

# Appendix E Home-based support for older people

## Key points

- Most people experience a decline in health and ability as they age. Consequently, they may need various kinds of help to keep living at home.
- The principal source of government-funded support for older people at home is the health system. The Ministry of Health (MoH) funds home-based support for older people as part of a broad programme of support services for older people and people under 65 who have disabilities. During 2013/2014 District Health Boards (DHBs) spent approximately \$217 million on home support services, comprising over 10 million hours of support to about 75 000 older people.
- Support services for older people at home comes in other forms, including Accident Compensation Corporation (ACC) rehabilitation services for older people suffering injury, and home visiting services for isolated older people.
- In addition, government support for older people living at home is only one of a range of possible sources of assistance. Family members, friends, community organisations and other volunteers provide valuable support and social networks.
- A number of lessons can be drawn for the Commission's inquiry from this case study.
  - More client choice is generally better, but needs to be accompanied by systems that provide guidance and information for older people exercising choice, and that guard against abuse.
  - Focusing on service outcomes requires new approaches to commissioning and contracting, as well as supporting systems such as good performance monitoring.
  - Purchasing practices can improve services but need careful management, as there is frustration about government processes for renewing or re-tendering contracts.
  - Service integration benefits from ensuring different service funders and providers are well-informed about other services, and ensuring there are shared values emphasising the importance of integration.
  - Workforce development and carer support are important concerns for services funders, to address issues including high turnover of staff, inadequate training, lack of staff support and supervision, worker dissatisfaction with pay and scheduling and the changing nature of support work.

Home-based support for older people is one of four case studies that the Commission has selected in response to the inquiry terms of reference. The case studies draw out lessons that can be applied more widely across the social services landscape rather than draw conclusions about the effectiveness of particular services.

## E.1 Purpose

This case study considers the help that people may need at home as they age. It explores features of home-based support that are relevant to the Commission's inquiry into more effective social services, and considers lessons for the inquiry.

## E.2 Context of home-based support

### Support needs

Most people experience a decline in health and ability as they age. Older people commonly have more than one long-term condition, and a person with multiple long-term conditions is more likely to experience physical impairment (Figure E.1).

**Figure E.1 Ageing and long-term health conditions**



Source: Ministry of Health, 2014b.

People may need various kinds of help to live at home if their health and ability declines with age. Physical frailty may make personal care and housework more difficult, or homes may need to be equipped with handrails or ramps. Some older people that feel isolated in their home may wish for nothing more than the odd visitor. This case study defines "home-based support" as any service that an older person receives in their own home to help cope with declining health and ability.

### Increasing demand

Home-based support for older people is a significant policy issue in light of two trends. First, New Zealand's population is ageing. The number of New Zealanders aged 65 and over is increasing, and is expected to nearly double by 2031, reaching about 1.1 million (MoH, 2014b). Coupled with increasing health needs as people age, this indicates an increasing demand for health services. Second, an increasing proportion of older people live in their own home. While 28% of people aged 85 years or older lived in aged residential care in 2006/07, this number dropped to 23% in 2013/14 (MoH, 2014b).

## E.3 Support through the health system

### Policy settings

The government's Health of Older People Strategy sets overarching objectives for all government health policies and services for older people. The Ministry of Health (MoH) is leading work to update the Strategy. The Strategy's current vision is:

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 co-ordinated and responsive health and disability support programmes (MoH, 2002).

## Commissioning arrangements

The principal source of government-funded support for older people at home is the health system. The MoH funds home and community support services for older people as part of a broad programme of support services for older people and people under 65 who have disabilities. The aim of support services is to assist people and their families to increase independence and participation in social life (MoH, 2003a). Services include support with household tasks and personal care, provision of equipment to enable people to manage everyday activities, and support for carers (Figure E.2).

**Figure E.2** Examples of DHB-funded home and community support services in New Zealand

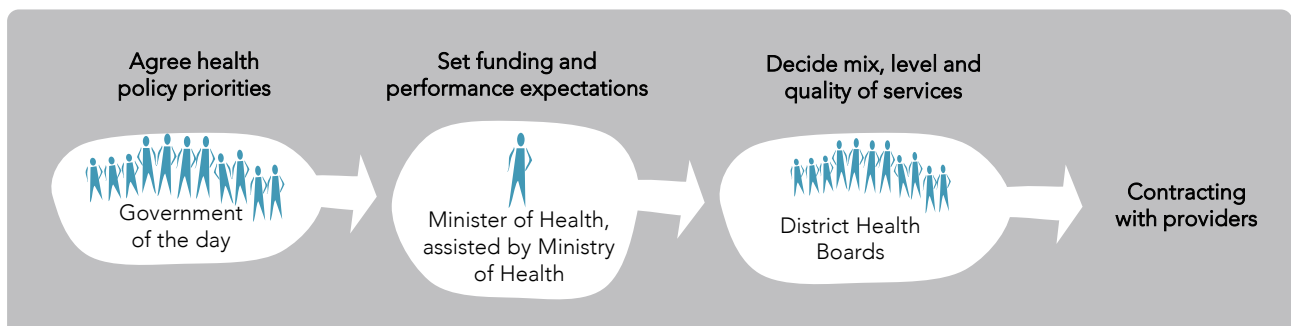
Personal care	<ul style="list-style-type: none"> <li>• Help getting out of bed, showering, dressing, medication management, daily exercises, strength and balancing; goal based approach</li> </ul>
Equipment	<ul style="list-style-type: none"> <li>• Equipment to help with safety at home</li> </ul>
Household support	<ul style="list-style-type: none"> <li>• Cleaning, assisting with meal preparation; goal based approach</li> </ul>
Carer support	<ul style="list-style-type: none"> <li>• Help for someone who lives with the older person and/or looks after them for 4 hours or more a day</li> </ul>
Specialist and therapy assessment services	<ul style="list-style-type: none"> <li>• Speech-language therapy, physiotherapy, social worker support and medical care, etc</li> </ul>
Respite care services	<ul style="list-style-type: none"> <li>• Temporary care to provide the usual informal carer with a break (respite) from their caring role</li> </ul>

Source: Ministry of Health, 2011; Productivity Commission.

Support services for people aged 65 and over are commissioned differently to services for those aged under 65. The MoH purchases support services for under 65s directly from non-government service providers. By contrast, funding for over 65s is devolved to New Zealand's 20 District Health Boards (DHBs), which in turn purchase services from non-government service providers. During 2013/14 DHBs spent approximately \$217 million on home-support services, comprising over 10 million hours of support (MoH, 2014b).

