the last 12 months.⁵¹

⁴⁹ Access Economics, The Economic Cost of Arthritis in New Zealand in 2010, page 11

⁵⁰ Intervals of care need: need for care and support in advanced age, LiLACS NZ, University of Auckland, page 19

⁵¹ Health, Independence and Caregiving in Advanced Age Findings from LiLACS NZ, University of Auckland, 16

1.4.2 Instability and risk of hospitalisation

Home Care assessed clients are more likely to experience less stable health than their LTCF counterparts (CHESS score) and there is high variation around DHBs. Less stable health is an indicator of potential entry to aged residential care, but can also flag an opportunity for intervention.⁵²

1.4.3 Poor quality of life for longer

Whilst people are living for longer and are experiencing some increases in life quality in some areas, the evidence shows that they are likely to need support over a longer period. Between 1996 and 2013, independent life expectancy increased in an absolute sense for all groups apart from Māori males. In relative terms, all groups experienced a decrease, that is, the proportion of years they lived independently relative to their life expectancy was lower than it was for their counterparts in 1996. A 2013 MoH report on Independent Life Expectancy states that :

"Today people are living longer, but spend more time in dependent health states. The ageing population structure is likely to influence this finding: with a higher proportion of older people in the population, the proportion of people with functional limitations is likely to be correspondingly higher."

As life expectancy increased faster than Independent Life Expectancy (ILE) between 1996 and 2013, the proportion of years lived independently decreased for all groups, indicating that morbidity is expanding in relative terms. ILE is not keeping pace with life expectancy and the proportion of life spent in 'good' health is decreasing"⁵³

1.4.4

Over the last 25 years, health loss from coronary heart disease has halved and stroke rates are down 23%. People who have had strokes are living longer than they did 25 years ago.⁵⁴

1.4.5 Older people dying at home

Due to the ageing demographic, we can expect an increased proportion of clients requiring palliative care due to cancer or some other condition. MoH data shows that 22.3 % of all deaths occur at home and 28.2% of those who die from cancer die at home. Other major causes of death at home include CPD, heart attacks, stroke infections and accidents (e.g. falls)⁵⁵

Currently hospital and private residence are the most common places for male deaths, and residential care is the most common place for female deaths. This supports the theory that men are dying earlier with spousal and hospice support, whereas women do not have as much support and tend to move into residential care where they die. Again, MoH data shows that 41% of women die at home, compared to 60% of men⁵⁵, and that Māori, Pacific and Asian groups (for those over 85) are more likely to die at home.⁵⁶

⁵² National interRAI Data Analysis Annual Report 2015/16, page 41

⁵³ Ministry of Health. 2015. *Independent Life Expectancy in New Zealand 2013*, p.vi

⁵⁴ MoH, Briefing to Incoming Minister, December 2017

⁵⁵ Deaths in New Zealand: Place of Death 2000-2010, Palliative Care Council of NZ, 2014 (MoH Data)

⁵⁶ Deaths in New Zealand

1.4.6 Older people using multiple medications, Drug Burden

Cumulative exposure to medications in older adults has been shown to impact on their physical and cognitive function. A 'Drug Burden Index' (DBI) has been developed to measure this exposure. Recent research Jamieson, Nishtala et al has matched the DBI against variables of home care clients (from interRAI assessments). The DBI was found to be independently and positively associated with a greater risk of falls in this cohort, and there was a dose-response relationship between DBI levels and falls risk.⁵⁷

Some combinations of medications are seen to have potentially much greater risk factors for falls, kidney injury and renal failure, especially for older adults. In its 2017 domain update the Health Quality and Safety Commission noted the frequency of prescription relating to specific combinations of drugs, noting that Medsafe recommends avoiding the combined prescription of angiotensin converting enzyme (ACE) inhibitor/ angiotensin receptor blocker (ARB), a diuretic and a non-steroidal anti-inflammatory drug (NSAID). It also cautioned about a combination of drugs is that of benzodiazepine or zopiclone and a strong opioid following a public hospital event. The combination of a benzodiazepine or zopiclone and a strong opioid carries an increased risk of over-sedation. It noted that around 4,000 older people were dispensed the combination of a benzodiazepine or zopiclone and a strong opioid following a public hospital event in 2016. It noted that "the rate increased significantly with age, from 0.35 percent of those aged 65 – 74 years up to 1.6 percent in the 85 and over age group."⁵⁸ Age related changes to drug effects are well documented.⁵⁹

1.4.7 Mental health

Bipolar Disease (BD) among older adults is not uncommon, and numbers will increase as the population ages. In a 2017 cross-sectional study of 71,859 homecare recipients, 1.1% (n=798) older people had a BD diagnosis. Participants' sex, age and ethnic identification were significantly related to BD. Participants with a higher number of comorbidities had greater odds of BD. Almost all considered social and environmental variables were significantly and detrimentally associated with BD, such as living in squalid conditions. The report writers concluded that "*clinicians and decision-makers need to be aware in their planning and service delivery that significant deficits in environment quality and exposure to stressful living circumstances remain for older adults with BD*".⁶⁰

1.5 Effectiveness of support services for older people

In the LiLAC study 31% of people received informal support (unfunded help or assistance), and 49% of people received formal support (home help and personal care)⁶¹.

The LiLAC study showed that support services seem to protect and maintain physical Health Related Quality of Life (HRQOL). The figure from that study copied below shows that participants receiving support services maintained physical HRQOL whereas physical HRQOL significantly declined for those not receiving services. The study indicated that mental HRQOL was similar for those older people who received home support services and those who did not.⁶²

⁵⁷ Jamieson, H. A., Nishtala, P. S., Scrase, R., Deely, J. M., Abey-Nesbit, R., Connolly, M. J., ... Schluter, P. J. (2017). Drug burden and its association with falls among older adults in New Zealand: A national population cross-sectional study. *Drugs & Aging*. Advance online publication. doi: 10.1007/s40266-017-0511-5

⁵⁸ <https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/polypharmacy/>

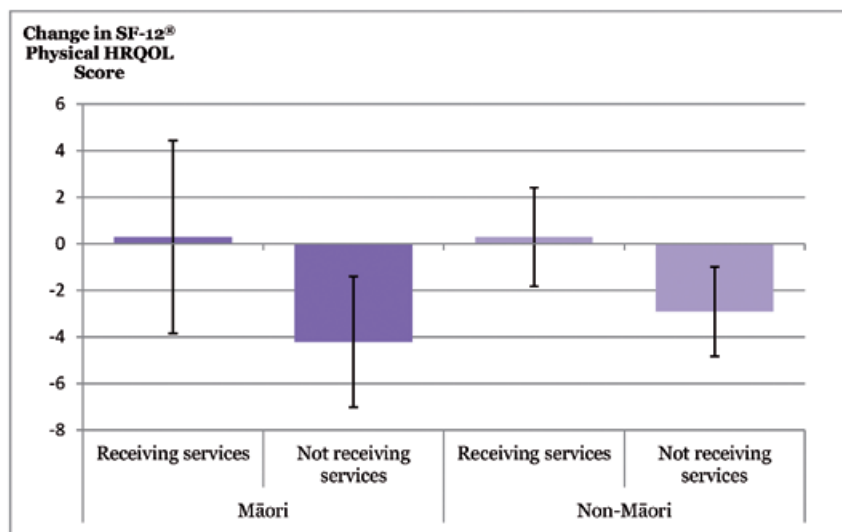
⁵⁹ POLYPHARMACY, BPAC, 2006

⁶⁰ Schluter, P. J., Lacey, C., Porter, R. J., & Jamieson, H. A. (2017). An epidemiological profile of bipolar disorder among older adults with complex needs: A national cross-sectional study. *Bipolar Disorders*. Advance online publication. doi: 10.1111/bdi.12511

⁶¹ Health, Independence and Caregiving in Advanced Age Findings from LiLACS NZ, University of Auckland, page 64

⁶² Health, Independence and Caregiving in Advanced Age Findings from LiLACS NZ, University of Auckland, page 64

Figure 3-6 : Change in physical HRQOL by receiving services & ethnic group, Waves 1 to 4



Source: LiLACS NZ

1.5.1 Combining informal and support services.

The figure above has been copied from that study. The study showed that a combination of informal care and support services has a significant effect.

“Over time the physical HRQOL score of those who received support services and informal care significantly increased (by 4.2 points) compared with those who received only support services (score decreased by 0.5)... In contrast, the physical HRQOL score for those who did not receive services significantly decreased over time, regardless of whether they also received informal care)”⁶³.

1.6 Other relevant factors for older people

Regional differences. Many regions of New Zealand have experienced a reduction in birth rates, with proportional increase in the older population. We have seen some regional decline and there are predictions that over the next two decades we will see one Territorial Authority after another reach the end of growth and, in most cases, shrink in size with a change in proportional representation of older people.⁶⁴ For example by 2028, over a quarter of Nelson’s population will be 65 years or older and by 2043, older people will contribute a third of the Nelson population.⁶⁵ This will also impact upon workforce availability.

1.6.1

Information on falls and injuries for older people, including pressure injuries is provided in the next section.

⁶³ Health, Independence and Caregiving in Advanced Age Findings from LiLACS NZ, University of Auckland, page 64

⁶⁴ Jackson, N ‘Aging populations and regional decline’ 13.12.2015

⁶⁵ Nelson City Council. (2017). Nelson’s Ageing Population A background paper on Nelson’s demographic trends and on characteristics of the population aged 65 years and over, to better understand the implications for Nelson of an ageing population. Retrieved from: <http://nelson.govt.nz/assets/Our-council/Downloads/population-demographics/2017/Ageing-Population-Nelsons-Older-Population-Summary-of-Research-Feb2017-A1602240.pdf>

1.7 Gaps in knowledge

The number of older people receiving support is not well counted at a national level.

1.7.1 Irregular assessments and uneven allocation of supports

There is considerable variation across New Zealand in terms of the frequency of interRAI assessments for people living at home with support, and also variation in where the assessments take place (hospital, home).⁶⁶ This makes it very difficult to compare and monitor the health or support outcomes of older people receiving home support at a regional or national level. There also appears to be considerable variation in the level of support allocated according to need from one area in New Zealand to another. This results in inequitable access to services. It also reduces the ability to make comparisons across DHBS, and make national plans and policies.

1.7.2 Socio-economic and housing status

There is little information available on the socio-economic status of older people receiving home support services compared to the general population and to those living in aged-residential care or supported living in retirement villages. There is no information available about how many home support clients are living in homes that they own, and how many are living in rental accommodation. There is some association between health and tenure. Poorer health and socioeconomic status of public renters has implications for their likely need of future residential care.⁶⁷ We need more information about the impact of housing options and future availability on older people's health.

There is little information available about the comparative socio-economic status of older people needing higher levels of support. There is a policy question about whether there will be sufficient residential supports available for poorer people in future.

1.7.3 Under 65 chronic conditions support

We could not find any information available on those under 65 who are being provided with support via the DHBs as a result of chronic conditions. Because of the structural ageing, it can be expected that demand on these services will also grow. More data gathering and a national approach is needed.

1.7.4 The incidence of sepsis

The incidence of sepsis in community settings is not well known.

⁶⁶ National interRAI Data Analysis Annual Report 2015/16

⁶⁷ J. Cumming et al., *Tenure and health: early findings, Power-point presentation*. Victoria University of Wellington.

2.0 Injured citizens including older citizens

2.1. Current fall injuries, older people

Fall injuries for people over 65 currently account for around 18% of all active ACC claims, so as the population ages we can expect more falls and more rehabilitation needs. Of people aged 85 and over, 26 percent had at least one ACC claim due to a fall in 2015.⁶⁸ 8.7 percent people aged 85 and over were admitted to hospital as a result of a fall in 2015 with the average length of stay being 14 nights. The top injuries for older people were arms, knees, hips, spine and lower leg. Those aged 80+ are more likely to have injury to arms and hip.⁶⁹ More than 1/3 of the participants in the LiLAC study had fallen in the last 12 months.⁷⁰

The University of Otago injury prevention research Centre database can be used to generate the numbers of falls relating in use of hospital services for New Zealanders aged 80 years and over, and for those 65-79 years.⁷¹

2012 to 2016 New Zealand Public Hospital Injury Discharges, Fall, Unintentional intent, both genders, 80 year olds and over, all NZ

| Gender | Number of Discharges | Rate / 100,000 people |
|--------------|----------------------|-----------------------|
| Females | 27,451 | 5,756.4 |
| Males | 11,177 | 3,434.7 |
| TOTAL | 38,628 | 4,814.7 |

Table: reported falls, from interRAI assessments⁷²

| | 65-74 years | | 75-84 years | | 85-94 years | | 95+ years | |
|--------------------------------|-------------|--------|-------------|--------|-------------|--------|-----------|--------|
| | n | (%) | n | (%) | n | (%) | n | (%) |
| Falls^a | | | | | | | | |
| No fall in last 90 days | 4,757 | (64.1) | 11,127 | (60.6) | 10,102 | (56.3) | 805 | (47.7) |
| Last fell 31-90 days ago | 674 | (9.1) | 2,016 | (11.0) | 2,081 | (11.6) | 212 | (12.6) |
| One fall in last 30 days | 1,028 | (13.9) | 2,989 | (16.3) | 3,496 | (19.5) | 409 | (24.2) |
| Two plus falls in last 30 days | 962 | (13.0) | 2,219 | (12.1) | 2,277 | (12.7) | 261 | (15.5) |

⁶⁸ <https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/falls/>

⁶⁹ ACC Falling Injuries Overview 2012-2013 Data Analysis (HCHA OIA data analysis request, Job No. 826, 3/12/2013)

