Ageing Well Service and Funding Models

Repositioning Dementia Conference

September 2024

Te Kāwanatanga o Aotearoa
New Zealand Government

DRAFT – Not Government Policy

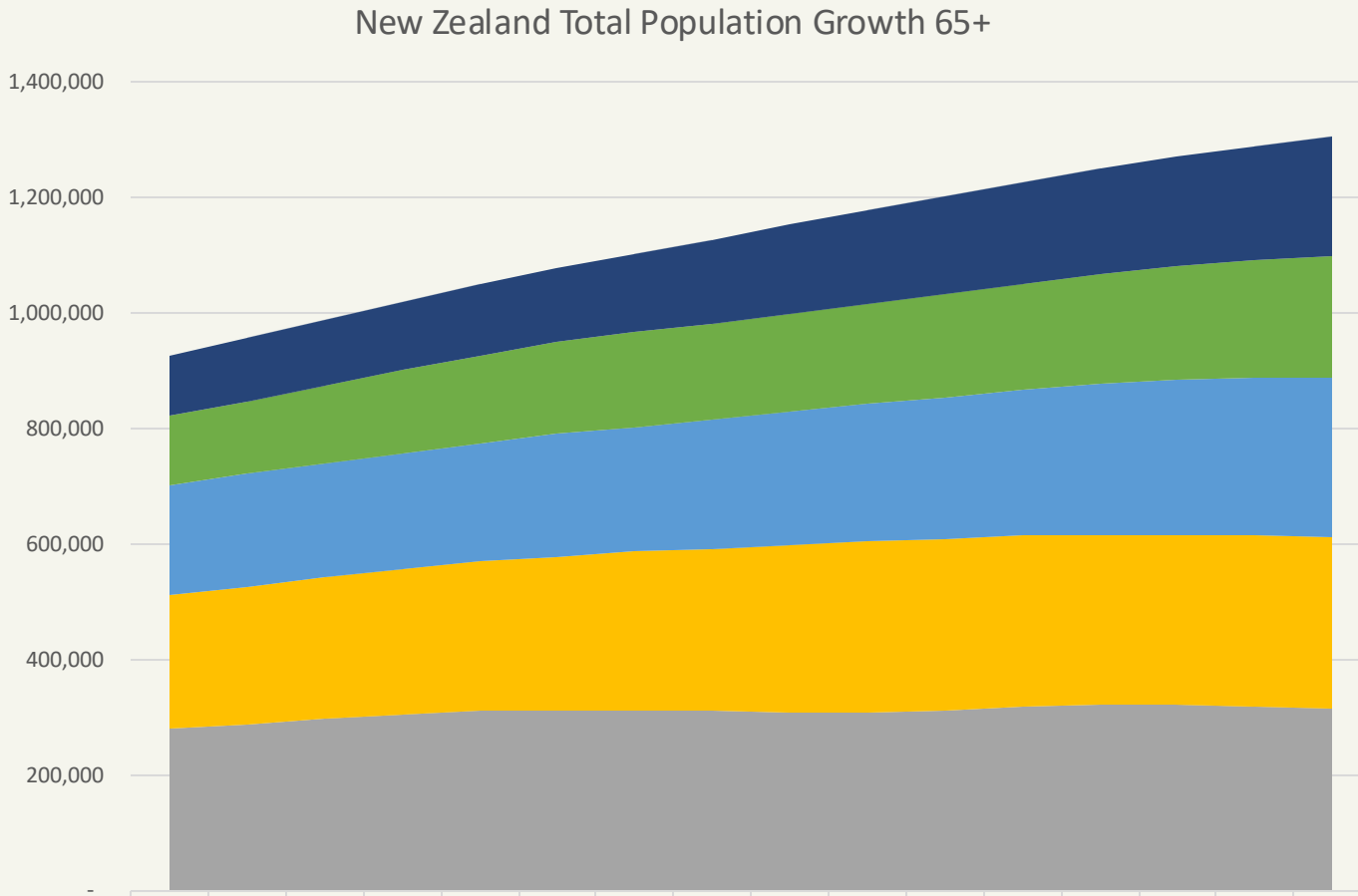
Health New Zealand
Te Whatu Ora

Clearing up some rumours

Are we removing Rest Home Level Care?	**No**
Are we raising the threshold to access Residential Care?	**No**
Are we planning for no growth in aged residential care for dementia and psychogeriatric care?	**No**
Do we want to provide minimal to no support for rural and regional aged care?	**No**