As part of the devolution of funding, the central government retains the right to tell DHBs which kinds of support services they should purchase. There is in effect a chain of influence in support services that extends from the Government to the DHBs, and from there on to providers and their staff. Figure E.3 indicates decisions that are made before DHBs get to the stage of contracting with support service providers.

**Figure E.3** Important decisions that set the scene for home and community support services



In addition to making decisions about health priorities and funding levels, the Government regulates the way support services are provided. Home and Community Support Sector Standard NZS8158 2012 regulates the

way support should be delivered. Providers are also required to respect the rights of older people and ensure safe conditions for older people and their workers, in line with laws such as the Health and Disability Services (Safety) Act 2001, the Health and Safety in Employment Act 1992, the Human Rights Act 1993 and the Privacy Act 1993.

## Contracting arrangements

Most DHBs purchase home help from providers using a “fee-for-service” model of contracting. Under this model, a DHB will refer an older person to a home-support provider following a needs assessment, and the DHB will pay the provider for the number of hours of support it provides. The hourly rate varies by DHB (Deloitte, 2015).

The other DHBs purchase home help from providers using bulk funding, where the DHB and the provider agree on a package of care to be provided to a specified client population, and the DHB pays the provider in lump sums for home-help services.

## Needs assessment

DHBs use the International Residential Assessment Instrument (InterRAI) to assess needs for home and community support services. It provides rules and criteria for assessing whether an older person needs various types of support, including medical care, rehabilitation and support at home. By mid-2015, all age-related residential care facilities in New Zealand will use the long-term care facility version of InterRAI to inform the development of care plans for older people (National Health IT Board, 2014).

Using InterRAI and a “case-mix” system, DHBs generally sort people into categories based on the type of support required. Case-mix was originally designed for hospital in-patient services, to provide “the basis for reimbursement, benchmarking (for facilities or programmes) as well as meaningful clinical descriptions of clients” (Sajtos et al, 2014, p. 191). Academics and DHBs in New Zealand have successfully tailored case-mix in the context of home-based care of older people.

DHBs subsidise home and community support services for older people with low incomes. The Ministry of Social Development (MSD) provides Community Services Cards (CSCs) to people with low-to-middle incomes (less than \$27 637 a year before tax for single people living alone). If a person over 65 has a CSC and they are assessed as needing some care, they will get all home management and personal care services paid for. If they do not have a CSC they are only entitled to personal care support. People without a CSC must contribute some or all of the costs of support for household tasks, depending on their income. Older people may also be entitled to a MoH carer support subsidy to assist unpaid, full-time carers to take a break from their caregiving role, and a MSD disability allowance for costs such as gardening.

Under these assessment criteria, about 75 000 older people receive home and community support services through the health system over a year. This compares to 31 000 older people who are in aged residential care (MoH, 2014).

## Provider landscape

Currently 70 non-government organisations provide home-based and community-based support services for DHBs, though this includes providers of home and community support services to younger people with disabilities. Thirty seven of the providers are not-for-profit (NFP) organisations and 33 are for-profit (FP) organisations (Figure E.4)

**Figure E.4 Non-government providers of DHB home and community based services****Not-for-profit organisations**

CCS Disability Action Bay of Plenty Incorporated  
 CCS Disability Action Tairāwhiti Hawkes Bay Incorporated  
 Community Connections Supported Living Charitable Trust  
 Counties Manukau Homecare Trust  
 Disabilities Resource Centre Trust  
 Disability Resource Centre Southland Charitable Trust  
 Hokianga Health Enterprise Trust  
 Home Support North Charitable Trust  
 Huakina Development Trust Board  
 Independence House Connelly Trust  
 Korowai Aroha Trust  
 Manawatu Supported Living Trust  
 Ngāti Hine Health Trust Board  
 Ngāti Porou Hauora Charitable Trust Board  
 Pacific Island Homecare Services Trust  
 Presbyterian Support (Northern)  
 Presbyterian Support (Upper South Island)  
 Presbyterian Support Central  
 Spectrum Care Trust Board  
 Tautako Service Charitable Trust  
 Te Hauora O Te Hiku O Te Ika Trust  
 Te Korowai Hauora o Hauraki Incorporated  
 Te Oranganui Trust Incorporated  
 Te Puna Ora Mataatua Charitable Trust  
 Te Roopu Taurima o Manukau Trust  
 Te Runanga O Ngai Te Rangi Iwi Trust  
 Te Runanga O Ngāti Whatua  
 Te Whanau O Waipareira Trust  
 The LIFEWISE Trust  
 The Nurse Maude Association  
 The Salvation Army New Zealand Trust  
 Tuwharetoa Health Charitable Trust  
 VisionWest Community Trust  
 Waiapu Anglican Social Services Trust Board  
 Waiheke Health Trust  
 Whaiora Homecare Services Incorporated  
 Whaioranga Trust

**For-profit organisations**

Access Home Health Limited  
 Aged Care Central Ltd (Maryann Rest Home)  
 Ali's Home Help Limited  
 Aotea Health Limited  
 Central Health Limited  
 Central Otago Living Options Limited  
 Christchurch Residential Care Limited  
 Community Living Limited  
 Forward Care Home Health Limited  
 Geneva Healthcare Limited  
 Geneva Northlink Healthcare Limited  
 Healthcare of New Zealand Limited  
 Healthcare Rehabilitation Limited  
 Healthvision (New Zealand) Limited  
 IDEA Services Limited  
 IRIS Limited  
 Lavender Blue Nursing and Home Care Agency Limited  
 Miranda Smith's Personal Home Care Limited  
 Nelson Nursing Service Ltd  
 New Zealand Care Ltd  
 Ngāti Ranginui Home and Community Support Services Company  
 Ngāti Whatua O Orakei Health Clinic Limited  
 Omahanui Homecare Limited  
 PACT Group  
 Pasifika Integrated Health Care Limited  
 Presbyterian Support (South Canterbury) Inc  
 Q-Nique Limited  
 Royal District Nursing Service New Zealand Limited  
 Shirley's Home Care Limited  
 Te Ata Resthome Partnership  
 Te Kohao Health Limited  
 The Florence Nightingale Agency (Marlborough)  
 Tui Ora Limited

*Source:* Provider names are those listed in the Government's recent final settlement agreement with providers on travel costs (MoH, 2014e). NFP or FP status was determined from a search of the New Zealand Companies Office Register ([www.business.govt.nz/companies](http://www.business.govt.nz/companies)) and New Zealand Charities Register ([www.charities.govt.nz](http://www.charities.govt.nz)) on 7 January 2015.