⁷⁰ Intervals of care need: need for care and support in advanced age, LILACS NZ, University of Auckland

⁷¹ University of Otago, Injury Prevention research Centre Database

⁷² Schluter, P. J., Lacey, C., Porter, R. J., & Jamieson, H. A. (2017). An epidemiological profile of bipolar disorder among older adults with complex needs: A national cross-sectional study. *Bipolar Disorders*. Advance online publication. doi: 10.1111/bdi.12511

2.2 Hip fractures

For every hip fracture in a public hospital, there are approximately 30 hip fractures in the community.⁷³ Only half of those who survive a hip fracture will walk unaided again, and many will not regain their former degree of mobility. Between 10 and 20 % will be admitted to residential care, 60% will require assistance with activities of daily living a year after the event, and 27% will die within a year of their hip fracture. More than 3,640 people over 50 presented to New Zealand hospitals with a hip fracture in 2014 (an 8% increase from 2013), directly costing the system approximately \$171 million (dollars). A hip fracture resulting in three weeks in hospital costs \$47,000 (on average), and or whereas a hip fracture with complications, followed by discharge to an aged residential care facility costs \$135,000.⁷⁴

2.3 Pressure injuries

It is estimated that there are around 4,655 instances of Pressure Injuries (PI) in the home support sector each year.⁷⁵

Table 1: Estimated Incidence of PI by Grade & Setting

| Type | DHB Hospitals | Home Care (HC) | Residential Aged Care | Total |
|--------------|---------------|----------------|-----------------------|---------------|
| Grade 1 | 36,217 | 3,009 | 1,372 | 40,597 |
| Grade 2 | 8,843 | 1,241 | 994 | 11,078 |
| Grade 3 | 1,987 | 265 | 195 | 2,448 |
| Grade 4 | 346 | 140 | 101 | 587 |
| Total | 47,393 | 4,655 | 2,662 | 54,710 |

The effects of PI include constant pain, loss of function and mobility, depression, distress and anxiety, embarrassment and social isolation, increased financial burdens, prolonged hospital stays and septicaemia, or even death.

PI are more common in people with reduced mobility, such as older people, or those confined to a bed or chair. While PI are often associated with older people, they are also common in neonates, people who have undergone surgery, or the disabled.

Consultation with stakeholders has found that:

- there is insufficient emphasis of PI throughout the New Zealand health system
- Line staff responsible for caring for PI are not authorised to make prevention decisions.
- The impacts of PI on a patient's quality of life are not often observed by the healthcare worker whose actions or inactions caused them.
- Family and whanau involvement in patient care is not utilised to assist in providing basic preventative measures.

⁷³ S. Jones et al., Reducing harm from falls, New Zealand Medical Journal, vol. 129, 2016, p..... or, Vol 129, No. 1446

⁷⁴ Reported in Reducing Harm from Falls. Jones, S, Blake S, Hamblin R, Petagna C, Shuker C, Merry A, NZMJ, 2.12.2016, Vol 129, No. 1446

⁷⁵ KPMG, The case for investment in: A quality improvement programme to reduce pressure injuries in New Zealand, 19.11.15

PI are predominantly seen as a nursing problem due to nurses often being involved in both the prevention and treatment phase. This has two effects, firstly it removes the responsibility of PI from management and other professionals involved in the care process such as families, doctors, and care givers; and secondly, within nursing, it has encouraged prevention of PI to become the domain of the wound care specialist or tissue viability specialist. Consequently, this provides the opportunity to shift responsibility for both prevention and care away from the front line of care⁷⁶

2.4 People living with serious injury

Approximately \$394 million spent on 4,230 active working age serious injury clients (as at 30 June 2015). Around 2,700 clients receive attendant care payments, around 2,700 receive income support.⁷⁷

Supplementary information. We have asked ACC to provide more detailed information on client numbers and geographical spread. They have offered to provide this after their service review is published on GETS (in the near future but post the deadline for this report). We will then provide a supplementary report.

2.5 The ageing of people with spinal cord injury

A study reported in the New Zealand Medical Journal in 2016 states that people with spinal cord injury are living longer. Approximately 80–130 people are diagnosed with a SCI in New Zealand each year, with an estimated incidence rate ranging from around 30 per million, to 49.1 per million people. The report writers note that, from the information available:

*"marked gender and ethnic differences, with estimated age-standardised incidence rates for males (71.9 per million) significantly higher than for females (26.0 per million), while Māori (46 per million) and Pacific (70 per million) people have significantly higher incidence rates than people of European origin (29 per million). Males aged between 15 and 29 years account for nearly half of all newly acquired SCIs, with motor vehicle accidents (54%), followed by falls (24%), the leading causes of these injuries."*⁷⁸

The study reports that in recent years life expectancy, mortality, and morbidity have changed dramatically for the majority of people with SCI. However it also notes that people with SCI live and age in ways that differ from their able-bodied counterparts.

*"Once regarded as a relatively stable condition, SCI is now seen as dynamic and changeable over time. People living and ageing with SCI, depending on the age that the initial injury occurred, seem to have a period of relative stability post injury of 20 or so years before they develop a variety of physical secondary conditions (eg, shoulder pain, stenosis, musculoskeletal deterioration). These secondary conditions are often associated with medical complications which can seriously compromise a person's lifestyle and even be life threatening."*⁷⁹

⁷⁶ KPMG, The case for investment in: A quality improvement programme to reduce pressure injuries in New Zealand, 19.11.15

⁷⁷ 'What do we know about people receiving MoH Disability Support Services?' recorded on <https://www.odi.govt.nz/assets/Whats...files/2016-12-13-A3-disability-forum.pptx>

⁷⁸ Richard Smaill, Philip J Schluter, Pauline Barnett, Sally Keeling, NZMJ, 15th July 2016, Volume 129 Number 1438

⁷⁹ Richard Smaill, Philip J Schluter, Pauline Barnett, Sally Keeling, NZMJ, 15th July 2016, Volume 129 Number 1438

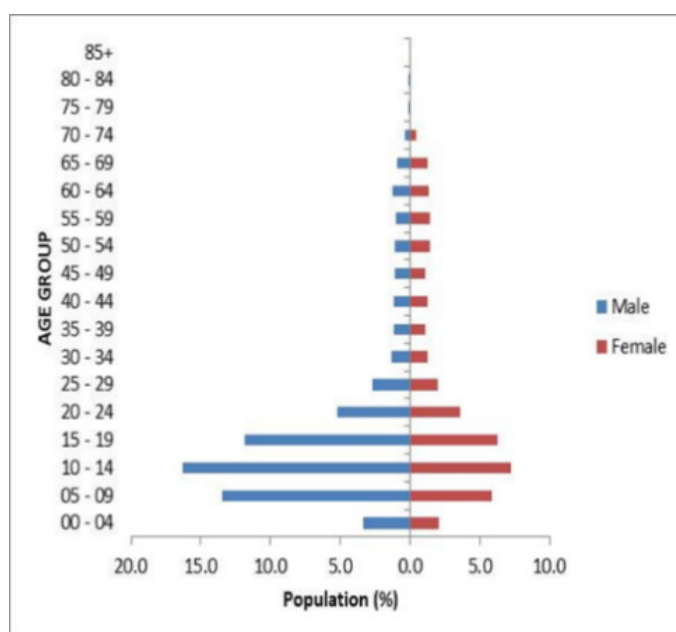
3.0 People living with disabilities

3.1 Numbers, gender, ethnicity

There are approximately 7,900 disabled people under 65 who are receiving contracted home and community support services. A further 2,477 people are receiving Individualised funding and 399 are receiving Enhanced Individualised Funding (399) of which some of these will be utilising home and community support services in some form.⁸⁰

Increasing demand (hours of support). Between 2011/12 and 2015/16, there was a 4.4 percent increase in the number of disabled people receiving community care services, and a 14 percent increase in the average hours of support disabled people received (from 21.8 to 24.9 hours per week).⁸¹

Based on 2013 data 54% are female, and there are two peaks of age distribution for HCSS services: teenagers and 55-69 year olds. The teenage peak is predominantly male, and the 55-69 peak is predominantly female.⁸²



The ethnicity of disabled people receiving HCSS services is - 70% European/Other, 15% Maori, 7% Pacific and 5% Asian. The geographical spread by ethnicity is shown in the table following (as at 2013).

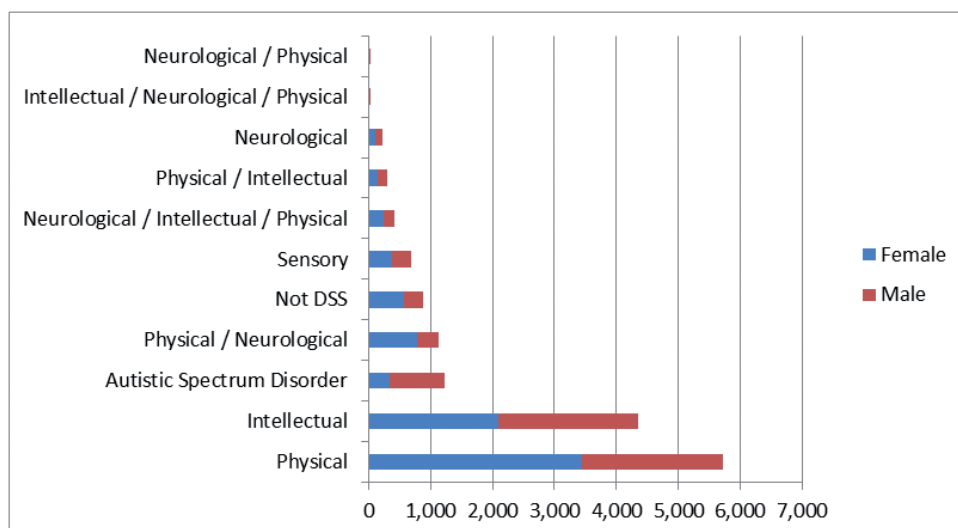
⁸⁰ MoH Information provision, December 2017

⁸¹ MoH, Briefing to Incoming Minister, December 2017

⁸² MOH DSS Client Demographics Report September 2013

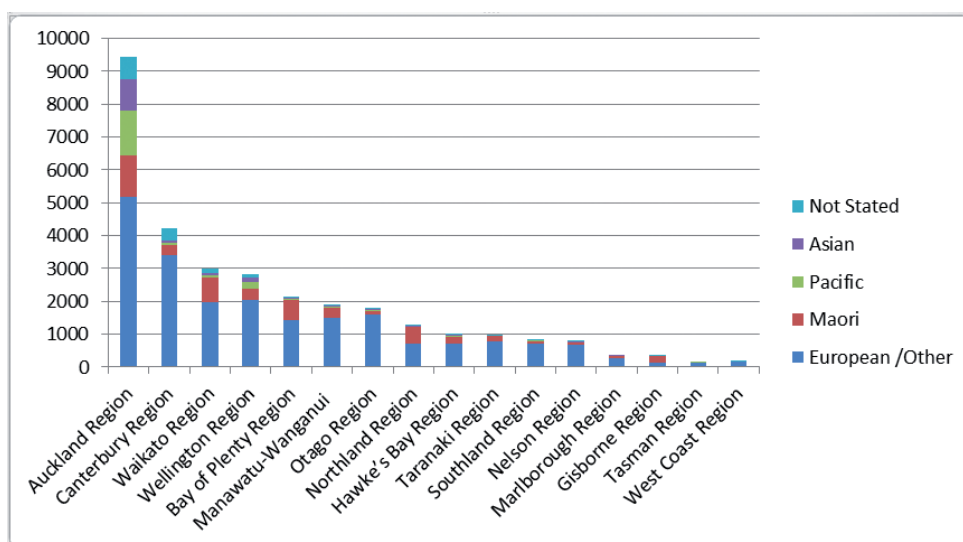
3.2 Principal disability type

HCSS services provide considerable support to people living with both physical and intellectual disabilities. There is not a great deal of data available on the types of physical and intellectual disabilities that comprise the majority of client lived experience.



Distinguishing and/or grouping disabled people by their disability may be seen as negative and stereotyping. In addition, whilst disabled people want to receive support from people who are competent, some are seeking other aptitudes. The transformation towards more choice and control by consumers over service delivery is likely to result in significant changes to the types of support being sought.

3.3 Geographic location of HCSS DSS clients, also by ethnicity



3.4 Other information on disabled people

From the Office for Disability Issues 2016 report on the 2013 census:

- Disabled people are less likely to be employed compared to non-disabled people.
- Disabled people are less likely to have educational qualifications compared to non-disabled people.
- Disabled people are more likely to be represented in low income groups compared to non-disabled people.
- Disabled people are less likely to feel healthy compared to non-disabled people.⁸³

3.5 Change

Disability Support Services is on the journey towards substantial transformation, which will affect numbers being supported and workforce competencies. This is reported on in more detail in Background Paper Two.

⁸³ Office for Disability Issues, 2016 report on 2013 census

4.0 People living with mental health and addiction challenges

Some HCSS providers are contracted to provide specific services for people living with either mental health and/or addiction challenges. For all other providers, the people they support include people who live with mental illness and/or addictions who may not necessarily be receiving support from a specialist mental health and addiction service. This makes it important for staff to understand the impact of mental illness and addictions, and how to support clients who experience these conditions.

