NZ COUNCIL OF CHRISTIAN SOCIAL SERVICES

HEALTH OF THE SECTOR: SERVICES FOR OLDER PEOPLE SURVEY

September 2004

NEW ZEALAND COUNCIL OF CHRISTIAN SOCIAL SERVICES

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A. EXECUTIVE SUMMARY

This report presents the findings of a New Zealand Council of Christian Social Services (NZCCSS) Services for Older People survey conducted in 2004. The survey was, in part, a follow-up to a similar Health of the Sector survey conducted by NZCCSS in 2000. The survey also included a series of additional questions relating to providers' relationships with District Health Boards (DHBs) and Primary Health Organisations (PHOs), not asked in 2000.

Survey questionnaires were sent to 120 provider organisations from the NZCCSS membership database. This report incorporates information from survey respondents and from subsequent telephone interviews with senior managers from a selection of key member organisations.

The report provides a useful snapshot of providers' experience of and attitudes towards the current climate in the Health of Older Persons sector.

Summary of Conclusions

The survey has identified and confirmed a number of trends in the aged care sector:

- A reconfiguration of services is taking place. In residential services, rest home beds are reducing while hospital beds increase, reflecting the increasing acuity levels of residents. Home and community-based services generally are expanding, in line with the commitment of providers to implementing the ageing in place concepts.
- The price paid for services provided plays a decisive role in the continuing viability of the organisations operating in the sector. Major service providers in the sector are facing difficult decisions as whether to invest in upgrading services or to exit entirely.
- Providers are more conscious than ever of the need to be more flexible and responsive to consumers' needs in providing their services.
- There is a strong emerging pattern of regional inconsistency in the implementation of the Health of Older People strategy by government agencies (Ministry of Health, District Health Boards). The devolved environment in which the sector is operating has brought with it considerable risks for older people in

those regions where services for older people are not prioritised in service provision and funding decisions.

The aged care sector is in a delicate state of health and in the process of negotiating a difficult transition period. The outcome of that transition measured in terms of delivering services which meet the needs of older people in an appropriate way depends greatly on the response of policy and decision-makers to the issues identified in this report. Change is being implemented in the sector in a way which places the future of quality service delivery at risk. Uncertainty about service delivery models and funding pressures may lead to serious gaps in service provisions, particularly for poorer and vulnerable older people.

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KEY FINDINGS

SECTION 1 – STATE OF THE SECTOR

- There has been a slight *decrease* in the number of rest home beds provided between 2000 (86%) and 2004 (81%). There has been a slight *increase* in the number of hospital (continuing care) beds provided between 2000 (54%) and 2004 (56%). Indications from the survey suggest that home-based care levels remained the same between 2000 and 2004.

- Of all changes to older persons' services (service type, mix, staff and facilities) over the last five years, the most *significant* change made by providers was to their *facilities/buildings* (69%). En suites, studio units, serviced apartments and the upgrading of existing buildings were common examples given. The main reason given for service changes overall was *market trends*.

- 8 respondents had exited some aspects of service provision – 4 of these within residential care, and 4 within home care. 2 major providers had exited residential care entirely. The main reason given for exiting services was *financial viability*, closely followed by *deliberate desire to focus on community services*.

- The main indicated changes to *future* service delivery related to further redevelopment or upgrading of buildings/facilities. En suites, studio units featured strongly, as did development of residential/retirement village. Main reasons cited for future changes were market trends, competition and ordinary planned changes.

- Future reconfiguration of services (2004-2009) emphasised an increase in home based care and dementia care.

- Main criteria cited as to whether to remain in a specific service provision related to (in order of priority) *client and community need*, *occupancy*, and *price*.

- The majority of respondents (78%) felt quality of care provided had improved as a result of past changes, and 93% felt that quality would continue to improve as a result of planned future changes. Main reasons given included the advent of

Continuous Quality Improvement programmes, building improvements, and the increased range of services offered.

SECTION 2 – RELATIONSHIP WITH GOVERNMENT ORGANISATIONS

- Respondents stated that the main nature of their *interaction* with DHBs was primarily through face-to-face meetings and, to a lesser extent, through telephone conversations. The majority found their DHB to be *appropriately proactive*.

- The converse was true in terms of respondents' interaction with the Ministry of Health (MOH), where telephone conversations were twice as common as face to face meetings. The majority of respondents found the proactiveness of the MOH to be of an appropriate level.

- The majority of respondents (78%) felt DHBs shared their understanding of the policy framework for providing services to older people.

- Respondents were invited to measure the performance of their DHB in the last 12 months, in terms of
  (a) devolution of these services to DHBs
  (b) management of older persons' services
  (c) extent to which DHB understands these services

  In each case, respondents were equally divided – 50% positive; 50% negative.

- The positive responses towards DHBs centred around improved lines of communication at the local level, increased consultation and sense of partnership, more creativity and collaboration, and increased responsiveness.

- The negative responses centred around the DHBs' underfunding of the sector, lack of understanding of older persons' services, and increased bureaucracy and paperwork.

- Gaps in services: Underfunding was the most frequently cited gap, followed by recruitment and retention of staff, and issues around needs assessment processes.

- Respondents also indicated services not currently funded (e.g. convalescent care, slow stream rehabilitation, mental health, palliative, transport) as a significant gap.

- Respondents cited more flexible approaches to funding arrangements as the key means of rectifying such gaps, followed by improved service delivery design, and the development of a national needs assessment tool.

- The majority of respondents indicated that they had no contact, knowledge or understanding of PHOs, as PHOs were either new or non-existent in their area. Two respondents were members of PHOs.

B. BACKGROUND

New Zealand has seen significant upheavals and changes to its health policies and models of health care delivery over the past fifteen years. Indeed, the health system in NZ could be called a system in chaos. As Robin Gauld writes, "The chaos is partly because organisation of the New Zealand Health Sector has been in active transition mode since the early 1980s…there is little stability or predictability through which advances may be consolidated." (Gauld, 2003).

Services for older people (including residential and home based services) have not been exempt from this scenario – and, indeed, many providers are struggling to maintain viability and quality of service delivery due to a variety of reasons, such as:

- Continuation of an Ageing Population; over 65 group due to reach 25% of population by year 2005;
- Devolution of funding and management of aged care provider contracts from MOH to DHBs;
- Development of Health of Older Persons and Positive Ageing Strategies;
- Greater emphasis on Home-based care and development of Ageing-in-Place initiatives;
- A $636 a week 'cap' on funding for residential aged care providers – no CPI adjustment since 1994;
- Introduction and maintenance of Continuous Quality Improvement systems;
- The continual thrust of contractual obligations, and increased regulatory compliance requirements – e.g. staffing effectiveness, certification, and changes to the Holidays Act;
- Greater number of private operators and/or property developers entering the sector, particularly in area of Retirement Villages and studio/Rental Units; and
- Some Religious & Welfare not-for-profit providers exiting residential aged care.

C. INTRODUCTION

NZCCSS decided to conduct this survey for several reasons. Firstly, the information uncovered in the survey will assist NZCCSS to inform the Ministry of Health on the current 'health status' of the Religious and Welfare aged care sector, and in particular the 'new environment' now that funding and contracting responsibilities have been devolved to the 21 District Health Boards.

NZCCSS also has the opportunity to give feedback and support to its members by capturing trends, patterns and themes in the aged care sector, building on the results of its previous survey conducted in 2000. As well as revealing an internal snapshot of the aged care provider scene, this survey will add the wider dimension of current provider relationships with DHBs and PHOs.

Questions of interest are: How is the devolution working? Are the DHBs managing Health Services for Older People in a manner that is consistent with strategies and policies such as the Health of Older People Strategy and the Positive Ageing Strategy? What does service provision look like now for NZCCSS providers? What will it look like in the future? What is the current role and focus of the PHOs with regard to provision of services for older people?

The 2004 NZCCSS 'Health of the Sector: Services for Older People Survey' has two Sections. Section one builds on an earlier survey conducted in 2000 and focuses on trends, changes and planned changes in service delivery in the aged care sector from 2000 to 2009.