Population trends, primary care and hospital use

- New Zealanders over the age of 65 comprise for **16.6%** of the 5.1m person national population
- In the next 15 years the over 65 years population is expected to **increase by 44%** (based on StatsNZ medium growth forecast)
- Over the same period the 85+ population will **double** to 198,900 people
- The overall population will grow by just **11.8%**
- In 2023 New Zealanders over the age of 65 accounted for a total of 1.26M bed days, **55%** of the national total.
- The average bed days per 1,000 population was **440 days** in 2023.
- For over 65 it was **529** bed days per 1,000
- For over 85 years it was **3,831** bed days per 1,000
- As our population ages the relative impact on hospital capacity will increase significantly
- Enrolment in general practice for 65+ is **higher than average** at 96.2%, yet anecdotally many Care Homes report difficulty in getting adequate general practice support to care for residents
- 32% of 65+ New Zealanders receive five or more long term medicines, this **rises to 52%** of those over 85. One in 20 65+ receive 11 or more long term medicines.
- The number of medicines taken increases the likelihood of adverse drug reactions, poor adherence and geriatric syndromes (including cognitive impairment, incontinence and increased risk of falls)

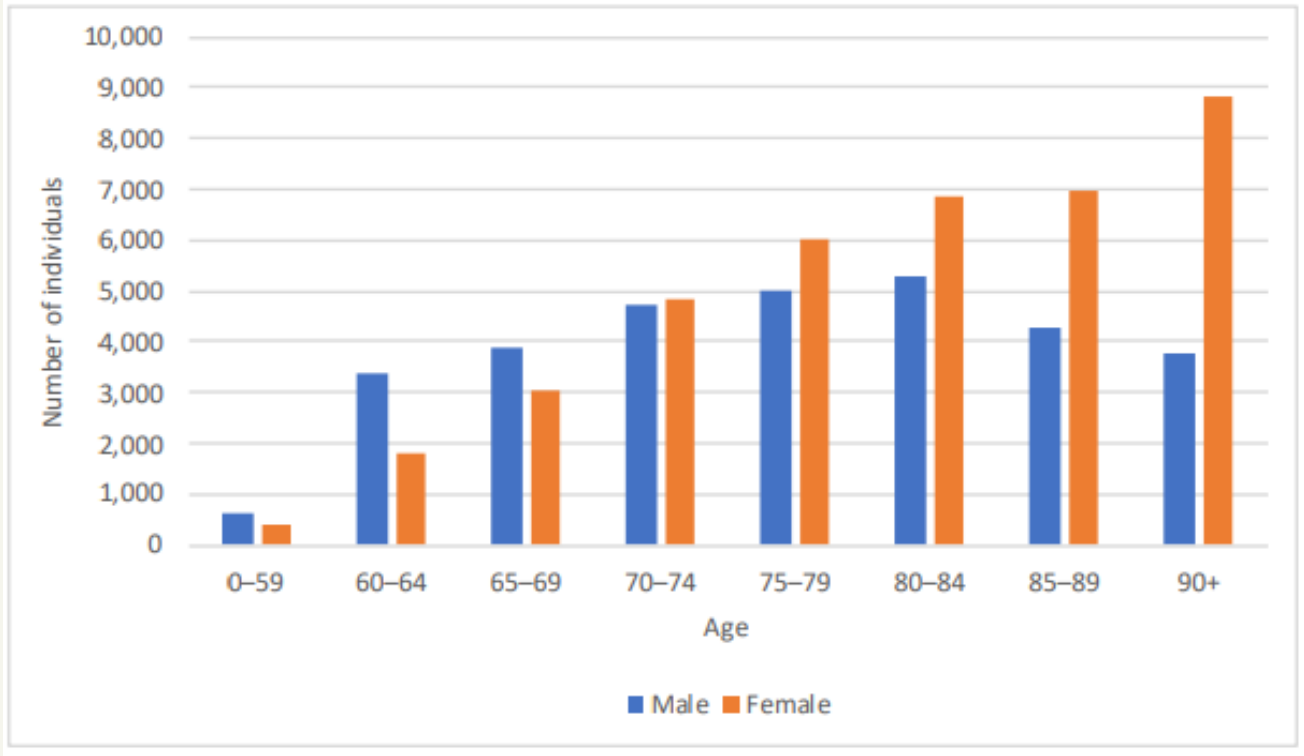


	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039
85+ years	103,800	109,500	115,100	118,100	123,100	128,600	134,900	144,700	154,000	162,100	170,000	177,200	184,500	191,600	198,900	206,400
80-84 years	120,400	124,400	133,200	144,100	151,900	159,100	164,700	167,000	169,600	173,800	178,400	184,100	189,800	196,000	203,000	209,500
75-79 years	190,500	197,000	199,100	201,700	206,000	210,900	217,000	223,200	230,000	237,500	244,600	252,500	260,800	268,400	273,100	275,700
70-74 years	231,700	238,000	244,400	251,300	259,100	266,500	274,700	283,200	291,100	295,900	298,300	297,700	296,200	295,100	296,400	298,700
65-69 years	279,900	288,200	296,900	305,000	309,600	312,000	311,100	309,200	307,800	308,700	310,900	316,100	320,100	320,900	318,400	314,000