A mental health and addictions epidemiological study (2006)⁸⁴ listed the lifetime prevalence of MH&A disorder by age group as follows:

41.6% - people aged 16-24

45.1% - people aged 25-44 years

39.7% - people aged 45-64

22.4% - people aged 65 and over

The same study provided information about the extent of physical disorder and mental disorder comorbidity in the general population. Overall, two-thirds of people with a mental disorder also had at least one of the chronic physical conditions that were investigated in the survey, compared with just over half of the population without mental disorders.

The survey results also confirmed that people with chronic physical conditions had a higher prevalence of mental disorder compared with people who did not have a physical condition.

Mental disorders and chronic physical disorders were generally associated with similar degrees of disability, but the combination of both types of disorder was far more disabling than either disorder on its own.

Similarly, more recent research (2017)⁸⁵ has identified a significant gap in mortality between people with severe mental illness and the general population. People using mental health services had more than twice the mortality rate of the general population, people with a primary substance use diagnosis had two and half times the mortality rate and people with a psychotic disorder had three times the general population mortality rate. Similar to the findings from the international literature, the majority of deaths were due to treatable physical illnesses, with cancer and cardiovascular disease accounting for the most deaths.

⁸⁴ Te Rau Hinengaro: The New Zealand Mental Health Survey. Retrieved from: <https://www.health.govt.nz/system/files/documents/publications/mental-health-survey.pdf> p.62e

⁸⁵ Cunningham et al.,(2014). Premature mortality in adults using New Zealand Psychiatric Services. *New Zealand Medical Journal*, 127 (1394), 31-41.

Background paper ^{two}:

Summary of impacts of current and emerging legislation and legal challenges, funding pressures, commissioning/contract changes, strategies and technology developments, through the lens of workforce planning and development, April 2018

Contents:

1. Potential implications of impacts
2. Industrial relations, legislation and legal challenges
3. Health, Disability and ACC funding pressures
4. Emerging commissioning/contract approaches and barriers to change:

| | |
|---------------------------|--------------------------------------|
| Casemix | Broadening and narrowing of services |
| Consumer directed care | Assessments by providers |
| Fee for service | Provider reduction |
| Whānau Ora | ACC integration, casemix, choice |
| Disability transformation | Cross departmental work |
5. Strategies & plans most relevant to HCSS workforce development:

| | |
|---------------------------------|--|
| Health Strategy | Healthy Ageing Strategy |
| He Korowai Oranga | 'Ala Mo'ui |
| NZ Disability Strategy | Kaiāwhina Workforce Action Plan |
| ACC Health Services Strategy | Primary Health Care Initiatives |
| Traumatic Brain Injury Strategy | Te Ara Whakapiri and the Palliative Care Action plan |
| HCSS Medication Guidelines | |
6. Technology changes

Disclaimer: *There are limited sources of information on the home and community support workforce. HCHA has based this background paper on information received or obtained, on the basis that such information is accurate and complete. For the most part we are reliant on information and data gathered by others. The information contained in this report has not been reviewed.*

1. Potential implications of impacts on workforce development

Industrial relations, legal challenges

- Providers may need to grow capacity, within available funding, to support staff training.
- Providers may need to keep monitoring qualification levels proportionate to client need and funding available to remain sustainable and to be legally compliant. Some providers will mature some of their workforce performance and management processes.
- Some funders may prescribe qualification levels through contracts.
- Some providers will broaden their options in relation to staff training and qualification attainment, at recruitment and for training support.
- Providers may experience a more diverse range of employment situations.

Cost pressures on funding streams

- Funders operating in the context of debt and rising demand, may seek further cost efficiencies from service reviews or continue prioritising funding to provider arm services. Since support worker wages are legally prescribed this may force providers to find further efficiencies from training, quality and HR support.

Emerging commissioning/contract approaches

- Further application of casemix, bulk, funding, rehabilitative and restorative care would generate more work at the complex personal care level, and would also drive training, recruitment and performance practices that ensure staff are competent to support and encourage wellbeing and client independence.
- Increased integration of services and in places broadening of services will demand a range of increased skills, competencies and attributes for support workers.
- Increased emphasis on consumer choice may change the skills needed to work with clients who are more 'in charge'. This will apply first in the disability sector, but will also emerge in health of older people and ACC services.

Strategies

- There are higher expectations of the role and value of kaiāwhina/support workers and HCSS Services. Strategies envisage more integrated services; closer alignment to client needs and to the aspirations of communities such as iwi and those living with disabilities. Strategies also aims for services that are more connected in their focus on equity, health outcomes and efficiency, and that take a life course approach to health and wellbeing. Strategies also aim for more responsive services that may demand both bespoke and 'just in time' training and workforce development approaches.

Technology changes

- Providers may to include digital literacy in recruitment, training and performance processes.

2. Industrial relations, legislation and case law

2.1 Pay equity

- The wage increases that form the pay equity settlement have lifted the value of the home support workforce. This is very positive for the workers and their families. The full value impacts will take some time to be realised.
- There is some expectation, and anecdotal accounts, that the wage increases will make the home support sector more competitive with other sectors and more attractive to current staff and to new entrants. There is potential for workforce shortages to be partly met. It is also positively impacting in terms of a reduction in turnover. Providers also report that many older staff have chosen to reduce their working hours as a result of an overall increase in their take home pay. A substantial number of current employees are nearing retirement.
- Providers are anticipating a change in the workforce over time which will enable an increase in productivity, and potentially in quality and breadth of service provision. Providers expect the pay equity impacts to drive higher personal expectations of staff. Whilst the core work of personal care and household management will remain, additional competencies can be expected to:
 - enhance this work in terms of the range of skills that the support worker takes into any support visit;
 - result in tensions where there is not enough challenging work to meet staff expectations.
- It can be expected that the pay equity legislative requirements will over the next several years drive changes in human resource management: recruitment practices, training development policies and processes, performance review and performance management; and in relationships with staff and with unions or other staff representation.
- Wage movement on qualifications equivalency has resulted in higher numbers of staff progressing to higher pay equity wage steps than anticipated in the pay equity funding models. This is likely to put tension on funding available for wages. Funding flows for outyears are not yet assured and there remain unmet costs, both historical and ongoing. Providers have had to match wages for coordinators to maintain immediate relativities, and have faced other unmet costs such as annual leave accrual, oncosts and the increased cost of unfunded guaranteed hours. They are also concerned that their training costs over time will increase above sustainability levels.
- Providers consider that current staff have reduced incentive for staff to sit higher level qualifications when they have progressed to those levels on the basis of tenure or a qualification that has been deemed equivalent but does not result in specific required competencies to meet client need. This is a particular challenge at the more complex levels of care, where staff usually need specific training, such as brain injury, spinal injury and complex disability support.
- Many providers have noted that they do not need substantial numbers of staff at Level four, but those who they do need above Level 3 need specific training/competencies.
- One commissioning agency has introduced a contractual expectation of training for all support staff to Level 2 in contracts. We may see this reflected in other contracts.

2.2 In-Between Travel

In-Between Travel has increased incentives for staff to travel between visits, though pay equity has reduced the value of that incentive because the payment gap between working and travelling has widened. Overall one can expect some positive impact on recruitment, though finding staff in more remote environments will remain a problem.

2.3 Guaranteed hours

The implementation of Guaranteed hours for all staff from 1 April 2017 has generated the largest human resources change ever to occur in the home support sector.

MoH contracted with Sapere to review the implementation of guaranteed hours. Its report is not publicly available, however early results are indicating:

- Around 85% of support workers are on guaranteed hours, with the mean being 36 hours per fortnight;
- There is substantial variability in unfilled hours between workers and providers with causes including geography, client demand, features of specific contracts or clients;
- Providers have had to substantially resource this endeavour, in the areas of coordination, payroll, project management, IT development, management, legal support, backfill support, wage relativity, and report/data provision. This equates to millions across the sector.
- Providers have noted the negative impact of the implementation of guaranteed hours on some clients: client choice now needs to be balanced against staff availability, and the funding available to support reduction in hours.
- The implementation of guaranteed hours also appears to be driving higher travel costs due to the requirement on providers to find alternative work when there are client cancellations.
- The implementation of guaranteed hours is not yet business as usual. It is changing the human resource environment for providers. It has required substantial upskilling and resourcing of human resource activity, payroll and Information technology. It requires more financial risk around reduction in hours and offers of guaranteed hours. It requires careful monitoring of the workloads and rosters of both casual and part time permanent staff to ensure employers are legally and contractually compliant.

2.4 In-Between Travel Time Settlement Agreement

For providers there remain outstanding elements from the IBTT Settlement, not least the agreed funding for training, as part of the regularisation of the workforce. There are also recommendations from the Director General's Reference Group report that remain unaddressed, including more national consistency in funding; the use of evidence-based costing models; closer matching of competency to client need, and the removal of barriers to regularisation.

2.5 Further employment legislation and regulatory challenges

- At the time of this report an Employment Relations Amendment Bill is moving through Parliament. This will affect the home support sector in relation to some financial elements such as meal breaks and tea breaks, and also in relation to collective and multi-employer collective agreements. It will also increase the coverage of the 'vulnerable workers' section of the Act (Part 6A) to include all employers.
- The Government has indicated its intention to lift the minimum wage to \$20 by 2021. This will have an impact upon Schedule 2 of the Care and Support worker legislation, which will then require further adjustments upwards to support worker wages. This may generate tension at that time, or this year depending on how pay equity cost pressure funding for 2017/18 and outyears flow or do not flow to providers.
- The government has indicated that it intends to create a framework for 'Fair Pay Agreements' which is likely to result in required industry standards.
- Fair pay agreements may encompass a broader range of 'work' relationships other than the current narrow employee-employer (eg contracting arrangements). This may affect independent contractor arrangements now emerging in some areas.
- The Government also intends to pass Equal pay legislation that will set out a process for Equal pay claims. Employers can expect to have claims from nurses.

2.6 Health and Safety legislation. Safety of employees.

- The Health and Safety at Work Act sets out the principles, duties and rights in relation to workplace health and safety. HSWA recognises that a well-functioning health and safety system relies on participation, leadership, and accountability by government, business and workers.
- Businesses have the primary responsibility for the health and safety of their workers and any other workers they influence or direct. They are also responsible for the health and safety of people at risk from the work of their business.
- Contracting agencies do not have control over the work site but have control over matters such as timelines and contractual arrangements. A contracting agency should not set unrealistic expectations that would encourage cutting corners.
- Workers must take reasonable care for their own health and safety and that their actions don't adversely affect the health and safety of others. They must also follow any reasonable health and safety instruction given to them by the business and cooperate with any reasonable business policy or procedure relating to health and safety in the workplace.
- Other people who come into the workplace, such as customers/clients, also have some health and safety duties to ensure that their actions don't adversely affect the health and safety of others.
- In the home support situation, where a provider (or a client as employer) is contracted by a funder to employ workers to undertake support work in a person's home, there are multiple overlapping responsibilities. Information, governance and management oversight, policies, training, monitoring of practice, record keeping, employee involvement, and response to reported injury are all important elements of maintaining and improving health and safety of employees.

2.7 Legal challenges

- In February 2018 the Court of Appeal upheld an appeal by Chamberlain & Moody who sought more than 11 hours of funding for the support Mrs Moody provides her disabled son. The Court rejected the MoH argument that it can only pay for personal care and household management and not for supervision. The Court reflected that if a service is necessary to maintain the mental and physical health of a person with disabilities in the home environment, then the service is essential, and that can include night-time attendance. The Court directed the Minister of Health to "make appropriate allowance for Mrs Moody's provision of personal care services to meet Shane's immediate intermittent needs as they arise at any hour of the day."¹
- This decision will have implications for funding under Vote Health in relation to family carers who provide essential intermittent care at any hour of the day. Other services that are currently provided free of charge could also be open to challenge on payment liabilities. Those include support for people with age-related disabilities, mental health conditions, chronic health conditions, palliative care, and following discharge from hospital.²

¹ Court of Appeal, CA460/2017 [2018] NZCA Chamberlain, Moody AND Minister of Health, Decision by Harrison, Asher and Brown JJ 7 February 2018

² Cabinet Paper – Implications of the Court of Appeal's decision (28 May 2012)

