Review of Home and Community Support Services

Advice to the Director-General’s Reference Group for In-Between Travel

July 2015

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# About this document

| **Area** | **Description** | |
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| Purpose | The purpose of this document is to provide advice to the Director-General’s Reference Group on the future provision of Vote: Health-funded home and community support services (HCSS) in New Zealand. The Settlement Agreement for In-Between Travel required a review of HCSS, including a comprehensive analysis and response to the wider issues, including but not limited to levels of future demand, complexity of future demand, service changes, and levels of funding required within sustainable Government funding and any other system or environmental constraints associated with ensuring a sustainable home and community support services sector. | |
| Working group members | The overarching purpose is to ensure high-quality services for all people receiving Vote: Health-funded HCSS that meet the needs of the consumers in a cost-effective way, are based on best practice and evidence, and enable flexibility in service provision. | |
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# Executive summary

| **Area** | **Background** |
| --- | --- |
| Review of home and community services | In September 2014 district health boards (DHBs), HCSS providers, unions and the Ministry of Health agreed that from 1 July 2015 home and community care and support workers would be paid for the time they spent travelling between clients. This was formally set out in the In-between Travel Settlement Agreement (the Settlement Agreement) (Ministry of Health 2014).  The agreement also established an independent Director-General’s Reference Group to oversee two work streams to conduct a review into the health-funded home and community support service, and to develop and oversee the transition to a regularised workforce.  Two working groups were established to provide advice to the Director-General’s Reference Group, covering:   * a review of home and community support services (Working Group One) * the impact and affordability of transitioning to a regularised workforce (Working Group Two).   This report presents the findings and recommendations of Working Group One.  After considering both reports, the Director-General’s Reference Group will make a report to the Director-General of Health advising how the Government can achieve:   * a clear strategy for the delivery of home and community services on a national basis * a flexible framework for the provision of integrated and joined-up care * a strategy for funding nationally consistent, sustainable, stable and equitable services * a plan for transition to a regularised workforce. |
| Key issues highlighted in the Settlement Agreement | The issues to be addressed in the review of HCSS fall under three broad areas.  *Future demand:* a significant increase in the proportion of older people and disabled people is expected to put pressure on service funding and delivery. Working Group One looked at what service models and funding approaches would help meet the increasing demand and ensure sustainable, high-quality and integrated services across a variety of funders.  *Workforce sustainability:* there are significant recruitment and retention challenges due to low pay, lack of training options, lack of employment security, competitive market dynamics and an ageing workforce. High turnover of staff makes it difficult for providers to make an enduring investment in their staff and services. The group looked at funding and service models that would support workforce development and build on the initiatives of Working Group Two.  *Sector complexity:* well-intentioned programmes to meet demand can span several ministries and directorates and add to system and operational complexity, reduced transparency, client confusion, cost escalation and reduced equity of access for clients. The group looked at models to improve shared information and planning and reduce duplication. |
| What the review found and what sits behind the recommendations | Working Group One identified three main population groups using HCSS:  1. a ‘health’ group, comprising mostly older people, but also including people under 65 with chronic or long-term conditions, and people needing support after being in hospital, funded by DHBs  2. disabled people funded by the Ministry of Health  3. people recovering from injury funded by the Accident Compensation Corporation (ACC).[[1]](#footnote-1)  A client may be in more than one group; for example, an older person may have a fall and require additional support to recover from the injury; an older disabled person may experience age-related health issues and require a different range of services.  The support workforce delivers services to all client groups. This raises issues about workforce training to meet the different needs of clients, the different contracting approaches and outcomes sought by the different funders, and how well HCSS are integrated into wider health and disability services.  Alongside HCSS, many populations also engage with community-based Māori and Pacific health providers, Whānau Ora providers, mental health providers, drug and alcohol services, telemedicine services, and other non-government organisations (NGOs) or non-profit agencies, in addition to their primary care provider.  Four key ‘stakeholder groups’ were identified, who are participants in the sector but have differing, but inter-related, concerns and interests. The four groups and their main concerns are:   * *clients* – who want services that meet their needs (including culturally) and that are easily accessible, transparent, effective, integrated and coordinated * *care and support workers* – who want to be respected by other health care providers as part of the health team, supported to deliver services and have sustainable conditions of employment * *providers* – who want certainty in their income stream, the ability to forward plan and invest for demand and sector changes, flexibility to meet client need, and the ability to incentivise, recognise and reward staff with higher qualifications * *funders* (and government) – who want service delivery that is effective and efficient, meets client need, and contributes to wider government objectives (such as reducing avoidable hospital admissions). |
| Key themes | We grouped our work under four broad headings, as described below. 1. Embedding a client, and a population focus There are clear trends across the health and disability sector towards greater client involvement, choice and control over the supports they receive. These considerations need to be reflected across the sector and throughout the care and support pathway, from assessment to service delivery, funding and reporting.  No single model of care will apply to all three population groups included in this review of HCSS. Therefore, rather than endorse a single model, the group endorsed the principles of:   * client-directed care * support being provided in a holistic way * better information sharing across services to reduce multiple plans.   We use the term ‘client-directed care’ to mean an approach where the client is an active participant in planning their care, setting their own goals, determining the services they need, and owning the outcomes of their care plan. The degree of control will vary according to the client, with some wishing to take full control – including over their individual budgets. We acknowledge that, especially among older people, it is likely that agencies will manage on the client’s behalf. Our key point here is that as far as possible the provider should be the client’s agent, and the client regarded as an active participant, not a passive recipient of care.  Our preferred approach is not a particular model but a pathway of care that begins with a standard assessment tool (appropriate to each type of need, such as aged care, disability or injury), and incorporates a client-directed approach that enables the client to identify their needs, preferences and goals or outcomes they wish to achieve. A standard service allocation tool should identify the level of resources available so that each client can develop an appropriate ‘package of care’ for their own circumstances.  This thinking led to recommendations to embed a client-directed approach for HCSS, and for tools such as information technology (IT) to improve service coordination, transparency, outcome measurement and the sharing of information (including for clients). The Health Quality and Safety Commission is developing a primary care patient experience survey to find out what patients’ experience in primary care is like and how their overall care is managed between their general practice, diagnostic services, specialists and/or hospital staff. Working Group One would like to see this work extended to include HCSS. |
| Key themes (continued) | 2. Improving sector planning, coordination and alignment Getting the best outcomes for clients means reviewing all aspects of service delivery, including the over-arching policy settings and approach to service delivery. Our review indicates that it is necessary to improve planning, integration and coordination and reduce duplication. Client engagement and choice are meaningless concepts if there is no ability to look at the totality of an individual’s needs and at how different service elements can best form an integrated package of care in the most efficient manner. ‘Client directed’ also means clients being part of the process that drives the formulation of the overall services.  Furthermore, providers are faced with significant variations in objectives, practices and reporting standards from a multitude of different contracts with 20 DHBs, the Ministry of Health, primary health organisations (PHOs), ACC and other providers. Although well intentioned, these variations in processes, reports and goals can distract providers from focusing on the key issues (such as the delivery of care or workforce initiatives), and result in an unnecessarily high administrative burden or duplication of activities that ultimately increases costs to the sector.  We believe that an integrated Community Health and Disability Strategy should be developed to take a broad view of the range of services or domains that need to play a role in supporting people to live at home, outline how to improve the alignment of these services and best facilitate the connection of clients to their community, family and whānau.[[2]](#footnote-2) The use of better joint planning tools, data, and/or technologies such as shared care plans is also relevant here, as is the need to ensure staff have appropriate training and support infrastructure. 3. Contracting and funding approaches that balance a desire for consistency and flexibility Various contracting and funding approaches are currently in place, and each has strengths and weaknesses. The outcomes of all these approaches are variable for clients, workers, providers and funders, and there is no clear evidence supporting one funding model over another. We have looked at the desirable characteristics of a funding approach, including the need for the Government to prioritise funding to the care and support workforce.  The union and provider representatives believe that to provide quality and consistency of service for clients, and enable regularisation of the workforce and certainty for providers, there need to be a national quality standard, a national agreement and a national costing methodology. The agreement requirements would need to be varied, based on population group, given the substantive differences between the population’s and the funder’s expectations. Standardising these aspects for DHBs would create savings in back office functions, improve efficiency and reduce the total market cost of procurement processes, remove regional differences that do not improve performance, and would mean providers would not have to maintain multiple models. Unions and providers consider that some scope for regional innovation can be maintained within a national agreement framework.  This approach would identify consistent national service-level standards with a national pricing structure based on an agreed costing methodology, negotiated between funders and providers annually. This agreement would have local variations within an *alliancing* approach to ensure DHBs retain flexibility to meet individual population need and ensure service integration with other health and disability services across the care continuum. Alliancing has been used nationally and internationally to enable good conversations between funders and providers, and to promote better outcomes for clients.  DHB representatives were unable to commit to a national agreement or national pricing structure without further engagement with all DHBs. Although a national structure may provide benefits, there was limited time to fully understand the implications within current frameworks. Once further engagement has occurred on these issues, a more informed position can be settled on. |
| Key themes (continued) | 4. Information on quality and service efficiency is needed to inform policy and practice As noted above, there is significant variation in the way services are delivered, and it is difficult to compare the quality and efficiency of different models or providers. Work is needed to ensure that quality can be measured and improved − for clients, funders and referrers.  To get the best outcomes for clients, funders should look at the value of the home support services they purchase, not just the lowest possible price. The lowest-price service would miss opportunities to add worthwhile value by achieving better outcomes. Higher prices enable providers to pay higher wages and the workforce to be better trained, which, up to a point, will be worthwhile for clients and for reducing demand on other parts of the health and disability system.  These points led to a discussion of the need to:   * streamline assessment, service coordination and case management * ensure sector standards and evidence-based models are applied consistently * develop information systems and indicators to measure quality, effectiveness and client experience and satisfaction.   Currently, the national Home and Community Support Standards are not mandated, but they are included in contracts. There was discussion whether the Standards should be regulated to ensure coverage where services are provided outside of contract arrangements. We did not come to a clear view on this but wish to see the use of the Standards enforced across the sector. Better information will enable funders to better understand the best balance between the price paid for services and the value of the services purchased.  Our recommendations are given below, with indicative timelines for their implementation. |
| Future review and next steps | This initial review of HCSS has developed key recommendations drawing on a core group of stakeholders and preliminary data analysis. It is a significant event and marks the first time funders, providers, workers and client representatives have discussed these issues around the same table. Given the breadth and complexity of the sector (in addition to the difficulty of accessing the limited centralised data), it is recommended that further research, planning and engagement be conducted as part of the development of the recommended Community Health and Disability Strategy. It is essential that clients be involved in this process. |

