

Overview of the aged care sector

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To:	Hon Simeon Brown, Minister of Health		
From:	Andy Inder, Director, Ageing Well		
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Consulted	N/A		

Contact for further discussion (if required)

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Attachments

Appendix 1: Average weekly hours fee-for-service vs case-mix

Appendix 2: Sapere Report – Phase 2: Modelling options for improved funding and service models.

Purpose

1. You have requested a background briefing on the aged care sector, including an overview of the current configuration and any known issues and pressures facing the sector. You also requested an indication of likely new investment/uplift for the upcoming year to be funded from Health NZ | Te Whatu Ora (Health NZ) baselines.

Discussion

2. Aged care in the community is a significant part of the health system, receiving \$2.478 billion in funding in 2023/24. Health NZ expects to spend \$2.618 billion on aged care services this financial year (2024/25). The growing and ageing population is expected to increase demand, cost, and workforce pressures across the health system.
3. Core aged care services comprise:
 - i. 688 Aged Residential Care (ARC) facilities caring for around 35,000 older people.
 - ii. 52 Home and Community Support Services (HCSS) providers supporting around 45,000 people each week in their own homes.
4. Other aged care services delivered in the community include respite care, post-diagnostic support, and health service navigation.
5. We anticipate demand for aged care services growing significantly in the next 15 years, driven primarily by the doubling of the over 85 population to 200,000 (noting the people over 85 currently use over 3,800 hospital bed days per 1,000 people compared to 440 bed days for all of New Zealand, and 529 for people over 65).
6. In this period, demand for ARC beds is expected to grow to between 45,000 and 59,000 beds, and HCSS hours are expected to grow from 9 million to 12-15 million.
7. General practice and community pharmacy play crucial roles providing medical care for both ARC residents and those receiving HCSS and will play increasingly important roles in community-based care for older people in the future.
8. Aged care services delivered in the community play a fundamental role in enabling older people to live well, and support reduction in use of hospital services. Without a fundamental shift in how care is provided, we anticipate unmet need and limited access will lead to increased demand on Emergency Departments (ED) and acute care services.

Aged Residential Care

9. Over the past 10 years, ARC bed supply has generally kept pace with resident demand at a national level, although district supply is not uniform. ARC will provide an estimated 12.5 million bed days this year, but the mix of residents has changed with stronger overall growth in use of dementia and hospital-level care beds. Consistent with this, more people are entering ARC with higher care needs, leading to sector calls for a funding model that more accurately reflects resident complexity within rest home and hospital levels of care.
10. ARC facilities are funded through a combination of means-tested contributions from residents and government subsidies, plus any additional charges paid by residents as allowed by the Age-Related Residential Care (ARRC) agreement.

11. In 2024, there was a 9.6% growth in residents assessed as required to pay the maximum contribution. The maximum contribution is paid by those assessed as having the means to pay for part, or all, of their care and is equivalent to the rest home bed day price, which is the lowest ARC bed day rate. Those paying the maximum contribution are often referred to as private payers.
12. Although this is good news for the funder (as more people paying for all or part of their care would generally see a reduction in the total amount paid to ARC by Health NZ), any financial gains are offset by a 4.1% increase in the total number of ARC residents. This growth was driven by a 6% increase in residents needing care at hospital and dementia care levels. Health NZ pays for all ARC care costs above the rest home-level rate for private payers, and also all residential care costs for those funded via the Residential Support Subsidy (excluding a portion contributed by the individual via their superannuation).
13. Consecutive independent reviews (2010, 2019, 2024) have found that ARC is underfunded. The market has responded to this through increased application of additional charges. Premium Room Services charges (as described in the ARRC agreement as additional charges for rooms with additional features of a permanent or fixed nature) are now levied on 43% of beds (up from 30% in 2010), and Occupational Rights Agreement (ORAs are defined under the Retirement Villages Act and give residents the right to occupy a unit/villa within a village, which can be certified for ARC) beds now account for 14% of all beds and more than 50% of new beds.
14. The increasing ORA and Premium Room Services charges are significant barriers to entry for people who cannot afford to pay these additional rates and are exacerbating inequitable access to ARC services for the most at-risk population groups.
15. As a result of funding levels, facilities providing only standard beds (primarily in the not-for-profit and rural portions of the market), are doing so at a very low margin proposition, exposing them to business failure from unexpected capital or operational costs, and older people being unable to access residential care in their communities. Correcting funding for this level of service should be prioritised over a broad increase for the sector.
16. Due to these factors, there are now material capacity constraints in some districts. For example, Tairāwhiti has 12 ARC beds available while Counties Manukau (with a population of 530,000) has 82 ARC beds, just eight of which are dementia beds. The lack of standard beds for those without the means to pay additional charges is also negatively impacting hospital discharge and timely placement into care (e.g., people without means to pay additional charges waiting in hospital until a standard bed is available as they cannot be safely supported in their own home).
17. In addition, many ARC facilities will only receive new admissions Monday to Thursday, citing additional, unfunded costs of admission (e.g., additional nursing, GP, and pharmacist time) as the rationale. The absence of seven-day admissions into ARC contributes to hospital bed days, with patients ready for discharge from hospital over the weekend having to wait until Monday to be admitted to ARC.