**Support workforce**

The consulting firm BERL Economics described the health and disability workforce in a report commissioned by Careerforce, New Zealand's Industry Training Organisation for the health and community support sectors. Of the 41 232 people that BERL identified as carers based on the 2013 Census, 5772 were carers of aged or disabled people. In addition, 29 859 of the 41 232 carers were personal care assistants and some of these workers may be also providing home-based care to older people. Nearly half of the carers (49%) were aged 50 or over, and nearly nine in ten carers (89%) were female. Of the carers identified in the Census, 68% identified as European, 14% as Māori, 14% as Asian, 9% as Pacific peoples and 1% as other ethnicities (BERL Economics, 2013). A recent survey of aged care workers in homes and residential facilities provides more detail about this workforce (Box E.1).

**Box E.1 The New Zealand Aged Care Workforce Survey 2014**

In 2014, Auckland University of Technology's New Zealand Work Research Institute and Faculty of Business and Law conducted a survey of employees and managers in residential and home-based aged care. The responses from 574 workers in home-based aged care (a response rate of 15%) reinforce the findings of the BERL Economics report as well as adding many new insights.

- 94% of respondents were female.
- 69.5% of respondents were New Zealand born. Non-New Zealand born participants came from a variety of countries, most notably the United Kingdom (36.3% of non-New Zealand born participants).
- The majority of respondents were in the age range of 45 to 64 years old.
- The majority of respondents indicated that they had no children (0 to 15 years) living with them, although 89.2% of participants indicated that they spent 0 to 30 hours per week caring for family members.
- Of 536 responses to length of experience in aged care, 53.8% had worked in aged care for a total of up to 11 years (not counting any breaks), and 29.8% for 12 to 23 years.

*Source:* Ravenswood, Douglas and Teo, 2015.

## Health treatment services at home

Some additional home-based services in the health system are not provided through the system of support described above. For instance, older people may be treated at home for a range of health conditions, as an alternative to treatment in a hospital.

A recent example of this is the Community Rehabilitation Enablement Support Team (CREST) programme. The CREST program provides restorative and rehabilitative services for older people in their own homes. This supports timely discharge from hospital, reduces hospital length of stay and works to avoid admissions for older persons at high risk. Chapter 3 of the inquiry's report discusses CREST and also provides the example of the Canterbury Clinical Network (CCN)'s Acute Demand Management System. This system provides short-term resources for interventions – such as repeat home visits to older people – to avoid hospital admissions.

In addition to reducing hospitalisation rates, home-based or community-based care programmes can reduce the likelihood that an older person will need to move into residential care. Parsons et al. (2012) reviewed evaluations of three New Zealand programmes to support older people to remain in their homes rather than residential care. They found that such programmes reduce the risk of a frail older person being permanently institutionalised (Parsons et al., 2012).

## E.4 Support outside District Health Boards

### Rehabilitation from accident injuries

The Accident Compensation Corporation (ACC) provides people with access to home-based support services as they rehabilitate following injury. As with support through the health system, ACC-funded support services cover personal support and household support. Clients may get support for a short period while they recover from injuries such as a broken arm, or over a longer period for long-term conditions such as spinal cord injuries (ACC, 2014). ACC's submission to the inquiry also notes:

Depending on a client's needs and circumstances, ACC may fund other rehabilitation services, such as aids and appliances and housing modifications. ACC can also fund injury prevention assistance, for example to prevent people injured by falls from experiencing further falls when they return home. (sub. DR 219, p. 2)

ACC contracts six suppliers to provide services nationwide or in certain regions, and these suppliers can subcontract some or all of their services to other home-care providers.<sup>1</sup> However, as ACC notes in its submission, “a client entitled to HCSS [home and community support services] can choose whether their support is delivered through contracted care, non-contracted care, or a mix of both” (sub. DR 219, p. 2). ACC describes its arrangements as follows:

Under contracted care, an ACC-contracted provider delivers the care. Contracted care is funded at higher rates than non-contracted care, to reflect the additional costs of overheads, such as staff training and monitoring, above the carer’s hourly rate.

Under non-contracted care, ACC provides funding to clients to purchase their care needs. The rates for non-contracted care are set to allow clients to pay their carers an hourly rate and contribute toward other employment obligations, such as holiday and sick leave.

A large majority of clients choose to receive HCSS from contracted providers. Also, over recent years, the proportion of clients who choose contracted care has increased steadily. (sub. DR 219, p. 2)

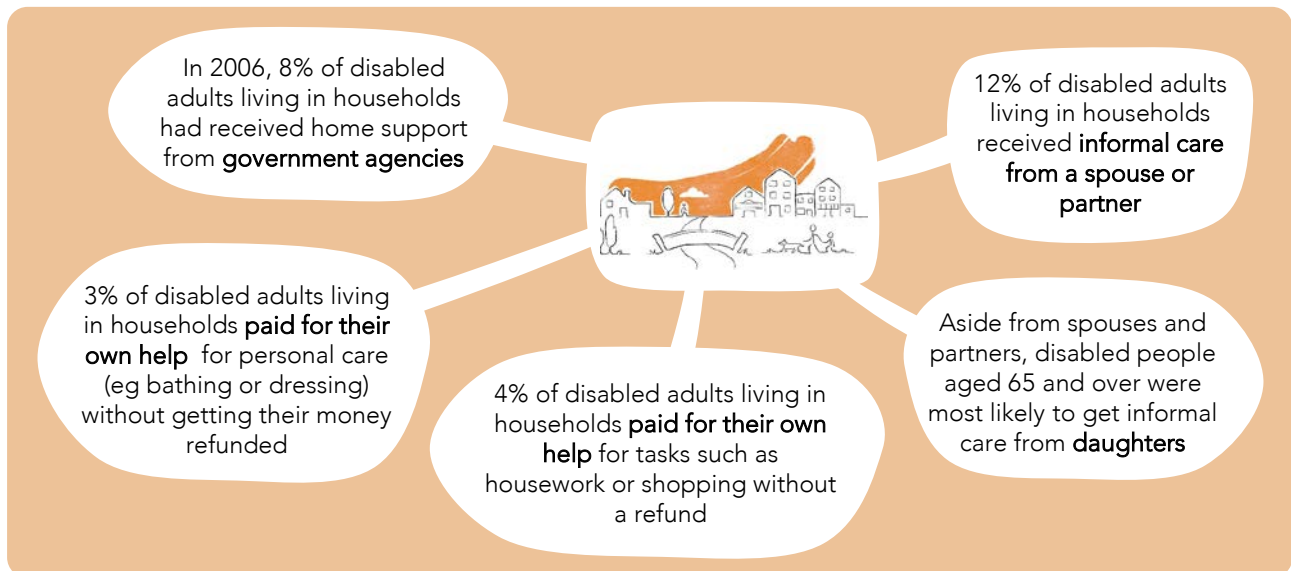
## Other government services and financial assistance

The Government funds other services to assist older people at home, including services to help prevent elder abuse and neglect, as well as advisory services for people living in retirement villages or rented accommodation. The Government provides financial assistance in the form of rates rebates for low-income homeowners (delivered through councils), subsidised taxis for people with limited mobility and the SuperGold Card.