Section two has been circulated for the first time in 2004 and focuses on relationships between aged care providers and the newly formed DHBs and PHOs over the last few years since their inception in 2001 and 2003 respectively.

The survey results are followed by a discussion of the findings.

METHODOLOGY

A two-part questionnaire was sent to 120 organisations that the NZCCSS database recorded as providing some form of services for older people.

Of the 120 questionnaires sent, 47 were returned completed, a response rate of 39%.

Not all respondents answered all questions. Some questions were irrelevant for some respondents. In some cases, respondents chose not to answer particular questions. There was a greater and more detailed response rate to section two of the questionnaire.

Where percentages are given, they are for the number of respondents who answered a particular question. A copy of the questionnaire is attached as Appendix 1.

The discussion and policy implications of this report are based on the results of the survey, general discussion with the Services for Older People Policy Group of NZCCSS, and nine post-survey follow-up telephone interviews with senior managers of NZCCSS member organisations.

D. FINDINGS: SECTION ONE

(I) SERVICES PROVIDED BY NOT-FOR-PROFIT (RELIGIOUS AND WELFARE ORGANISATIONS

Not-for-profit providers are responsible for a significant number and wide variety of services for older people. 36 respondents answered this question.

	2004 Survey	2000 Survey
Rest Home care:	29 (81%)	(86%)
Respite care:	26 (72%)	(74%)
Day care:	26 (72%)	(54%)
Continuing Care hospital:	20 (56%)	(53%)
Stage III/ Dementia care	12 (33%)	(37%)
Home Support:	12 (33%)	(34%)
Community Social Support:	11 (31%)	(n.a.)

Other services listed:

Falls Prevention	1
Counselling	1
Group Education	1
Meal Service	1
Meals on Wheels	3
Community meals	2
Transport	1
Home Handyman Service	1
Social Work	1
Carer Support	2
Supported House (Rental & License-to-Occupy)	1

Villas / Independent Living Units	1
Retirement Village	3
Boarding Facilities	1
Studio Units	2
Volunteer Service	2
Community FIRST	1
Pilot of Specialist Day Programme	1
Laundry Service	1
Palliative Care Rest Home	1
Dinner, Bed & Breakfast	1
Semi Acute Convalescent Care	1
Cottages	1
Rental Accommodation	1
Ownership Accommodation	1
Parish Based Services – Day Care, Parish Nursing for Elderly	1

(II) CHANGES MADE TO SERVICES IN THE PAST FIVE YEARS (2000-2004)

This section of the questionnaire sought to find out whether organisations had made any significant changes to their services over the past five years and if so, what these changes had been and why they had made them.

1.1 When asked whether they had made any changes 27 (93%) of the 29 respondents who answered this question said yes and 2 (7%) said no.

1.2 Types of changes made:

Changes in the *type* of services provided:	12 (41%)
Changes in the *mix* of services provided:	15 (52%)
Changes to the *facilities* from which services are delivered:	20 (69%)
Changes in the number or type of *staff*:	14 (48%)
Other changes:	6 (21%)

1.2.1 Changes in the type of services provided

12 of the 29 organisations who answered this section of the questionnaire (41%) indicated that they had made changes to the *type* of services they provide. The most common changes mentioned were:

- Introduction or extension of home-care or community-based services – mentioned by 5 respondents
- Introduction of Day care – mentioned by 3 respondents
- Increased dementia services – mentioned by 2 respondents

Two respondents noted their exit from the provision of residential care.

1.2.2 Changes in the mix of services provided

15 of the 29 organisations who answered this section of the questionnaire (52%) indicated that they had made changes to the *mix* of services they provide. The most common changes mentioned were:

- Adding more hospital beds – mentioned by 10 respondents
- Reducing the number of rest home beds – mentioned by 4 respondents
- Increasing the number of dementia/stage III beds – mentioned by 4 respondents
- Some palliative care now provided – mentioned by 2 respondents
- Purchase of additional residential facilities

1.2.3 Changes to the facilities from which services are provided

20 of the 29 organisations who answered this section of the questionnaire (60%) indicated that they had made changes (e.g. refurbishment, redevelopment or additions) to the facilities from which services were provided. These included:

- Adding en suites were mentioned by 9 respondents
- Building studio units, rental accommodation and serviced apartments were mentioned by 5 respondents
- Upgrading existing rest home rooms to hospital standard was mentioned by 2 respondents

1.2.4 Changes in the number or type of staff used to deliver services

14 of the 29 organisations who answered this section of the questionnaire (48%) indicated that they had made changes to the number or type of staff employed.

- All respondents noted an increase in the number of staff employed – especially Registered Nurses, Occupational and Physiotherapists (10 respondents)
- 5 respondents indicated an increase in hours/numbers of diversional therapists, caregivers and/or physio assistants
- One respondent noted re-establishment of team leader/charge nurse positions

1.2.5 Other changes

In addition to the changes listed above, seventeen (17) respondents mentioned other changes they had made. These changes were quite diverse, and included:

- Adding a gymnasium to improve fitness and mobility
- Private meal service for clients unable to access DHB Meals on Wheels
- One provider took over cleaning/laundry contract from an outside contractor
- Full-time RN employed in a training position
- ESOL classes for older refugees introduced
- Introduction of Parish Nursing and parish-based services

1.3 Why did respondent organisations make these changes?

This question sought to identify the primary motivation for making the above changes. 37 respondents gave the following reasons for their decisions:

Market trends	17	(46%)
Ordinary planned changes	14	(38%)
Competition	8	(22%)
In response to government policy	11	(30%)
Contract requirements	4	(11%)

In addition to the reasons listed, 15 organisations listed 'other reasons' for their decisions. These included:

- Response to client/community need (mentioned by 7 respondents)
- Reduced funding of services (mentioned by 3 respondents)
- Intentional move away from reliance on government funding

1.4 - 1.5 Changes in bed numbers between 2000 - 2004

46 respondents provided changes in their rest home and continuing care/hospital bed numbers for the period 2000-2004.

Rest Home:

Stayed the same:	30	(65%)
Increased:	9	(20%)
Decreased:	6	(13%)

Continuing Care/Hospital beds:

Stayed the same:	31	(67%)
Increased:	13	(28%)
Decreased:	2	(4%)

1.6 – 1.8 Other changes to service provision

Respondents were asked whether they had made any other changes to service provision between 2000-2004. Of the 30 respondents who answered this section, 16 indicated that they had made other changes.

Changes to service provision noted were:

- More dementia beds (5 respondents)
- More home care services (5 respondents, including the introduction of one 'ageing in place' initiative)
- More day care services (3 respondents)
- Reduced dementia beds (1 respondent)

Those respondents who indicated other changes were asked to indicate why such changes had been made. Of the few responses made, key reasons related to competition and response to need.

1.9 – 1.11 Services respondents exited (stopped providing)

This section sought to ascertain whether providers had exited some services during the period 2000-2004 and why. 33 respondents answered this question. The majority had not ceased the provision of any service during this time.

Providers who did not exit services:	25	(76%)
Providers who exited services:	8	(24%)

Of the 8 who had exited services:

- 4 had stopped providing some aspect of residential care (including 2 large providers who had exited residential aged care entirely)
- 4 providers had exited some aspect of home care or community-based services

3 key reasons were given for exiting services:

- financial viability (5 respondents)
- a deliberate more towards a focus on community support (3 respondents)
- competition (3 respondents)

(III) FUTURE CHANGES (2004-2009)

The next part of this first section of the questionnaire sought to find out what changes providers of services for older people might be planning to make over the next five years.