DRAFT NOT GOVERNMENT POLICY

Dementia prevalence

- 70,000 Aotearoa New Zealanders were living with dementia in 2020
- This is expected to rise to 102,000 by 2030 and
- By 2050 almost tripled to 170,000.
- Prevalence of dementia varies by age and gender in different populations
- A number of potentially modifiable risk factors for dementia have been identified, broadly falling into two categories
  - physical health factors (smoking, obesity, hypertension etc) and
  - brain health factors (education, social isolation, hearing loss etc).
- Almost 50% of dementia in NZ is potentially preventable



Dementia prevalence by age and sex, 2020 (Deloitte Dementia Economic Impact Report 2020)

Community support

- Community based support is a critical to people and carers living with dementia
- Dementia wareware action plan Pilots
- Seven new services were commissioned under the plan, with funding for four years (2023-2027).
- Provider selections focused on priority populations - Māori, Pacific, people living in rural areas and people with younger onset dementia.
- All seven have services underway
- Ministry of Health are funding an evaluation and are in the middle of an RFP to select a supplier to undertake this.

Alzheimers New Zealand

Dementia New Zealand

- Health NZ support Age Concern to provide
  - 47,206 in person visits and
  - 21,867 calls to older people requiring one on one support to socalise
- 70% of clients are over the age of 80
- Delivered almost exclusively by volunteers who are older as well
- Support 224 peer-led groups with over 3,500 participants
- Dementia New Zealand and Alzheimers New Zealand are also very valuable sources of information, networking and support for New Zealanders with Lived Experience of dementia
- Want to acknowledge demand is increasing for your work

AGE CONCERN NEW ZEALAND
He Manaakitanga Kaumātua Aotearoa

Thank you

Phase 1 Findings & Stakeholder Engagement Feedback

Phase 1 Findings

- Aged Residential Care (ARC) and Home and Community Support Services (HCSS) are under-funded. While operational costs are covered in residential care, insufficient incentive exists to drive new capital investment.
- The funding models used to distribute funding to the sector are no longer fit for purpose, and commissioning arrangements do not deliver the service mix the system needs.
- There are material ethnic inequities in accessing aged care services.
- The aged care sector continues to face significant workforce pressures.
- Issues with aged care are exacerbated in regional and rural New Zealand

Stakeholder Engagement Feedback

- Access and awareness of and to services reflecting the nonlinear pathways of supports and care required for older persons is needed.
- Quality of and quality management of services is required.
- More nuanced funding models and policy options for service providers.
- Consistency and transparency in service offerings to ensure equitable access.
- Integrated service offerings across primary care, pharmacy, home and community support services, hospitals and home.
- Need to utilise technology solutions for information management, monitoring and supports (self-assessments, enduring power of attorney etc.).
- Ensure that every patient or aged person with clinical or non-clinical needs has a unique journey that can be agile and change with the needs of the person.
- Recognise that there is no one-size-fits-all across aged care reflecting the need for agility models of care that allow seamless pathways within clinical and non-clinical touch points.
- An increased need for visibility of aged person receiving care, support and medications to ensure that care is planned and managed more frequently supported by digital technologies and navigation services.