# Recommendations

| **Broad area of concern** | **Recommendations** | **Timeframe** |
| --- | --- | --- |
| Sector planning, coordination and alignment | We recommend that: |  |
| 1. engagement on preliminary recommendations occur, including with client representatives and Māori and Pacific communities | August 2015 |
| 2. the Ministry of Health develop an integrated Community Health and Disability Strategy, ideally across DHBs, ACC and relevant ministries, and with Māori and Pacific communities, clients, providers and unions | December 2016 |
| 3. the Ministry of Health lead the requirement for cross-agency integration of needs assessment functions and service coordination processes to improve effectiveness and efficiency for the client and the system | December 2018 |
| 4. population information be captured and shared for the purposes of measuring outcomes to inform future planning | December 2016 |
| Client and population focus | 5. all home and community support services support a client-directed approach that can be demonstrated and measured | December 2016 |
| 6. the National Health Information Technology Board prioritise the development of a shared care record to be owned by individuals | December 2017 |
| 7. the Health Quality and Safety Commission extend its work on client experience to include home and community support services | December 2016 for agreement of the tool December 2017 for implementation |
| Contracting and funding | 8. the Government prioritise funding to invest in the further development of the workforce to ensure the support workforce is recognised and valued to reflect the skill, responsibility, and complexity of care and support work | December 2016 |
| 9. all procurement of home and community support services use alliancing arrangements | 2015/16 for new arrangements 2017 for existing arrangements |
| 10. DHBs and providers move to a national agreement that reflects individual population needs, and that:  a. identifies national service-level standards  b. has a national pricing structure based on an agreed costing methodology  c. has a national minimum base price that is reviewed and negotiated annually  d. enables flexibility to reflect individual population need. |  |
| Quality and service excellence | 11. the home and community support sector meet the requirements of the Health and Disability Sector Standards. | 2018/19 |

# 1. Introduction

| **Area** | **Description** |
| --- | --- |
| Purpose | The purpose of this document is to provide advice to the Director-General’s Reference Group on the future provision of Vote: Health-funded home and community support services (HCSS) in New Zealand. The In-between Travel Settlement Agreement (the Settlement Agreement) required a review of HCSS, including a:  comprehensive analysis and response to the wider issues, including but not limited to levels of future demand, complexity of future demand, service changes and levels of funding required within sustainable Government funding and any other system or environmental constraints associated with ensuring a sustainable home and community based support sector. (Ministry of Health 2014)  The overarching purpose is to provide recommendations to ensure high-quality services for all people receiving Vote: Health-funded HCSS that meet the needs of the consumers in a cost-effective way and are based on best practice and evidence, and enable flexibility in service provision. |
| Background to and nature of this report | In 2014 the providers, employees and funders of HCSS agreed that from 1 July 2015 support workers would be paid for the time they spent travelling between clients, at a rate based on the Minimum Wage. The Settlement Agreement between the parties also provides for a minimum travel allowance.  Settlement Agreement negotiations led to discussions about the sustainability of HCSS under the current employment model. As a result, the parties agreed to investigate the impact and affordability of a sustainable regularised workforce. A Director-General’s Reference Group was established to conduct a review of Vote: Health-funded HCSS in one work stream, and to report on the impact and affordability of transitioning to a regularised workforce within two years of ratification of the Settlement Agreement in a second work stream.  Both working groups included representatives of the Settlement Agreement parties. In addition, representatives from ACC joined the discussions and took an active part in the deliberations of both groups. Both working groups were required to report to the Director-General’s Reference Group, which will in turn make combined recommendations to the Director-General of Health.  This report presents the summarised findings of Working Group One. Each member of Working Group One brought views and perspectives based on their experiences in their respective roles in the sector. Members have sought some informal feedback from their communities on the issues under discussion by Working Group One, but there has not been sufficient time for formal consultation on the content and recommendations.  In most areas we agreed on the general directions but sometimes disagreed over details. In some cases the ideal scenario for one settlement party could not be supported by other settlement party representatives. It was generally felt that most differences were not insurmountable, but instead represented issues that need further working through in the implementation process. Where significant differences of view remained, these are indicated in this report. |
| Scope of the report | Working Group One was required to provide information, advice and recommendations to the Director-General’s Reference Group, including identifying:   * the changing nature and complexity of current and future demand * service changes and the levels of funding required to meet future demand within sustainable government funding * any other systemic or environmental constraints associated with ensuring a sustainable home and community sector.   The main objectives were to develop recommendations on how the Government can achieve a clear mandate for the delivery of HCSS that:   * comply with the Home and Community Support Sector Standards * are effective and efficient, and provide value for money * lead to better outcomes for service users * are sustainable over the longer term.   Although there is some overlap, the report does not specifically cover clients or the workforce in:   * services or activities provided in Vote: Health-funded residential facilities (including residential facilities for people with disabilities) * respite or day-care services * mental health services * privately purchased services. |
| Link with Working Group Two: regularisation | Working Group Two’s focus was on the implications of regularising the workforce, including consideration of training issues. It strongly supported the development of a national service-level contract and a case-mix funding model. Working Group One had a higher-level focus on the whole HCSS sector, and the primary consideration was the needs of the client rather than the workforce.  Working Group One completed an analysis of the current HCSS environment, and also completed a literature review of models in operation in New Zealand and internationally. It found that the models used in New Zealand have not been in operation for long enough, or have not been sufficiently evaluated, to enable the working group to recommend one service model over another. However, there was a general consensus among the working group representatives to support a recommendation to move to a national service-level agreement for HCSS, underpinned by an agreed costing methodology. In particular, working group members agreed that it is important to develop a minimum service level to ensure both clients and HCSS staff live and operate in a safe environment.  We believe that our recommendations are not inconsistent with those of Working Group Two for moving towards a regularised workforce. |
| Application of this report to ACC | This report relates to Vote: Health-funded services providing home-based care to disabled clients and those aged 65 and over. The same workforce supports and provides care for ACC clients recovering from a short-term injury or requiring ongoing home-based care. ACC was not a party to the Settlement Agreement because it relates to Vote: Health funding only. However, ACC has agreed to negotiate arrangements, subject to the satisfaction of all relevant parties, that will have the effect of ACC paying for in-between travel at similar rates to those agreed in the Settlement Agreement.  In principle, ACC supports the recommendations made by Working Group One with regard to supporting an effective and sustainable home-based support sector. ACC has provided advice on and support for the development of these recommendations and is committed to supporting an effective and sustainable home-based support sector, but notes that because ACC is not party to the Settlement Agreement, ACC is not bound by these recommendations.  Once the Director-General’s Reference Group has finalised its recommendations, ACC will consider what further work will be needed to support effective and sustainable ACC-funded home-based support services. This process will be subject to approval from ACC’s Executive and Board, as well as the Minister for ACC, and may require further engagement with the sector. |
| Stakeholder engagement | Although there was some informal engagement during the development of the report, there has been no formal consultation with DHB, provider, consumer or union constituencies. Furthermore, there was no time for engagement with Māori and Pacific groups, other than that provided by Ministry of Health teams. Recommendations made to, and by, the Director General’s Reference Group therefore require further testing among affected parties and communities before being formally adopted. |