## Wider networks of support

Government support for older people living at home is only one of a range of possible sources of assistance. Many older people organise and fund their own support. Family members help one another around the home. Friends make good company and provide welcome assistance during tough times. Community organisations and volunteers provide a range of services not funded by government, or only partly funded. Although government support can be essential, especially for very frail older people or people with few family and friends, it is only part of the picture (Figure E.5).

**Figure E.5 Sources of support**



Source: Office for Disability Issues and Statistics New Zealand, 2009; Office for Disability Issues and Statistics New Zealand, 2013.

<sup>1</sup> The six providers are Access Home Health (nationwide); Geneva Health International (nationwide); Realise [Healthcare New Zealand] (nationwide); Medibank Health Solutions (nationwide); Enliven [Presbyterian Support Northern] (Auckland, Waikato and Bay of Plenty); and the Royal District Nursing Service New Zealand (Auckland) (ACC, 2014). Enliven advertises itself as “the only ACC home-based support service lead provider that does not subcontract – a referral to Enliven means services are delivered by Enliven” (Enliven, n.d., p. 2).

## E.5 Lessons for the inquiry from home-based support services

### A range of lessons

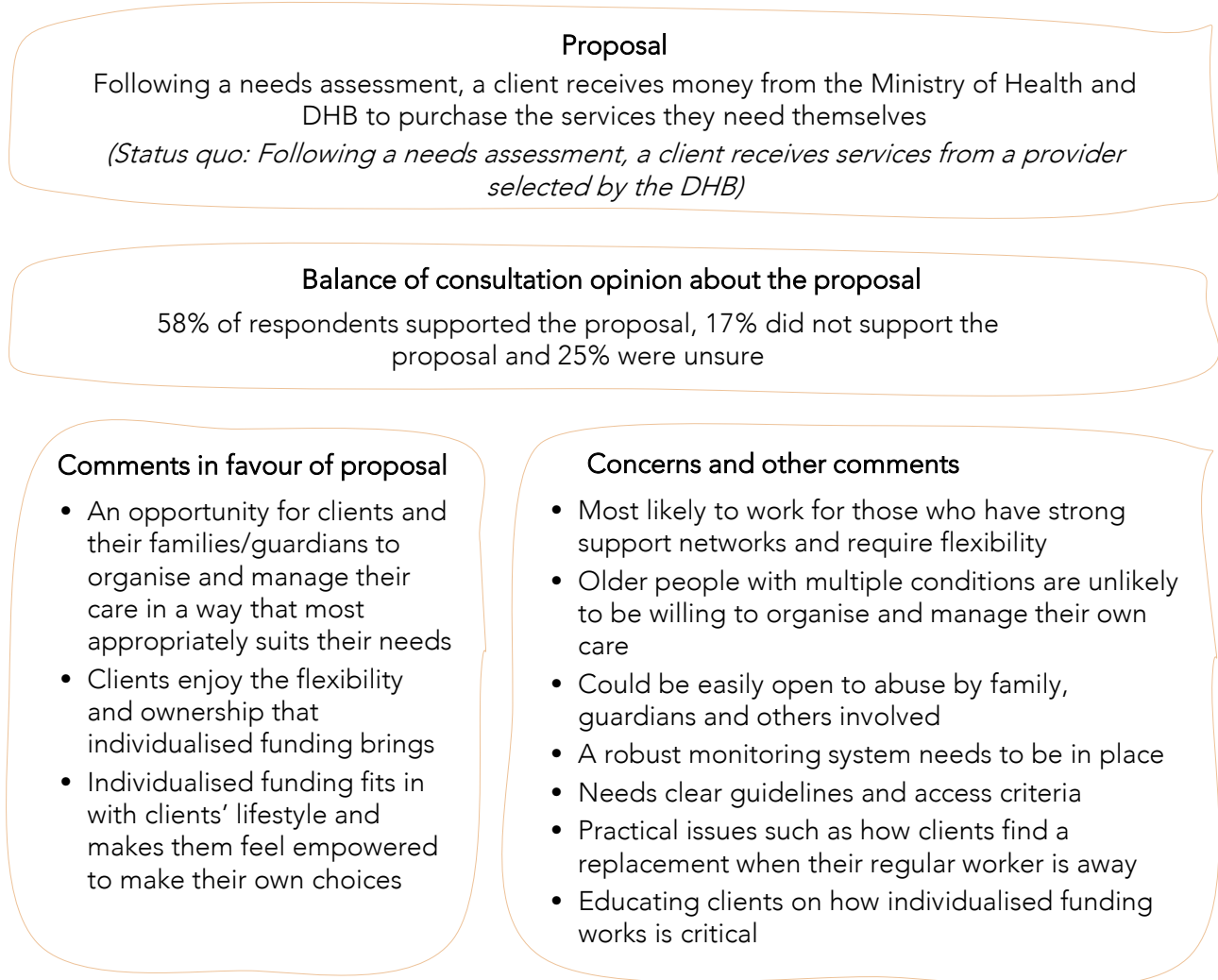
The government's experience of commissioning and contracting home-based support services provides a number of lessons that can be applied to the commissioning and contracting of other social services.

### Increased client choice is better, but needs supporting systems

A central concern for the inquiry is the extent to which clients of social services can choose their own services and choose the person or organisation that provides those services.

One recent attempt to establish increased client choice provided useful feedback on this type of model. In 2013, Waitemata DHB surveyed people on a set of proposed changes to home-based support services, including a proposal for individualised funding. The thrust of the feedback was that more choice is better, but needs to be accompanied by systems that provide guidance and information for older people exercising choice, and that guard against abuse (Figure E.6).

**Figure E.6 Waitemata DHB's proposal for individualised funding**



Source: Waitemata DHB, 2013a; 2013b.

The Home and Community Health Association's submission on the inquiry Issues Paper echoed this qualified support. It noted that "consumer directed care would work in some situations in aged care, for example in relation to respite care, and for some cultural situations where there is a strong level of current family support". However, it cautions that "options need to be available and accountability controls in place" (sub. 114, p. 2).



