



**Review of**

**Aged Related Residential Care**

**in the**

**Otago Southland Region**

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**September 2007**

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Otago and Southland District Health Boards

## Table of Contents

1.0	Executive Summary.....	2
2.0	Introduction .....	3
2.1	Overview .....	3
2.2	Aged Related Residential Care .....	3
2.3	Funding of Age Related Residential Care.....	3
2.4	Demand for Age Related Residential Care .....	3
3.0	The Range of Publicly Funded Aged Care Services .....	4
3.1	Aged Related Residential Care .....	4
3.2	Certification of Age Related Residential Care Facilities .....	6
4.0	The Needs Assessment and Income and Asset Testing Process.....	7
4.1	Choosing a Facility .....	7
4.2	Residential Care Subsidy.....	7
4.3	Income and Asset Testing .....	8
5.0	Population Analysis.....	10
5.1	Total Population.....	10
5.2	Population Over 65.....	11
6.0	Aged Related Residential Care Facilities .....	13
6.1	Location of Age Related Residential Care Facilities .....	13
6.2	Location of Age Related Residential Care Beds.....	13
6.3	Providers of Aged Related Residential Care Beds.....	14
6.4	Occupancy of Age Related Residential Care Facilities .....	14
7.0	Utilisation of Age Related Residential Care .....	16
7.1	Profile of Population in Age Related Residential Care .....	16
7.2	Current levels of service.....	19
8.0	Trends in Aged Residential Care .....	21
8.1	Historical Trends.....	21
8.2	Trends Driving Future Demand for Capacity .....	21
9.0	DHB's Role in Planning Future ARRC Capacity.....	23
10.0	Key Issues .....	24
10.1	Migration .....	24
10.2	Utilisation of Age Related Residential Care .....	24
10.3	Ratio of Specialist Care Beds .....	25
10.4	Projecting Future Age Related Residential Care Utilisation .....	25
10.5	Specific Issues.....	26
11.0	Options.....	27
11.1	Short-term.....	27
11.2	Medium-term .....	27
11.3	Long-term .....	27
12.0	Appendices.....	28

## 1.0 Executive Summary

This report reviews Aged Related Residential Care (ARRC) capacity in the Otago DHB and Southland DHB districts from a regional perspective. It has been commissioned jointly by the two DHBs and carried out by the regional Otago Southland Planning and Funding team within the DHBs. Reviewing this issue regionally has been beneficial because the issues have been looked at from a broader perspective. It has also enabled the Queenstown Lakes Territorial Local Authority (TLA) area which spans the two DHB districts to be looked at as a whole. Further data on resident migration is being sourced and will be incorporated into this report when it is available. While the additional data will provide information for the sector, it will not alter the findings of this report. It will however enhance our understanding on some of the reasons for the trends identified here.

The analysis has looked at issues relating to location, capacity and utilisation of ARRC beds in the Otago Southland region as well as the potential future trends in this sector and the role of the DHBs. The review has produced the following key findings:

- Overall, capacity and utilisation of ARRC beds is similar between the two DHBs, both being higher than the national average
- There is significant variation in both capacity and utilisation of ARRC beds across the eight TLAs within the Otago Southland region
- In general, capacity, occupancy rates and therefore utilisation rates are higher in larger urban areas than smaller centres and rural areas
- Areas with higher per capita rates of beds also tend to have higher occupancy rates within facilities, indicating that in general there is a good match between the location of capacity and demand for capacity
- Notable exceptions to the previous point include Long Term Hospital Level residential beds in Queenstown and Rest Home Level Beds in Wanaka, both within the TLA with a very high population growth although notably the increase in people over the age of 65, and specifically over 85 is very moderate
- The provision of ARRC capacity is almost exclusively by private providers, both not-for-profit and commercial
- Recent changes to the Social Security Act have resulted in a market driven model determining capacity and location of ARRC beds. DHBs now have an obligation to subsidise any eligible ARRC resident in any ARRC certified bed. ARRC certification is independent of DHBs
- The development of additional capacity does not create a funding issue for DHBs as the number of residents receiving DHB funded ARRC is determined by needs assessment and income and asset testing, not by sector capacity. However, increased capacity in certain areas may have a positive impact on the location residents can choose to receive care
- The development of additional capacity will impact on overall ARRC occupancy rates, which will in turn impact on overall sector financial performance and viability, and potentially have a negative impact on some providers
- The Otago and Southland DHBs cannot determine the location or capacity of ARRC beds in the future. DHBs can provide information to help ARRC providers in making good investment decisions. This can be achieved through the collection, analysis and dissemination of accurate, relevant and timely information about population demographics and trends within the regions and existing population migration trends both within the region and out of the region.

## 2.0 Introduction

As people age they may require assistance to remain independent. Assistance can be provided through:

- Support services into the family home
- Supported living arrangements.

If independence cannot be maintained, elderly people may have the option of entering age related residential care.

### 2.1 Overview

District Health Boards promote the concept of older people remaining in the community where possible. This is referred to as 'ageing in place' and is an integral part of the *New Zealand Health of Older People Strategy (2002)*<sup>1</sup>, a guiding document for Southland DHB and the Otago DHB.