# 2. Current situation

| **Area** | **Key observations** |
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| Strategic context | The delivery of HCSS occurs in the context of a legislative and policy framework that binds, guides or limits funders, providers and workers. The strategic context under which the HCSS operate is set out in Table 1.  Table 1: Strategic context for HCSS   |  |  | | --- | --- | | New Zealand Public Health and Disability Act 2000 | This Act establishes DHBs, making them responsible for improving, protecting and promoting the health and independence of all New Zealanders in a way that is consistent with the New Zealand Health Strategy and the New Zealand Disability Strategy. | | ACC Act 2001 | This Act requires the Corporation to contribute to, or provide, HCSS where clients have an assessed injury-related need. | | United Nations Convention on the Rights of Persons with Disabilities 2006 | The Convention is a comprehensive human rights treaty that describes the rights of disabled people and sets out a code of implementation. As a signatory to the Convention (and the Universal Declaration of Human Rights 1948), New Zealand is obliged to develop and carry out policies, laws and administrative measures for securing the rights recognised in the Convention, and to abolish laws, regulations, customs and practices that constitute discrimination. | | New Zealand Health Strategy 2000 | First established in 2000, the Strategy describes key principles that should apply across the health sector, and identifies goals and objectives and population health priorities for the Ministry and DHBs. The Strategy sets the platform for the Government’s action on health. The New Zealand Health Strategy is currently under review, with a draft for consultation due later this year. | | New Zealand Disability Strategy 2001 | The New Zealand Disability Strategy (NZDS) provides an overarching vision for the full participation of people with disabilities in our society. In relation to HCSS, the NZDS seeks to ensure the workforce providing services is skilled to deliver home help and personal care, and specifically requires:   * the creation of long-term support systems centred on the individual * support for quality living in the community * support for lifestyle choices, recreation and culture.   The NZDS has a strong focus on the right of disabled people to lead a normal life. | | Health of Older People Strategy 2002 | The overarching vision is that ‘older people participate to their fullest ability in decisions about their health and wellbeing, and in family, whānau and community life. They are supported in this by coordinated and responsive health and disability support programmes.’  The strategy is currently being refreshed and the revised Health of Older People Strategy will need to align with the refreshed New Zealand Health Strategy. | |
| Strategic context (continued) | |  |  | | --- | --- | | Whāia Te Ao Mārama: The Māori Disability Action Plan 2012 | The aim of Whāia Te Ao Mārama: Māori Disability Action Plan 2012 to 2017 is to establish priority areas of action to enable Māori disabled to achieve their aspirations, and to reduce barriers that may impede Māori disabled and their whānau from gaining better outcomes. Four key priority areas are: improving outcomes, better support for whānau, good partnerships, and monitoring and reporting. | | Pacific Health and Disability Action Plan 2002 | The Pacific Health and Disability Action Plan sets out the strategic direction and actions for improving health outcomes for Pacific people and reducing inequalities between Pacific and non-Pacific people. It is directed at the health and disability service sectors and Pacific communities, and aims to provide and promote affordable, effective and responsive health and disability services for all New Zealanders. | | Home and Community Support Sector Standards  Health and Disability Services Standards | Various sector standards have been established to ensure consistent high-quality service delivery in various sectors. Some are regulated (eg, the Health and Disability Services Standards) while others, such as the Home and Community Support Sector Standards, are enforced through contractual requirements.  The advantage of regulated standards is that they apply irrespective of the contractual arrangements under which services are provided. | | Positive Ageing Strategy | The Positive Ageing Strategy is a comprehensive strategy setting out 10 goals and actions that span many areas, including income, health, housing, transport and employment. The Office of Senior Citizens reports annually on progress against all 10 goals. | |
| Other key influences within the wider health system | Several initiatives are under way that have some bearing on the HCSS sector, as shown in Table 2.  Table 2: Health initiatives relevant to the HCSS sector   |  |  | | --- | --- | | Review of health funding | This review will look at what funding arrangements are appropriate and how funding is allocated within the health and disability system. It will also consider how the Ministry of Health can improve its internal review and prioritisation processes for Vote: Health (it will not look at the total funding available for Vote: Health). | | Review of capability and capacity | This review will look at progress made to ensure the New Zealand health and disability system improves its adaptability and responsiveness to meet future needs. In particular, the review will consider how the contracting environment, capacity and relationship management between the DHB sector and NGOs are best placed to meet health system and user needs. | |
| Other key influences within the wider health system (continued) | |  |  | | --- | --- | | Kaiāwhina Workforce Action Plan | A five-year action plan has been prepared to support the development needs of the non-regulated workforce (kaiāwhina) to meet future requirements. A key goal is that kaiāwhina workers are regarded as valued members of an integrated service delivery team seeking to improve health and wellbeing outcomes. | | Streamlined contracting | The Ministry of Business, Innovation and Employment (MBIE) is leading a cross-agency project to streamline government−NGO contracts. This is expected to reduce the variation between government agencies in their contracting approaches, and standardise reporting requirements, which should reduce the burden on providers when negotiating, and reporting against, contracts. | | Pay equity legal action | A case was presented to the Employment Court in 2014 arguing that care/support workers in the aged residential care sector receive lower than average wages because they are in a female-dominated occupation. The outcome of this action may have implications for the home and community support workforce. | |
| HCSS: what are they, how are they funded and what is the volume of service? | Home and community support services (HCSS) have historically included:   * personal care (including meeting personal hygiene and dressing needs), mobilisation (including assistance with mobility aids, hoist transfers, exercise programmes), feeding, medications, socialisation and integration in the community, and observing and reporting changes * household management (including cleaning, laundry, meal preparation and other activities that support people to remain in their homes).   Care models have changed over time and there is now greater diversity. In some areas HCSS have expanded to include supervision (the presence of support to be safe in the home or community), education (support to build individual capacity), respite (the presence of support to give the full-time care giver a break), facilitating community access and participation, and education and employment through the presence of supervisory or personal care support.  As part of the review of HCSS, Working Group One also looked at needs assessment and service co-ordination (NASC) and services to support people discharged from hospital (or to prevent admission to hospital).  People who use HCSS can be grouped into three population groups,[[3]](#footnote-3) broadly reflecting differing needs and differing funding arrangements:   * **people with health needs**,including older people (aged 65 and over), people with long-term medical conditions, and those requiring short-term care following discharge from hospital (funded through DHBs) * **disabled people** (funded directly through the Ministry of Health) * people **recovering from injury**, or living with the long-term effects of injury (funded by ACC). |
| Number of people receiving services | Figure 1 gives an indication of the relative size of each population group. Note, however, that there is some fluidity, as clients can receive funding from more than one funder.  Figure 1: Number of people receiving HCSS, 2013/14  Figure 1: Number of people receiving HCSS, 2013/14  Source: DHB, Ministry of Health and ACC.  Note: There is some double counting of DSS clients (possibly up to a third) because clients who receive both household management and personal care services may be counted twice.  Older people are by far the greatest service users numerically, which clearly drives a large part of the cost, as noted below. It also means that most of the workforce will need the skills to work with older people. In addition, there are significant numbers of clients of all ages with disability and injuries, requiring differing skill sets. Some clients may have combined needs. |
| Expenditure across service funders | Figure 2 shows the general expenditure across funders. Again there is some overlap as some clients will have contributed to costs for more than one funder.  Figure 2: Expenditure on HCSS ($million), 2013/14  Figure 2: Expenditure on HCSS ($million), 2013/14  Source: DHB, Ministry of Health and ACC  Across DHBs, Ministry of Health and ACC expenditure on HCSS amounted to $626 million in 2013/14, which was 4.5% of Crown health expenditure. By way of comparison, approximately $939 million was spent by DHBs to fund aged residential care for around 31,000 older people.  As can be seen, although almost 60% of the people receiving HCSS are older people, expenditure on services for this group accounts for barely 40% of the total spending.  The higher expenditure for disability and injury reflects the greater complexity of care needs in these population groups. |
| Average cost of care per person per year across main service types | The cost of care per person per year is given in Figure 3. It shows that, although more older people receive HCSS overall, they have the lowest cost per person. The highest cost per capita is for disabled people, closely followed by ACC clients. The high per capita cost for ACC results from a small proportion of clients with serious injury (especially spinal and head injuries) requiring high levels of ongoing care.  Figure 3: Average cost of care per person per year, by population group, 2013/14  Figure 3: Average cost of care per person per year, by population group, 2013/14  Source, DHB, Ministry of Health and ACC data and contract information.  This graph clearly shows the higher per-person costs for disabled and injured clients. Individualised funding costs are significantly higher due to the need for a wider variety of services, and possibly due to the newness of the programme. |
| Forecast of future demand among older people | Statistics New Zealand forecasts that the over-65 population will grow at around 3.5% a year over the next five years, a similar rate of growth as has occurred over the last five years. This amounts to an expected growth of close to 20% in the demand for HCSS over the coming five years if utilisation rates increase at the same rate as the projected population growth of older people. However, growth in utilisation of HCSS may not occur at the same rate, because each age cohort is healthier than the one before. Offsetting that will be continuing efforts by DHBs to enable people to remain at home.  Figure 4 shows the predicted increase in HCSS use by older people, based on Statistics New Zealand population projections.  Figure 4: Projected number of HOP clients, 2013/14−2017/18  Figure 4: Projected number of HOP clients, 2013/14−2017/18 |
| Projected increase among older people by age | Table 3 shows projected increases in the use of HCSS by older people, by age group. For the next five years the largest numerical increase is in the 65+ years age group.  Table 3: Projected growth in number of older people and proportion accessing HCSS, 2014/15–2019/20   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Population projections** | | | | | | |  | **2014/15** | | **2019/20** | | **5-year increase** | | **Age** | **Number** | **Percent of NZ population** | **Number** | **Percent of NZ population** |  | | 65+ | 662,595 | 14.6% | 784,123 | 16.4% | 18% | | 75+ | 278,825 | 6.1% | 332,355 | 6.9% | 19% | | 85+ | 78,668 | 1.7% | 90,650 | 1.9% | 15% |   Source: Statistics NZ  A trend affecting aged care is the increasing number of people with dementia. Currently an estimated 50,000 older people have dementia, and this is predicted to increase to 78,000 by 2026. This increase will affect the training needs of support workers and may have an impact on rostering and case‑loads. |
| Disability forecasts | Based on current patterns of service use, it is projected that DSS client numbers will grow by a little over 10% over the next five years, while annual expenditure is expected to grow by around 8.5% (assuming no other changes). |