Respondents were asked to indicate whether they were likely to make changes within the same range of categories previously identified. Of the 26 respondents, the following answered 'Yes' in each of the categories:

Types of changes planned:

Changes to the *facilities* from which services are delivered:	20	(77%)
Changes in the *mix* of services provided:	12	(46%)
Changes in the number or type of *staff*:	12	(46%)

Changes in the *type* of services provided:	10	(38%)
Other changes:	8	(31%)

1.12.1 *Changes to the types of services provided*

10 respondent organisations (38%) intend to make changes to the type of services they provide over the next five years. The changes planned include:

- Increase or develop community services – mentioned by 6 respondents
- Develop serviced apartments/rental ownership accommodation – mentioned by 2 respondents
- Develop transitional care contract with DHB – mentioned by one respondent
- Further hospital and stage III beds – mentioned by one respondent

1.12.2 *Changes to the mix of services*

12 of the respondents (46%) indicated that they planned to make some of the following changes:

- More hospital beds– mentioned by 7 respondents
- Less rest home beds– mentioned by 6 respondents
- Increase respite and palliative beds– mentioned by 1 respondent
- Increase dementia care- mentioned by 1 respondent

1.12.3 *Change to the facilities from which services are delivered*

This type of proposed change was the most common. 20 respondents (77%) indicated that they planned to make significant changes to their facilities over the next five years. The most common proposed changes mentioned were:

- Redevelopment or upgrade – mentioned by 13 respondents
- Adding en suites to existing rooms – mentioned by 5 respondents
- Development of a brand new Retirement/Residential Village –mentioned by 3 respondents.
- Building rental studio units – mentioned by 2 respondents.
- Building supported housing – mentioned by 1 respondent

1.12.4 *Changes in the number or type of staff*

Changes to staffing arrangements are planned by 12 of the respondent organisations (46%). The most common changes mentioned were:

- More staff generally – mentioned by 7 respondents
- Changes in staff mix – mentioned by 4 respondents
- More specialist staff required to specifically cope with increasingly frail residents – mentioned by 2 respondents.

1.12.5 *Other changes*

8 respondents (31%) mentioned 'other' changes they were likely to make in the future.

There were a diverse range of responses to this section however one trend emerged, namely:

- A conscious effort to link residential and community/develop a continuum of care by adding, increasing and diversifying services currently provided (e.g respite, convalescence, hospice care, day care) – mentioned by 5 respondents

Other responses included:

- Introduction of a computerised nursing care system – mentioned by 1 respondent
- Development of apartments, from 320-1050 – mentioned by 1 respondent
- Review of residential services with a view to exiting and focusing on isolated elderly in the community – mentioned by 1 respondent.

1.13 The reasons why organisations are planning to make changes

This question sought to identify the primary motivation for making the above changes. 26 respondents gave the following as reasons for their decisions:

Market trends	13	(50%)
Competition	13	(50%)
Ordinary planned changes	13	(50%)

In response to government policy	8	(31%)
Contract requirements	2	(8%)

In addition to the reasons listed above, 16 organisations listed 'other reasons' for their decisions. These included:

- In response to client and/or community needs/expectations (9 respondents)
- In response to ageing-in-place initiatives/continuum of care (2 respondents)
- In response to a DHB tender (1 respondent)

1.14 Planned major redevelopment of *buildings* during the period 2004-2009

18 out of the 28 respondents (64 %) who answered this question said that they planned major redevelopment of their buildings over the next 5 years. 13 respondents indicated plans for major upgrade, rebuilding or extensions. Reasons given for such work included:

- To accommodate change in mix
- To replace an existing rest home (built 25 years ago)
- To provide integrated community support
- For rental or license-to-occupy
- To accommodate increase in day care clients
- To provide more hospice and dementia care

1.15-1.16 Plans for reconfiguration of *services* during the period 2004-2009

9 of the 30 respondents who answered this question (30%) indicated that they planned to reconfigure their services. Plans included:

- New community/home-based care services (6 respondents)
- Increased dementia care (2 respondents)
- More services integrating stronger linkages with government and community agencies, and closer working relationships with PHOs (1 respondent)
- Providing new aged services from a parish base (1 respondent)
- Providing a new retirement community (1 respondent)

1.17 Criteria used to decide whether or not to continue providing services

Respondents were asked to indicate the criteria used to decide whether or not to continue to provide a particular service. 25 organisations responded to this question, with the following reasons (in order of priority) given:

- Client/community need (9 respondents – 36%)
- Occupancy (8 respondents – 32%)
- Price (8 respondents – 32%)
- Competition (6 respondents – 24%)
- Government policy (2 respondents – 8%)

Other responses included:

- Unwillingness to rely on government assistance
- Desire to fit with organisation's strategic plan and vision
- Funding status and financial viability

1.18 The quality of care as a result of *past* changes

This question sought to find out whether respondent organisations thought the quality of care clients received had improved since 2000. Of the 32 who answered this question, 25 respondents (78%) indicated 'yes'. 30 gave reasons for this:

- Continuous quality improvement systems (accreditation/certification) were mentioned by 13 respondents
- Improved/increased training (3 respondents)

Reasons for negative responses to this question (i.e. those respondents who felt that quality of care had not improved) included:

- Cost, contractual demands and constraints
- Increased resident and relative expectations

9 respondents felt quality of care had remained the same.

1.19 The quality of care as a result of *proposed* changes

Respondents were asked whether they believed that the changes they planned would provide a better quality of service to future clients. 28 organisations responded as follows:

Yes	26	(93%)
No	2	(7%)

Those respondents who thought the quality of their services delivery would improve if they made planned changes gave the following reasons for their answer:

- Provision of en suites and other building improvements – mentioned by 5 respondents
- Improved range of services, and better access to services – mentioned by 4 respondents

1 respondent noted that while quality of care may not necessarily improve, the accommodation changes proposed would better meet client and family expectations.

E. FINDINGS: SECTION TWO

PROVIDER RELATIONSHIPS WITH DHBs AND PHOs

This second section of the survey was conducted for the first time in 2004 in response to both a request for feedback from the Ministry of Health and also as a way of NZCCSS providing information and feedback to its members. It focuses on provider relationships with DHBs and PHOs (where relevant).

2.1. Which DHB(s) do you provide services in?

1. Auckland (2 respondents)
2. Bay of Plenty (4 respondents)
3. Canterbury (4 respondents)
4. Capital & Coast (7 respondents)
5. Counties Manukau (3 respondents)
6. Hawkes Bay (3 respondents)
7. Hutt (4 respondents)
8. Lakes (1 respondent)
9. Mid Central (4 respondents)
10. Nelson Marlborough (3 respondents)
11. Northland (2 respondents)
12. Otago (6 respondents)
13. South Canterbury (1 respondent)
14. Southland (3 respondents)
15. Tairawhiti (2 respondents)
16. Taranaki (5 respondents)
17. Waikato (6 respondents)
18. Wairarapa (1 respondent)
19. Waitemata (3 respondents)
20. West Coast (No respondents)
21. Whanganui (2 respondents)

2.2 Which PHO(s) is/are active in your area?

33 organisations answered this question. 10 indicated that either no PHOs were active, or they did not have this information. Of those who indicated active PHOs, the following were identified:

- Capital PHO
- Tumai
- Porirua Plus
- East Health
- Hawera Healthcare
- Hawkes Bay
- Tairawhiti
- Wairoa
- Lake Taupo
- Mornington & South Link
- Mosgiel
- Nelson
- Marlborough
- Top of the South
- Canterbury Community
- Partnership Health Canterbury
- Rural Canterbury
- Hurunui/Kaikoura
- Northern Lower Hutt
- Otaki Access
- Pegasus
- PHI
- ANO
- Te Waipuna
- Pinnacle
- TKI
- Te Tihi Hauora
- Pinnacle
- ProCare
- Secpho (Southeast City)
- Wairarapa Community PHO

2.3. How often do you communicate with representatives from (tick those that apply):

At least:	weekly	monthly	quarterly	annually
Ministry of Health	3	9	24	9
DHB	12	17	16	0
PHO	7	4	6	3
Other agencies (specify which)	6[1]	7[2]	5[3]	1[4]

Notes on other agencies:

1. Access Ability, NASC, ACC
2. NASC, WINZ, Capital Support
3. Supportworks, Capital Support, HDANZ
4. None specified

2.4. Nature of interaction with representatives:

	Meetings	Telephone conversations	Site visits/audits	Other (specify)
Ministry of Health	13	24	16	17
DHB	31	25	9	8
PHO	10	8	3	3
Other agencies (specify which)	13	13	6	1

(a) The following other *agencies* were noted: ACC, MAISS, Elder Care Canterbury, NASC, Service Co-ordinator, WINZ

(b) The following other *types of interactions* were noted: emails, ad hoc aged care meetings, statistics, conference training, faxes, invoicing, reporting, monitoring returns, contracts, filling out forms

(c) Additional comments:

- Relating to DHBs – respondents indicated that meetings are related to: contract issues, provision of services, case managers' meetings,

quarterly support link, provider liaison group, discussion document forums

- Relating to MOH – auditing (by designated auditing agency), conference training
- Relating to PHOs – only 2 of the total 47 survey respondents indicated that they belong to PHOs in their region. Some others had been to initial 'set-up' meetings.