3. Funding pressures

3.1 DHBs:

As at February 2018, the Ministry of Health is predicting a combined deficit of \$189 million across all DHBs for the year ended 30 June 2018. The targeted budgeted year-end result was \$143 million deficit³

| DHB | Year To Date Result 2017/18 | Unfavourable /favourable to budget- February 2018 | Variance from previous month | 2017/18 Plan Approved | Budgeted Result 2017/18* | Forecast YE Result as at February 2018 |
|------------------------|-----------------------------|---|------------------------------|-----------------------|--------------------------|--|
| Auckland DHB | \$12.711M | (\$0.596M) ● | \$0.292M ● | Yes | Breakeven | Breakeven ● |
| Bay of Plenty DHB | (\$4.567M) | (\$3.275M) ● | \$0.611M ● | Yes | (\$2.739M) | (\$8.870M) ● |
| Canterbury DHB | (\$25.739M) | (\$2.757M) ● | (\$1.845M) ● | No | (\$53.644M) | (\$58.582M) ● |
| Capital & Coast DHB | (\$11.248M) | \$1.911M ● | \$1.665M ● | No | (\$21.000M) | (\$21.000M) ● |
| Counties Manukau DHB | (\$8.581M) | \$0.454M ● | (\$0.154M) ● | No | (\$20.013M) | (\$20.042M) ● |
| Hawke's Bay DHB | (\$2.717M) | (\$1.688M) ● | (\$0.252M) ● | Yes | \$1.500M | (\$0.653M) ● |
| Hutt Valley DHB | (\$3.985M) | (\$1.497M) ● | (0.645M) ● | Yes | (\$2.103M) | (\$5.619M) ● |
| Lakes DHB | (\$0.942M) | (\$0.043M) ● | (0.731M) ● | Yes | (\$3.751M) | (\$3.751M) ● |
| MidCentral DHB | (\$3.410M) | (\$2.021M) ● | (0.273M) ● | Yes | (\$3.796M) | (\$5.374M) ● |
| Nelson Marlborough DHB | \$1.0170M | (\$1.259M) ● | 0.049M ● | Yes | \$3.500M | \$2.500M ● |
| Northland DHB | (\$1.916M) | (\$0.552M) ● | 0.952M ● | Yes | (\$8.403M) | (\$7.075M) ● |
| South Canterbury DHB | \$0.327M | \$0.354M ● | (0.045M) ● | Yes | \$0.011 M | \$0.011M ● |
| Southern DHB | (\$9.710M) | (\$4.919M) ● | (0.520M) ● | No | (\$14.000M) | (\$17.484M) ● |
| Tairāwhiti DHB | (\$3.104M) | (\$3.751M) ● | (0.425M) ● | No | Breakeven | (\$5.505M) ● |
| Taranaki DHB | (\$4.065M) | (\$3.254M) ● | (0.976M) ● | Yes | (\$2.000M) | (\$5.890M) ● |
| Waikato DHB | (\$3.783M) | (\$2.214M) ● | (\$1.338M) ● | No | (\$10.000M) | (\$21.800M) ● |
| Wairarapa DHB | (\$2.805M) | (\$1.044M) ● | (\$0.162M) ● | Yes | (\$3.159M) | (\$4.902M) ● |
| Waitemata DHB | (\$1.991M) | (\$0.556M) ● | \$0.202M ● | Yes | Breakeven | Breakeven ● |
| West Coast DHB | (\$1.252M) | (\$0.093M) ● | (\$0.082M) ● | Yes | (\$2.041M) | (\$2.844M) ● |
| Whanganui DHB | (\$1.379M) | (\$0.520M) ● | (\$0.253M) ● | Yes | (\$1.899M) | (\$2.599M) ● |
| Total | (\$73.156M) | (\$27.284M) | (\$5.152M) | | (\$143.538M) | (\$189.478M) |

| | | | |
|------------|-----------------|--------------------------------|-------------------------------|
| KEY | DHB on target ● | DHB displays possible issues ● | DHB report negative results ● |
|------------|-----------------|--------------------------------|-------------------------------|

The major contributors to DHB debt this year are have been driven from outsourced personnel costs (\$43M) and clinical supplies (\$30M) and infrastructure/other supplies (\$18M).

³ Ministry of Health Memorandum to Minister of Health 28 February 2018: District Health Board Sector Financial Performance for year to date 28 February 2018, Health Sector Report 20180518, page 4.

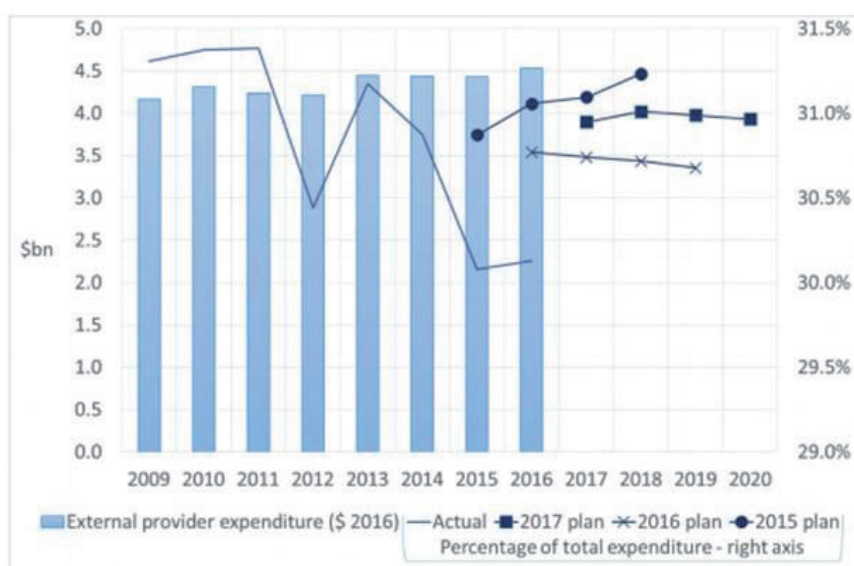
3.2 Provider-arm vs non-provider arm expenditure

In its analysis of District Health Board Financial Performance to 2016 and 2017 Plans February 2017 Treasury noted that:

"DHBs' role as funders of a broad range of health care (primary and community, secondary and tertiary level) should create incentives to fund care at the most cost-effective point in time and minimise cost escalation from delayed treatment. However, in combination with their other role as a health services provider, it raises the structural risk that DHBs prioritise funding for their own provider-arms (hospitals) at the expense of externally provided services (for example primary care). This risk may be particularly apparent when DHBs are under pressure to meet hospital output targets and avoid running deficits. Accordingly we monitor how DHBs split their spending between their provider-arms and external providers. ...and in aggregate DHBs' funding balance has shifted toward their provider arms (hospitals) over time..."

"At an aggregate level DHBs' external provider expenditure has generally been increasing over time in real terms. However, it has been falling slightly as a percentage of total expenditure; and it has been below the planned percentage (figure 11). This indicates a gradual shift toward a greater proportion of funding committed to hospital services."⁴

Figure 11 : External provider expenditure in \$2016 and as a percentage of total expenditure



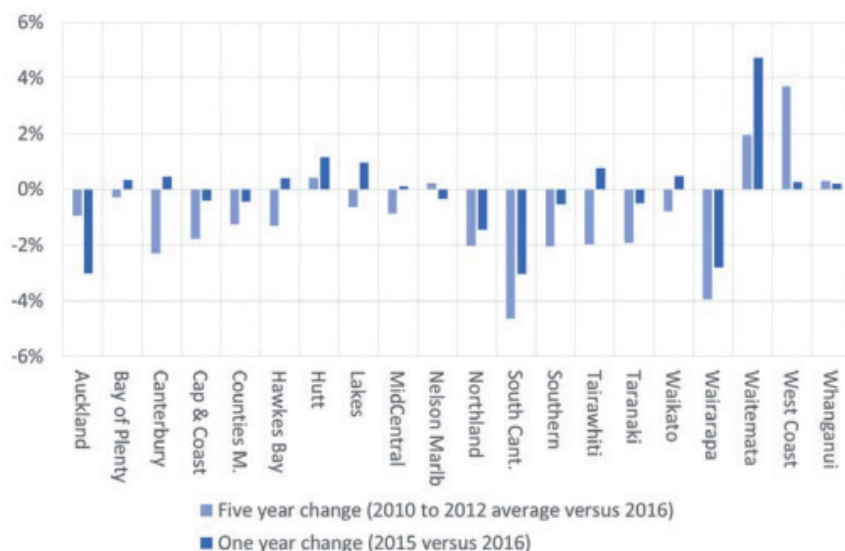
Note 1 Inter-district flows, which contain some external provider expenditure, are excluded (from the expenditure figures and the numerator of the percentages) as they mainly relate to provider-arm care.

⁴ Treasury, District Health Board Financial Performance to 2016 and 2017 Plans February 2017, pg 23

Treasury notes that this trend has occurred in most DHBs although there has been signs of change in the last year.

"The pattern of falling external funding as a percentage of expenditure has occurred in most DHBs over the last five years (figure 12). There may be signs of change, however. Eleven DHBs increased their percentage of external expenditure for 2016 versus 2015, compared to two DHBs for 2015 versus 2014 (numbers not shown)."

Figure 12 : Percentage change in external expenditure as a proportion of total



Note 1 Inter-district flows are excluded.

Note 2 Five year change has been calculated using the average of three years 2010 to 2012 (rather than a single year) to reduce the effect of variations in the denominator year when assessing longer term change.

3.3 ACC

ACC's actuarial approach means that it has one eye on year by year expenditure and another on its Outstanding Claims Liability (OCL). It looks at outcomes over a longer term, which informs its investment strategy. In its 'Financial Condition Report, 2017 ACC notes a number of financial stress factors in relation to social rehabilitation services (serious and non serious injury services):

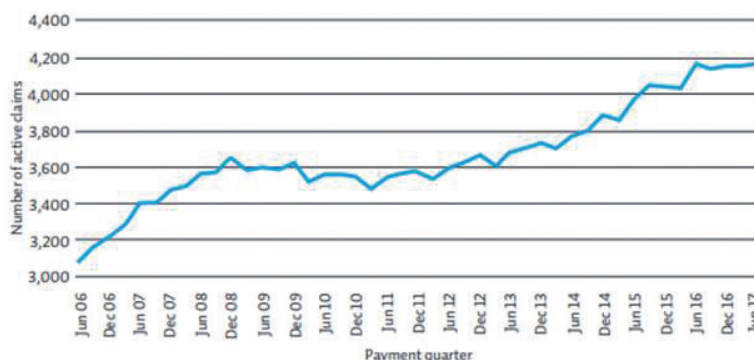
"Social rehabilitation makes up close to half of the June 2017 OCL. The vast majority of payments relate to non-capital expenditure for seriously injured clients. Attendant care payments for seriously injured clients make up a large component of the OCL because of the lifelong nature of the support provided. Social rehabilitation for serious injury is of primary concern, particularly given the marked increase in payments in the last 12 months and resultant impact on the OCL. Non-serious injury social rehabilitation is, at 4%, relatively small in the context of the overall OCL. However, payments to this cohort have been higher than expected recently, so this also needs focus...

"The number of active serious injury claims increased to June 2008, and has increased again in recent years following a period of stability between 2008 and 2013.Following increases in the last two years, the number of new serious injury claims was lower than expected in 2016/17. Active claim numbers have stabilised in 2016/17."⁶

⁵ Treasury, District Health Board Financial Performance to 2016 and 2017 Plans February 2017, page 24

⁶ ACC Financial Condition Report 2017 (FCR)

GRAPH 11 – ACTIVE CLAIMS FOR SERIOUS INJURY NON-CAPITAL PAYMENTS

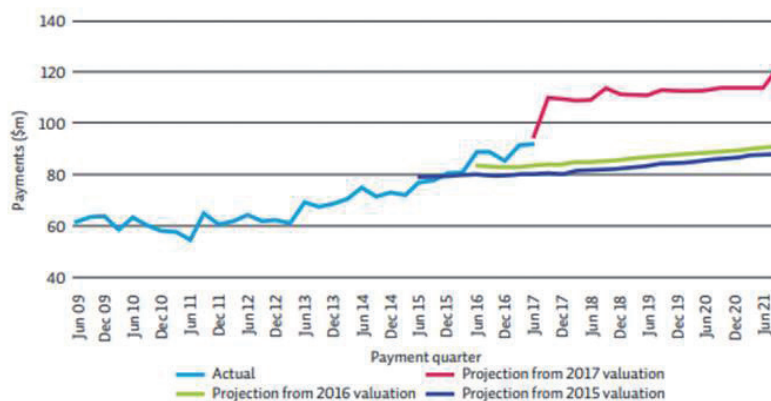


Note that in this graph above social rehabilitation non-capital payments (for serious injury) are categorised as care (attendant care, home help, child care and residential care) or non-care (active rehabilitation, training for independence, supported activities, assessments and travel). Of these, attendant care support is the largest contributor, at around 60%."

ACC has highlighted the need to encourage more independence for clients, including seriously injured clients, and to reduce their ongoing attendance care and support needs where possible, is important.

In the same report, ACC shows the impact of pay equity and regularisation on serious injury non capital payments, and also the anticipated decrease expected from the new HCSS funding model being put in place in 2018.

GRAPH 10 – SOCIAL REHABILITATION – SERIOUS INJURY NON-CAPITAL PAYMENTS



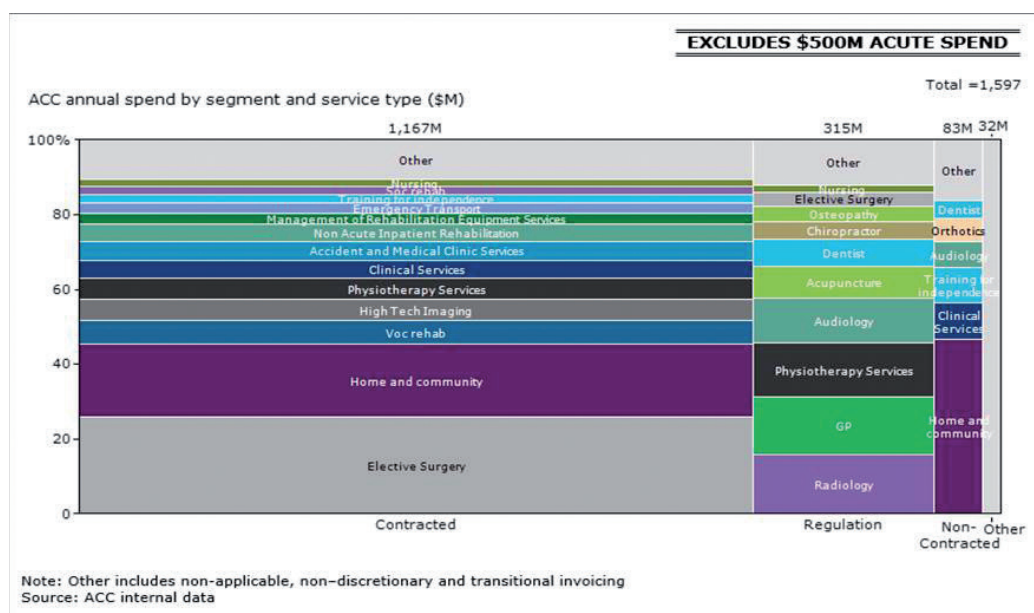
4.2.5 The June 2017 valuation projection shows the increases expected from the pay equity legislation and regularisation payments, with the October 2018 decrease expected from the new HCSS funding model. In addition, the projection was increased to reflect the higher recent payment experience before the introduction of the legislation.