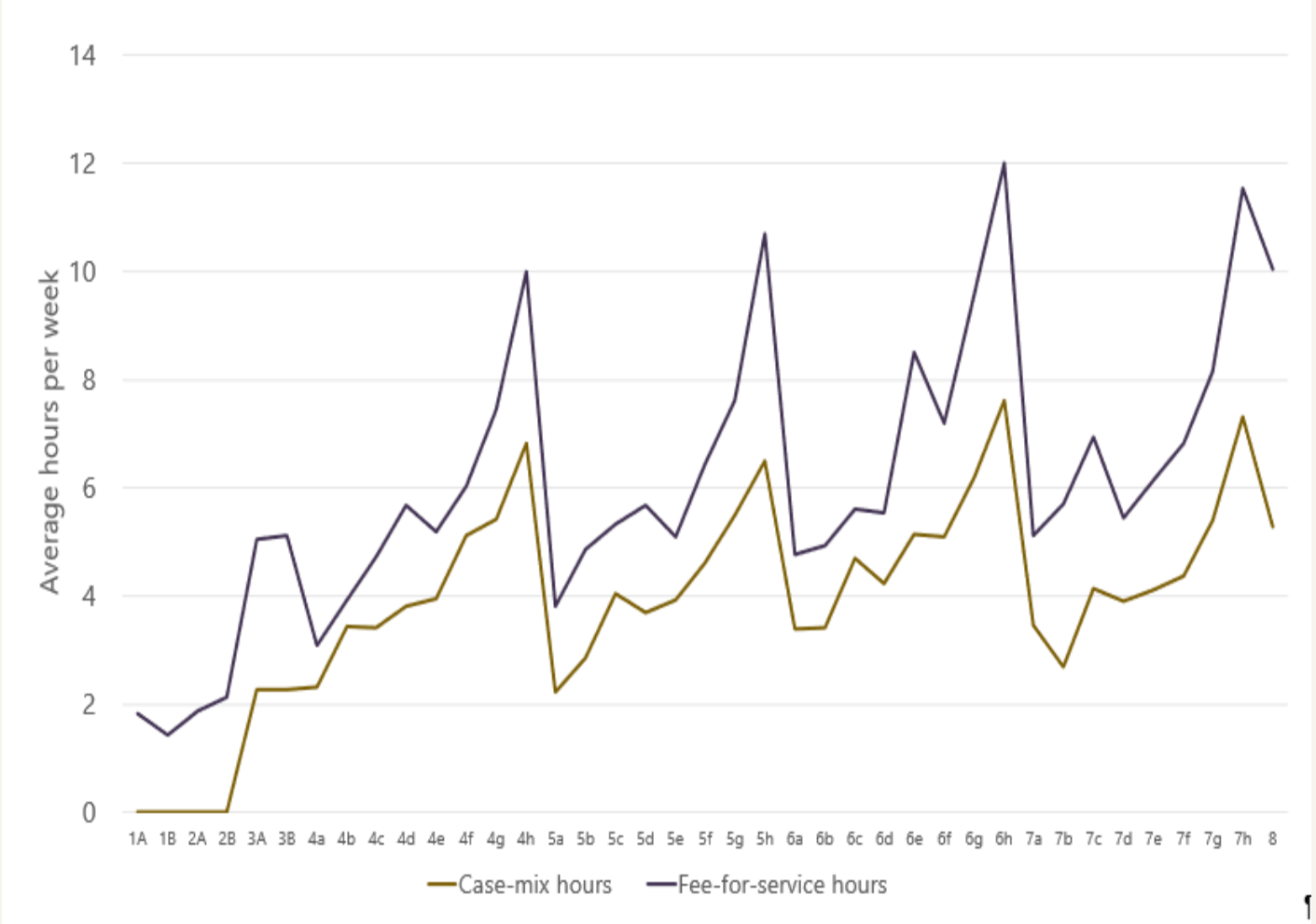
Programme update

Milestone	Detail	Status/date
Review of current state of Aged Care Service and funding models	Phase one report commissioned with Sapere in July 2023 for completion in December 2023. Review of ARC, HCSS and assessment processes for older people	Completed in January 2024 Publicly released in March 2024
Sector Engagement	Two webinar's, eight regional workshops and 15 group engagements completed. Online survey completed by 860 older people	Completed Public summary due for release mid-September 2024
Phase two report into service demand	Phase two report commissioned. Scope scaled back in April/May to focused only on demand forecasts	Completed in late July 2024
Development of business case for future investment	Currently underway	Due 31 October 2024
Service Design	With the sector pending decision making	Post October 2024