| ACC forecasts | ACC does not forecast demand in the same way as health and disability funders do, because injuries cannot be predicted in the same way as demographic change. ACC’s provision and funding of HCSS is demand driven. ACC provides HCSS on an entitlement basis, which means that clients are entitled to receive HCSS if they have an assessed injury-related need. This approach to providing care means that ACC does not operate within the same funding and provision constraints as the Ministry of Health and DHBs, where funding is subject to capitation.  Funding for ACC’s HCSS clients comes from a combination of levies (eg, on earnings and the Motor Vehicle Account) and government funding (eg, for the Non-Earners’ Account), depending on the nature of the client’s injury. The significance of this is that it is not capped in the way health funding is.  Over the past five years the number of ACC clients with serious injuries receiving HCSS has stayed relatively stable. ACC expects the number of these clients to continue to stay relatively stable (± 3% per annum) in the future. However, the average cost of HCSS per serious injury client has increased slightly over the past two years, which may be, in part, due to the shift from non-contracted HCSS to contracted HCSS. Over the past year average care hours have declined, but due to the difference in pricing, costs have increased. ACC expects this trend may continue (an average 6% increase in cost per serious injury client).  The number and total cost of non-serious injury clients receiving HCSS has been variable in the past. ACC’s provision of HCSS is demand driven, and ACC has little control over − and little ability to predict − the number of people who will have an accident and who will require HCSS. However, the average cost of HCSS per non-serious injury client has stayed relatively stable over the past five years, and ACC expects this long-term trend to continue.  In summary, ACC expects:   * around 3% growth in the number of clients with serious injury * decreasing average hours of care * increasing average cost of services. |
| What does the increasing demand mean? | Taken together, these scenarios show that significant increase in client demand is likely. Retaining and upskilling existing staff will be critical for the short to medium term. Creating an attractive work environment to encourage new workers with appropriate skills is needed, as is sufficient expenditure to meet demand. |
| HCSS providers | There are approximately 70 providers of HCSS, of which approximately half are not-for-profit providers. Over recent years there has been a trend towards more for-profit providers, and several acquisition programmes involving a few of the larger providers acquiring smaller providers. This has caused some rationalisation of the HCSS sector in terms of the number of providers. However, it is not possible to say whether or not this trend towards fewer HCSS providers will continue in the coming years.  The two largest for-profit HCSS providers (Healthcare New Zealand Limited and Access HomeHealth Limited) currently share over half the market. There are also several other large/medium-sized private and charitable organisations (Geneva Healthcare, Nurse Maude Association, Presbyterian Support , Salvation Army New Zealand Trust). The remainder of HCSS providers are smaller private, charitable, and iwi-based organisations.  Most providers have agreements with both DHBs and the Ministry of Health. Several providers also contract (or sub-contract) to provide services for ACC. Providers may have differing service requirements, payment rates and methods, and differing reporting obligations arising from separate contracts.  Providers and unions have indicated that the variability in pricing across DHBs for the delivery of HCSS to older people can be problematic. Currently, providers are paid an average of $25.50 for every hour of care and support delivered, with payments ranging between $22 and $28 per hour, representing a 27% variation.  The contracting picture from the perspective of providers is also complicated further because they might also hold parallel contracts with the Ministry of Health and ACC to deliver disability support services and post-accident care and support, respectively.  ACC has moved to a limited supplier model for purchasing contracted HCSS care, whereby it holds strategic contracting relationships with six providers (down from 200), who in turn sub-contract with others to provide HCSS. This model was developed to improve ACC’s ability to work with suppliers to drive quality, training and innovation and achieve greater consistency. All providers are required to comply with the Home and Community Support Sector Standards.  Ministry of Health HCSS contracts for disabled people and ACC contracts are relatively simple for providers to accommodate because they generally act as sole funders of services to the disability and post-accident population groups, respectively. In addition, national policy approaches and a single needs assessment and allocation framework and set of tools reduces complexity, especially for providers that operate nationally. |
| Workforce | There are approximately 20,000 care and support staff delivering HCSS to DHB-, Ministry- and ACC-funded clients.Within this overall total there are approximately 16,500 dedicated support workers with non-permanent hours and irregular work, who are backed up by a further few thousand casual workers.  Here are a few essential facts about the HCSS workforce.   * More than 90% of support workers are women aged between 45 and 64 years. * Less than half (46%) of support workers hold level 2 or level 3 qualifications. * Around 40% of support workers are paid the minimum wage of $14.75 per hour. * Workers delivering home-based care receive wage rates in the range of $14.75 per hour to $17.00 per hour. * Pay rates vary across the country, and there is no consistency between qualification and pay level. * Workers have insecure employment arrangements. * Around 30% of carers were born overseas, compared to 18% of the total New Zealand workforce.   (Ministry for Women 2013; Ministry of Health 2015a, 2015b)  This raises issues of the ‘fit’ of services with the clients being served, with a need for younger staff and more men, and people with a range of cultural competencies. Very little is known about the support workers assisting people using individualised funding, but it is thought to be a younger workforce, often recruited through personal contacts.  Another major factor affecting the workforce is high staff turnover (with estimated rates of between 20 and 40%). Turnover is high because many seek better-paid employment elsewhere in the service sector. In some respects, the HCSS sector provides a stepping stone to other opportunities. Staff can gain qualifications within a relatively short space of time and therefore move on to other areas. This increases recruitment costs for, and reduces the profitability of, service providers. High turnover also acts as a disincentive to invest in staff development and training. These factors reduce the potential to improve productivity and have a negative impact on the quality of services being provided.  Improving workforce capability and stability requires making HCSS work desirable so that staff stay in the sector. Appropriate pay, conditions and recognition of skill are central to achieving this. |
| Framing the discussion: what are the concerns we need to address | The sustainability of the HCSS sector is under pressure from three inter-related issues:   * demand is increasing * the workforce is largely unskilled and unstable * the sector is complex, with fragmented contracting and service arrangements.   These issues are discussed further below. |
| Future demand | There are two key drivers of demand: demographic growth and increased complexity. Increased life expectancy, higher levels of chronic disease in the population, a greater number of disabled people living into older age, and higher rates of dementia are likely to lead to greater complexity of needs among people requiring support to remain at home.  Counterbalancing these driving factors of future utilisation rates of HCSS use are:   * a general health improvement among future comparable population age cohorts * better use of technology and tele-care within HCSS * improved integration of related health care services − HCSS, hospital care and residential care * increasing use of community-based support services.   Although these changes will take time to flow through the system, there is a sense of urgency around a need for improvement, because it will take time to build and maintain the workforce and configure services for the future.[[4]](#footnote-4)  Rates of entry into aged residential care have been slowly but steadily declining, and this trend is not expected to change. This means that additional older people (that is, over and above demographic increases) are likely to require support in their own homes. The policy objective of ‘Ageing in Place’ will require greater levels of investment to keep clients with potentially more complex needs at home. |
| Workforce sustainability | High turnover in the sector results from very low wages, little training, insecure employment and lack of a career path. Working Group One expressed the view that HCSS are something of a ‘Cinderella’ service: marginalised and not well regarded.  High staff turnover increases recruitment costs and reduces profitability for service providers. High turnover also acts as a disincentive to invest in staff development and training. These factors reduce the potential to improve productivity and have a negative impact on the quality of services provided. The majority of workers have casual terms of employment, and may only work in the sector for a short time, especially if other employment opportunities arise in the community with better pay and/or conditions.  The 2012 Human Rights Commission Report *Caring Counts* noted that the low pay for carers reflects the low priority given to supporting older people. It advocated for greater training of the workforce to reflect the increasing complexity of need, and noted that greater security of employment would lead to increased productivity and improvements in quality. It also noted that the need for flexibility arising from a client focus can be a challenge for rostering, and that funding models can inhibit flexibility.  The increasing pressure to deliver health services to people in their own homes, coupled with increasingly complex health needs, will require a highly skilled and responsible workforce to ensure a reduction in turnover and high-quality services for clients. Investment in the HCSS workforce is needed to ensure a workforce capable of practising across all client populations. These investments include secure employment, pay rates that reflect the nature and value of the work, career pathways, and an ethical framework. |
| Sector complexity | Individual clients may need care and support services due to age, chronic ill health, disability, injury or any combination of these. Care and support workers must be able to provide services across all these domains. Service funding, however, comes through three separate streams: DHBs, Ministry of Health (disability) and ACC. This has led to differing approaches to funding, contracting and reporting, multiple points of assessment and assessment tools, and different ways to allocate services.  Needs assessment and service co-ordination (NASC) exemplifies this issue. Each funder pays for separate NASC. Each funder uses different tools to calculate the volume of assistance an individual may require. Several different processes are in place to determine how much funding is allocated to match the level of assessed need.  Another layer of complexity derives from the differing approaches taken by 20 DHBs, which is associated with a lack of consistency in access to services. DHBs also vary in the models of care they use and the way in which they fund them (discussed further in sections 4 and 5 below). |
| Sense of urgency around the need for attention to HCSS | In its 2011 review of home-based services for older people, the Office of the Auditor-General noted that the overall delivery of home and community support was generally adequate, but it did not consider that the Ministry of Health and DHBs could be confident that services were effective and efficient, or capable of meeting the expected future increase in demand (Office of the Auditor General).  A report on provider sustainability shows that some providers are struggling financially after several years of under-investment, and that urgent attention to this is required in the short term (Deloitte 2015). The increased funding for travel between clients resulting from the Settlement Agreement will ease some of the pressure. However, it is clear that additional funding will be required to ensure ongoing sustainability of the sector (discussed in Section 5 of this report). |
| What overall outcomes do we want to see? | Collectively there are four distinct stakeholder groups that have related but differing aspirations. We have identified high-level outcomes for each of the stakeholder groups that relate back to issues raised in the Settlement Agreement. These are set out in Table 4.  Table 4: Outcomes sought across key stakeholder groups   |  |  | | --- | --- | | **Group** | **Outcomes sought** | | Clients (and their family/whānau) | * Client-directed care and support, measured through client experience * Equity of service access for each population group nationally * Service models that are responsive to varying needs and preferences | | Workforce | * A permanent, stable workforce with guaranteed hours * Workforce qualifications, competency and training matched to complexity of assessed client need * Ability to attract suitable people to the role * Remuneration is comparable to equivalent-sized occupations | | Providers | * Services are provided that meet client need * Services are integrated to ensure HCSS providers do not work in isolation – care/support workers are part of a wider team * There is sufficient funding to invest in staff and service development | | Funders/government | * Procurement of sustainable services to meet assessed population need * Service quality and efficiency can be demonstrated and measured * Wider social objectives are met, especially around supporting people to remain healthy and independent in their own homes and minimising their need for acute or residential care * Integrated service delivery | |
| Framework for HCSS | We developed a framework for looking at the HCSS sector, starting with the three population groups and four key stakeholders, and the outcomes noted above. Other elements of the framework are explained in the rest of the document. The framework is described below.  Figure 5: Future home and community models  Figure 5: Future home and community models  Moving from left to right in Figure 5, we have identified the population groups and their overarching philosophies. The orange box identifies high-level outcomes for each of the stakeholder groups. Our review of national and international literature and best practice led us to recommend a broad approach that can apply across all population groups, rather than recommend a particular model of care. The high-level outcomes required of the Settlement Agreement are identified and informed our recommendations. |