Home and Community Support Services

18. New Zealand's 52 HCSS providers deliver support annually to around 80,000 people living in their own homes with a wide range of health and disability needs, and are funded entirely by Health NZ.

19. HCSS providers help people in-home with the activities of daily living and medication management. HCSS providers employ around 16,000 care workers and deliver around 9 million hours of care per year.
20. There are two distinct HCSS funding models used across the districts: bulk-funded case-mix, and fee-for-service (FFS). The bulk-funded models transfer around 40% of assessment from hospital-employed Needs Assessment Service Coordination agencies (NASCs) to providers (with NASCs completing all assessment under the FFS model), enabling more responsive service delivery. This approach aligns more closely with early supported and complex discharges, helping to reduce hospital bed days.
21. The bulk-funded case-mix model enables better management of fiscal risks by providers in partnership with Health NZ. As funding is known and agreed in advance with providers (compared to the FFS model, which is demand driven), efficient delivery of services by providers is incentivised, while still ensuring service level requirements are met.
22. Seven districts currently deliver HCSS under the FFS model, but plans are underway to transition these to bulk-funded case-mix over the next two years.
23. Unwarranted variation in service provision and lack of national standardisation in price will be addressed through the implementation of nationally consistent bulk-funded HCSS supported by a national service specification, national data collection, and internationally validated health outcome measures.
24. In general, HCSS providers are low-margin businesses and have been so for many years. This has limited their ability to invest in infrastructure, including technology solutions, which in turn limits providers' ability to integrate with other health services, especially general practice and pharmacy.
25. HCSS providers visit 45,000 of the most vulnerable New Zealanders every week in their own homes and could be a valuable resource to identify emerging needs and prevent ED presentations or hospital admissions with the correct incentives and models of care in place.

Care in the community, respite and support to carers

26. Community services such as those delivered by organisations like Alzheimer's NZ, Dementia NZ, and Aged Concern provide older people with post-diagnostic support, information, navigation and advisory services, and play an important role in our system.
27. Community services delivered by these NGOs are, in general, only partially funded by Health NZ, with a reliance on volunteers, grants or fundraising to cover full costs. Providers have reported that the current funding arrangements with Health NZ are not sufficient and the needs of all older people who require these services will not be met.
28. Respite care supports caregivers or whānau caring for an older person living in the community to take a break from their caring role. Access to respite (short-term overnight care in ARC, or in the community through day programmes or via the Carer Support Subsidy) varies across the country, either because of funding arrangements or availability of services. In-facility respite access relies on the available ARC capacity in an area, meaning if there are no or limited ARC beds in a region, respite may be unavailable. Carer stress is a predictor of entry into ARC, and support for carers plays a role in enabling older people to live well in their own home

General practice and pharmacy

29. General practice and pharmacy play a key role in managing the clinical risk of ARC residents and people receiving HCSS.
30. While people over 65 have high rates of enrolment in general practice (98%), current general practice workforce constraints are a material barrier to older people receiving timely primary care services, potentially exacerbating ED demand and use of hospital bed days by older people.
31. Many ARC facilities struggle to secure affordable general practice (GP) support for their residents (as required under the terms of the ARRC agreement), further undermining their financial sustainability.
32. A future bespoke ARC/Older persons GP model, delivered by a smaller number of providers able to meet enhanced care standards, could better support ARC and HCSS in the delivery of care, better enabling 24/7 care and integration with secondary care.
33. S9(2)(f)(iv)
34. S9(2)(f)(iv)
35. Future work will consider the opportunity to move the funding model for pharmacy services for older people to remuneration based on the number of enrolled users (i.e., the number of older people using ARC, and possibly HCSS) and away from volumes of medicines dispensed.