2.5. How proactive are agencies in contacting/communicating with providers?

Organisations were asked, 'How proactive are the following agencies in contacting/communicating with you?

	Appropriate for my needs	**Not frequent enough**	**Too frequent**	**Communication is non-existent**
Ministry of Health	26	6	0	5
DHB	27	10	0	4
PHO	12	3	0	10
Other agencies (specify which)	13*	0	0	0

* Agencies noted were: ACC, Capital Support, MAISS

Comments: Responses differed according to specific DHB regions – e.g. "Feels like we need to chase them" versus "open access and regular invitations to DSAC meetings".

2.6 - 2.7 Organisations were asked: 'Does your DHB share with you their understanding of the policy framework for delivering services for older people? (e.g. Positive Ageing Strategy and Action Plan, Health of Older People Strategy)'

YES: 29 (78%)
NO: 8 (22%)

25 of the 29 respondents who answered 'Yes' gave examples as to how DHBs understand/share with them their understanding of the policy framework for delivering services for older people. Many gave examples of

DHB/provider interface groups which have been developed locally such as seminars, regular meetings, advisory groups, consultation groups and forums where ideas are discussed, consultation sought and information disseminated regarding:

- business/strategic plans
- HOP strategy
- 'proposals for a continuum of care' (Otago)
- 'older person's plan'
- Ageing-in-place strategies
- Eldercare Canterbury and 'Slow strategy development (Christchurch)
- 'Agewise' (Waikato)
- 'Positive Ageing'(Nelson).

4 of the 29 respondents did not believe that the DHB has a good understanding of the framework for delivering services for older people. 2 of these cited non-response to proposals and lack of pro-activity on the part of the DHB.

2.8. Organisations were asked, 'How useful do you find the resources that have been produced to offer guidance to the sector on services for older people?'

	Very useful	**Quite useful**	**Only sometimes useful**	**Not useful at all**	**I am not familiar with this resource**
Government NZ Health Strategy	6	15	19	1	1
Positive Ageing Strategy and Action Plan	7	23	13	0	0
Health of Older People Strategy	9	22	10	0	1
Service Guidelines	10	24	5	1	1
DHB Annual Plans	5	12	7	5	12
PHO Annual Plans	2	4	2	3	20

2.9. What action, if any, have you seen in the last 12 months that demonstrates any changes in the way services for older people are being managed?

The majority of respondents noted that the main difference in the way older persons' services are being managed was due to the advent of the DHBs. Observed changes in the management of services for older people resulted in positive, negative and neutral responses, although six respondents believed they had not noticed any change.

a) Positive responses (10) included:

- Better lines of communication with DHB at local level than with MOH (2 respondents)
- DHB support for Community First
- Waikato DHB has a consultation document out: 'Older Person's and Rehabilitation Proposed model of Care and Consultation'. "This is a big improvement for this region."
- Improvement in discharge planning from hospitals in Christchurch
- Influence of Eldercare Canterbury
- More Day care subsidies provided by DHB
- Increasing well-focused groups working towards the HOP strategy requirements
- Closer relationship with DHB has helped
- DHB responding to local need and service gap with pilot programme for Health Care recovery
- More contact with DHB portfolio manager

b) Negative responses (11) included:

- More paperwork to meet certification - (2 respondents)
- Introduction of HDSS – positive in principle, but bureaucratic set-up diminishes the value
- Change of licensing to certification in principle positive – however the costs without increased funding compromise quality of care for residents
- Totally controlled by financial budgets, with new providers or redeveloped providers taking market share from the initial aged care operators

- DHBs finally engaging and still tentative, but risk averse and with limited understanding of the industry
- Increasing number of older people entering rest homes for short-stay care (2 respondents)
- Devolution to DHBs has produced changes which impact on Providers – a collective direction and approach to service provision has been lost
- The under-funding illustrates how Govt and the bureaucracy seriously under-value older people with H&D or social issues. There seems to be no genuine willingness to sort this out
- Disturbing moves towards saving money. Clear messages from ODHB regarding cutbacks across board
- Admission to residential care becoming more difficult to access
- Smaller operations are exiting services

c) Neutral responses (7):

- New contracts (e.g. dinner, bed and breakfast)
- Population-based funding
- Compliance with Health and Disability sector standards
- Development of HOP plans by DHBs
- Implementation of managed bed policy
- Less people but higher dependency levels on entry in to rest home
- more older people with level of dementia entering residential care

2.10. What changes have you experienced, if any, as a result of services being formally devolved to the DHB(s)?

As with the previous question, the responses for this question produced a 50/50 split in opinion.

17 out of 40 (42 %) respondents gave a negative response. They felt that there had been no changes and/or negative changes. Examples they gave were similar to responses above and included:

- Decreased admissions to rest home care (2 respondents)
- No increases in funding
- More bureaucracy ("another unfortunate layer of bureaucracy")

16 out of 40 (40 %) respondents gave a positive response:

- Better liaison/communication and a sense of partnership (10 respondents)
- More local/one-to-one/easier access and responsive relationships (6 respondents)

Other responses included:

- More feedback
- More ownership
- More creative innovation

2.11. To what extent does your DHB demonstrate an understanding of the services you provide? (Give specific examples, where possible, e.g. identify the specific strengths or knowledge gaps)

Yet again this question resulted in a 50/50 split in respondent opinion.

17 out of 35 (53%) respondents felt that the DHB has a good understanding of services provided.

16 out of 35 (50%) respondents felt that the DHB has a poor understanding of the services provided.

2 out of 35 (6%) respondents felt that the DHB was still / only now “getting to grips” with the services provided.

Respondents who felt positively towards a DHB understanding mentioned:

- Good understanding
- Willingness to listen and talk to us
- Good exchange of ideas
- More focussed than before
- Endeavour to be open to comments
- DHBs are very keen to work collaboratively with the sector, open to suggestions and new ideas (Auckland)

Respondents who felt negatively towards a DHB understanding mentioned:

- Poor understanding
- They don't know how residential care works
- Limited understanding demonstrated
- Main focus and emphasis has been on managing financial risk
- Staff changeovers at DHB have caused difficulties (2 respondents)

2.12. In your view, what service issues or gaps exist in your area? (e.g. funding, inter-agency coordination, service specification, knowledge gaps, recruitment, needs assessment – please list in order of priority, and give examples, where possible)

Every respondent answered this question, with many respondents giving more than one example. In total there were 88 examples given.

- *Funding*: This was the most frequently-cited gap/issue (28 responses – 32%)

  Examples included:

  i. understanding by DHB of inflation and cost increases, and cost of certification
  ii. expected to provide higher level of care for same dollars
  iii. funding constraints threaten continuance of some services, e.g. social work and specialised counselling
  iv. $636 cap not CPI adjusted for 10 years
  v. funding does not cover all the extras we have to cover for our subsidised residents
  vi. underfunding effects recruitment and staff

- *Recruitment*: (21 responses – 24%)

  Examples included:

  i. limited pool of skilled staff, and RN shortage (cited by 8 respondents)
  ii. no suitable caregivers available due to very good employment situation
  iii. inability to recruit/retain suitable staff for both residential services and home support
  iv. not enough home care assistants who want to work at weekends

- *Needs Assessment*: (14 responses – 16%)
  Examples included:
    i. needs assessment not nationally consistent and differs according to the individual assessors' views and understanding (6 respondents)
    ii. national needs assessment protocols and tools need to be in place soon
    iii. deficiencies in needs assessment
    iv. there is a long delay in assessment from rest home to hospital level

Other gaps cited by respondents pertained to services which are not funded, and therefore not provided – but it is felt that older people are in need of. Examples included:

- Community support beyond home care and basic day care
- Social support
- Medication monitoring
- Slow-stream rehab and convalescent care
- Quality, predictable, 'bookable' respite care
- Carer and older person health education
- Stronger links with palliative care
- Support for older people with low level mental health issues
- Transport to clinics etc for rest home elderly and those in the community – especially in rural areas
- Inadequacy of home based services, housing and accommodation for elderly
- Ageing in place leads to gaps (sociological/psychological) because it focuses only on disability and minimum service requirements
- 'Open stage III' or 'stage 2.5 level' – i.e. some dementia needs, but not secure care (higher staffing levels than rest home)

2.13. How could the identified service issues or gaps be rectified in your area?

Many respondents answered this question, with a number giving more than one example. In total there were 51 examples given. The majority of responses (24

out of 51) indicated that gaps could be rectified by more funding – with a number of specific suggestions offered – e.g.:

- More flexible funding arrangements / new approaches to funding
- More consultation
- More funding to enable higher wages to be offered
- More flexibility between Disability Support Services (DSS), Personal Health (PH) and mental health (MH) funding
- Funding needs to recognise the cost of increased compliance and changes to legislation
- Funding for staff education
- Attaching funding to clients and not to facilities

The next most common response in terms of rectifying gaps related to changes in service delivery design (i.e. new ways of doing things). Suggestions included:

- Increased short term service options for residential care
- Using residential services more to support ageing in place
- Short term care for older people living alone
- More engagement with PHOs
- Implementation of Health of Older People strategy

There was a cluster of suggestions around assessment issues, including:

- Development of national standard for needs assessment
- More transparency for providers in terms of needs assessment process
- Information re the results/outcome of the recent NASC review
- Needs assessment to include input from GP and other health professionals involved with clients – e.g. hospice

Finally, a group offered suggestions around DHB involvement, including several who said that the DHB has responsibility to fund service gaps, and that providers need to keep meeting with DHBs and working together. Other suggestions implied a frustration and impatience with the consultation process/reviews/promises – e.g.

- “DHB have over the years had meetings about service gaps and how to address these, but little action has resulted”

- "MOH work on workforce issues needs to be completed and results addressed ASAP"
- "DHB has done a review of its NASC service and ATR. Whether this will result in a better service remains to be seen"

2.14. What initiatives are you, or other local service providers, engaged in that address service gaps?

Most respondents gave generic answers regarding everyday liaison, meetings and communication with DHB and other agencies (including other providers). Of 42 responses overall, 22 indicated more general communication and contact (such as phone calls, meetings, lobbying, etc.). Only 17 named initiatives that they are involved with. These were:

- Self-funded pilot of physio, nursing and social day programme. Seeking to expand this with DHB funding
- Community First
- About to trial a new strategy model for home support where greater job security is offered
- Liaison with DHB; involvement with ElderCare Canterbury and Age Concern, identifying service gaps and service planning
- Planning for development of home care for frail older people
- Our facility will consider a lower fee for short term care, if the need arises
- Development of community support services for people who are socially isolated
- On DHB committee to address interface between mental health and DSS clients
- Provision of palliative care beds, where able
- Alzheimers/dementia day care
- Working with DHBs on home care issue
- Through the diocese we have been looking at parishes and where they see a need in their community. We have established an alliance with a rural trust and provided expertise to help them establish a rest home in their area
- Community lunch – invited socially isolated people from wider community. Loan of van for outings
- Horowhenua Masonic is running a rehabilitation scheme

- Presbyterian Support Central is attempting to address transport issues
- Positive ageing group runs quarterly positive ageing forums in New Plymouth
- We 'train' caregivers when we can't get certified and experienced people

2.15. Have PHOs had any involvement in the management and/or delivery of services for older people in your area?

Yes	9
No	26

2.16. If YES, what sort of involvement have PHOs had?

Of the 18 who answered this question, the majority (12) acknowledged that their PHO was in its infancy. The remaining respondents (6) said that they are working with PHOs in the development of policies and/or the development of primary health care services. One respondent noted that they were setting up funding of 'GP beds' for people requiring care and observation. Only 2 providers (of the 47 survey respondents) declared that they were members of a PHO.

Any other comments?

There were only 6 responses in this final section of the survey. 4 respondents summarised with very strong statements on the current state of the aged care sector, and how continued under-funding is the main underlying funding which has *not* been addressed – e.g.

- "Under-funding of residential care threatens to erode the base from which innovation will come."
- "Unless the funding issues are addressed, those of us with a genuine interest in the care of older people (that reflects our love and respect – and as they deserve) will leave the service, and only those interested in making money in any way possible will continue."

2 respondents sought more information and potential involvement with PHOs.

F. DISCUSSION

HEALTH OF THE SECTOR – 2004 SNAPSHOT

To some extent, the first part of section one produced a steady continuation of changes and trends indicated by respondents in the 2000 survey; a kind of 'more-of-the-same' scenario. Providers have continued to drop rest home beds and pick up hospital beds, and say they will continue to do so in to the 2004-09 period. There is a continued increase in the provision of home care, dementia care and day care. Palliative care is being mentioned more frequently.

The period 2000-2004 has seen a lot of continued building projects, with the majority of respondents having been involved in the development of en suites, studio units, serviced and rental apartments, upgrades. Building and development is in fact the main change that providers have undertaken, and this looks set to continue in to the 2004-9 period, with again, the majority of respondents indicating plans to 'upgrade', 'redevelop' and in three cases to build an entirely new Residential/Retirement Village complex. Building plans and concepts are becoming less traditional (e.g. rest home and hospital wings) and more 'modern' with the inclusion of rental and studio unit accommodation etc. This trend may reflect the fact that many facilities within the religious and welfare sector are older and in some cases run-down, compared to the growing number of new, purpose-built facilities in the private sector. Many in the religious and welfare sector are recognising the need to upgrade and/or reconfigure facilities in order to remain competitive. This puts many religious and welfare providers in the difficult situation of deciding whether to make such large capital investments in the face of inadequate and uncertain funding arrangements. Some feel that the imbalance developing in the sector will be exacerbated if the present focus on retirement village property development targeting the wealthier end of the market continues. Most those surveyed do not wish to compete in such a market, their focus is on providing a service accessible for all older people, regardless of their wealth and income.

Respondents have indicated that they have increased staffing numbers, especially to include more trained staff (RNs, physiotherapists, occupational therapists) as acuity of residents and hospital bed numbers increase. Frequent mention was made of the difficulty in recruiting and retaining staff at current wages levels.

These changes have been made principally in a response to market changes, existing planned changes and government policy. A significant number of respondents said that they were making changes in response also to community and client need, which implies a willingness and desire to stay in touch with older person's issues of care.

Four major providers have exited residential services since 2000, citing financial reasons as the main driver behind this, but also importantly, a desire to focus more on other aspects of care provision such as community services.

An overwhelming majority of respondents said that they believed the quality of care for clients had improved since 2000 as a result of past changes. A large number of respondents attributed this improvement to the advent of continuous quality improvement practices and policies such as accreditation and certification. Some felt that the quality of care had stayed the same or even deteriorated, citing cost and contractual demands as the reason.

A majority felt that the quality would continue to improve as a result of proposed changes, with several respondents citing building improvements as a reason for this. One respondent shrewdly noted that while improved accommodation was likely to better meet client and family expectations, they were not sure if the quality of *care* would necessarily improve. This is in fact points to the issue of evaluation of quality practices for providers – how can they be sure that embracing a quality culture translates in to improved care? Or is this assumed? Some respondents were critical of increased costs associated with the requirement of certification. There is clearly a significant danger that improvements to the quality of care will be compromised if the costs associated with meeting standards and certification requirements cannot be recovered.

RELATIONSHIPS WITH GOVERNMENT AGENCIES

The results of section two of the survey must be read in the understanding that each organisation answering this section will be operating in a unique environment – some providers will be working with multiple DHBs, while others may only provide services within one DHB area. Some providers will also be more exposed to the emergence of PHOs in their area. Every DHB was represented in the survey, except the West Coast of the South Island, which only has one NZCCSS member.

Respondents were far more familiar with and in communication with DHBs than PHOs, the latter being described often as “in their infancy” or “just beginning in our area”. However two respondent organisations are members of PHOs and actively involved with them.