ACC notes that most of the growth in non-capital payments for serious injury claims is due to increasing average costs per claim. In 2016/17 this cost growth was primarily a result of increased average attendant care cost, higher in-between travel (IBT) payments, and the greater complexity and severity of new serious injury claims.

ACC is also focusing on the increase in costs in the non-serious injury area, although growth in claims in this area is fluctuating.

In its ACC Health Services Strategy 2016-2021⁷, ACC provides the following diagram which shows the annual spend by segment and service type:

⁷ ACC Health Services Strategy 2016-2021



In that report ACC notes that its healthcare procurement spend has grown 5% per annum in the three years between 2013 and 2016, but some categories have grown at a faster rate including elective surgery (11%), home and community support (13%) and physiotherapy (11%).

3.4 Ministry of Health Disability Support Services

Ministry of Health Disability Support Services appropriation faced cost increases averaging more than 4% per year over the last ten years and in 2016/17 the spend was \$1,183 million. This was 18 million more than budgeted in that year, with the overspend spread across all areas. For 2017/18 the budgeted spend is \$1,208 million. The increase in funding is for increased demand, system transformation and the pay equity settlement.

Treasury financial appropriation documents note that Increases over the last decade have been driven by:

- Challenges resulting from court decisions (sleepovers, paid family carers);
- Ministry of Education Ongoing Resourcing Scheme [ORS] has increased by almost 4% a year over the same period (to \$228 million in 2016/17), mainly due to increases in the number of children supported;
- MSD Community Participation appropriation (\$61 million in 2016/17) has increased by about 1.2% a year. These increases primarily result from increase in the number of people with very high needs who are supported;⁸
- The Ministry of Health has also advised the Minister that the initiatives aimed at increasing people's choice and control have proven to be more expensive than traditional services. This is because of the lack of economies of scale, the need to adapt existing support infrastructures and the addition of cost factors (eg independent facilitators).⁹

⁸ The Estimates of Appropriations 2017/18 Health Sector B.5 Vol 6.

⁹ Cabinet Paper to Office of the Minister for Disability Issues and Associate Minister of Health Cabinet Social Policy Committee, February 2017

The proportionate breakdown in spend for DSS is shown in the figure below from :

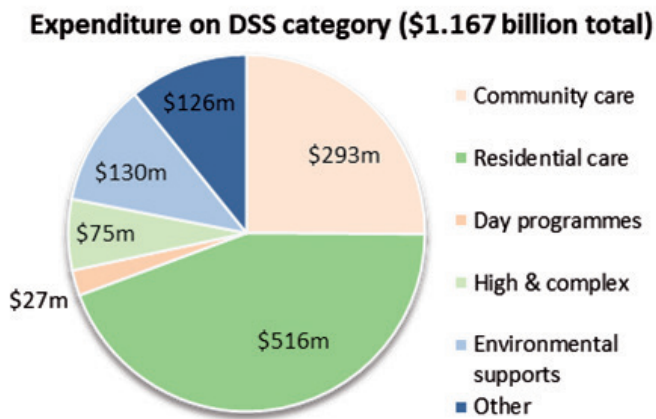


Figure copied from 'What do we know about people receiving MoH Disability Support Services?'¹⁰

3.5 What is not known about cost pressures on funders

Services under Chronic conditions under 65 is not well measured, particularly at a national level, and little data is available publicly. This undermines consistent national policy approaches.

¹⁰ What do we know about people receiving MoH Disability Support Services?' recorded on <https://www.odi.govt.nz/assets/Whats...files/2016-12-13-A3-disability-forum.pptx>

4. Emerging commissioning/contract approaches

4.1 Casemix

This needs allocation tool for older people services is now used in eight DHB areas, and aligned with bulk funding in seven of those. In a casemix model, clients are assessed to identify their needs and are then allocated services that will best meet these needs. Services can be funded according to the identified needs of a population grouping, while retaining an appropriate degree of tailored service provision, without needing to apply only limited service options, or to develop a bespoke service offering for every client. In terms of workforce this enables closer targeting of staff competencies and attributes to client need, more opportunity for goal centred and restorative practices with clients, more opportunity for staff to work as part of teams and better rehabilitative and responsive support.¹¹ A casemix model also supports public policy goals set out in the Ministry of Health Healthy Ageing Strategy (2016). It can be built alongside, or be underpinned by whānau ora approaches, and by models that place more choice and control in the hands of the consumer.¹²

4.2 Broadening or narrowing of services

- In older people services, supports are being targeted at those with highest need, with reducing allocation at those requiring supports such as household support.
- There have been instances where DHBs are including post-acute services and mental health services in core HCSS contracts, and utilising home support providers to provide in home strength and balance programmes. In other areas DHBs are developing in house post-acute services or strength and balance programmes.

4.3 Consumer directed care/support

The main area for change towards further consumer/ service user choice and control over their supports has occurred under MoH DSS services, and more information is provided on the DSS Transformation under 4.7. The Productivity Commission and the Director-Generals Reference group recommended consideration of consumer directed care in health of older peoples services. This innovation was also highlighted in the Healthy Ageing Strategy, and is now being considered as part of the MoH Models of Care Project. Some DHBs offer self directed options for clients with complex, long-term, chronic, health conditions. Other agencies are also actively seeking pilot opportunities with DHBs.

4.4 Changes to needs assessment and allocation

Some of the case mix models include the ability for providers to undertake non-complex assessments and service reviews, and to allocate services according to need within an overall budget. Where this is combined with bulk funding and a restorative model it can result in a service that is more responsive to changes in client need. Funders have also been looking at other options for assessment and needs allocation, such as self-assessment and electronic assessment.

¹¹ HCHA February 2018: Putting the Case: Improving the viability, delivery and outcomes of New Zealand's Home and Community Support Services: A national casemix delivery and contracting framework

¹² HCHA, Putting the Case.

4.5 Fee for service

Twelve DHB funders still use this model. Providers generally believe that this model undermines client flexible services, as well as coordinated and connected services, and that it disempowers both clients and providers in terms of taking ownership of, and realising outcomes.¹³ This is particularly the case when it is aligned with needs assessment that is slow and highly prescriptive. Providers have argued for at least the use of packages of care to enable more flexible services for clients.

4.6 Provider reduction

A feature of recent service reviews in Health of Older people's services has been a reduction in the number of providers. Approximately 20 providers have left the sector since 2015 through purchase, service contract loss or financial pressure. Further contraction can be expected, where funders seek reduction in funder-contractor administration, increased provider capacity to manage client volume, service integration, shifting of services from lower needs to higher needs, all within increasing fiscal constraints.

4.7 Whānau Ora

Te Puni Kōkiri contracts for whānau ora services through three Commissioning Agencies - Te Pou Matakana (North Island), Te Pūtahitanga o Te Waipounamu (South Island) and Pasifika Futures (Pacific people in New Zealand) to invest in a range of activities to achieve Whānau Ora outcomes and build whānau capability through providers and navigators. The commissioning agencies look across a broad range of whānau initiatives and priorities being developed. Accident Compensation Corporation has a commitment to develop (alongside Maori) a whānau service model in relation to Traumatic Brain Injury. There is little information available on District Health Boards approaches to whānau ora.

4.8 Accident Compensation Corporation

Accident Compensation Corporation has indicated its intention to include casemix as part of its 2018 service review, with the implementation of casemix from 2019. In 2018 it will choose a number of providers with whom it will work over a period of time, with the aim of implementing a case-mix and case-weight allocation process and a bulk funding approach, that will be in place by March 2019, for both serious and non-serious injury clients.

ACC Integration

As part of its 2018 HCSS service review ACC has indicated that it is aiming for integration of related contracts, such as community nursing, and training for independence. The changes may well drive an increase in rehabilitative roles for support workers under teams led or supported by allied or nursing staff. It will incentivise providers to focus support provision, and track support need reduction and increase more closely.

ACC may also be looking for **more flexibility in supports for clients**. For example, ACC is developing Client Self Service (CSS) – a digital channel for clients, making it easier for them to navigate through their recovery process. In its initial stages CSS will give control back to people who have suffered an injury by allowing them to manage aspects of their recovery themselves. People who need only a short burst of rehabilitative or functional support may be able to have substantial choice in how they use that package. There may also be changes to the needs assessment processes.

¹³ HCHA, Putting the Case.

4.9 Disability Support Services – system transformation

The NZ Disability Strategy¹⁴ is guiding the work of government agencies on disability issues from 2016 to 2026. In practice this has meant the development of pilots and projects that are now cross departmental, are based on a co-design approach (government agencies and the disability sector), and which aim for a long-term transformation of how disabled people and families are supported to live everyday lives. The vision is for disabled children and adults and their families to have greater choice and control over their supports and lives, and to make more use of natural and universally available supports. This includes full control over the budget that they are allocated and what they spend it on, a change in needs assessment processes, and the use of facilitators to support decision-making.

Cabinet signed off in February 2017 to a transformation design starting in mid-Central in 2018, followed by Waikato and Christchurch. It will initially focus on those with MoH funding.¹⁵ Organisations holding DSS contracts will, over time engage with budget holding disabled individuals or their advocates around the services sought by disabled people, rather than hold direct contracts with government agencies.

The transformation plan aims for a close alignment with EGL principles, and facilitation-based support on a 'person to person basis'. Organisations will need to review their culture and service delivery. The changes will drive different behavior of providers in terms of client engagement. There will be workforce and market issues, especially around qualifications and training. Organisational quality reviews may change markedly.

Workforce Training and other Implications:

- Organisations may need to substantially change their consumer engagement processes including staff training.
- Staff and governance will need training about transformation and principles.
- Communication styles need to be easy to understand, easy to read, where that is needed.
- Some disabled people will choose to not use agencies at all and employ their own staff. This may result in a loss of staff who want to work directly with disabled people.
- Organisations will need to look at how they engage with independent facilitators.
- Support staff may undertake a wider range of roles than they currently do.
- Some disability workers may simultaneously work in a range of employment situations – directly employed by the disabled person, acting as a contractor, and employed by an agency that has a contract with a disabled person; this may be a deterrent to employment.

Funding performance measures for DSS relating to vision and direction of services modelling

- In the 2017/18 Estimates of Appropriation, new performance measures were included that is indicative of the Government's intention to support more disabled people to live in the community:
- Percentage of Disability Support Service clients moving from mainstream residential service to community support services increases over time so that the percentage receiving community support services is greater than or equal to 77%.
- The percentage of self-directed funding arrangements to improve the person's choice, control and flexibility, (eg, Choices in Community Living, Individualised Funding, Enhanced Individualised Funding, Flexible Disability Supports, Personal Budgets and Enabling Good Lives) within the total client population is greater than or equal to 10%.¹⁶

¹⁴ MoH, NZ Disability Strategy 2016-2026

¹⁵ Cabinet Social Policy Decision SOC-17-MIN-0007, 15 February 2017

¹⁶ The Estimates of Appropriation 2017/18 – Health Sector B.5, Vol 6, pg 66

4.10 Cross departmental work, e.g. in disability and seniors

The social investment approach established by the previous government saw increased cooperation and activity across a range of government agencies, statutory and representative bodies. Relevant to our sector include:

- MSD, Health and Education in the Disability sector
- MSD and Ministry of Health in senior health and wellbeing
- Ministry of Health and DHBs in model of care for older people
- MBIE and relevant sectors in migrant regulation and support
- Careerforce ITO and Health Workforce NZ in Kaiāwhina vision
- MSD and MBIE in industry, recruitment and retention
- Treasury and various departments in expenditure and investment
- Government, Business NZ and unions in pay equity principles
- Ministry of Health and Unions in health sector workforce approaches
- Ministry of Health, unions and providers on sector issues
- Funding agencies, unions and providers in responses to Health and Safety legislation

5.0 Strategies and plans

5.1 The New Zealand Health Strategy vision is:



To achieve this vision, the strategy¹⁷ focuses on five themes:

- Person-centred services
- Services and supports when, where, and how people need them
- Best value
- Working together
- Innovation ready

Among many of the aims of the New Zealand Health Strategy that are relevant to home support are the intention to:

- Maximise New Zealander's wellbeing by taking a life-course approach, and providing people with choice and control over the delivery of their services and support.
- Shifting the focus from illness to health and wellbeing means looking at people's lives in terms of their place within a family and whānau and a community.
- Underpinning health spending in transformed approaches with deep changes to how the health and disability system enables, incentivises and supports change. This requires new attitudes to leadership, performance, innovation and asset management.
- Supporting innovation that is beneficial and cost-effective. Taking advantage of the opportunity that rapid technological development and convergence offers us to improve awareness and access, enhance quality and reduce costs in the health sector, and improve integration with the social and economic sectors.

¹⁷ Ministry of Health, New Zealand Health Strategy (2016)

5.2 The Healthy Ageing Strategy

The Healthy Ageing Strategy was published in 2016 and presents the strategic direction for change and a set of actions to improve the health of older people, into and throughout their later years. The Strategy refreshed and replaced the Health of Older People Strategy (2002) and aligned it with the New Zealand Health Strategy.