Challenges and Opportunities

Area	Challenge	Opportunity
Aged Residential Care	• Underlying funding model is insufficient to incentivise new stock, and to maintain/improve ageing stock • Number of ARC facilities approaching us for financial support is growing • Funding model does not always allow the purchase the services the health system needs • 43% of beds now attract a premium charge (median of $21,000) • 12% of beds are sold under Occupational Rights Agreement (over 1,000 of which are vacant) • Providers report difficulties in accessing appropriate primary care services in some locations	Work up options 1. to adjust the underlying funding model to stimulate new capacity 2. Incentivise standard bed capacity 3. Manage incentives to generate new capacity in correct locations 4. Size and commission specialist care capacity to better support hospitals (eg bariatric care if required)
Home and Community Support Services	• The funding model contains insufficient margin to invest in more modern systems • Move to bulk funding restorative models of care keenly sought – we also need to establish better underservicing risk management processes • Strong evidence base that these models save hospital bed days • Need to integrate whānau based care into HCSS models especially for Māori populations	1. Stand up analytics capacity and approach to support implementation of case-ix bulk funding in remaining regions and manage service and quality risk 2. Support regional change programmes to move to new funding models with providers (North Island) 3. Strengthen Whanau based care options in service and contract frameworks
Primary Care	• Strong primary care services (pharmacy and general practice) are a critical enabler for both HCSS and ARC • Increasing numbers of ARC providers are having difficulty securing primary care services and older people report timely access is an issue. Both are worse in remote and rural NZ • Small scale primary care solutions compound this: Sixty five percent of our current general practices serve 5,000 patients or less, requiring up to three general practitioner FTE,	1. Explore incentivising development of scaled models of general practices by via payment of enhanced capitation for our population within aged care facilities initially 2. Define clear new model requirements 3. Integrate secondary care clinical leadership into community model
Community Pharmacy	• Community Pharmacy is incentivized on dispensing volumes not on the delivery of better patient or system outcomes. • Persistent polypharmacy trends in in older people are directly linked to increased risk of hospitalisation.	1. Explore how we scale the scaled robotics dispensing services to cover at least 80% of ARC facilities, with an opt in option for people receiving HCSS services 2. Move incentive model to patient care from medicine volume

Indicative forecast hours for HCSS

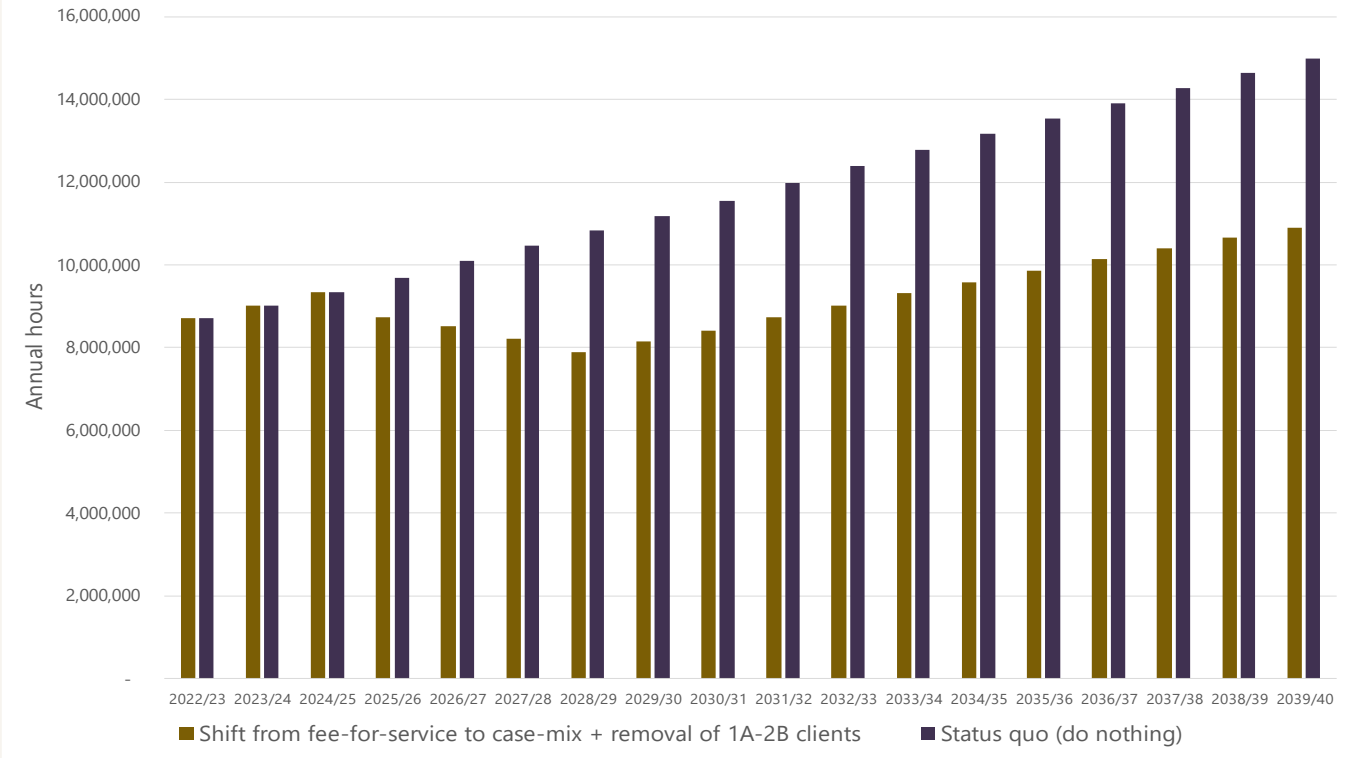


There is a clear correlation between fee-for-service and case-mix in hours delivered.