ACC allows some client choice, albeit between a small number of suppliers. ACC's submission to the inquiry noted:

[F]or home and community support services (HCSS), a number of hours of support are approved by ACC, and packages of support enable providers and clients to decide how to allocate these hours between different services, such as attendant care and child support.

This flexibility requires high confidence in providers. For HCSS, this is enabled by quality requirements and a limited supplier model. This model involves a small number of suppliers contracted to ACC and supports more strategic relationships and management of quality. (ACC, sub. 30, p. 6)

There have been recent attempts to provide older people with greater choice in home-support services in the health system, at the level of individual DHBs. The first attempt to introduce choice in health-based support services was in the Otago DHB, which established the Elders Project in 2006. Through this project, the DHB provided funding to older people via a non-government organisation called Standards Plus. The older person then had discretion to use the funding to employ a support worker directly, or purchase support services from a service provider. The funding could also be used to purchase services that support the older person's family to provide care (Australian Productivity Commission, 2008).

The Australian Government recently rolled out "Consumer Directed Care" for home-based care and residential care for older people. Under this new model, older people "will have more control over the types of care and services they access and the delivery of those services, including who delivers the services and when" (Department of Social Services, 2015).

## Focusing on service outcomes requires new approaches to commissioning and contracting

Improving the health and wellbeing of older people through home-based support is not an easy outcome to achieve. A recent New Zealand PhD thesis on home-based support surveyed a range of international studies and reported that, while some programmes had benefits, others had no benefits, and still others had negative health effects (King, 2012).

Recent evaluations of New Zealand home-support services and an Australian service indicate that some new models of restorative care are improving outcomes for clients. The Australian evaluation is notable in making a case that services to restore health are more cost effective than conventional home-care services (Table E.1).

**Table E.1 Recent evaluations of New Zealand and Australian home support services**

Study	Evaluation objective	Method	Results
Parsons, M. et al. (2013)	Determine the impact of a restorative model of home care on social support and physical function among older people living in dwellings in a residential community setting	Cluster-randomised controlled trial	There was greater change over time in physical function, but no associated increase in social support
Parsons, J. et al. (2012)	Establish the impact of intermediate care on frail older people not living in an institution who are referred for needs assessment in New Zealand	Meta-analysis of three independent randomised controlled trial evaluations	Intermediate care using a care-management approach reduces the risk of frail older people dying or being permanently institutionalised

Study	Evaluation objective	Method	Results
Lewin, Alfonso & Alan (2013)	Determine whether older individuals who participated in a re-ablement (restorative) programme rather than immediately receiving conventional home-care services had a reduced need for ongoing support and lower home-care costs	Analysis of service records of older individuals who had received a re-ablement service, versus a conventional home care service	Individuals who had received a re-ablement service were less likely to use a personal care service throughout the follow-up period or any other type of home care over the next 3 years. This reduced use of home-care services was associated with median cost savings for each person of approximately A\$12 500 over nearly 5 years

In New Zealand, the 'restorative home support' or RHS model is the main new service model. Parsons and Baird describe the objectives of the RHS model:

The RHS model does not focus entirely on improving the independence of clients ... It focuses on developing a minimum standard of education and training as well as a career path for Support Workers, regular reviews for clients, appropriate assessment, individualised goal setting, enhanced communication between support workers and coordinators, functional rehabilitation where appropriate and involvement of health professionals in assessments and reviews. (forthcoming, p. 7)

DHBs have taken up the RHS model at different speeds and in different forms:

A number of DHBs have incorporated this approach into both short and long-term provision of services (South Canterbury in 2004; Nelson Marlborough in 2006; Capital Coast in 2006; Auckland in 2008; Canterbury in 2010; Southern in 2012) with others for plans for 2015/2016 (Waikato, Tairāwhiti, Lakes, BOP, Taranaki, Waitemata). One DHB (Canterbury 2010) has incorporated District Nursing services as an integrated part of the model to remove duplication across clients receiving both support and clinical care. A common plan exists for the management of these clients and where practical the nurse providing clinical care also provides oversight for the support inputs. Practical examples of this also exist for example on the West Coast (Westport) where a nurse has a shared role as a district nurse and as a home based support coordinator. (Parsons & Baird, forthcoming, p. 9)

Healthcare of New Zealand Holdings (HCNZH)'s submission makes the case for revamping the whole model of home-support services, based around the outcome of restoring health and independence. It criticises DHBs for focusing too much on cost savings ahead of quality improvements:

One of the challenges we as a sector face is that some funders have misconstrued the intent of the restorative model (primarily about improving quality) and have used it as an opportunity to extract direct savings from the home based support services they fund in the face of an ageing population and rapidly increasing demand. The extraction of savings from this critical service undermines the wider savings to aged care numbers, ED presentations and inpatient admissions. (sub. 51, p. 21)

The Office of the Auditor-General (OAG) considered restorative care in its 2011 review of home-based support services for older people. The report then commented on progress in implementing restorative care:

The intent of the restorative model of care is that older people will gain improved independence or maintain their level of function for as long as possible. The model relies on a multi-disciplinary team (primarily a registered nurse, physiotherapist, and occupational therapist) to provide an in-depth support plan. The plan sets goals and targets for an individual to restore some function where possible and so increase their independence and reduce their reliance on support ...