An overwhelming majority of respondents felt that the DHBs understood the policy framework for delivering services to older people. They were highly aware and involved with seminars, committees, forums etc where the Older Person’s Health Strategy and local DHB Plans for delivering and funding services for older people were being discussed.

However when this question was broken down in to questions about changes emanating from these policy framework understandings, the respondents were evenly split in their views. Fifty per cent felt positively towards new changes for such reasons as: better local contact and communication, Ageing-in-place initiatives, a sense of partnership. Fifty per cent gave negative responses for reasons such as: continuous under-funding, DHB’s financial focus, another layer of bureaucracy.

When asked if the DHB understood the services they provided, there was again a neat 50/50 split in response. The ‘positive’ group felt that there is now a greater willingness to talk and listen, better exchanges of ideas and a keenness to work collaboratively. The ‘negative’ group felt that the DHB did not understand aged care residential. They felt that the DHB’s main focus was in managing financial risk. Constant staff changes within the DHB’s was mentioned as problematic in terms of communication.

The implication of these responses are that a significant numbers of District Health Boards are not performing adequately when it comes to service provision for older people. The successful implementation of the policies contained in the Health of Older People strategy is heavily dependent on the response of District Health Boards. Where insufficient funding is made available and those responsible for coordinating services do not understand or prioritise the needs of older people, there is a significant risk that older people will miss out on services they urgently need.

INNOVATIONS AND INITIATIVES

Innovations are called such because they imply something new and creative. Providers certainly need to look at new ways of delivering services. Traditional models of residential care (rest home, hospital, dementia) are firstly no longer viable as entities in themselves, and secondly (and perhaps more importantly) they no longer meet the needs of older people who are increasingly looking for a range of 'mix and match' options along the continuum of care.

Survey respondents indicated a variety of examples of innovation that they are either (a) trialling, (b) actually carrying out, or (c) currently negotiating funding for (see Appendix 3). It should be noted however that innovation should not be at the expense of appropriately funding existing services. While both are necessary (to provide flexibility of service delivery and choice) currently both are being funded from within the same limited funding stream devolved to DHBs. This is a major constraint placed on the sector's capacity to develop and implement innovation in line with the goals of the Ageing in Place and Health of Older People strategy.

Innovations are, of necessity, regional in nature. An urban example is one provider's 'assisted living' programme, where older people are referred by the 'Homeless Team'. Board, meals and clean linen are provided at low cost. This need has arisen due to the fall-out effect from the closure of boarding houses in inner-city Auckland. A rural example is that of one provider's alliance with a rural trust and provision of expertise to help that trust establish a rest home in their area.

The results of Section 2 of the survey, however suggest that providers seem to be thinking and behaving in two distinct ways in the new DHB/PHO environment. There are those who seem to be passively waiting for more funding and/or contracts to come their way, and expect a continuation of services in much the same way as has been the case in the past. They are cynical about attempts by the DHB to behave differently. Others, however, are embracing the new environment and despite their dissatisfaction with inadequate funding are stepping out into innovative partnerships in a proactive way, initiating ideas, forming partnerships and service delivery arrangements with their local DHB.

Similarly, different DHBs are behaving differently. Some seem to be more open and innovative and responsive to the needs and concerns of Aged Care sector providers. Other DHBs, however, are behaving in quite the opposite way and are not responsive to doing things differently. They have not incorporated the consumer-focused emphasis in their planning nor have they been open to a more flexible and cooperative approach to service provision. Such an identified weakness in promoting change among some District Health Boards puts older people in those areas at a significant disadvantage.

GAPS IN SERVICES

When asked about service gaps in their area, not surprisingly, the main response from respondents was to do with a financial gap or under-funding. The second gap in order of priority was felt to be recruitment and retention issues – especially of Registered Nurses and caregivers. Thirdly, there was quite an extensive dissatisfaction with needs assessment practices in NZ. In particular respondents felt there was an urgent need for nationally consistent, transparent assessment protocols and tools.

Providers were quite clear as to a number of actual service gaps for older people, namely - slow stream rehabilitation, transitional care, convalescent care, palliative care, mental health support, counselling, affordable supported accommodation options, transport and psycho-social support around ageing in place. This final example represents a seriously neglected facet of community-based care. Current traditionally-focused care packages tend to place their emphasis on meeting physical needs rather than meeting emotional and psycho-social needs through such services as social work, counselling, befriending, etc.

Providers indicated that the main way to address the gaps is via more flexible funding arrangements and new approaches to funding. It is difficult to deliver innovation from within established funding strategies. However, more innovative funding frameworks would encourage both more seamless links between residential and community care, and new forms of funding such as ‘packaged’ care and/or funding following the client. Providers are trapped in traditional task-allocation approaches to service delivery, despite their knowledge of more suitable, appropriate and necessary services for older people that support the notion of ageing in place. Feedback needs to be obtained from older people themselves as to their expectations and aspirations, and acted upon.

A real concern is the gap between the rhetoric of the Health of Older People Strategy (which supports flexibility and the provision of alternative service delivery options) and, in reality, the limited outcomes achieved to date. A further discrepancy is that the government agency setting the direction of policy (MOH) is now no longer the agency directly funding the implementation of such policy – that responsibility having been devolved to the DHBs. As a consequence, the continual sequence of reviews, consultations, scoping exercises, cost-benefit analyses and discussion groups, while necessary at one level, has not enabled providers to draw any closer to meeting the goals of the Health of Older People Strategy – despite providers' endorsement of its intent.

A more 'intangible' gap mentioned by one interviewee relates to attitudes towards older people in our society. The needs of older people are increasingly seen as a 'problem' (due to a rapidly ageing population). Traditional services for older people fall largely within a medical/disability/dependence model. People are 'assessed' as to their 'care needs'. They are seen as being 'at risk'. Older persons' own views as to how and where they want to live are seldom sought. Society prefers not to think about older people at all. The NZ health system is chronically under-funded across all sectors, but attitudes towards older persons' worthiness, deservedness and value are dubious. This is reflected in the way that older people are at the 'end of the queue' when it comes to funding priorities and allocations. As a consequence, the workers involved in the care of older people are also under-valued and seen to have lower status and worth.

THREATS AND OPPORTUNITIES FOR AGEING IN PLACE

Respondents were concerned that the isolation of older people in the community may itself lead to elder abuse and compromised safety and security. Maintenance and upkeep of older persons' property was seen as another threat to the notion of ageing in place. It was also noted that ageing in place can only work if there is a supporting infrastructure in place, including appropriate transport and social support options. The current workforce crisis in home-based services was also seen as a threat.

The main positives for ageing in place were seen as the ability to meet the wishes of older people to live and die in their own home. It is thought likely that this desire will increasingly become the norm for up-coming generations of older people. They will also want increased flexibility in their housing/accommodation options in the community.

RELIGIOUS AND WELFARE SECTOR – WHAT IS ITS DISTINCTIVENESS?

The respondents drew on a number of themes in addressing the distinctiveness of the religious and welfare providers in the sector. Some felt that there is a different 'feel' to R & W services and facilities. It was however acknowledged that care and service provision in the R & W sector was not 'all good', and private sector 'all bad'. The distinction is not as simple as that. The R & W sector does not necessarily do things better, although numerous instances of 'charitable' behaviour (e.g. organising and paying for the funeral of a resident who had no money and no family) are able to be cited.

However, all respondents felt that there was something (however elusive) that made the R & W sector distinctive. Most attributed this to a sense of being driven by an underlying philosophy and mission (e.g. "Christian ethic", "a desire to work with the underprivileged", "people before profits", "importance of a person's spiritual wellbeing", "looking after the disadvantaged"). There is a strong sense of putting the older person at the centre of the R & W sector's operations. Client and community need featured strongly as the rationale for maintaining and/or developing particular services.

One respondent said, "What should distinguish us is that we should go for the gaps." This was echoed in another statement, that we "should be more innovative precisely because we are not profit-driven." Another respondent stated, "We have a theoretical imperative to work with those at the bottom of the heap."