However, hours are predicted to be lower for every case-mix group under case-mix. This output demonstrates the efficiency of case-mix funding models, and the optimisation of service delivery in Southern, Canterbury, Waikato, Capital & Coast and Hutt Valley.

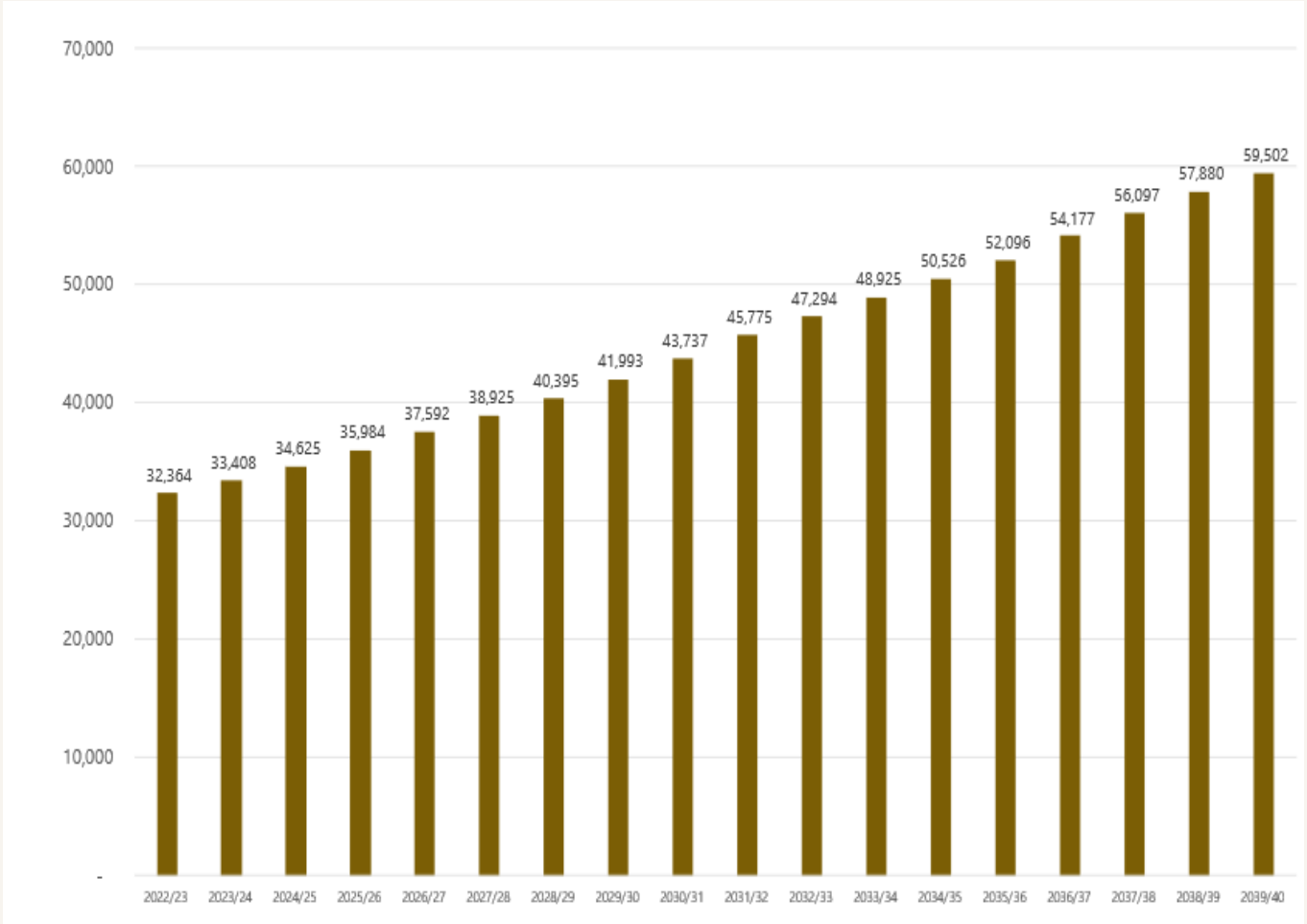
DRAFT NOT GOVERNMENT POLICY

Do nothing scenario for current fee for service growth vs move to bulk funding



- We assume that providers would optimise services to levels observed in the benchmark districts after a transition phase of approximately three years, implementing from 2025/26 onwards. We use 2022/23 actual data as the baseline to forecast growth in demand and gains in efficiency from case-mix.
- Lower estimated hours in 2039/40 relative to actual hours delivered in 2022/23 implies that the negative effect to volume from the efficiency of case-mix exceeds the positive effect from the growth in population-driven demand.
- The reduction in hours in the forecast is also driven by the ongoing reduction of 1A-2B clients across all districts.