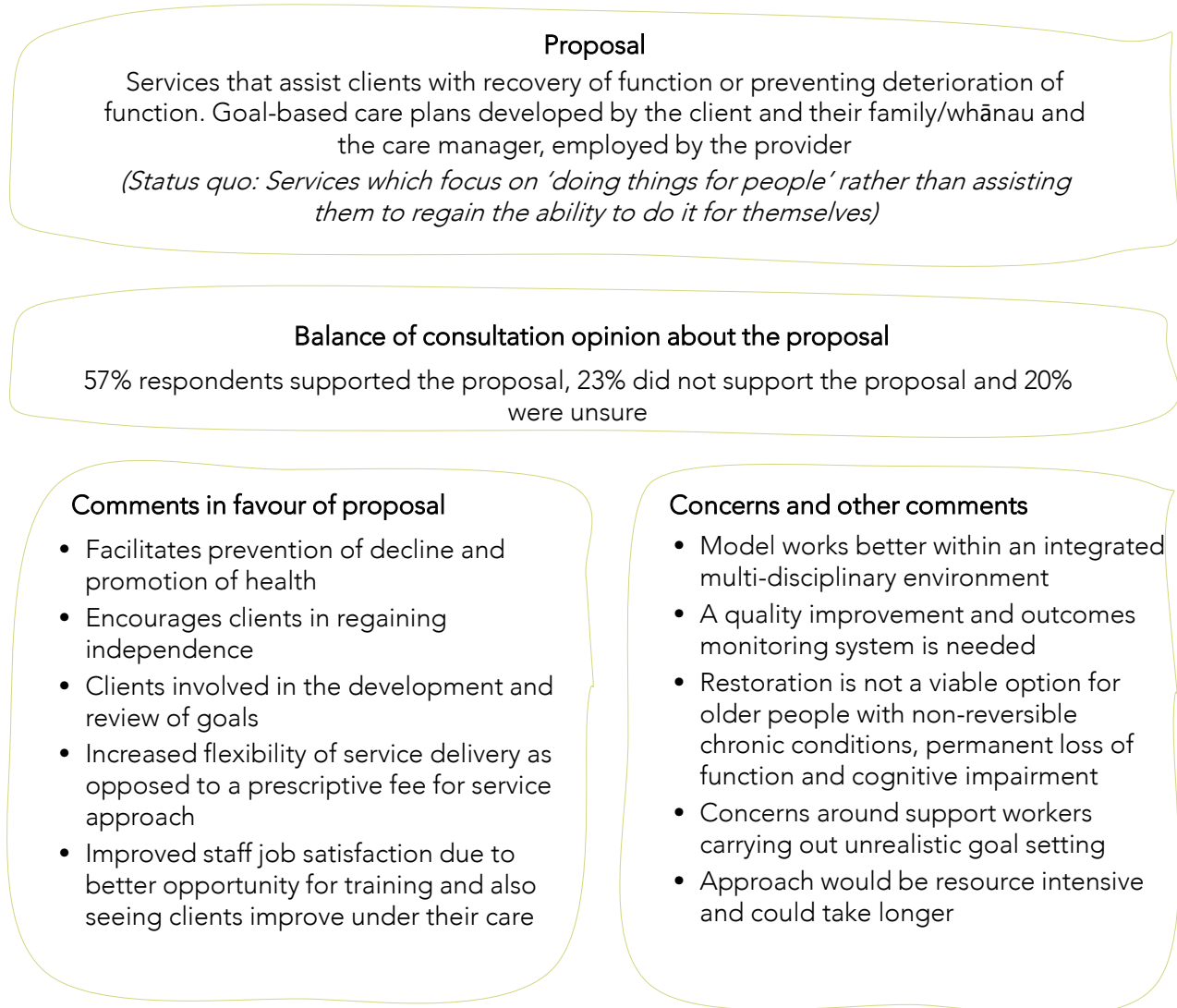
The Ministry has outlined in its Operational Policy Framework 2010/11 that it requires DHBs to include a restorative model of support. It is not clear how DHBs are to implement this model. For example, as at September 2010, nine DHBs (45%) were still delivering a more traditional model of support and eight (40%) were delivering a mix of traditional and restorative care. DHBs are implementing the restorative approach within different timeframes.

Our work has indicated that DHBs have been slow to implement restorative care for a variety of reasons, including not having enough resources, inadequate staff training, uncertainties about the cost of restorative care, and a lack of clear leadership from the Ministry. The inconsistent progress is leading to

differences in the approach taken to developing support packages for older people and therefore differences in the quality of support they receive. (OAG, 2011, p. 37)

DHBs have responded to calls for a greater focus on restorative care, and this has led to a better understanding of how to implement such models. Waitemata DHB proposed a shift to a restorative approach in 2013. The DHB's consultation with local providers, service users and other stakeholders indicated support for the move, as a means of promoting the health of older people or arresting decline in health and ability. However, feedback suggested that a restorative approach needed to be accompanied by a number of other changes to home-based support, including integration of different health services and better performance monitoring (Figure E.7). Feedback was also cautious about the possibility of improving outcomes across all clients.

**Figure E.7 Waitemata DHB's proposal for a restorative model of home-based support services**



Source: Waitemata DHB, 2013a; 2013b.

The Home and Community Health Association considers that New Zealand providers and workers are well-placed to take on the challenges of an increased focus on restorative care:

The [home-based support] service is very transactional, but the organisations that operate in the sector are skilled at that and we would challenge any government agency to match the level of efficiency in terms of direct service to overheads relativity that we have. The service [is] also very successful in halting the increase of reliance on aged care beds. There is great potential for this service to also be useful in reducing ED admissions and helping people manage chronic conditions. Our staff, whilst very concerned about wages and conditions, love the work they do. We think that home support for older people is an amazing success story. (sub. DR 192, p. 6)

## Contracting practices can improve services but need careful management

Providers are frustrated about government processes for renewing or re-tendering contracts. The picture that emerges is of a contracting approach that is static for long periods of time, but punctuated by disruptive changes. This suggests a preference among providers for more gradual change.

For contract renewals – where the DHB maintains the same provider with a new contract – there is frustration about the static nature of the process. The Commission heard that contracts change very little over time, and that DHBs simply mailed out new contracts to providers with a request to sign. The exceptions were the DHBs who shifted from a fee-for-service contract to a bulk-funding contract.

By contrast, the tendering of contracts – where DHBs invite all providers to apply for a service contract – appears to have been a disruptive experience for some providers for various reasons (Box E.2).