Actions in the strategy that are particularly relevant to the HCSS workforce are:

- Plan to increase strength and balance of people living at home.
- Explore options for partnership in promoting mental health for older people
- Encourage services to promote the reduction of alcohol related harm
- Work across agencies on socioeconomic determinants of health
- Improve health literacy of the workforce in provider organisations
- Support older people's uptake of technologies for communication with providers and their whānau
- Increase public and workforce awareness about the use of powers of attorney and advance care planning
- Support initiatives to reduce unnecessary acute admissions
- Streamline acute assessment tools and processes
- Enhance early supported discharge planning
- Ensure patient experience and cultural responsiveness are reflected in quality measures
- Make use of data to identify older people at risk of falls and coordinate a response
- Develop best practice in rehabilitation partnerships, home based restorative and rehabilitative models, staff working at the top of their scope.
- Improve models of care for home and community support services (person centred, needs based and equitable). Review needs assessment, involve older people.
- Use interRAI assessment data to identify quality indicators
- Regularise and improve training of the kaiāwhina workforce in HCSS services.
- Progress training packages to enhance capacity of kaiāwhina to support people with long term conditions
- Develop a range of strategies to improve recruitment and retention of those working in aged care
- Better use the allied health workforce to enhance care for older people
- Enhance workforce capability to encourage more entry and retention of the workforce among Māori and Pacific people and other ethnic groups.
- Improve training and information for family carers
- Share educational resources and good practice on ways to increase physical activity levels amongst older people with debilitating conditions
- Better coordinate and integrate rehabilitation for people recovering from a stroke
- Ensure home and community support models of care cover advice to and support for older people to remain physically and mentally active, and strengthen skills they may have lost
- Promote the use of assistive technologies to support home care workers to achieve good outcomes
- Identify and promote innovative care arrangements for the oral health care of older people receiving HCSS support
- Disseminate updated information and advice on dental care to older people's families
- Review the quality of HCSS support in supporting older people with high and complex needs, promote service commissioning models that enable such people to receive the care most suited to their needs, removing unnecessary barriers moving between care settings.
- Trial commissioning one organisation to coordinate health and support services for frail elderly people that could include primary health care, pharmacy, ambulance, HCSS, aged care and acute care services.

- Improve access to physical health services among people with high mental health and addiction needs and improve integration of these services with residential and HCSS services.
- Improve integration of information from assessment and care planning with acute care services
- Ensure HCSS staff are able to contribute to shared care plans and interdisciplinary teams
- Develop education partnerships between pharmacists and other health professionals to increase medication adherence
- Ensure models of care and contractual arrangements provide equitable access to medication management services.
- Support the implementation of Te Ara Whakapiri: Principles and Guidance for the Last Days of Life
- Implement a system to collect a minimum dataset on Kaiāwhina workforce¹⁸

5.3 The Kaiāwhina Workforce Action Plan

The Kaiāwhina Workforce Action Plan¹⁹, which commenced on 1 July 2015, has foregrounded the non-regulated workforce, generated discussion, and enabled inclusion in planning and action around training, skills and workforce projections and planning.



¹⁸ Healthy Ageing Strategy, 2016, <https://www.health.govt.nz/publication/healthy-ageing-strategy>

¹⁹ <https://www.workforceinaction.org.nz/>

The Action Plan framework was co-created with multiple key stakeholders from across the health and disability sector, and it remains a living document. Combined and individual efforts have resulted in gains under each of the seven domains identified in the 5-year action plan.

5.4 He Korowai Oranga: Māori Health Strategy

He Korowai Oranga: Māori Health Strategy sets the overarching framework to guide the Government and the health and disability sector to achieve the best health outcomes for Māori. The Strategy was refreshed in June 2014, expanding the aim of He Korowai Oranga from whānau ora to pae ora – healthy futures. Specific elements relevant for HCSS providers include:

- Health structures encourage Māori to determine their own aspirations and priorities for health and disability, and provide mechanisms for ensuring these are taken into account in the planning and delivery of services.
- Increased Māori participation at all levels of the health and disability sector in decision-making, planning, development and delivery of health and disability services. This also supports Māori provider and workforce development
- Effective health and disability services that aim to ensure that whānau receive timely, high quality effective and culturally appropriate health and disability services to improve whānau ora and reduce inequalities.
- Workforce – noting that Māori community health and voluntary workers, many of whom are Māori women, have a pivotal role in improving the health of Māori whānau. This needs to be recognised with the development of mechanisms to encourage community workers, public health workers, and voluntary workers into professional training.

5.5 New Zealand Disability Strategy and Disability Action Plan

The New Zealand Disability Strategy will guide the work of government agencies on disability issues from 2016 to 2026. The three principles of the Strategy are Te Tiriti o Waitangi, the Convention on the Rights of Persons with Disabilities, and ensuring disabled people are involved in decision-making that impacts them. The Strategy sets in place outcomes where disabled people are consulted on and actively involved in the development and implementation of legislation and policies concerning supports and services. The principles and outcomes have been reflected in the Disability Action Plan (2014-2018), and specifically in relation to disability support services through the Disability Support System Transformation Project.

This impacts of this project on workforce development are described in 4.9. The priorities for the project are to:

- promote disabled people having choice and control over their supports/services;
- promote the involvement of Disabled People's Organisations in the design and monitoring of the disability support system transformation;
- increase the capability of disability support service providers to be of service to disabled people;
- develop and implement effective ways for disabled people and DPOs to provide feedback about the quality of services and support and to monitor, evaluate and scrutinise and make providers accountable to funders for achieving outcomes; and to ensure providers are responsive to disabled people and provide choice and tailoring of services

5.6 Primary Health Care Initiatives

The Primary Health Care Strategy was developed in 2001 to provide a clear direction for the future development of primary health care in New Zealand. The Better Sooner More Convenient approach to integrated health care across primary and secondary health providers was introduced in 2009, with the patient rather than the institution as the centre of service delivery. District health boards (DHBs), PHOs and general practices now work more closely together in alliances. The aim is to promote a more seamless patient journey across community, primary, and hospital sectors, greater use of primary and community care, and care being provided closer to the patient's home. Through initiatives such as the Health Care Home there is progress on improving patient access to their health information through client portals, and to enable proactive, coordinated care for those that need it most.

Fragmentation remains within primary care and between primary and community care. There are efforts within primary health to establish more wide-reaching change across the primary health sector, encouraging further integration of services and alliances with community health and disability services.

5.7 'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014-2018

'Ala Mo'ui has been developed to facilitate the delivery of high-quality health services that meet the needs of Pacific peoples. It sets out the strategic direction to address health needs of Pacific peoples and stipulates actions, which will be delivered from 2014 to 2018. This edition builds on the successes of the former plan from 2010-2014.

5.8 ACC Health Services Strategy 2016-2021

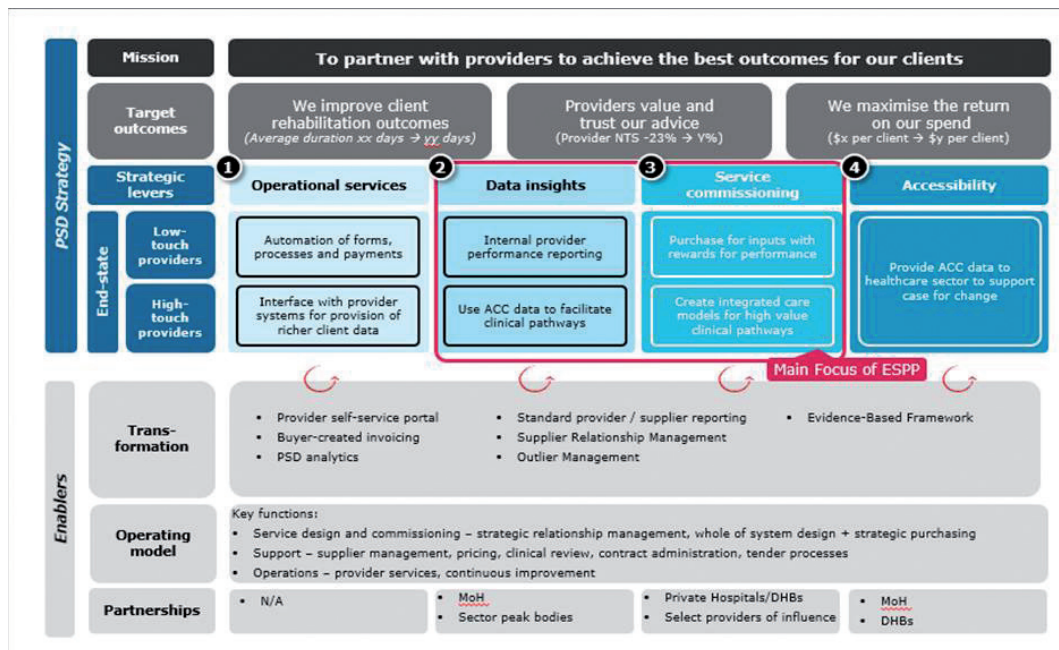
the ACC Health Services Strategy is focused on greater collaboration and partnerships with providers to improve client outcomes. This ACC strategy is a five-year plan that builds on information gained from work done following the elective services review in 2013/14. The aim is to move ACC from a reimbursement function, with largely transactional relationships with providers, to one that collaborates with and incentivises providers to optimise client outcomes. ACC want to move Provider Service Delivery (PSD) from transactional to strategic. ACC plans to be an 'instigator of change' for high-touch providers²⁰, using data and purchasing for outcomes and be a 'basic funder of healthcare' for low touch providers²¹. This would include a focus on delivering the basic services well, with better rigour and consistency around provider performance monitoring and reporting.

Success for PSD, and ACC more broadly, will be defined by three core outcomes; improved client rehabilitation outcomes, high provider trust and confidence in ACC and its objectives, and efficient management of ACC's healthcare spend.²² This Strategy will underpin the 2018 ACC HCSS Services review.

²⁰ High touch providers: manage serious injury and/or managed claims.

²¹ Low touch providers: primarily handle self-managed claims

²² ACC Health Services Strategy 2016-2021



5.9 Traumatic Brain Injury (TBI) Strategy and Action Plan 2017-2021

The outcomes of the TBI Strategy and Action Plan relating to workforce sit around cultural competency of providers; knowledgeable and adaptable services to meet the needs of clients; sharing of resources that help workforces provide responsive services; and ACC being actively involved in supporting workforce capacity amongst specific cultures and professional groups.

5.10 Te Ara Whakapiri: Principles and guidance for the last days of life

This document outlines the essential components and considerations required to promote quality care at the end of life for all adults in New Zealand. It also provides examples of useful approaches and tools that will serve as aids for the development of national and/or local resources as part of implementation. In terms of workforce it recommends organisations to provide training and qualifications in communication skills and compassionate communication, and provide or refer staff for support and clinical supervision as required, recognising the impact that caring for people in the last days of life can have on the health of practitioners themselves.

The Palliative Care Action Plan also aims to grow the capability of communities and informal carers. This includes 'assessing needs and gaps in workforce development for carers, kaiāwhina and the home and community support workforce' and to "Roll out new training and development programmes for carers, kaiāwhina and the home and community support workforce."

5.11 HCSS Medication Guidelines under consultation

HealthCert is currently coordinating consultation on Medication guidelines for home and community services. It can be expected that the guidelines will become accepted as best practice. They may require more regular monitoring of employee competency around medication assistance, more responsibility on both the support worker and their managers to support the safe and appropriate use of medications by clients, better recording and reporting of changes, and referral to the appropriate health professional where medication reviews may be needed.

6.0 Increasing technology changes

- Increasing use of smart phones, apps and other handheld devices by staff, and a range of apps and software to manage various work processes. More line of sight to service provision.
- Much greater use by clients of assistive technologies that will reduce the need for support change the nature of that support or require different or new skills and knowledge.
- Increasing connectivity of systems within provider technologies and to those of other agencies.
- Increasing availability of whole data sets (interRAI, health status, workforce data) to inform service planning and delivery. More development of data sets enabling population health views, gap and equity analysis, outcome measurement and research.
- Provider access to aggregated client interRAI reports.
- Increasing tracking and reviewing of medication use and change.
- Access to digital online learning tools and platforms.
- More digital innovations to support client communication and inclusion.
- Improvement of access to central health data systems (eg momentum).
- Increased access by clients to their own health information, potentially moving towards client control.
- Trialling (isolated) connecting, monitoring and rehabilitative technologies.
- Remote monitoring in response to legal challenges on sleepovers and families supporting parents at home.

Background paper three:

Present and emerging workforce statistics, supply

Contents:

1. Number, gender, ethnicity
2. Ageing workforce
3. Age distribution of the workforce
4. Tenure
5. Hours worked per week
6. Growth in the workforce
7. Work undertaken
8. Qualifications
9. Impact of pay equity
10. Gaps in information on formal carers
11. Informal carers

Disclaimer: *There are limited sources of information on the home and community support workforce. HCHA has based this background paper on information received or obtained, on the basis that such information is accurate and complete. For the most part we are reliant on information and data gathered by others. The information contained in this report has not been reviewed.*

1. Number, gender, ethnicity

1.1 Number

- Data from the MoH's March 2018 pay equity washup has counted 16,303 home support employees (DHB and MoH). That number excludes staff working solely on ACC contracts, and in private services.

The 2011 HCHA Study and the AUT study indicate that home support workers comprise between 86% and 95% of the total home support workforce. Also employed are coordinators, registered and enrolled nurses, physiotherapists, training & quality staff, administrative and finance staff, and managers.