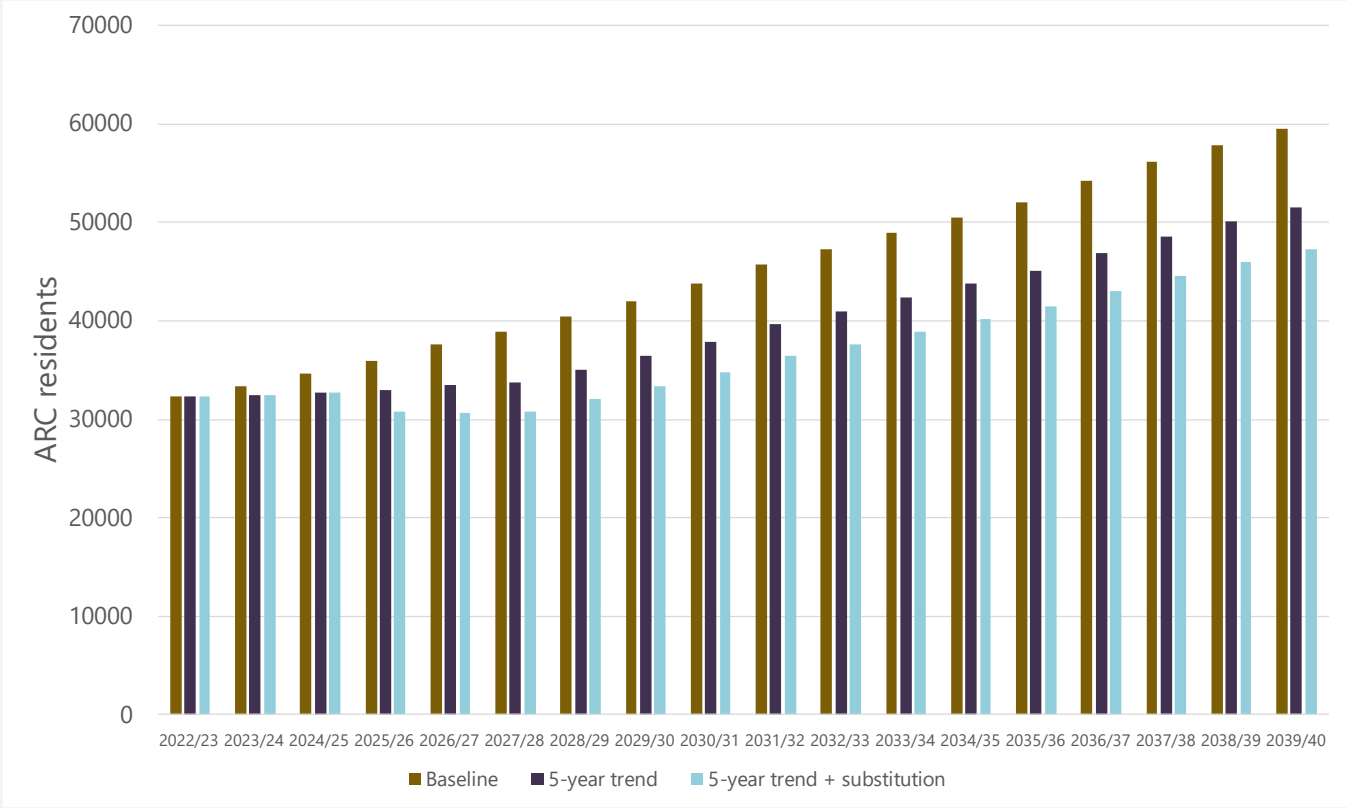
Indicative baseline forecast ARC – assumed no material changes



Our baseline forecast suggests that by 2040, using population growth and current utilisation trends, demand for ARC services could increase by 84 per cent if not supported by an integrated model of care

DRAFT NOT GOVERNMENT POLICY

Indicative change forecast in ARC if recent trends and patient led substitution models applied



