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Nurse Practitioners New Zealand

Health of Older People
Policy Business Unit, Ministry of Health
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Response to Discussion Document

Premium-only Aged Residential Care Facilities and Stand-down Provisions for Mixed Facilities

Thank you for the opportunity to respond to the above discussion document. Nurse Practitioners are currently providing care in Aged Residential Care (ARC) facilities in New Zealand and have first-hand experience of the complex needs of older residents and the support required by their families. Nurse Practitioners are also keenly aware of the challenges faced by Aged Residential Care providers. Some of these challenges reach across the entire healthcare sector impacting continuity and quality of care, as well as ARC payment structures. NPs have additional concerns not addressed in this discussion document. These include the crucial nation-wide need to review cost alignment of care models for staffing, quality and continuity of care, along with this exploration of "premium" facilities' payment structures.

a. Do you agree with the proposals for premium-only facilities and a stand-down in mixed facilities?

NPs work in a variety of geographic and demographic settings and as such their views regarding agreement with this proposal are diverse. In general NPs do not agree with the 'premium only' proposal because it promotes a two-tiered system. Their concern is that this may lead to a lesser standard of care for many older people, thus creating a fundamental care access inequality.

The proposed document appears to mainly focus on the financial implications, and we acknowledge that additional cost is currently already charged by some providers. However, without exploring the human as well as the financial consequences of 'premium only' facilities, it is difficult to agree with the proposal.

NPNZ members have the following concerns:

1. It is unclear what the definition of a standard room will be in this proposal. Currently, neither the HDSS Standard nor the ARC contract are descriptive about the actual size of rooms and generally states that there should be appropriate room to move and safely maneuver with personal care and mobility aids. Room size and /or the availability of en suites and the location of the room should be a clinical decision based on resident need and not ability to pay. For example, someone with mobility concerns may need an en suite as part of a falls prevention strategy.

2. Is the additional financial support gained by 'premium-only' rooms intended for staffing, wages, and resources such as pressure area prevention devices, mobility aids or food, etc. to improve quality of care, or will it primarily be directed to the overall financial health of the business?

3. The document notes that it is the intention to provide choices. However, older people may no longer have choices as standard facilities and rooms may not be readily available or be located away from family or out of the district. People no longer able to afford premium facilities may be required to move around facilities. There is a real possibility of a shortage of standard rooms as there will be more profit potential with premium rooms. The number of premium beds should be limited in a mixed facility and the number of premium facilities limited within geographical areas.

   A stand-down provision could possibly lead to longer hospitalisations, and increase the burden on family caregivers. This may endanger older people who must continue to live in unsupported environments while waiting for a bed. This would result in more care needed in the community, or as is often the case, a

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person who is no longer able to live in the community having to stay in hospital until a bed is available. There is a significant body of literature providing evidence that prolonged hospitalizations are detrimental to the well being of older people, particularly in regards to infections and stress related illnesses.

Australia experiences long hospital waiting times due to the lack of beds. Waiting for a facility bed in hospital is costly and increases health risk. Waiting for a needed ARC bed in the community can be dangerous in cases of advanced dementia. This is a very stressful situation for family and friends.

A stand-down provision can also lead to residents being shifted within facilities or across facilities. This can cause adverse health effects and disorientation, and can negatively affect the health of people in general and specifically the health of people with dementia.

4. Currently, many DHBs have no consistent information about facility premium rate practices due to individual contracts with residents. This provision has some potential to protect consumers, inform the DHBs and allow increased monitoring of provider's practices. With this proposal, if the provider is not allowed to evict a resident, then if a resident is no longer able to pay the premium, does this then become the DHB's responsibility?

5. NPNZ would like stronger language in the submission stating that the DHBs will never pay a facility above the subsidized rates. NPNZ strongly suggest that any changes to bed status be the responsibility of the DHBs as they hold the contract and are ultimately responsible for health care provision.

6. It is not clear how beds will be allocated across an entire DHB to avoid some communities not having any standard rooms available. This is a particular issue in rural areas. There is also discussion between DHBs to 'share' their percentages which is concerning. There does not appear any evidence about how the 10% per district per service categories is justified. In a small rural facility 10% of dementia care beds may limit affordable care in the district.

Thank you for your consideration on behalf of Nurse Practitioners New Zealand.

Kind Regards,

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Chair,

Nurse Practitioner New Zealand

Jane Jeffcoat, RN, NP, MN (Hons)

Chair Elect,

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