# 3. Client and population focus

| **Area** | **Key observations** |
| --- | --- |
| Client choice as the central focus | Over the last decade there has been an increasing focus on the client (and family) as central to the assessment of care and support needs, and in determining the type, level and timing of support provided. This is especially well developed in the disability sector, drawing on its rights-based foundation. There is an expectation that future clients (eg, baby boomers) will expect to have greater input and choice in determining the care and support they need and receive.  Internationally and nationally an evidence base is building on the positive effects of increasing client choice and control. Despite the wide-ranging models of home-based support services that exist, relatively few have been systematically evaluated, or have published data on their clinical experiences or their model of care (Beck et al 2009).  In many countries, moves to a greater client focus are occurring alongside increasing demand and a need to maximise cost-effectiveness, particularly by reducing spending on acute hospital care, long-term care and residential care. Irrespective of whether the evidence supports cost-effectiveness, however, increased client choice and control fairly consistently deliver increased client satisfaction.  Logically, if an outcomes focus is adopted, then a central outcome for services to support people in their homes has to be aligned to the needs of the individual client. This focus, therefore, needs to be reflected in the structures that surround the client.  In its review of home-based support for older people, the Productivity Commission reviewed the evidence and sought the views of clients, providers and funders. It concluded that ‘more client choice is generally better, but needs to be accompanied by systems that provide guidance and information for ... people exercising choice, and that guard against abuse’ (New Zealand Productivity Commission 2015, Appendix E).  Increasing client choice can have benefits at the individual and system level, leading to a better match between individual needs and the care and support people are offered, the training that staff receive, and the way service quality and effectiveness are measured. Increased client choice can strengthen incentives for providers to look for new ways to deliver their services. And client choice can be a driver of integration and coordination among providers and funders.  Various terms are used to describe client choice. Working Group One chose the term ‘client-directed’ to mean that the client is an active participant, rather than a passive recipient, in the processes of assessment, service allocation and service delivery. Individual clients will vary in the extent to which they exercise choice and control, and providers will adjust their services accordingly.  In the context of this report, client-directed care is not a new model for the delivery of HCSS, nor does it relate solely to individualised funding packages. It signals a direction underpinning a change in mind set by both providers and clients to ensure a more flexible partnership is established. Providers and their clients will need to work together to ensure clients have more choice and control in the delivery of their support than is currently the case. The shift is from a provider-controlled service delivery, where the person’s problems are the focus of services delivered, to one that is client-directed, where individuals are actively involved in the assessment and care planning process to identify their strengths, values and life goals, and the support needed to overcome any barriers to achieving them. |
| Client-focused model We developed this model to convey the idea that the client is at the centre of the home and community support sector | Figure 6: Client focused model of care  Figure 6: Client focused model of care |
| Elements of the model | Elements of the model include:   * **client needs**, preferences and experiences as the start and end points for the delivery and funding of home and community support * the home and community support **workforce** appropriately trained, fairly paid and supported to provide safe, high-quality services to meet client needs with respect and dignity * HCSS **providers** resourced to meet the assessed needs of their clients in a way that recognises client choice and engagement, efficiently manages staff resources, and builds a stable, confident workforce * **funders** with sufficient resources to ensure a sustainable sector, using national tools and local alliancing approaches to meet the assessed needs of their client populations * the **Government** prioritising the provision of care and support to enable people to remain in their homes and communities,and collecting information on client experience and system efficiency * the **communities** where clients live, work and engage with others being recognised as important partners in the care and support of people who need HCSS. |
| Models of care | Working Group One was required to consider service design, or models of care, as part of the review of HCSS. Several models of care are currently in use for the different populations under consideration, and they each have their strong and weak points. A brief description of the key models is provided below. Supportive care In broad terms, the traditional model for the older people health group is a supportive approach that provides assistance with household management and personal care, with the care/support worker providing hands-on care. It is task-based, and is often characterised as *doing for* rather than assisting or supporting. A provider is funded to provide a specified amount of time, and the care and support worker is allocated particular tasks to carry out. There is some flexibility to vary the tasks/support within allocated hours. Restorative care A restorative model is an approach to care that seeks to: promote independence, restore function and/or prevent decline, ensure the comfort of the person, and help them attain set goals. The model integrates principles from medicine, rehabilitation, goal facilitation and nursing to improve functional outcomes for people. The role of the worker is changed from a traditional tasked based approach to an approach where workers take a trainer/facilitator approach to assist a client to return to independence (Parsons et al 2015). |
| Models of care (continued) | Table 5: Key elements of a restorative approach   |  |  | | --- | --- | | **Restorative element** | **Explanation** | | Goal facilitation | A key concept of restorative care is to base a support programme on the goals and aspirations of the older person. This requires the identification of both a long-term goal and the short-term goals required to attain the long-term goal. | | Function and repetitive activities of daily living (ADL) exercises | Functional exercises involve working on muscle groups used in everyday activities, and programmes are undertaken by the person, under the supervision of the support worker. | | Support worker training and enhanced supervision | Restorative home support relies on support workers to collaborate with clients to maximise their independence. In addition, restorative home support encourages enhanced health professional integration. |   Evidence shows that individuals who receive restorative home care show greater improvement in their self-care, home management and mobility scores at discharge than those receiving traditional home care, and the quality of service provision is enhanced and benefits both the older client and the support worker (Tinetti et al 2002; Auckland Uniservices Ltd 2006; King 2010).  Restorative models are currently used by some DHBs for older people, for people post-hospital discharge, and for people recovering from injury. Some DHBs use what might be called Restorative-Plus, where additional interventions are delivered by a community-based workforce to improve health outcomes.  Early supported discharge models (to speed the transition from hospital to home), such as START (Supported Transfer and Accelerated Rehabilitation Team) and CREST (Community Rehabilitation Enablement and Support Team), have been shown to reduce length of stay in hospital, prevent hospital readmission and lower costs overall. Te Whiringa Ora is a long-term condition management programme that has been shown to improve people’s health and wellbeing, and by doing so reduce the number of emergency department presentations, hospitalisations and outpatient visits for people with complex health needs. (For more information about these initiatives, see Appendix 1.) These prevention initiatives support restorative care models. Restorative model for people with dementia Historically, restorative home-based support services for people with advanced dementia have not been widespread, and as a result there is limited evidence and evaluations of models to support these individuals. Some advances have been made internationally and show improvements in the daily function of the person, quality of life, mood and health status. The rate of institutionalisation is reduced, and improvements are recorded in caregiver confidence and overall wellbeing (Graff et al 2008; Gitlin et al 2000; Eloniemi-Sulkana et al 2001). Care/support worker views Surveys of support workers in New Zealand have shown they enjoy working in a restorative approach, but that there are challenges, including lack of adequate information on new clients and resistance from some clients and families. Most of those interviewed said they had not received training in how to determine which clients should receive restorative care, rehabilitative care or supported care interventions.[[5]](#footnote-5) |
| Disability models | Models of care for disabled people are rights based (stemming from the UN Convention on the Rights of Persons with Disabilities) and focus on enabling a person to ‘live an ordinary life’. They are therefore necessarily broader in nature than personal care and household management, and may include assistance with accessing social activities, education and wider community life. New ways of organising support are being trialled, including models where the clients take the lead in coordinating their support needs and managing their budgets. Currently over 2000 disabled people are using individualised funding. |
| Individualised funding approaches | Individualised funding approaches give clients direct control of a personal budget for their care and support needs. In New Zealand, individualised funding is available to disabled people who meet the eligibility criteria. Internationally this approach is also used for older people. Generally it is younger people who take up this option, however, and locally it is expected that up to around 20% of disabled people may eventually take up this option.[[6]](#footnote-6) Being actively involved in the management of their own health and wellbeing, and being supported to take opportunities to provide feedback on health services used, is particularly important for Māori and provides a mechanism to contribute to quality improvement programmes (Ministry of Health 2015a). |
| Care for injured people | Care and support for injured people fall into two main streams:   * return to independence, which focuses on restoring people to their pre-injury state * maximising independence, which focuses on assisting a person (usually with a longer-term need) to reach and maintain as high a level of functioning as possible.   These approaches are similar to the disability and restorative models, and also include supportive care for those clients who require greater support with their activities of daily living.  ACC clients have had the ability to choose a model similar to individualised funding for HCSS for over 15 years (called non-contracted care). More recently, in 2013 ACC introduced self-management for serious injury clients with stable needs and living conditions. Since the introduction of the new HCSS contract (September 2012), large numbers of clients have shifted from non-contracted (private) care to contracted care. While some of this shift is financially driven, it can also be attributed to the administrative burden that non-contracted care places on the client and their carer. As of February 2015 there were only 33 seriously injured clients using self-management. |
| What does the evidence say in general about models of care? | The international literature on cost-effectiveness of home care appears relatively conclusive, with researchers reporting that home care is cost-effective compared to alternative care options such as acute care and residential care (Hollander 2001; Elysium Services Ltd 2008; Beck et al 2009; Smith et al 2006; Kellog and Brickner 2000; Martin-Matthews and Sims-Gould 2008). |
| What does the evidence say in general about models of care? (continued) | Beyond this finding, the evidence supporting particular models of care and funding approaches is patchy and uneven, with very mixed results. Some studies demonstrate positive outcomes for clients and/or budgets, while others do not. Many studies do not focus on workforce needs and implications. Several themes can, however, be distilled from international literature on models of care that describe the elements of an ideal model of care. These are consistent with our belief that HCSS need to:   * be client directed * use team-based approaches * take account of the wider family and community context.   In addition, care and support should be delivered in a way that is:   * personalised and flexible * accessible and equitable * integrated and coordinated.   There also need to be processes to ensure:   * access to relevant information * effective prioritisation * a collaborative approach * ongoing sustainability of services.   Overall, the international evidence on individualised funding is mixed, and shows there is:   * strong evidence to suggest this approach improves client wellbeing and satisfaction * little evidence to suggest health outcomes are better or worse than under agency-directed approaches * little evidence to link client direction to increasing or decreasing levels of social isolation * some evidence that costs can be higher than alternatives, though this may result from poor eligibility criteria and latent demand * little evidence to suggest the risk of abuse is higher or lower with client-directed care * little evidence on the impacts on care/support staff, and the evidence that exists is mixed.[[7]](#footnote-7)   Working Group One notes the findings of an evaluation of Te Whiringa Ora (or TWO), which provide clear evidence of improved health outcomes, quality of life for the client, as well as a decreased frequency of outpatient usage and decreased presentations to emergency departments through a community-based approach that facilitates interdisciplinary care. Assessment of client experience indicates that TWO is appropriate across all cultural groups, including Māori. This is important, because only 2% of aged residential care residents are Māori, compared with 92.4% European. Kuia and kaumātua are more likely to be cared for at home by whānau, meaning that an appropriate, culturally appropriate response from HCSS is very important (Human Rights Commission 2012). |
| What does the evidence say in general about models of care? (continued) | CREST is a multidisciplinary approach to HCSS for older people that demonstrates a reduced load on acute occupied bed days and reduces readmission to hospital. This is an intensive, short-term programme, specifically targeted at people coming out of hospital. Its utility and cost as a programme for longer-term care/support has not been tested, nor has client experience been explored. One of Working Group One’s consumer representatives was not supportive of some of these models because of their short-term nature and the fact that client experience was not evaluated.  Decreasing use of aged residential care (ARC) and increasing rates of older people remaining in their homes were noted in a survey of 389 ARC facilities. There has been a low rate of growth in ARC bed numbers, despite the growth in the over-65 population. Between 2001 and 2005 subsidised home support service hours increased from 6.5 million to 10.2 million, representing an increase of 56%. During the same period, the over-65 population increased by only 9%. The increased availability of home support has led to 15% more older people accessing 36% more home support hours per client (Thornton 2010). An increasing body of New Zealand-based research shows that the development of integrated community solutions is essential for enabling older people to retain their independence and functioning as long as possible (Parsons et al 2008). |
| Ideal components for models of care | Each model of care has strengths and weaknesses, and has evolved within a complex and evolving procurement environment and in response to the different needs of particular populations of clients. For this reason we felt it was not possible to recommend a single model of care that would be applicable across the three population groups. However, we agreed on key components that must underpin any care model to ensure HCSS clients receive optimal care outcomes, as follows.   * Clients requiring HCSS have access to high-quality care, support and information, which are tailored to meet their needs. * Services are client-directed, and people are supported to live safely at home, where appropriate, while maintaining independence and personal choice. * Needs assessment, service co-ordination and allocation, and funding are informed by evidence and best practice. * Care and support are provided in a holistic, integrated way that recognises the interconnected nature of HCSS requirements. * Workforce qualifications, competency and training are matched to the complexity of assessed client needs. * The quality of care and effectiveness of service delivery can be measured.   These are high-level outcomes that are universal across the different service models and funders. It is not always easy to measure these things, but information collection will be critical for providers and funders to know whether progress is being made towards achieving these outcomes. This is discussed further in the following sections. |
| Tools to support integrated care | If clients are the focus, and care and support workers are the eyes and ears of the wider multidisciplinary team, there needs to be a way to facilitate information sharing and care planning. For this reason, Working Group One recommends that the National Health Information Technology Board give priority to shared-care technology development that includes home and community services. |

# 4. Sector planning, coordination and alignment

| **Area** | **Key observations** |
| --- | --- |
| Why is sector planning an issue? | Strategies, policy settings and service organisation shape and direct the focus, content and delivery of services. If a client focus is to be implemented, it needs to be woven through all parts of the system. As noted above, there are differing pieces of overarching legislation, policies and strategies that define and shape the delivery of services. These differing drivers contribute to what are commonly referred to as separate ‘silos’, whereby services often work alongside each other.  At one level, silos make it easy to direct and monitor government expenditure: accountability lines are clear and spheres of influence are clearly defined. But from the client and provider perspective they often don’t make sense. Starting from the point at which clients enter the system, these silos mean there is duplication of effort, such as multiple plans and assessments. As well as complicating the lives of clients, this has a cost to the system. Also, previous planning has not always included client voices at every level. |
| Starting at the beginning: needs assessment and service co-ordination | As noted, there is considerable duplication across needs assessment and service co-ordination (NASC) services.  Older people are assessed for home and community support services using the InterRAI tool, including when they are being discharged from hospital. InterRAI is an internationally validated tool modified for use in New Zealand. It gives a comprehensive clinical assessment that helps staff select appropriate support requirements for older people. It was introduced to DHBs from 2008, and while it is supposed to be used for all assessments of older people, this is not always occurring. In many areas an initial screening is done by the NASC, which then determines if the client requires a complex or non-complex assessment. In some DHBs the client is referred to a provider who completes non-complex assessments. There are various methods of determining the level of service and the associated funding required for each individual (service funding allocation is discussed further in section 5 below).  Disabled people are assessed by separate NASC using a separate needs assessment tool, which uses a strengths-based approach (rather than a deficit approach) and includes a broader range of topics, such as wider educational and social needs. Supported self-assessment tools are being trialled for use also. The service coordination part of the service (which may be a separate service) then determines the amount of assistance a person can receive, and this is the basis for a discussion with the client about how best to organise support.  Injured people also undergo assessments delivered by separate assessors using their own assessment tools. People with long-term conditions may also have varying assessments, carried out by their general practitioner or specialist, who may also develop a care plan.  Clearly, the needs of people will differ when they result from disability, chronic ill health, ageing or injury. We are not advocating a single assessment tool, but there is merit in investigating the extent to which NASC systems could be improved within, and across, the population groups. This would reduce multiple assessments for clients, and should result in some system efficiencies. A key facilitator in this regard could be a shared care record,[[8]](#footnote-8) with the details worked through locally. Some PHOs have developed shared care plans that allow multidisciplinary sharing of information and involvement in care planning.  Care and support workers are well placed to be the eyes and ears of the broader care team, but they need to be appropriately trained and trusted to take this role, and there needs to be a mechanism or process for providing feedback to the wider care team. Technology and systems have a role here, and Working Group One recommends priority be given to how HCSS services can link to shared care plans. |
| Service integration | Service integration (ie, joining up or coordinating services) is integral to the delivery of a seamless service to clients, and should reduce duplication and gaps. Integration at the policy level is also required. As observed by the World Health Organization (2002):  Patients need integrated care that cuts across time, settings and providers, and patients need self-care skills for managing problems at home. Patients and their families need support within their communities and support from broader policies to effectively manage or prevent long-term conditions. Optimal care for long-term conditions requires a different health care system.  We see integration as the wiring board that sits behind the façade of ‘seamless services’. The word ‘façade’ is not meant to imply that it is a fake; rather that a seamless service is what the client wants to see: easy access to coordinated delivery of care and support. At its best, the concept implies there is no wrong door, as any entry point leads into the system, and − irrespective of the funding flows, assessment tools, contract forms and payment methods − results in co-ordinated, responsive, high-quality, personalised care/support.  The Productivity Commission also supports a need for integration, defining it as:  the management and delivery of social services so that clients receive the right mix of preventive and curative services according to their needs over time. Service delivery is co-ordinated within the social services system to make it timely and convenient for clients. (New Zealand Productivity Commission 2015: 208)  This definition suits our purposes, especially because it implies co-ordination of a range of primary-care-level services, and contemplates both more complex health care and care beyond the health sector.  The main benefits of integration are improved effectiveness for clients, and cost-effectiveness for funders and providers. Integration works best where services are linked in a chain (eg, community, primary and secondary care) and for clients who have a complex set of needs. It also requires all parties to be willing.  As part of the work being done to update the New Zealand Health Strategy, the Ministry of Health is testing a set of 10 to 12 key integration attributes. Although this work has been led in the primary care sector, the aim is to develop ‘non-denominational’ guidance that can be applied to different parts of the health and disability sector. Consultation on the draft revised strategy will occur within the next few months, and we would expect the HCSS sector to be involved in this process. |
| Community health and disability strategy | To systematically address the issue and impact of separate service silos, and the marginalised status of the home and community sector, and to achieve better coordination of services, Working Group One recommends the development of an integrated community health and disability strategy. Such a strategy would sit over the separate health of older people, disability and primary care strategies and would provide a broad view of the priorities and inter-relationships that are needed across all services delivered in the community to provide coordinated and seamless care.  By way of example, Canterbury DHB has developed a variety of ‘care pathways’ that map out diagnostic and treatment paths for people with particular conditions. They provide general practitioners with information, advice and access to various specialists and other services to provide coordinated care for their patients. This is an example of integration being built from the bottom up. A community health and disability strategy would promote integration from the top down, and should facilitate a much broader view of providing care in the community.  Our view is that a community health and disability strategy would provide much greater visibility of the place of the home and community support sector in the provision of primary-level care. |