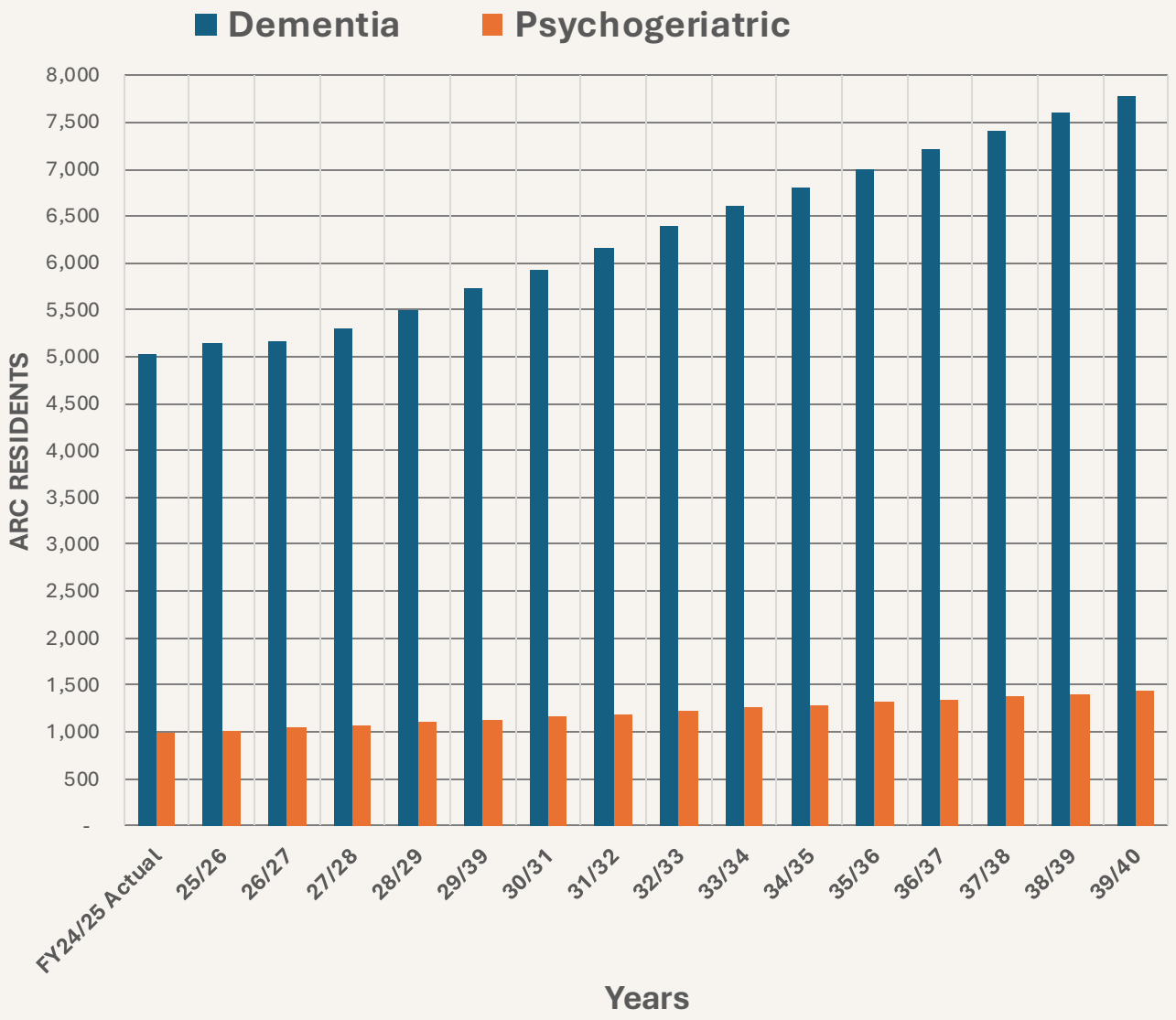
Summarises all ARC demand scenarios:

- **Baseline:** driven solely by population growth.
- **Five-year trend:** driven by population growth and five-year utilisation trends by care level and age.
- **Five-year trend + substitution:** driven by population growth, five-year utilisation trends by care level and age, and substitution impacts from shifting low-acuity individuals from ARC to HCSS.

NB: patient substitution would be led by patient choice

DRAFT NOT GOVERNMENT POLICY

Specifically for Dementia and Psychogeriatric indicative demand



Ageing Well Model of Care

- Patient journeys are not linear
- There are a range of sector priorities to balance across different care settings (eg business sustainability, demand, reducing portion of hospital bed days)
- System and provider sustainability is closely linked with patient outcomes
- Prioritisation of investment will need to be linked to hospital patient priorities
- We need a system that responds to both long- and short-term care
- Whānau care and carer support options need tighter integration into our HCSS model of care
- Community based support will continue to be important
- Some hospital-based workforces may need to work differently and in different settings in the future
- This will be a long journey – ambitious but patient