The entry of the commercial/private sector into the provision of aged care services that have traditionally been the preserve of the R & W sector has changed things forever. Whether or not there is a significant distinction is not measurable in the end, with older people and their families experiencing both good and bad care from R & W and private sector providers alike.

BUT respondents are clearly saying that there *should* be a difference. The R & W sector has the background, the sense of mission, the philosophy and a desire to give priority to working with the disadvantaged. In recent times they have been obliged to work within a competitive business model in order to survive. Some have chosen to exit services for older people after many years of provision. Others are planning to do so.

Clearly the private sector is 'meeting the market' (by virtue of standardised service specifications) to a required standard. Nevertheless, the concern of many within the R & W sector is as to what will be lost if Christian providers continue to reduce or withdraw from their service provision. In particular, who will support those older people who do not have the financial resources to access services in an increasingly commercial market? Historically it has been the R & W sector that has met this need in society.

It is interesting to note that Bonnie Robinson, in her introduction to a 'Talk on the Trends and Health of the Not for Profit Aged Care Sector' following the initial survey in 2000, wrote: "Some respondents questioned whether religious and welfare providers should remain in residential aged care due to financial risk, the proliferation of private providers, and questions about what residential care is really providing for older people". She went on to quote a respondent's comment from the 2000 survey:

> "Rest homes are now long-stay hospitals, dementia care is a psychiatric service and hospitals are hospices for the dying elderly. A long way from the vision of [residential care] providing dignity and security in the last years of life."

On the one hand, while it is not hard to understand the above respondent's sentiment (especially in the light of continued financial difficulties and lack of support in the Aged Care sector) on the other, this is a curious statement indeed. The fact that the *nature* of aged care provision has changed is irrelevant. That older people are sicker on entry to residential care services, that they are not living as long once there and that dementia is more prevalent and visible in our society, in no way detracts from the "vision of providing dignity and security in the last years of life." This is surely and always will remain one of the key goals of providers. The increased acuity and more complex health issues of older people entering Not for Profit services may have changed, but surely the underlying philosophy, and vision and duty to care for our elders despite all, has not.

This indeed is the greatest problem for the Religious and Welfare sector to resolve: how are older people to be cared for with the respect, dignity and love they deserve *despite* these services being carried out in a financially hostile environment, and *despite* the increasingly complex and acute nature that some of these services inevitably demand? In the words of one respondent from this current survey:

> "Unless the funding issues are addressed, those of us with a genuine interest in the care of older people (that reflects our love and respect – and as they deserve) will leave the service, and only those interested in making money in any way possible will continue."

SUMMARY

Both the survey responses and the follow-up interviews demonstrate the pivotal moment at which the aged care sector stands. All involved support and seek to implement the Ageing in Place and Health of Older People strategies. They are committed to serving older people in way which helps them to keep control over their lives and maintain their social networks. Underlying this commitment is a desire to be innovative in meeting the needs of a growing number of older people.

The commitment of providers in the sector to deliver quality services faces a series of profound risks and problems. The survey respondents expressed their deep concern that older people simply are not valued and cared about in the wider community. They tend to be seen as a "problem" and not as people with needs and rights. This lack of interest in older people's well-being is reflected in the lack of political priority in health funding for their particular needs. The most significant threat to the future of the sector they see is the continued lack of funding of existing services or for new initiatives. The staff working in the sector do not receive adequate wages, employers are often dependent on the goodwill and commitment of their staff to caring for older people in order to even be able to offer appropriate services.

Religious and welfare provides will not be abandoning the care of older people, their commitment remains. What however is clear from this survey is that the form of this commitment will change. There are major strategic issues which carry great risks in a sector where policy direction, implementation and funding are unclear. The balance brought to the market in the care of older people by the presence of religious and welfare providers whose first priority is care for those in need will be lost if they find themselves unable to remain involved in some areas of service provision.

G. RECOMMENDATIONS

On the basis of the survey information there are a number of specific policy recommendations which we address to Ministry of Health, District Health Boards and service providers for consideration and action.

District Health Boards

- Need to develop more flexible funding arrangements which take into account the multi-faceted nature of Older Peoples' needs.
- Need to address the level and priority of funding for services for older people within DHB budgets.
- Need to shift away from outcome/problem focus in services for older people towards a preventative/health promotion/early intervention model.
- Evaluation of DHB and ageing in place initiatives, and of programmes maximising older persons' capabilities (e.g. PILS and falls prevention programmes).
- Exploration and implementation of alternative supported housing and accommodation models for older people (including pilot projects where appropriate).

Ministry of Health

- Creation of a database of current and potential aged care sector service provision initiatives/innovations/collaborations/partnerships, particularly those which are succeeding or could succeed in the new health care environment.
- There is an urgent need for the Ministry of Health to involve aged care providers in the development and evaluation of a nationally consistent assessment tool and practices for older people.
- A mid-way (2005) independent evaluation of the outcomes achieved through the Health of Older People and Positive Ageing Strategies thus far. Which objectives have been met? Why? And if not, why not?
- Research into new, improved, sustainable service delivery models appropriate to the aspirations of older people, as reflected in the Health of Older People and Positive Ageing Strategies. The research should include guidelines for 'transitioning' from traditional to new service models.
- Research into the views and aspirations of baby-boomers as they enter old age. Will they want greater flexibility and range of services? A longitudinal study (of

people using services from their mid-50s onwards) was suggested. Research could follow their trajectory and provide valuable information for the ongoing development of services.

- Research that intentionally takes into account the older persons' perspective. What do older people want from a key worker? What makes older people feel safe in their own home? What makes a difference to them?

Service Providers

- Providers need to move beyond the initial seminar/forum/consultation phase and encourage/lobby DHBs to move from concept and rhetoric to practical developments.
- Providers need to be proactive in developing their relationships with DHBs. It is not sufficient in the current environment to rely on the DHB to come to you, rather, it is necessary to seek out appropriate contacts within the DHB structures and negotiate service delivery issues and new initiatives.

H. REFERENCES

Gauld, R. ed, (2003). ***Continuity amid Chaos – Health Care Management and Delivery in New Zealand***. Otago University Press, Dunedin.

Ministry of Health (2002), ***Health of Older People Strategy: Health Sector Action to 2010 to Support Positive Ageing***, Ministry of Health, Wellington.

Ministry of Social Development (2001), ***Positive Ageing in New Zealand: Diversity, Participation and Change***, Ministry of Social Development, Wellington.

Woodbridge, S. (2003). ***Coping with Change: Comparing the Retirement Housing Decisions of Older People***. Centre for Social Change Research, Queensland University of Technology.

APPENDIX 1

HEALTH OF THE SECTOR: SERVICES FOR OLDER PEOPLE SURVEY

By answering this survey you will:

- have direct input and influence on the shape of government policy on services for older people.
- See how other Christian service providers around New Zealand are responding to the changed environment in which we operate.
- assist NZCCSS to gain a picture of changes, planned changes and challenges in the current environment of the older persons' services sector.

This survey has two parts.

The first part builds on an earlier survey conducted in 2000, and will give us a clear picture of trends and changes, and also planned changes in service delivery in the sector from 1995 to 2009. (For your information, we have attached as an Appendix the Executive Summary of the earlier survey *Trends in and Health of the Not for Profit Services for Older People Sector – A Report for the New Zealand Council of Christian Social Services (November 2000)).*

The second part of the survey is intended to illustrate how DHBs and the newly formed PHOs are interacting and working with providers of services for older people, as part of their new roles. (It is part of the MOH contract requirements that we provide this information).

As well as fulfilling our MOH contractual obligations, information from the survey will be used in NZCCSS' interactions with Government to try and secure a better deal for not-for-profit providers of services for older people.

In appreciation of the time taken to participate in this, we offer you a discount on your conference registration if you complete the survey and have it in on time.

NZCCSS thanks you for taking the time to read and complete the survey.