# 5. Contracting and funding

| **Area** | **Key observations** |
| --- | --- |
| Contracting or procurement approaches | Each year the Government funds DHBs through the Crown Funding Agreement (CFA), which is the agreement between the Minister of Health and DHBs. Through the CFA the Crown agrees to provide funding in return for specified services. Currently DHBs are required to provide home and community support services as part of a suite of older people’s services (others include, carer support, residential respite, age-related residential care, community health services, rapid response and discharge services, rehabilitation and stroke services).  In order to plan and deliver HCSS in accordance with the CFA, DHBs must provide:   * needs assessment * service coordination * personal care services, delivered primarily in a person’s home (eg, assistance with dressing, bathing, eating and toileting).   DHBs are allowed to income test for household management services (eg, assistance with meal preparation, laundry and cleaning). Household management services are free for Community Services Card (CSC) holders. If a person does not have a CSC, a part or full charge can apply. In practice, DHBs often charge CSC holders who receive only household management services; clients with a CSC receiving both personal care and household management might not be charged.  It is against this backdrop that DHBs engage in procurement processes to meet the HCSS demands of their respective populations. Procurement of HCSS requires DHBs to consider population needs, funding availability and methodology, pricing, risk management, quality, eligibility, performance measurement, information flows, provider market sustainability and interactions with other services, and to choose an appropriate service model. Procurement of HCSS is also affected by the funding DHBs make available; there is a view that provider arm services attract more funding than community services.  Any change to the HCSS service model is likely to affect other services provided across the care continuum. Therefore, procurement not only considers the model of care being purchased and associated funding and contracting arrangements, but also the broader context of other services operating to support older people and what other changes will need to occur to ensure both cost and service effectiveness across the whole health of older people environment. |
| Alliancing approaches to procurement | Since 2010, alliance agreements have been used in the health sector by the Better, Sooner, More Convenient (BSMC) businesses. Alliances promote integrated resource management, with decisions about health care services being made by all the relevant professionals and organisations. An alliancing approach is essentially a discussion between funders and providers on the population needs to be addressed, the likely volume of service, and the level of funding, goals and outcomes sought.  This approach provides a more ‘fit for purpose’ arrangement that promotes and facilitates integration, regional service planning, and alliance funding and planning, all of which supports service development and integrates this with funding and financial risk management in a shared risk framework. Alliance agreements create a high-trust, low bureaucracy environment with high quality and accountability. They also provide a mechanism for clinical leadership in the development of health services. Within these alliancing relationships, both DHBs and providers continue to face huge challenges to deliver high-quality and safe patient care that is financially sustainable in the long term.  In principle, alliances support shared decision-making and shared accountability to deliver high-quality, results-based outcomes. Alliances vary between DHBs, and one of the key issues is how authority and risk are to be shared. Not all alliances include social support services, and it is not clear how vested interests are dealt with. |
| Alliancing approaches to procurement (continued) | There is no clear set of operating procedures, but the Ministry of Health has developed some broad guidance.[[9]](#footnote-9) The aspects of procurement for HCSS that are important to DHBs include:   * a model of care that: * is directed in the first instance at people with high and complex needs * is responsive to Māori, and other locality-specific ethnic groups * enables the home and community support workforce to be part of the wider primary care team, including taking a key role as the *eyes and ears* in the home to recognise a person’s deteriorating condition (either physical or social) and linking into other support services * takes pressure off other parts of the system (eg, unnecessary presentations to hospital) * being supported by a funding and contracting model that: * recognises complexity and acuity * shares risk appropriately between funder and provider[[10]](#footnote-10) * incentivises performance and can measure effectiveness * maximises certainty for providers (this will support the regularisation of the workforce) * maximises economies of scale within a district or locality * provides HCSS providers with annual funding increase adjustments similar to providers with national contracts, including PHOs, ARC and Community Pharmacy[[11]](#footnote-11) * includes the principles of alliancing.   Future enablers include:   * the use of technology – an electronic shared care record that can be accessed by all providers involved in a person’s care, including the person themselves * a national community care strategy (rather than a primary care strategy based largely on PHOs) that recognises the important contribution of the home and community sector to improving health system performance and health outcomes * a review of national policy settings * implementation of continuous improvement strategies. |
| Alliancing approaches to procurement (continued) | A costing model was developed jointly between DHBs and providers, with input from the Ministry of Health. For funders, the use of such a tool provides an ‘order of magnitude’ indication of service price. It can also help identify providers that have greater economy of scale, or other factors that make them more efficient than others. For providers, such a tool helps identify the variable and fixed costs of its service.  The assumption was, perhaps, that DHBs would adopt the prices arrived at in the modelling and apply them to service contracts. This has not occurred for a variety of reasons. The first reason is affordability. With constrained funding and multiple priorities it is difficult for DHBs to increase service prices over and above the real annual increases they receive in the funding package each year, especially as funding increases must cover demand and cost growth. From the provider point of view, the gap between their current prices and the modelled price is significant.  The second reason is that, at the time this work occurred, DHBs were increasingly moving away from unit price models towards bulk-funded models. DHBs were re-contracting for services in a competitive market, and in many cases stayed within their current funding envelope for HCSS.  The third reason is that price alone does not take into account the logistics of efficiency. Some DHBs believe they have too many providers operating in their district, which contributes to diseconomies of scale. Services with diseconomies require a higher price to operate sustainably. It is worth noting that the size of the provider does not necessarily determine economies of scale – a small or local provider can achieve economy of scale in the delivery of home and community support services if it has other (complementary) services. And a large national provider may not have economies of scale in a district if they are one of many operating in an area with small volumes.  We therefore recommend that HCSS funders adopt an alliancing approach to better align incentives for organisations to work together towards a common goal. |
| Funding allocation tools: strengths and weaknesses | Funding allocation tools take the assessment information (scores, categories or levels) and convert this into a level of support, such as hours per week or dollars per client. It is not just a mechanical formula, however: it is a combination of technical tools that calibrate the quantity of support required, along with clinical judgement.  It is important to note that the funding model does not necessarily determine the service delivery model. The choice of funding model does, however, affect service delivery through how much flexibility the provider has and who bears the risk of under- or over-delivery. There are a variety of funding models operating across the sector, which are broadly described in Table 6. |
| Funding allocation tools: strengths and weaknesses (continued) | Table 6: Comparison of common funding allocation approaches   | **Funding approach** | **How it works** | **Strengths and weaknesses** | | --- | --- | --- | | Payment per hour of care delivered (fee for service) | Following needs assessment, the funder allocates hours of specific tasks, such as dressing, showering and feeding. Providers are paid in blocks of time (usually fortnightly) for services actually delivered at agreed rates per hour. Increases in hours of care, week to week, need to be approved by the funder.  Where the funder does not specify the hours or services closely, the ‘payment per hour’ approach comes close to the ‘payment per person’ approach (discussed below). | The payment per hour of care approach:   * is simple to administer and provides good volume and expenditure data * lacks flexibility to address changing client needs unless the funder very quickly responds to provider reassessments * provides no incentive to discharge, or reduce service for, clients that no longer need them (which may lead to over-servicing) * may make it more difficult for providers to introduce new ways of meeting client needs, as agreement with the funder is required * can make it difficult for care and support workers to maintain their income when clients change, go on holiday etc, and may create a disincentive for providers to guarantee hours or make greater long-term investment in training and qualifications (unless the rate of payment accounts for potential non-service days and training) * means that clients’ needs may not suit the half-hour blocks of time allocated, potentially using service time inefficiently. | |
| Funding allocation tools: strengths and weaknesses (continued) | | **Funding approach** | **How it works** | **Strengths and weaknesses** | | --- | --- | --- | | Payment per person per week (or longer period) with people assigned to payment categories | Funders allocate clients to a category (eg, by case-mix algorithm from interRAI data, or other means, such as eligibility for ‘supported living’).  Each category is a broad group that shares similar levels of need, and payment to the provider is a set amount each period. Providers determine the specific tasks and hours provided each week. | The payment per person approach:   * gives the provider greater flexibility to manage overall costs across a pool of clients * provides greater scope to develop a regularised workforce and the ability to offer guaranteed hours of work and greater investment in training and qualifications (unless the rate of payment accounts for the expected level of non-service days); more frequent changes in service hours may make regularised hours more difficult * provides an incentive to reduce unnecessary services, and to match staff skill to client need, but also creates an incentive to reduce *all* service levels, which must be managed; also regularisation reduces the incentive to reduce unnecessary services because in some cases the provider will be paying for the hours * current case-mix tools derive from hospital inpatient services and do not translate easily to community services, so it cannot completely account for differences in clients’ ‘natural supports’, but with large numbers in each category it may be adequate for setting an average payment rate; a ‘package of care’ approach better accounts for individual circumstances * allows trade-off between time integrating with other health services (when they are required) and time directly meeting client needs * means greater flexibility (potentially), which allows for greater client involvement in determining packages of care to suit their individual circumstances. | |
| Funding allocation tools: strengths and weaknesses (continued) | | **Funding approach** | **How it works** | **Strengths and weaknesses** | | --- | --- | --- | | Bulk funding | Providers are allocated a fixed sum per year (based on an estimate of the volume and complexity of client need the provider will have to manage). Providers determine how to allocate the funds across their entire client group. Any changes in the payments need to be negotiated.  Bulk funding arrangements with end-of-year wash-up for differences between actual numbers or levels of need bring the approach closer to the payment per person per week. | The bulk funding approach:   * caps costs for the funder, and provides funding certainty for the provider (depending on arrangements for end-of-year wash-ups) * means the risk of larger numbers or higher average client needs falls on the provider, in the first instance, to prioritise services or raise prioritisation or extra funding with the funder * provides an incentive to reduce unnecessary services, and to match staff skill to client need, but also creates incentives to reduce all services that must be carefully managed * rewards innovation and substitution * provides greater scope to develop a regularised workforce and the ability to offer guaranteed hours of work and greater investment in training and qualifications * allows a trade-off between time integrating with other health services when they are required and time directly meeting client needs * provides greater flexibility (potentially), which allows for greater client involvement in determining packages of care to suit their individual circumstances. | | Individualised funding | The client is allocated a budget, which they manage either in its entirety or with assistance from a host agency.  ACC also funds some clients directly through its ‘non-contracted’ stream. | The individualised funding approach:   * means the client takes responsibility for identifying the range of services, employing their support worker and paying for services, thereby more closely matching their needs * makes it more difficult for the funder to monitor quality and performance * potentially gives insecure status to the care/support worker and no formal training or support mechanisms, which means a potential risk for the support worker when the client is also the employer. | | Rather than recommend a single funding model, Working Group One has developed a proposed pathway of care for older people that can be funded by any of the funding models discussed above. The model below is proposed for services funded through DHBs in the first instance, because there is more variation in this sector. | | | |
| Proposed care pathway for the health of older people | Figure 7: Proposed model for health of older people  Figure 7: Proposed model for health of older people |
| Contracting approaches | Working Group One discussed the option of a national agreement (with national prices) as a way to improve consistency and certainty in the sector. Minimum standards for quality and workforce should be adopted to ensure that price competition does not undermine quality. Further work needs to be done to investigate how quality could be reflected in a national price, and how prices can be maintained (eg, when wage rates change). The benefits of this national approach are that it could:   * provide national consistency – for some providers still on fee for service the increase in funding could be substantial in some districts where prices are lower * guarantee an annual price increase, noting that sectors with national contacts such as PHOs, ARC providers and Community Pharmacy have been guaranteed price increases each year, often in excess of the contribution to cost pressures received by DHBs in their annual funding package (up until the 2015/16 planning year this was set as an expectation by the Minister; annual price increases to HCSS have been at the discretion of DHBs, with variability in approach across DHBs from year to year) * provide a national negotiation process, which could provide more leverage for the sector * have the potential to resolve difficulties of the pay rates and practices of support workers who move across DHB boundaries * aid a national approach to workforce development * reduce transaction costs (especially for national providers).   Challenges with a national agreement approach include:   * *affordability* − particularly for any transition, in a severely constrained environment * *acceptability −* it is unlikely that a national price would be the highest price currently paid across all DHBs, and this would be difficult to promote across the sector * *autonomy −* some loss of freedom for providers in a more regulated environment, which may stifle innovation, and smaller providers are sometimes disadvantaged in a national negotiation process, particularly if they are not represented by an association * DHBs would lose the flexibility to respond to local priorities and funding pressures * other options are available to improve consistency, such as the requirement that DHBs and providers use an agreed costing tool as a basis for local discussions, and to work to develop an agreed case-mix algorithm to categorise need and use alliancing approaches to guide procurement.   We are aware that Working Group Two recommends a national contract. 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. |
| Ideal funding approach | We also identified several characteristics for an ideal funding approach. These are described in Table 7.  Table 7: Characteristics of an ideal funding approach   |  |  | | --- | --- | | Services meet client needs | To be person-directed, the services needed should be what the person wants, and up to the level the funder (or its agent) judges is needed (to be a good use of public resources, given the other health and disability needs of the population).  The type of service should be what the person wants, within the limits of the type of service it is publically acceptable to fund. The funder (or its agent) should offer advice on what will best meet needs, and the person may choose to follow that advice or direct otherwise. | | Flexible | The level and type of service should be able to be changed from week to week for clients who have changed needs. | | Minimum waste | Services that are not needed or valued should not be provided. | | Budgetary control | The funder should be able to accurately budget what costs it will incur to provide the service, and have the knowledge and ability to change service settings during the year to keep within its budget allocation. | | Agreed prioritisation | Where service levels need to be changed to maintain budgetary control, the approach to prioritisation of service delivery should be agreed between funder and provider. | | Viable business | Funding should enable the provider to operate a financially viable business. | | Regularised workforce | Funding and service allocation processes should enable a regularised workforce. | | Timeliness of service | Services should be provided with minimum delay. | | Integration | The level and type of home-based support services provided should integrate with other health and disability services (eg, hospital discharge services, primary care, allied health, probably with non-health community services). | | Administrative costs | Funders should use similar funding and allocation processes where that will significantly reduce the costs for those who provide services to multiple funders. The cost of operating the assessment, coordination and payment system should be minimised (eg, by avoiding duplicated service planning). | | National consistency | HCSS services should be nationally consistent, sustainable, stable and equitably funded with a nationally consistent contracting framework that supports integrated joined up care. | |
| Amount of funding | A survey of HCSS providers found evidence of impending financial hardship among some providers, resulting (in part) from a lack of movement in funding levels to account for changes in the Minimum Wage and other cost pressures (Deloitte 2015). It also noted that the average provider has had to achieve year-on-year overhead savings of 7% for the past seven years to maintain their margins, and that this would increase to 12.5% over time.  Some providers are facing considerable financial challenges, though others are in a stronger position, for various reasons. Nevertheless, Working Group One believes that financial assistance, or reprioritisation, will be needed in the near future. The amount is not yet known, but by way of example, the Deloitte report suggested that the 50% increase in the Minimum Wage in April this year (from $14.25 to $14.75) equates to an overall (unfunded) increase in expenditure of around 3.5% (Deloitte 2015: 10).  As noted in a BERL report, investment in the HCSS sector will reduce spending elsewhere in the health sector as long as services are provided in an efficient and effective manner. Better work conditions, terms and status, including regular hours, will help improve staff retention and thereby reduce recruitment costs. However, savings will only occur if the HCSS workforce is appropriately trained and qualified to meet the increasingly diverse needs of clients (BERL 2014).  Working Group One therefore recommends that the Government prioritise funding to invest in the further development of the workforce to ensure the support workforce is recognised and valued to reflect the skill, responsibility and complexity of care and support work. |