Uplift and investment to improve aged care

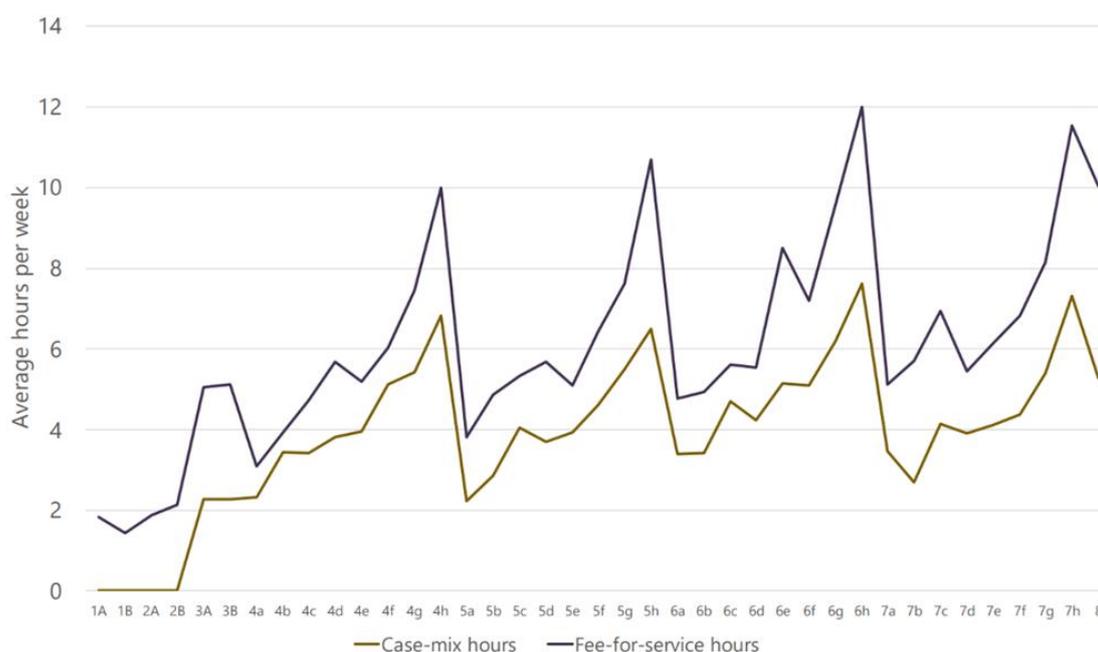
36. As discussed above, over the next 30 years New Zealand's demographic landscape will change significantly. This will place enormous pressure on our health system, particularly on ARC and HCSS and secondary-level care. To effectively manage the future needs of older people, services need to be proactively planned, integrated and sustainably scaled. Additional investment in the sector is required to ensure this is achievable.
37. You requested an indication of the new investment and uplifts needed from Health NZ baseline for aged care. Regarding uplifts, Health NZ's 2025/26 budget process is still underway and, as such, any uplift for ARC and HCSS is yet to be agreed. Separate advice will be provided on this in the next two weeks. The ARC sector specifically has communicated that a significant uplift is required to sustain care delivery.
38. ^s 9(2)(g)(i)

Appendix 1: Average weekly hours fee-for-service vs case-mix

The graph below compares the actual average weekly hours delivered by case-mix group in fee-for-service regions, and the predicted average weekly hours delivered by case-mix group using the benchmark from existing bulk-funded delivery. 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 where this is delivered.¹

¹ Sapere Aged care service model and funding review, 2024

Figure 11: Average weekly hours – fee-for-service vs. case-mix



¹ Sapere Aged Care service model and funding review, 2024

Appendix 2: Sapere Report – Phase 2: Modelling options for improved funding and service models

Attached as a separate document