### Box E.2 Experiences of government tendering as a disruptive process

#### Time spent understanding tender requirements

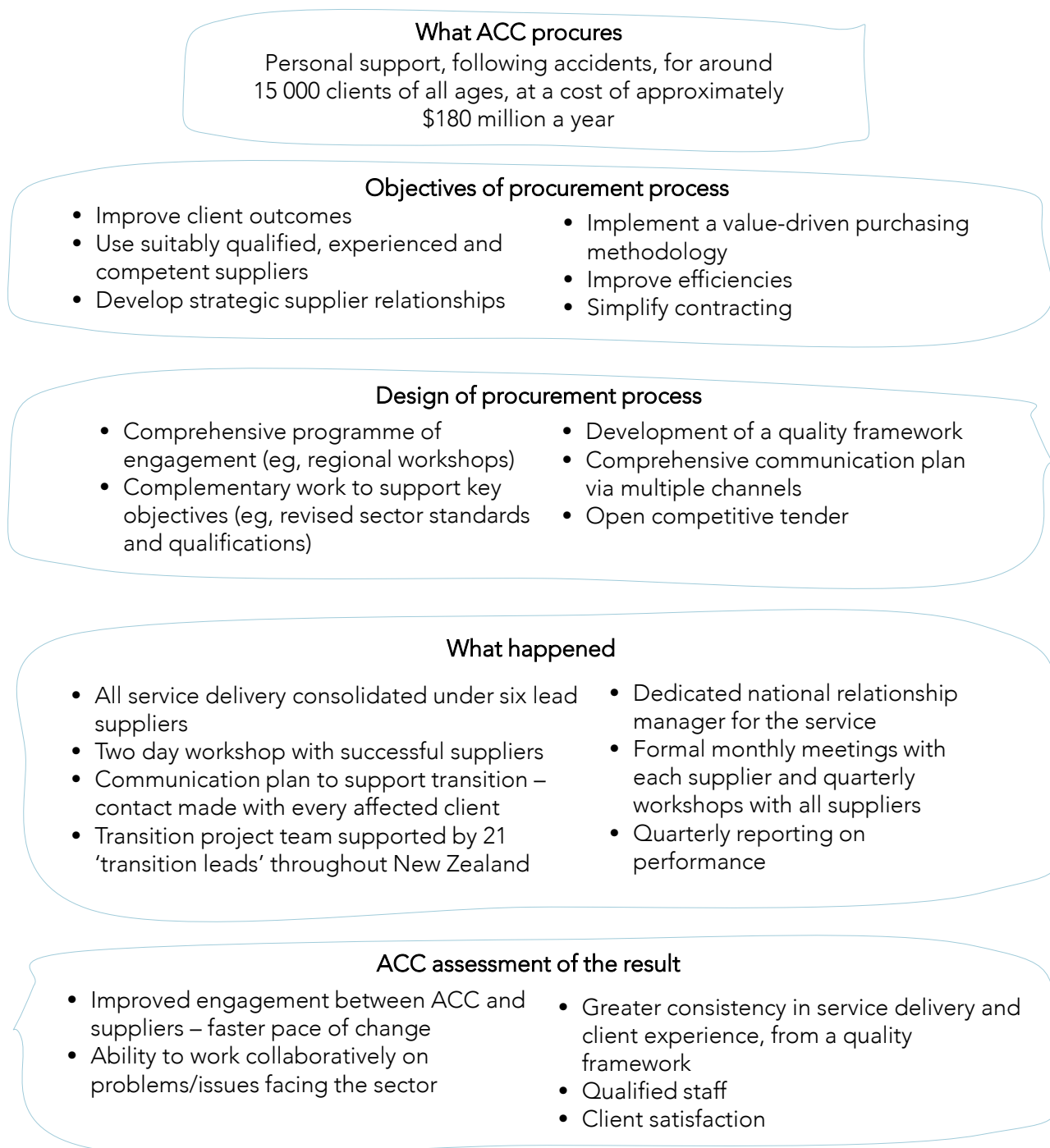
The biggest challenge we face in participating in contestable processes is understanding the funder's requirements including the scope of the service, the eligible population, the budget available, their expected methods of service delivery, and the scope for innovation. The quality, accessibility and usefulness of some of the information put out by funders during contestable processes is highly variable. In many cases the description/definition of the service to be provided is substandard increasing the amount of time and effort we need to dedicate to preparing our RFP.

As an example, in one recent case, a district health board included as indicative of their requirements for a new innovative restorative home based support service an old service specification that predated the devolution of the service by the Ministry of Health in 2003. Clearly this had no bearing on their expectations for the service or the future contract we would be asked to sign. (HCNZ, sub. 51, p. 13)

#### Disruption to staff and clients

The Southern region contestable RFP [request for proposal] in home support in 2012 led to the dominant provider losing the contract with consequential disruption to many staff and clients and reduced service. PSO [Presbyterian Support Otago] had provided an excellent service with significant effort put into responding to the more difficult situations that fell outside the parameters of the contract but required a solution, eg administration of insulin. (Presbyterian Support, sub. 76, p. 13)

There is some evidence that with careful management, changes in contracts and contracting processes can lead to better services and better service management. ACC staff presented to a procurement forum on their experience of adopting a new procurement process for home-based support services. They reported that the new process led to service contracts that improved engagement between ACC and its service providers and improved service consistency (Figure E.8).

**Figure E.8 The new Accident Compensation Corporation procurement process**

Source: Murray and Johnson, 2014.

### Information and shared values are essential to service integration

Older people with multiple chronic conditions often use a range of health and home-support services. Integrated delivery of the different services that an older person receives is therefore an important consideration for contracting arrangements. Age Concern's submission highlighted the need to ensure that the transition from one service to another is managed well. It noted situations where "a client is unable to manage the transition themselves or where any transition will jeopardise their wellbeing" (sub. 100, p. 9).

Two aspects of service integration that emerged from discussions around this case study were ensuring different service funders and providers were well-informed about other services, and ensuring there were shared values that emphasised the importance of integration.

Most of the discussion around the role of information in service integration focused on problems with the current arrangements. For example, Healthcare of New Zealand Holdings, a large provider of home-based support services, has submitted to the inquiry:

There is too little information about social services and social outcomes available in the public domain. In the health sector there is little or no publically available information available on ED presentations, inpatient hospital admissions, the use of home based support services and aged residential care, or even where money is spent. There have been recent reports about a lack of information on the number of people who meet the clinical criteria for a procedure but who cannot access it because of a lack of financial resources ... It is very difficult to have a conversation about the state of the health system and the innovations that might be beneficial when there is a lack of information in these key areas. (sub. 51, p. 15)

Another service provider was concerned at how difficult it was to obtain information from government agencies. It considered that a barrier to information sharing was misunderstanding the Privacy Act by the holders of information (this view was echoed by other inquiry participants during engagement meetings). The same provider also noted that it was inefficient that different providers of services to one person had to keep their own records. This leads to double reporting.

Alongside the sharing of written information, there is a concern with the lack of communication between funders and the different service providers more generally. The Human Rights Commission review of aged care reported on this in 2012:

The Commission heard from a number of participants and submitters about the need for better integration of services, including the need for better information flows. The manager of Te Whiringa Ora, which is piloting a navigator programme in the delivery of home support services in Eastern Bay of Plenty said, "one of the major barriers to overcome has been communication between various services and professionals. Shared client records have been one of the breakthroughs." The need for better information flows were also identified by the National Council of Women (NCWNZ) in its submission, "our members commented that, at times, communication between the caregiver and their supervisor is unreliable with a resulting lack of co-ordination in services. (Human Rights Commission, 2012, p. 121)

Discussions and research for this case study identified a couple of cases in which funders and providers have tried to improve the way they share information. One group of funders and providers has taken steps to coordinate planning and reporting across service providers. In the CCN, service providers meet as a group with the DHB to report on performance. Aside from home-based support services, philanthropic organisations in New Zealand have established group reporting by service providers. Under this arrangement, providers receiving grants meet together to report on performance, with the opportunity to question each other, and for the funder to ask questions.