1.2 Gender, wage earners, ethnicity

The AUT aged workforce study^{*} indicates that:

- 96.0% of staff are female (95% in the 2011 HCHA Survey).
- 53% of kaiawhina are the main earner in their family
- The ethnic composition reported in this study was:

| | |
|--------------------------------------|-------|
| - Pākehā/New Zealand European | 81.8% |
| - Māori | 12.7% |
| - Pasifika | 1.7% |
| - European (not born in New Zealand) | 1.7% |
| - Indian | 0.6% |
| - Chinese | 0.6% |
| - Filipino | 0.6% |
- 14% of respondents are fluent in a language other than English.¹

^{} 592 home support workers participated, along with 37 nurses. It needs to be noted that the survey was voluntary, online and in English. This may have affected the ethnicity proportions of the participants. In the 2011 HCHA survey responded to by 20 providers, of 4,650 staff counted, 18% were Pacific workers².*

¹ NZ Work Research Institute, AUT (2016). 'NZ Aged Care Survey 2016, Update: Age and Location of Healthcare Assistants'. Auckland, New Zealand. K. Ravenswood and J. Douglas. Retrieved from: https://workresearch.aut.ac.nz/__data/assets/pdf_file/0005/77828/FINAL-2016-survey.pdf

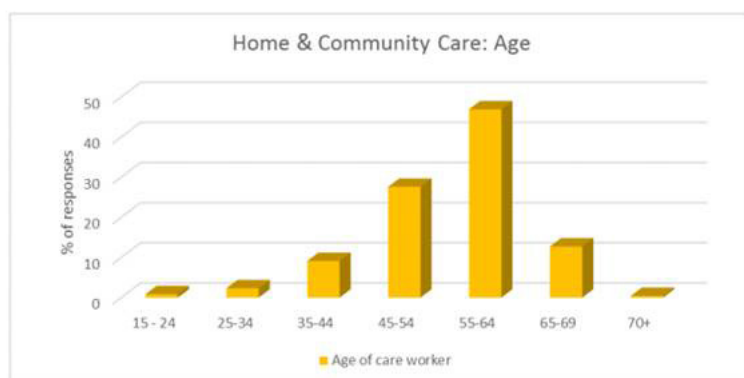
² NZHHA Skills Strategy: Survey for New Zealand Home Health Association (NZHHA), Quigley and Watts Ltd.

2. The ageing home support workforce

The AUT and other studies indicate that structural ageing and specific gender impact upon the ageing of the home support workforce.

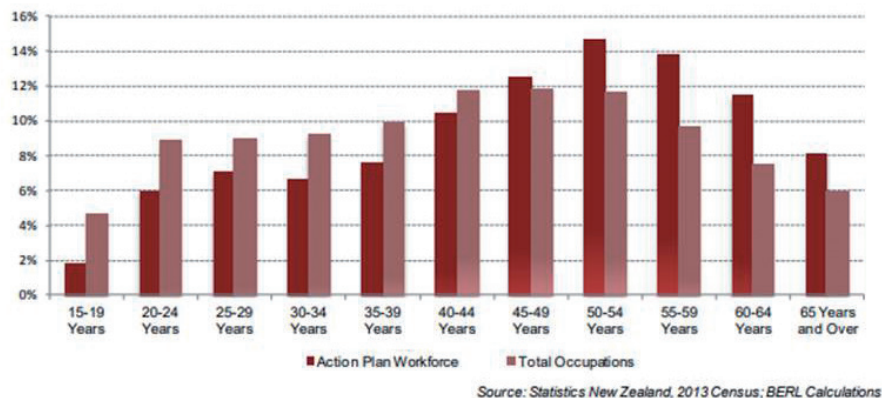
- a) There are significant numbers of older European women in the workforce.
- b) There are significant differences in regional/urban age distribution

55% of the participants in the AUT workforce were over 55 years of age and there were very low numbers under 34.



The 2014 BERL Kaiāwhina Workforce report also looked at the Age profile of workers captured within the broader Kaiāwhina workforce. It indicated a broader spread of ages across the whole workforce, but with the majority of workers aged 45 or older.

Figure 3.1 : Age profile of the Action Plan Workforce, 2013



BERL commented that:

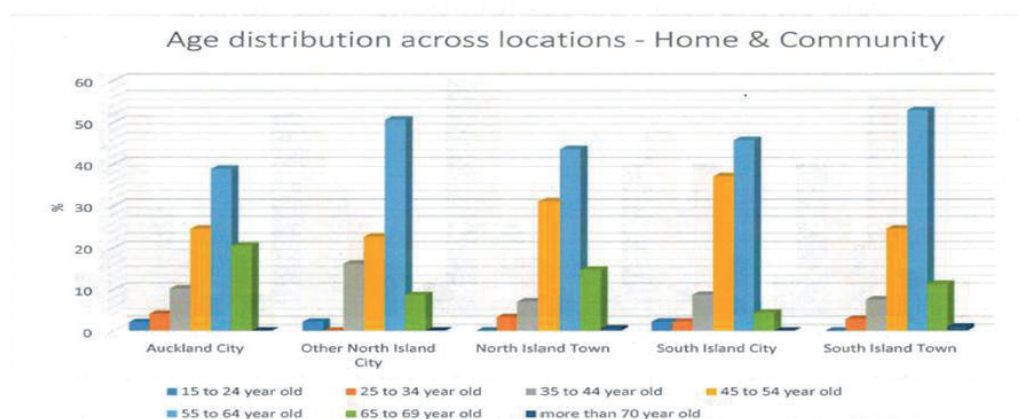
"In 2013, 61 percent of the Action Plan Workforce was 45 years or older compared to 47 percent of people across all occupations. This older age profile could be related to the tasks and interpersonal skills required in the Action Plan Workforce, which tend to be more suited to workers who are mature and are able to relate to a range of different ages and population groups. Table 3.1 shows that within the Action Plan Workforce, the age profile is relatively similar for Professionals, Support Workers and Carers occupations, where around 60 percent of people employed in these occupation groups were 45 years or older)."

3. Age distribution

3.1 Age distribution across locations

An update to the 2016 AUT Study provided to the Caring Counts Coalition in 2018 shows that in all locations the largest age group of respondents is in the 55-64 age bracket. The table below indicates the age structure across the country. South Island towns, in particular appear to have very high ratios of much older workers.³

Figure 3. Age distribution of Home and Community Aged Care workers across New Zealand locations



3.2 Age distribution compared to aged residential care

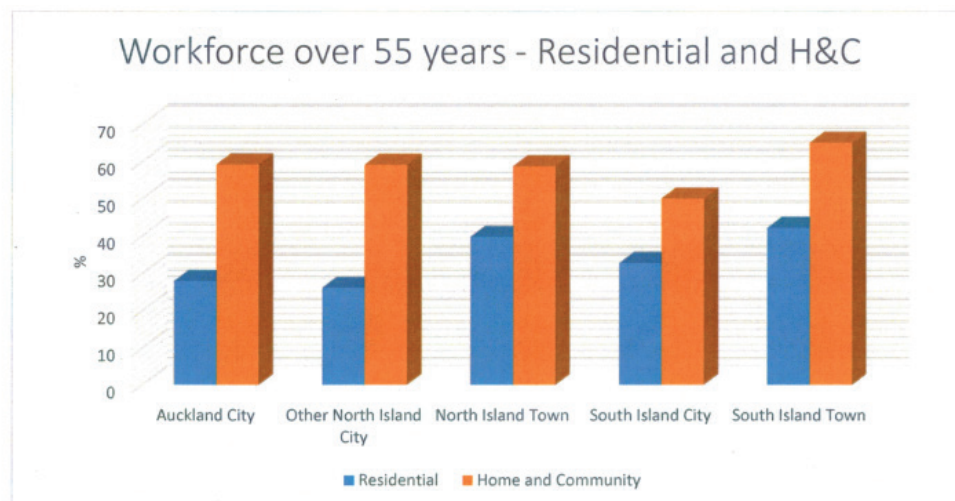
The AUT workforce survey update noted that a higher proportion of the home and community care respondents was in the 65-69 age bracket, compared to residential aged care. The difference was most pronounced in the "Auckland City" workforce, but was marked across all locations. Home Support employees were oldest in South Island towns: 65% of South Island Town respondents were 55 and older, with the other locations close to 60% each with a workforce 55 years or older.

Town respondents were 55 and older, with the other locations close to 60% each with a workforce 55 years or older.⁴

³ AUT, NZ Work Research Institute, NZ Aged Care Survey 2016, Update: Age and Location of Healthcare Assistants, Katherine Ravenswood and Julie Douglas

⁴ AUT, NZ Work Research Institute, NZ Aged Care Survey 2016, Update (2018): Age and Location of Healthcare Assistants, Katherine Ravenswood and Julie Douglas AUT Workforce survey 2016, Additional analysis by region and age, all aged care workers

Figure 4. Workforce over 55 years in the Residential and Home and Community sectors



3.3 Structural aging of workforce generally and impact on rural areas

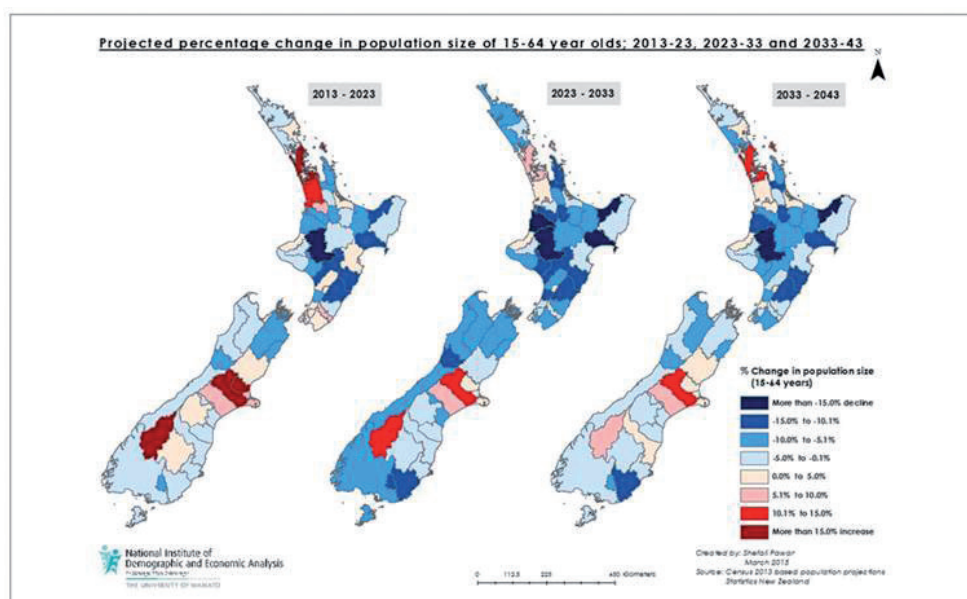
Dr Natalie Jackson has explained that the growth in New Zealand's population over the last two decades has been most strong in Auckland, Tauranga, Hamilton and Wellington, and that other Territorial authorities have either grown at a much slower rate or have declined in population. She comments on the reasons for this growth:

"the primary cause of New Zealand's rural depopulation is net migration loss primarily at young adult ages — the 'old' form of population decline. Increasingly, and with some imminence, migration-driven depopulation will be accompanied by the onset of natural decline, the end result of structural ageing that is ushering in more elderly than children and more deaths than births ... Over the next two decades we will see, with few exceptions, one TA after another reach the end of growth and, in most cases, shrink in size. By 2043 around 44 TA's are projected to be experiencing decline, by then affecting 22 per cent of New Zealand's projected population of 5.6 million.

... The ending of population growth is preceded by shrinking workforces, first as a proportion of the total population, and then numerically. New Zealand has already passed its peak proportion at 'prime' workforce age (15-64 years), doing so between 2006 and 2011. This trend is now accelerating. In 2013 there was, nationally, only eight people at labour market entry age (15-29 years) for every ten aged 55+ years, where, despite increased labour force participation at older ages, the 'retirement zone' looms.

At subnational level two-thirds of New Zealand's TA's already had fewer people at labour market entry than exit age. By 2018 this situation is projected to be the case in 85 per cent of TA's, and in 2023, in 90 per cent. By 2043 there are projected to be around 444,000 more New Zealanders aged 15-64 years than in 2013, but 51 TA's (76 per cent) are projected to have fewer. The accompanying map shows how the situation will approximately unfold.⁵

⁵ Jackson, N 'Aging populations and regional decline' 13.12.2015. Briefing Papers Online <http://briefingpapers.co.nz/ageing-populations-and-regional-decline/>



Dr Jackson also describes how the 65+ dependency ratio (the number of people aged 65+ per 100 people aged 15–64 years) increased gradually from 14 per 100 in the mid-1960s to 23 per 100 in 2016 and how it is projected to increase again.