# 6. Quality and service excellence

| **Area** | **Key observations** |
| --- | --- |
| Information is needed to measure service quality and effectiveness | As noted in the sections above, there is significant variation in the way services are delivered and funded, and there is varying ability to measure and compare client outcomes, system inputs and service costs. The ability to benchmark, or compare the quality and efficiency of services, needs to be improved.  Starting from our client focus, the collection of client experience, satisfaction and outcome information needs to be embedded in service contracting and delivery. This information can inform the matching of workers to clients, workforce training and service rostering.  Home-based support services should contribute to outcomes of reduced need for residential care, reduced need for acute care, good-quality home care, and a positive patient experience.  A community health and disability strategy could provide some structure to and guidance for the collection of information across the wider sector, so that investment in one area might be realised in benefits to another area. It is difficult, for example, to attribute HCSS use to lower rates of acute hospitalisation, but a broader view and finer-grained measures might detect improved health outcomes, such as reduced prescriptions, or better management of chronic conditions. |
| System indicators | System-wide quality information can contribute to service and policy development. Home-based support services should contribute to the outcomes of reduced need for residential care, reduced need for acute care, good-quality home care and a positive patient experience.  We examined whether DHBs that have moved to case-mix and bulk funding have seen better outcomes. We looked at the amount of resources each DHB put into HCSS and the use of residential care and acute care. The hypothesis is that, other things being equal, higher HCSS will reduce the need for residential and acute care.  However there was no demonstrated consistency of outcome. The DHBs using case-mix or bulk funding fare no better than other DHBs (see the map in Appendix 2). For example, Auckland has average costs and poorer results than other DHBs.. Accounting for inter-district flows into Auckland ARC facilities does not change the picture. Canterbury has high inputs, which produces lower than average acute care use ,but still high ARC use (although ARC use has reduced more than the average over the last five years). Southern has low HBSS inputs and poor outcomes. Hutt, which has similar inputs and outcomes to Southern, uses a traditional funding model. On the other hand Capital & Coast, using bulk funding, has just as low inputs, but low acute care use and only a bit higher-than-average ARC use. Capital & Coast has had one of the fastest reductions in acute care over the last five years.  Nelson Marlborough looks to have the best outcomes, with low inputs while achieving low acute care and average ARC use. Northland also achieves good outcomes (low ARC, lower-than-average acute) but with high inputs. South Canterbury has lower-than-average inputs and better-than-average outcomes. Whanganui has the same level of inputs as South Canterbury with better (low) ARC use and worse (average) acute care use.  Overall, there is no clear pattern to the resources committed to HCSS and the outcomes of low use of residential care and low acute care. Admittedly this is partly because attribution (ie, cause and effect) is problematic due to other factors that influence the use of residential and acute care (eg, demographics, geography, the general health of the population and utilisation of other primary care services). Even if a single funding model were used it would not remove these effects. |
| System indicators (continued) | Currently our information sources are not sensitive enough to paint a reliable picture of the overall effects of HCSS on wider health services. Data collection and coding differences between DHBs may be the cause of some differences; perhaps the DHB populations differ significantly, or there may be important differences in training or team dynamics, or perhaps it is too soon to expect to see flow-on effects. Whatever the reasons, there appear to be stark differences that are difficult to understand. Some conclusions we can draw from this are that:   * it is difficult to predict wider system impacts from changes in HCSS * different starting places and local contexts are likely to play a role in the outcomes that can be achieved * standard indicators can highlight differences,   In its review of government commissioning of social services, the Productivity Commission noted the challenges of providing social services in the context of an ageing population, increasing demand, and growing social expectations for which services should be provided and how they should be delivered. At a high level, it considers that a well-functioning social services system should:   * target public funds at areas with the highest net benefit to society * match the services provided to the needs of clients * ensure decision-makers (at all levels) have adequate information to make choices * respond to changes in client needs and the external environment * meet public expectations of fairness and equity * be responsive to the aspirations and needs of Māori and Pacific people * foster continuous learning and improvement (Deloitte 2015). |
| Value for money | The Productivity Commission makes the point that public funds should be directed towards areas with the highest net benefit to society. This means that funders should consider both the cost of services and the value the services generate. Ideally, funders should purchase services that achieve the maximum value (to the person and throughout the health and disability system) for the cost of the service. A higher price enables the provider to pay higher wages, offer greater training and undertake better coordination. That would, up to point, provide value for money.  However, in this context the value of the outcomes from purchasing better-quality home support for the client and for other health and disability services is difficult to measure, so funders need to judge the value of better-quality services compared to the extra cost.  Working Group One agrees with these points and notes that good information is needed to measure progress towards these goals. We therefore recommend that population-level information be captured and shared for the purposes of measuring outcomes and informing future planning. Some developmental work on identifying useful and sensitive indicators is likely to be needed.  We also suggest the support and promotion of a continuous improvement approach to improve systems and processes across the health and disability sector. Continuous improvement approaches fit alongside alliancing approaches, where open and constructive discussions are used to identify areas of service quality improvement and efficiency gains. |
| Standards and codes of ethics | There are agreed Home and Community Support Sector Standards that require providers to have client satisfaction and complaints systems in place. The standards are audited, but the audit reports pertain to the individual provider. Working Group One believes there needs to be a more comprehensive collection of client satisfaction information, and therefore recommends that the Health Quality and Safety Commission extend its work on client experience to the HCSS sector.  A useful way to incorporate standards into everyday practice is through the development of a code of ethics, owned by the workforce. Voluntary codes of ethics are in place in Australia, and may be a useful model for the HCSS workforce. This is an area that may be able to be developed through the Kaiāwhina Action Plan. |