Name:		**Position:**
Organisation:		
Phone:	**Fax:**	**Email:**
Key Services that you provide (tick all that apply): **Rest Home Care**	**Home Support** **Day Care**	**Dementia Care** **Respite Care**	**Community Social Support** **Continuing Care Hospital**	**Other (please list)** _____ _____
Section One		

1.1. Over the past five years have you made any changes to the Services for older people you are providing? YES/NO

1. 2. In what areas of service provision have these changes taken place? (tick all that apply and comment):

Type of change	**YES**	**NO**	***Comment***
Changes in the type of service we provide, e.g. from residential care to home care			
Changes in the mix of services you provide, e.g. less rest home care and more hospital services			
Changes to the facilities from which you deliver services, e.g. adding en-suites, studio units, redevelopment, etc.			
Changes in the number or type of staff we use to deliver the services			
Other changes: (please list and comment)			

1.3. In general why did you make these changes? (tick all that apply)

Market trends	
Competition	
Ordinary planned changes	
In response to Government policy	
Contract requirements	
Other (please explain)	

Comment: _____

_____

1.4. If you provide rest home care please state the changes in your bed numbers between 2000 and 2004:

From _____ beds in 2000 to _____ beds in 2004.

1.5. If you provide continuing care hospital services please state the changes in your bed numbers between 2000 and 2004:

From _____ beds in 2000 to _____ beds in 2004.

1.6. Did you change any other service provision to older people between 2000 and 2004 (e.g. home care services, dementia care)? YES/NO

1.7. If YES what service/s?

_____

1.8. If YES why did you stop delivering that service/s?

_____

_____

_____

1.9. Did you exit (stop providing) any services to older people between 2000 and 2004? YES/NO

1.10. If YES what service/s?

_____

1.11. If YES why did you stop delivering that service/s?

_____

_____

_____

The Future:

1.12. Do you plan to make any changes to the services for older people that you currently provide during the period 2004 – 2009?

Type of change	**YES**	**NO**	***Comment***
Changes in the type of service we provide, e.g. from residential care to home care			
Changes in the mix of services you provide, e.g. less rest home care and more hospital services			
Changes to the facilities from which you deliver services, e.g. adding en-suites, studio units, redevelopment, etc.			
Changes in the number or type of staff we use to deliver the services			
Other changes: (please list and comment)			

1.13. Why are you planning to make these changes? (tick all that apply)

Market trends	
Competition	
Ordinary planned changes	
In response to Government policy	
Contract requirements	
Other (please explain)	

Comment:

_____

_____

1.14. Do you plan any major redevelopment of your *buildings* during the period 2004 - 2009? YES/NO

Comment (if not already listed at question 1.12): _____

_____

_____

1.15. Do you plan any major reconfiguration of your *services* during the period 2004 – 2009? YES/NO

1.16. If YES what services, and why?_____

_____

_____

1.17. Are there any particular criteria you use to decide whether or not to continue to provide a particular service, for example, occupancy, price, government policy, compliance issues, competition?
Comment: _____

_____

1.18. Do you think your clients now receive a better quality of service than they did in 2000? YES/NO
Comment: _____

_____

_____

1.19. Do you think your planned changes will provide a better quality of service to your future clients? YES/NO
Comment: _____

_____

_____

Section Two: Provider relationships with DHBs and PHOs (where relevant)

In this section we want to know how each DHB and PHO is interacting with the sector.

We know each provider will be operating in a unique environment – some providers will be working with multiple DHBs, while others may only provide services within one DHB area. Some providers will also be more exposed to the emergence of PHOs in their area. Please answer the questions so we can understand, as far as possible, what your relationship is like with each DHB/PHO where you provide services for older people.

2.1. Which DHB(s) do you provide services in?

List: _____

_____

2.2 Which PHO(s) is/are active in your area?

List: _____

_____

2.3. How often do you communicate with representatives from (tick those that apply):

At least:	weekly	monthly	quarterly	annually
Ministry of Health				
DHB				
PHO				
Other agencies (specify which)				

Comments on specific DHBs/PHOs: _____

_____

_____

2.4. What is the nature of interaction with representatives from (tick those that apply):

	Meetings	Telephone conversations	Site visits/audits	Other (specify)
Ministry of Health				
DHB				
PHO				
Other agencies (specify which)				

Comments on specific DHBs/PHOs: _____

_____

_____

2.5. How proactive are the following agencies in contacting/communicating with you?

The amount of proactive communication is (tick those that apply):

	Appropriate for my needs	Not frequent enough	Too frequent	Communication is non-existent
Ministry of Health				
DHB				
PHO				
Other agencies (specify which)				

Comments on specific DHBs/PHOs: _____

_____

_____

2.6. Does your DHB share with you their understanding of the policy framework for delivering services for older people? (e.g. Positive Ageing Strategy and Action Plan, Health of Older People Strategy) YES/NO

2.7. If YES, examples include: _____

_____

_____

2.8. How useful do you find the resources that have been produced to offer guidance to the sector on services for older people? (Tick those that apply)

	Very useful	**Quite useful**	**Only sometimes useful**	**Not useful at all**	**I am not familiar with this resource**
Government NZ Health Strategy					
Positive Ageing Strategy and Action Plan					
Health of Older People Strategy					
Service Guidelines					
DHBs Annual Plan					
PHOs Annual Plan					

2.9. What action, if any, have you seen in the last 12 months that demonstrates any changes in the way services for older people are being managed?

Comment: _____

2.10. What changes have you experienced, if any, as a result of services being formally devolved to the DHB(s)?

Comment: _____

2.11. To what extent does your DHB(s) demonstrate an understanding of the services you provide? (Give specific examples, where possible, e.g. identify the specific strengths or knowledge gaps)

Comment: _____

2.12. In your view, what service issues or gaps exist in your area? (E.g. funding, inter-agency coordination, service specification, knowledge gaps, recruitment, needs assessment – Please list in order of priority, and give examples, where possible)

Comment: _____

2.13. How could the identified service issues or gaps be rectified in your area?
Comment:

2.14. What initiatives are you, or other local service providers, engaged in that address service gaps?
Comment:

2.15. Have PHOs had any involvement in the management and/or delivery of services for older people in your area? YES/NO

2.16. If YES, what sort of involvement have PHOs had?

Any other comments:

Please return this completed survey by Wednesday 19 May to:
SOP Survey, NZCCSS, P O Box 12-090, Thorndon, Wellington.

APPENDIX 2

TELEPHONE INTERVIEW QUESTIONS

1. What innovations / initiatives / 'success stories' are you currently involved with? Would like to be? Have been?

2. What do you see as the single most influential factor impacting upon the aged care sector today?

3. Future – Where do you see the focus of your organisation in five years? Others? What factors may change this assessment?

4. What do you see as the biggest service gaps for older people in NZ today?

5. If there was some research to be done in the aged care sector, what would it be?

6. What are the biggest threats and biggest 'plusses' to the 'Ageing in Place' policy?

7. What makes the Religious and Welfare sector different / distinct in your view (i.e. what do we have to offer)?

APPENDIX 3

EXAMPLES OF INNOVATIONS / INITIATIVES

- Self-funded pilot of physio, nursing and social day programme. Seeking to expand this with DHB funding
- Community First
- About to trial a new strategy model for home support where greater job security is offered
- Liaison with DHB; involvement with ElderCare Canterbury and Age Concern, identifying service gaps and service planning
- Planning for development of home care for frail older people
- Our facility will consider a lower fee for short term care, if the need arises
- Development of community support services for people who are socially isolated
- On DHB committee to address interface between mental health and DSS clients
- Provision of palliative care beds, where able
- Alzheimers/dementia day care
- Working with DHBs on home care issue
- Through the diocese we have been looking at parishes and where they see a need in their community. We have established an alliance with a rural trust and provided expertise to help them establish a rest home in their area
- Community lunch – invited socially isolated people from wider community. Loan of van for outings
- Horowhenua Masonic is running a rehabilitation scheme
- Presbyterian Support Central is attempting to address transport issues
- Positive ageing group runs quarterly positive ageing forums in New Plymouth
- We 'train' caregivers when we can't get certified and experienced people
- Tai chi / falls prevention programmes in community
- Day care centres
- Assisted living for homeless older people
- Pacific and Asian units within home based support service
- Dinner, bed & breakfast – DHB funded contract
- Metropolitan non-residential centre in the community, which provides befriending, social support, transportation, shopping
- Community-based older persons' day care (not attached to rest home)