"It is projected to increase significantly, with the ratio expected to be in the range of 33–39 per 100 in 2035, 37–49 per 100 in 2055, and 42–61 per 100 in 2068. This means that for every person aged 65+, there will be about 2.8 people aged 15–64 in 2035, 2.4 in 2055, and 2.0 in 2068. This compares with 4.4 people in 2016. This has implications for the role and load on unpaid carers, and on sourcing for the paid workforce."⁶

Dr Jackson advises that as structural ageing progresses we will see growing skill shortages and competition for labour. She also states that:

"Whilst technology and industrial change will see the demise of some jobs, it is equally certain that others will see increased demand. The community care services workforce, for example, has doubled in size since 1996 and risen from 17th largest to 6th largest."⁷

"The inexorable trends are unlikely to be resolved in the medium to longer term by either international migration or an increase in the birth rate. The number of migrants required to offset structural ageing is simply too large, whilst competition for them is growing across the countries from which skilled migrants are currently obtained. It should also be remembered that migrants also grow old – over 30% of today's older New Zealanders were born elsewhere."⁸

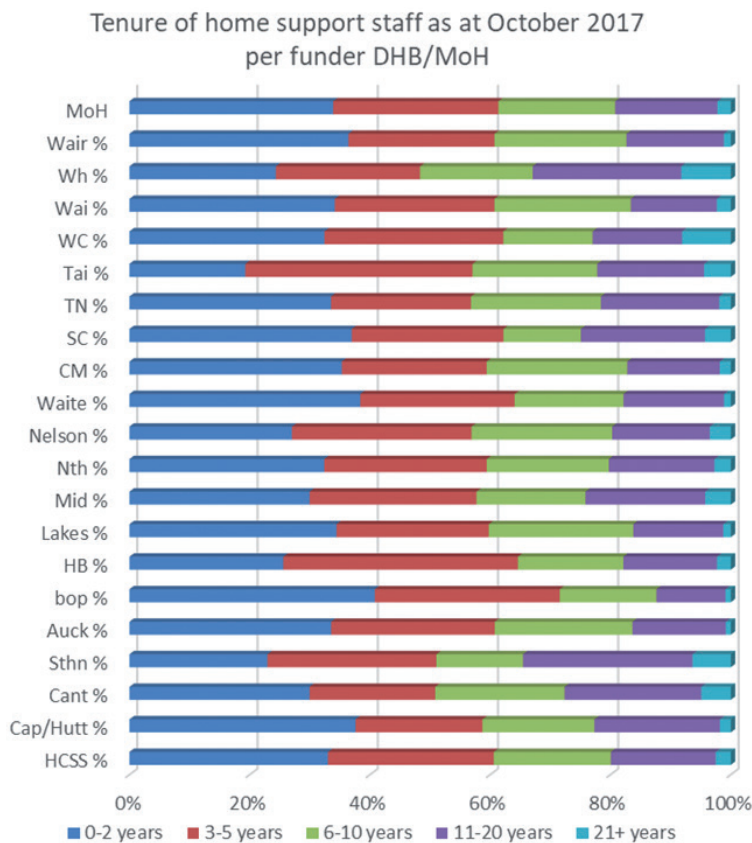
⁶ http://archive.stats.govt.nz/browse_for_stats/population/estimates_and_projections/NationalPopulationProjections_HOTP2016/Commentary.aspx#ageing

⁷ Jackson, N 'Aging populations and regional decline' 13.12.2015, Briefing Papers Online <http://briefingpapers.co.nz/ageing-populations-and-regional-decline/>

⁸ Jackson, N 'Aging populations and regional decline' 13.12.2015, Briefing Papers Online <http://briefingpapers.co.nz/ageing-populations-and-regional-decline/>

4. Tenure of HCSS Workforce (as at October 2017)

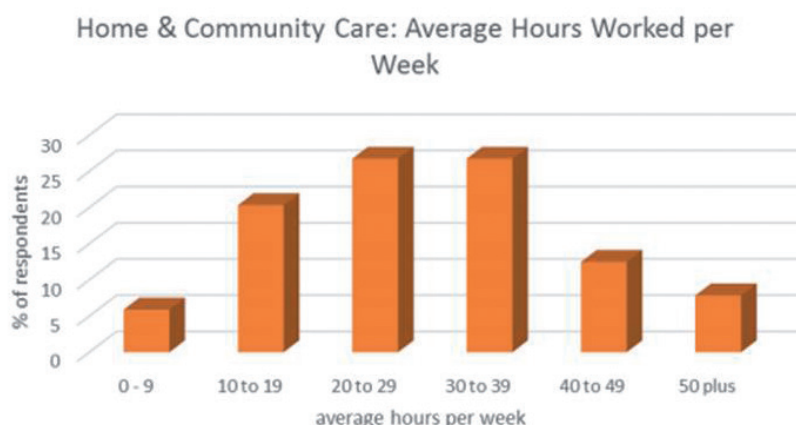
Tenure has particular relevance for workforce development in terms of turnover and for training development and career pathways. It is likely that pay equity will have some impact on turnover over a period of time. However, this may be offset by the aging workforce. The figure below shows the tenure of home support employees by District Health Board and MoH as at September 2017. There is considerable variability in tenure across DHBs. Taking the sector as a whole 33% of staff have been in the same job for 0-2 years, 28% have been employed for 3-5 years, 19% for 6-10 years, 17% for 11-20 years and 3% for 21+ years.⁹



⁹ Tenure, HCSS by DHB & MoH, using October 2017 Pay Equity Washup Data, provided to HCHA March 2018.

5. Hours worked per week

AUT Workforce respondents were asked how many hours they worked on average per week. Of the 561 respondents who answered, the largest groups were those who worked 20–29 hours per week and those who worked 30–39 hours per week (26.9% in each grouping). The next largest proportion (20.3%) were those who worked 10–19 hours per week, followed by 12.5% who worked 40–49 hours per week, 7.8% who worked 50 or more hours per week and 5.9% who worked 0–9 hours per week.



6. Growth in the workforce

It is difficult to count the HCSS workforce when it is not specifically identified in ANZSCO, and because a national view of the service is only just being considered. The 2014 BERL report noted growth in the broader Kaiāwhina workforce by 13 percent or 7,520 people between the 2006 and 2013 Censuses. The top five growth occupations within the Kaiāwhina Action Plan Workforce in terms of absolute growth between 2006 and 2013 were:

- Health and Welfare Support Workers (up 2,440 people or 36 percent)
- Aged or Disabled Carer (up 2,324 people or 67 percent)
- Community Worker (up 2,040 people or 40 percent)
- Social and Welfare Professionals (up 1,860 or 31 percent)
- Personal Care Assistant (up 1,620 or 6 percent)

The BERL report noted that:

"The growth in many of these occupations, particularly Aged or Disabled Carers, is likely to be driven by the ageing of New Zealand's population and the associated need for increased care and support. People aged 65 years and over grew by a total of 22 percent between the 2006 and 2013 Censuses compared to overall population growth of 5 percent over the same period."¹⁰

¹⁰ BERL, Health and Disability Kaiāwhina Worker Workforce 2013 Profile April 2014

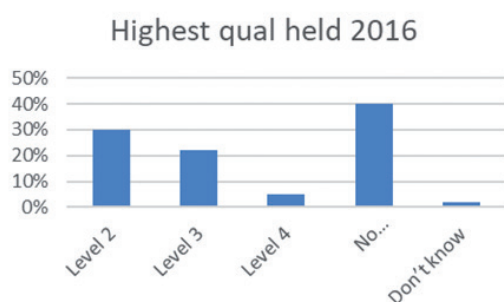
7. Work performed by home support employees

AUT Workforce survey respondents were asked 'What do you spend the most time doing in your job?' The majority (78.8%) responded that they spent the most time on personal care of clients, followed by 15.3% who spent the most time on cleaning/housework/domestic assistance. In a similar study undertaken by AUT in 2014, over seventy-four percent indicated that they spent the most time on personal care, followed by 21.4% in cleaning/housework/domestic assistance.

Respondents were asked if their role 'involves managing or supervising direct care staff', and of the 580 who responded, 85.5% said that they were not involved in managing or supervising.

8. Qualification levels 2016

There are two relatively recent data sources identifying training in the sector and one more dated (2011). The HCHA commissioned a training survey by HCHA in 2016. This asked employers to count the highest qualification completed. It counted 17,245 staff.¹¹



The second is the AUT Study in 2016 and 2014. It was completed by 568 respondents.



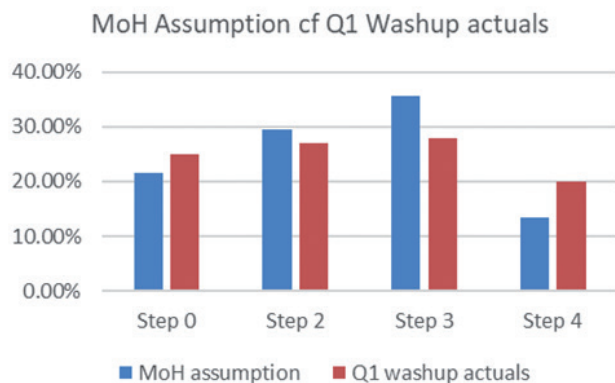
AUT Study 2016. NB: Foundation skills is also a level 2 qualification. The survey was voluntary online and in English and this question was completed by 568 respondents. It is possible that those with no qualifications were less likely to answer the survey.

In the 2011 research (Quigley and Watts), it was reported that 61% of support workers had no qualifications, 31% had Level 2, 9% had level 3 and 2% had level 4. 12% were studying for Level 2, and 6% studying for level 3 qualifications.

¹¹ HCHA commissioned Training Survey (Quigley Watts), 2016

9. The impact of pay equity legislation

The impact of the pay equity legislative wage framework, including progression up wage scales dependent on tenure and qualification equivalency, is highly relevant to workforce development planning, and is likely to also impact on the uptake of training. The following graph shows the anticipated and actual shifts in pay equity levels, and this was taken from the first three months of pay equity data, when many more qualification equivalency decisions were in the pipeline. We can expect more staff to move to Level 3 and Level 4 based on equivalency.¹²

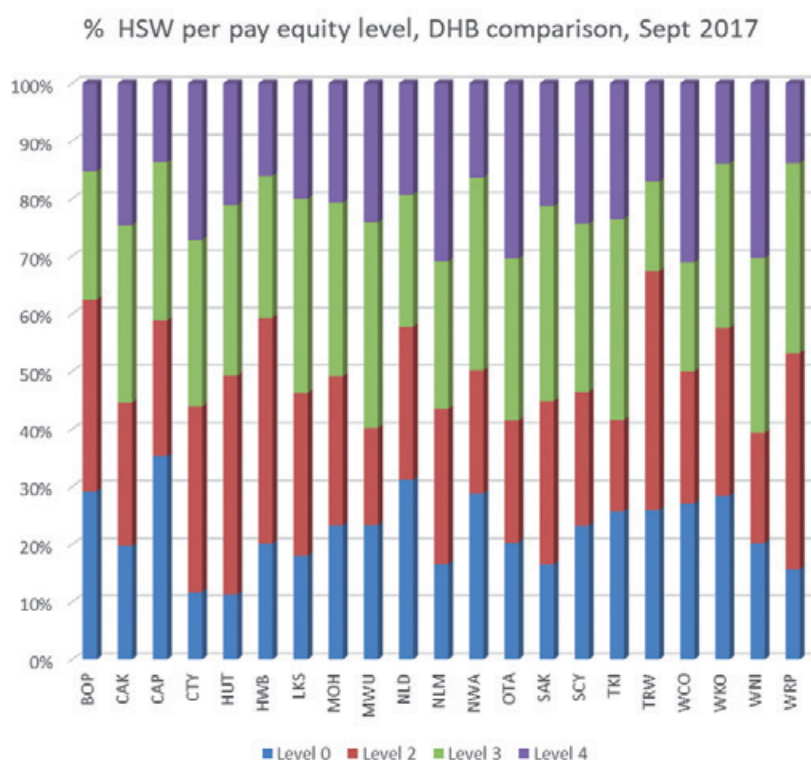


It is important to note that the table above shows movement in pay equity step levels based on both tenure and qualification equivalency assessment, and not on just qualifications. It is also important to note that this data was gathered in September 2017. There were still many qualification equivalencies in the pipeline at that time.

There is considerable variability across DHBs in the average pay equity levels held by support workers. The following graph shows the % by level by DHB at the end of the first pay equity 'wash up' data gathering.¹³ It is likely that some areas (eg Auckland, Wellington) have been impacted upon by the qualification equivalency process (eg where more migrant labour is used); where other areas may be affected by tenure progression (eg Whanganui). It is also important to note that there is likely to be further change as the impact of qualification equivalency assessments is more clearly known in the next data gathering exercise in April/May 2018.

¹² HCHA Analysis of pay equity data from Q1 washup for HCSS services (DHB/MoH)

¹³ HCHA, Data provided by MoH on pay equity Q1 washup for HCSS services (DHB/MoH)



10. Formal carers – gaps in information

There is still uncertainty in terms of published information on the kaiāwhina/home support workforce across all of the client funding streams including disability, injury, older people, those with chronic conditions, and in terms of regional and urban supply. This is needed because of what we do know about the ageing workforce.

There are actions within the Healthy Ageing Strategy workplan. Bearing in mind the aging workforce and client demographic changes, some more research based analysis is needed to understand workforce demand and supply pressures and opportunities.

11. Informal carers

The LiLAC study showed that informal carers of older people are more likely to be women than men (81% vs 19%). Informal carers were older than formal carers and were more likely to be a child or a child's spouse (over 50%), or the person's own spouse (around 30%). They were also likely to be living close to the person they cared for, employed full or part time in other jobs, and of the same ethnic group as the person they cared for. Carers of men had started caring earlier than carers of women. Māori men received the most hours of care per week from informal carers (more than 25 hours), and non-Māori women received the least (less than 15 hours). Spouses gave the most care.¹⁴

¹⁴ LiLACS NZ 'Health, Independence and Caregiving in Advanced Age

11.1 Informal carers - gaps in information

We could learn more about how many family/informal carers will be available to support family members during the ageing of the baby boomers. Most of the informal carers have already been born. Factors that will influence their availability will include employment, economy, geographic distribution, immigration, other caring responsibilities and accommodation options.

The health and wealth of ageing parents will also have implications for the support of middle aged disabled people who are dependent on family carers.

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