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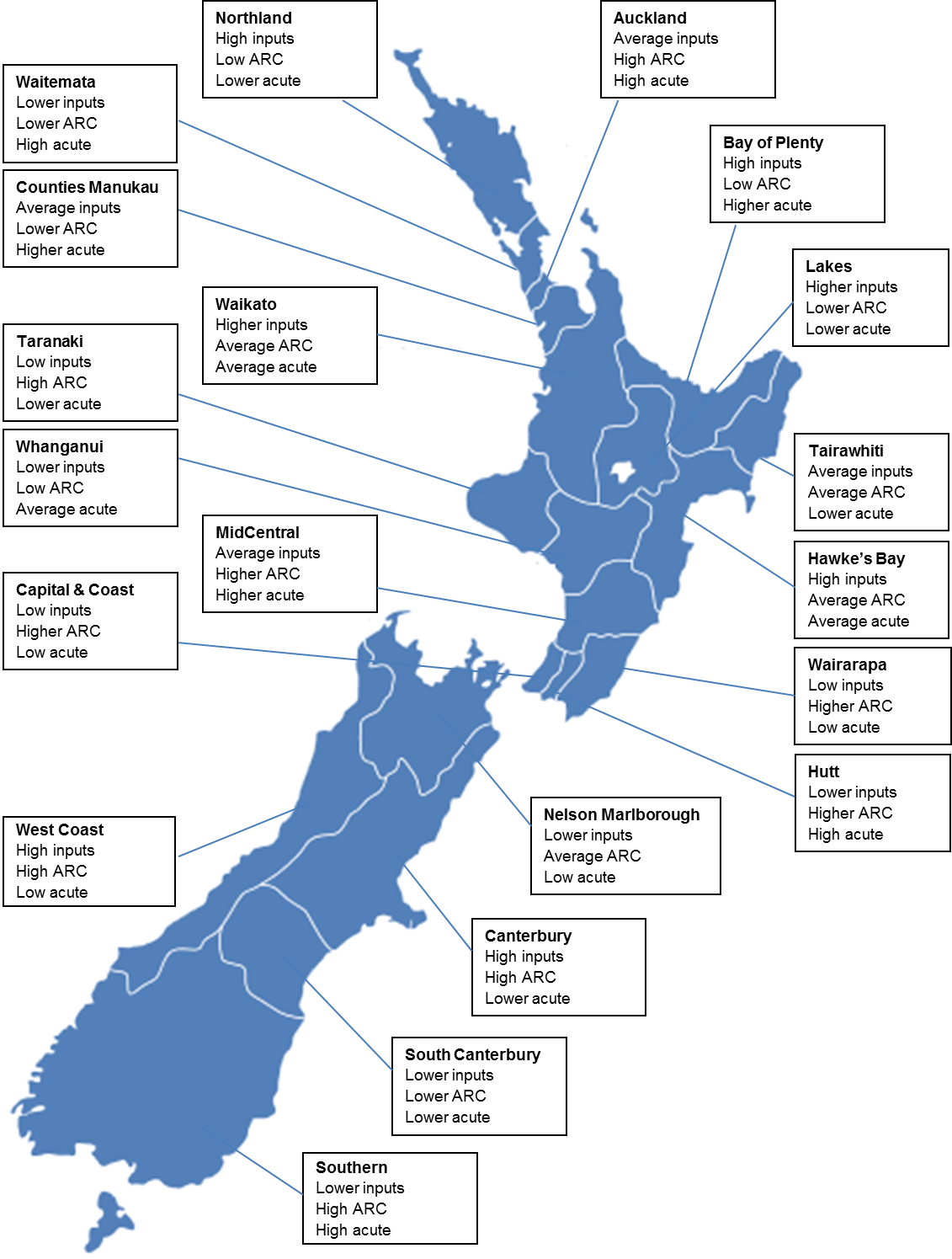
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# Appendix 1: Three particular models of restorative care considered by the working group

|  |  |
| --- | --- |
| START Waikato | START (Supported Transfer and Accelerated Rehabilitation Team) is part of Waikato DHB’s older persons and rehabilitation service and provides intensive rehabilitation for up to six weeks in clients’ homes following a stay in hospital or presentation to the emergency department.  Registered nurses, allied health and health care assistants work together with the client to develop specific goals and to build a home-based rehabilitation programme. The health care assistants provide HCSS with a rehabilitation focus to help the client become more capable.  START began in 2011 with the aim to:   * provide and promote rehabilitation of clients in their home environment, in collaboration with community therapy services and specialist geriatric medical care * provide and coordinate continuing clinical assessment to recognise deterioration and need for change in nursing or medical treatment or hospital admissions * work collaboratively with long-term care providers * provide and improve education to patients, carers and family * undertake a collaborative and individualised programme of health promotion for each client, with particular emphasis placed on the role of fitness and prevention of de-conditioning.   The second component of START is the admission avoidance process, where a START-registered nurse works with emergency departments to avoid unnecessary admissions and ensures a person is transferred back into their homes with intensive support. |
|  | Case study An 86-year-old woman wished to go back to her club five days a week for lunch. This was important for her because it provided nutrition, socialisation, motivation, confidence and exercise. The START team developed the steps necessary to achieve this goal. In the first week the programme included daily exercise with the health care assistant until she was confident. To go to the club she needed to shower and dress. The health care assistants coached her daily to do this until she was able to perform these functions independently. Over the next four weeks the client achieved all the steps to enable her to achieve her goal. |
|  | Evaluation shows that the START programme reduces the length of stay in hospital and the risk of readmission following discharge. The increased time the clients then spent recuperating at home under START care reduced costs for the DHB over six months. When comparing costs, per-participant costs in the usual care group were on average $16,943 compared to $10,836 in the START group (which included $1,618 of START costs) in the six months following initial hospital discharge.  However, while the case study alludes to greater client satisfaction, the evaluation did not highlight improved client outcomes. So while the early results are promising, further use of such models should specifically track client outcomes and experience. |
| CREST (Canterbury DHB) | CREST (Community Rehabilitation Enablement and Support Team) was planned prior to the February 2011 Christchurch earthquake, but its implementation was launched quickly following the earthquake to help cope with the loss of hospital and residential care beds.  The aim of CREST is to reduce the length of stay once the person is in hospital, reduce the chances of readmission, and delay admission to aged residential care. The model was rolled out over a three-week period and is based on a model used in Waikato, and similar to many intermediate care programmes used in the United Kingdom.  CREST provides varying levels of support to clients depending on their needs, which could be up to four visits a day, seven days a week. Goals are agreed with clients and, depending on the needs of the client, the service lasts between two and six weeks (with an average of four to six weeks).  The focus is on rehabilitation, with support not limited to medical and nursing, but aimed at assisting clients to become independent in order to manage everyday activities on their own (eg, being able to shop again, reconnect with friends and rebuild social networks): ‘Why scrub the shower to death once a week when it has only been used twice? Do that once a fortnight and use the time to get them walking to the post box again, or the shop, or reconnecting with friends.[[12]](#footnote-12)  Table A1: Example of basic programme and goals   |  |  | | --- | --- | | **Week** | **Goals and planned achievements** | | 1 | Long-term goal: to walk to fish-and-chip shop once a week to buy meal | | 1 | Have a robust plan to manage chronic symptoms:   * weekly weigh * respiratory education, domiciliary oxygen * prompt to do breathing exercises | | 2 | Walk to letterbox each day | | 3 | Take medication each day at the correct times  Key support worker to check daily for 3 days and then observe | | 3 | Eat 3 meals per day  Key support worker to check he has eaten each time they visit | | 3 | Wash and dress independently each day |   We also note that this is an intensive, short-term programme, specifically targeted at people coming out of hospital. Its utility and cost as a programme for longer-term care/support has not been tested. |
| Te Whiringa Ora | Te Whiringa Ora (TWO) is an integrated care service in the Eastern Bay of Plenty, based in the community. TWO facilitates interdisciplinary care and a web of care around patients (and their whānau) who have complex, long-term health needs and a high use of hospital services.  An evaluation of the service included impacts on client health outcomes, experience and access, as well as utilisation of secondary services, aspects that support success, and where improvements may be needed.  Findings (Appleton-Dyer et al 2013) included an improved quality of life for the client. The service contributes to improved primary care management of chronic conditions and long-term conditions, including a 10% reduction in hospital bed days (while the control group had an increase of 47% in hospital bed days).  TWO clients used inpatient services less frequently, had a decrease in the frequency of outpatient usage and decreased presentations to emergency departments. Overall, TWO clients experienced a better management of their condition.  An assessment of the client experience indicated that the TWO approach was appropriate across all cultural groups (including Māori). It looks beyond the immediate health needs of the client to broader and more holistic needs, and supports the client to navigate the health system. Clients found they had improved access to health and social services and a better understanding of their condition, and the capacity to ‘self-manage’. Clients were supported to achieve an outcome of a better quality of life.  Improvements noted were that there could be a more graduated discharge process, improved communication with general practitioners, and a broadening of the catchment of care.  Overall, Working Group One considered that this model provides a good example of improved health outcomes for clients, as well as improvements in their quality of life. |

# **Appendix 2: DHB health of older people home and community support services: cost and outcomes**



1. Although ACC was not a party to the Settlement Agreement, the nature of the topic draws them into its scope because the support workforce works across all client groups. [↑](#footnote-ref-1)
2. This is consistent with the United Nations Convention on the Rights of People with Disabilities (2006), Article 3(a): ‘respect for inherent dignity, individual autonomy including the freedom to make one’s own choices, and independence of persons’. [↑](#footnote-ref-2)
3. While some clients receive home support due to mental health problems, and some care workers provide services to these clients, we did not consider mental health clients as a separate population group. Most community- and home-based mental health services are delivered by salaried staff, who are therefore not affected by the Settlement Agreement. [↑](#footnote-ref-3)
4. Working Group Two reports on a proposal to ensure consistent levels of qualification for all staff within two years of their initial employment as a way to improve workforce capability. [↑](#footnote-ref-4)
5. Information drawn from the PSA Survey. [↑](#footnote-ref-5)
6. Australia has recently mandated the use of client-directed care for the provision of HCSS to older people, where clients direct decisions about how their needs will be met within a certain budget. Currently it appears that only a small proportion of clients take on full financial management, preferring instead to use an agency. [↑](#footnote-ref-6)
7. Summarised evidence from New Zealand Productivity Commission 2015, pp. 228−37. [↑](#footnote-ref-7)
8. The Ministry of Health has developed resources to provide guidance in relation to the development of shared care plans. [↑](#footnote-ref-8)
9. This is available on the Ministry’s website. [↑](#footnote-ref-9)
10. Risk is allocated and borne by the entity best able to mitigate it. For example, the population growth risk (change in the total number of people or average acuity) should sit with the funder. Allocation risk (the risk that support is over or under allocated) should sit with whoever controls the allocation (providers or NASCs). [↑](#footnote-ref-10)
11. Unlike other primary care providers, home and community support providers cannot charge a co-payment for publicly funded services and have not had the benefit of guaranteed annual funding increases, such as those received by PHOs, ARC and Community Pharmacy. [↑](#footnote-ref-11)
12. CREST case worker. [↑](#footnote-ref-12)