One area of focus for people seeking to coordinate services is the values and expectations of the service providers and their staff. The Commission met with a number of organisations involved in the CCN, and one of the values noted in these meetings was that of trust between funders and the different providers.

Changes in values and expectations play out in the language that staff use when they talk about their services. The Commission has heard how service coordination can slowly emerge over a year or two, as leaders set a vision for greater integration and reinforce these messages in discussions. One inquiry participant noted how in the Southern Region, "in the last year or two, the language is more about integration". Another participant noted the important change in talking about the "Canterbury health system", not just the "Canterbury DHB".

## **Workforce development and carer support are important concerns for funders of social services**

New Zealand studies raise a number of concerns in relation to workforce development for home-based support of older people. These concerns include high turnover of staff, inadequate training, lack of support and supervision and worker dissatisfaction with pay and scheduling (Deloitte, 2015; Parsons et al., 2004b; Parsons, Dixon, Brandt & Wade, 2004; Briar, Liddell & Tolich 2014). The OAG report on home-based care noted:

DHBs have identified the quality of supervision and training of providers' staff as a significant risk to future service delivery. Increased pressures on home-based support services will require better trained and supervised staff. At present, DHBs cannot ensure that this risk is appropriately managed. (OAG, 2011, p. 35)

In relation to workforce concerns, the New Zealand Council of Trade Unions noted:

The underpayment of workers in home-based care, and most symbolically demonstrated by the non-payment of travel time between clients, is a case of the workforce subsidising the social service sector over many years. The development of home-based services in providing more choice and reducing institutionalisation has been at the expense of the workforce. (sub. 103, pp. 15–16)

Government has recognised the need for skill development through Careerforce (the industry training organisation for health, disability and social services) developing a qualifications framework. In addition, Health Workforce New Zealand (the government unit responsible for health workforce planning) and Careerforce are working on a five-year action plan to develop the care and support workforce (MoH, 2014b, p. 22). The Commission has also heard that government contracts are increasingly requiring service providers to equip their workers with qualifications. However, providers have advised that these contractual requirements do not tend to come with funding for training and development.

In relation to informal care, support within families and among friends can be physically and emotionally draining. Where some family members or friends provide more support than others, it can seem deeply unfair. In some cases, carers or people receiving support are at risk of abuse. A number of submissions commented on the valuable role of families and volunteers and the issues they face (Box E.3).

### Box E.3 **Inquiry submissions on the role of families and volunteers in care**

Alzheimers New Zealand noted the role of families, whānau and other volunteers in supporting people with dementia, but noted the cost of this support:

Family/whānau remain under pressure – and the current eligibility arrangements mean they often struggle financially and face complex and repeated hurdles.

In Alzheimers NZ's view, this reliance on volunteers is to a level well beyond what is fair or appropriate – and potentially beyond what is sustainable as the number of people affected by dementia increases. (sub. 27, p. 3)

Carers New Zealand described the challenge of caring for a family member while making ends meet:

Being able to stay in work is one of the key challenges for family carers. It is a common experience for a family carer responsible for a person facing illness or disability in their home to not be able to continue to work. Many family carers work below their qualifications and experience simply to earn an income whilst juggling support commitments for loved ones, or work part-time. This has an impact on family carers and their families, and also on employers and the economy. It also has a potential impact on the social welfare system, if the family carer is eligible to receive a benefit. There is a very small likelihood that family carers might be entitled to be paid for the care they provide. (sub. 71, p. 3)

Carers New Zealand also noted a new development in respect of employment conditions for family carers:

In early 2015 Carers NZ will launch the CareWise workplace accreditation programme, for which employers will pay an annual subscription fee; in return they will receive an independent audit to check whether their workplace is carer friendly, recommend ways to become more so, and access to Carers NZ's information, services, and support for the organisation's caring employees. CareWise was developed without involvement or input from government, an example of how innovative relationships for 'big picture' outcomes can sometimes happen more quickly with private organisations and partners such as unions and Business NZ. (sub. 71, p. 3)

Submissions noted issues about access to services, such as public transport, banks and general practitioners (Age Concern New Zealand, sub. 100); about whether older parents have children still

living in New Zealand (sub. 100), and about whether older people own a home or have retirement income (New Zealand Council of Christian Social Services, sub. 35).

From a different angle, Hilary Stace explored some of the potential problems in family-based care:

... the service user may have relationships with family members that are not conducive to respectful support, or are not age appropriate. There are a concerning number of young carers of disabled family members. Some families are exhausted or absent. Others are potential abusers. (sub. DR 196, p. 4)

The Home and Community Health Association noted the value of different types of organised volunteers, including Age Concern, Alzheimers New Zealand and iwi volunteers. Such volunteers provide “home visits, assistance with shopping, meals on wheels, free classes such as tai chi and other church or community run activities”. In return, “there is value for the volunteer or non-paid carer in supporting others” (sub. 114, p. 3).

At the same time, the Association stressed the distinctive roles of volunteers and specialist support workers:

Home support agencies do not currently, and could not, manage volunteers to provide personal care or household management for clients as an alternative to government funding. The majority of older clients have complex needs, and it would be neither safe, nor practical to expect volunteers to undertake this work. (sub. 114, p. 4)

## E.6 Conclusion

Home-based care of older people is an example of a service provided by many different types of organisations and individuals. Government health and accident rehabilitation services are prominent, but family members, friends, community organisations and other volunteers provide essential support and social networks. The case study therefore provides lessons for other services that are provided to the same person by different organisations and people in government or within families and social networks.

The first lesson is the value of client choice, provided that clients are supported and well informed in making choices. Chapter 11 of the inquiry’s report considers client-directed service models in detail.

Focusing on service outcomes requires new approaches to commissioning and contracting, as well as good performance monitoring. Procurement practices can improve services but need careful management, as is indicated by the frustration of providers about government processes for renewing or re-tendering home care contracts. Chapters 6 and 12 consider commissioning and contracting issues.

Finally, a service such as home-based care requires coordination between care provided by different organisations and individuals. The case study indicates that effective service integration depends on different service funders and providers having good information about other services, and sharing values that emphasise the importance of integration. Service integration is addressed in Chapter 10 of the inquiry’s report.

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