Research tends to indicate that many older people who enter residential care would actually prefer to stay in their own homes<sup>2</sup>. Placing someone into age related residential care is considered once all other options have been explored.

### 2.2 Aged Related Residential Care

There are a variety of reasons why a person may enter long-term residential care. There may be a single issue, or it may be an accumulation of a number of smaller issues. Recognised factors include:

- The reduced ability to maintain basic tasks of every day life including eating, bathing, dressing and toileting. These are sometimes called activities of daily living (ADLs).
- Continence problems
- Cognitive impairment e.g. dementia
- Loneliness, social isolation and depression
- Mobility issues
- An absence of a carer to provide the necessary care for an elderly person to maintain their independence in the community
- A range of other non-health issues, such as marital status, death of spouse, ownership [or not] of residence and financial resources.

### 2.3 Funding of Age Related Residential Care

The public funding of age related residential care was devolved to District Health Boards (DHBs) in October 2003. DHBs fund all people into ARRC if they meet the access criteria. It is anticipated that \$62 million will be spent specifically on age related residential care in the 2007/08 financial year across the Southland Otago region. Southland is budgeting to spend \$22.4 million and Otago \$39.6 million on age related residential care in 2007/08. This represents 10.1% and 9.2% of total DHB funding respectively.

### 2.4 Demand for Age Related Residential Care

Both Southland and Otago DHB's provide access to age related residential care based on the needs of the older person. The demand for ARRC beds can be an area of confusion and misunderstanding for both ARRC providers and the wider community. There has historically been a perception amongst some ARRC providers that building more ARRC beds will be met with increased demand. Demand is determined by the number of people assessed as needing care and capacity.

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<sup>1</sup> New Zealand Health of Older People Strategy – <http://www.moh.govt.nz/olderpeople>

<sup>2</sup> ASPIRE – Assessment of Service Promoting Independence and Recovery in Elders, 2006

### **3.0 The Range of Publicly Funded Aged Care Services**

District Health Board [DHB] funded aged care services, also known as Disability Support Services [DSS], are available for people aged 65 and older who have long-term support needs. A range of services are available to assist elderly people remain in the community, or where appropriate, receive long-term residential care. These services are also available to a small group of people aged 50 to 64 who have been assessed as being “close in interest” to older people<sup>3</sup>.

DSS funding was devolved from the Ministry of Health [MoH] to DHBs in 2003. However both the age related residential care service specifications and Territorial Local Authority (TLA) bed day prices are negotiated and set nationally, and not by individual DHBs. This limits a DHBs ability to modify conditions for local requirements, especially extreme price pressures in a single locality.

#### **3.1 Aged Related Residential Care**

There are four main levels of age related residential care described by four separate service specifications. Each level of care is quite distinct, with significant differences in the supervision and services delivered, and the funding that each service level attracts.

The level of service an individual receives is dependent on the outcome of an assessment by the Needs Assessment and Service Coordination (NASC) service and not the age related residential care provider. In some exceptional circumstances, a provider may accept a private paying individual without a NASC assessment, but there is no obligation on the DHB to subsidise the patient at any future stage unless they are subsequently assessed by NASC as needing the level of service.

There is significant confusion surrounding the terminology and definitions of each level of ARRC service, especially between rest home level and hospital level care. Many people think the place of service delivery, in either a rest home or a hospital determines the level of care. Over 99% of all age related residential care, including rest home level care, hospital level care, dementia and psychogeriatric, is delivered within a registered aged residential care facility, commonly termed a rest home, in Southland and Otago.

The following gives a plain english definition that encapsulates each of the four service levels.

##### **3.1.1 Rest Home Care**

Rest home level care is for individual's requiring 24 hour supervision with 'activities of daily living' (ADLs)<sup>4</sup>. Clients usually display a degree of independence, but may require assistance, prompting or supervision in certain areas e.g. showering, continence. An individual is generally able to:

- Feed themselves
- Remain mobile with supervision
- Be independent or require limited assistance with the use of their aids, e.g. glasses, hearing aids, walking frames, etc.
- Maintain clear speech and able to retain information.

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<sup>3</sup> Close in interest are people who have conditions more commonly associated with ageing earlier than the general population, and who needs are best met by DHB's integrated health and disability services for older people.

<sup>4</sup> Activities of daily living (ADLs) are everyday tasks that encompass nutrition, mobility, personal hygiene, toileting and continence.

### **3.1.2 Long Term Hospital Level Care**

Long Term Hospital (LTH) care is for individual's requiring 24 hour supervision or care for more complicated medical conditions. These require Registered Nurse (RN) input and a more intense level of nursing for management of care. This may be for medication management or wound care etc.

Generally clients in long term hospital level care require assistance with all ADLs, they may be non weight bearing, incontinent, and require feeding/prompting.

Long Term Hospital care may also be referred to as hospital care, hospital level care, continuing care, or long-term continuing care.

### **3.1.3 Dementia Care**

Dementia (D3) level care is for individual's requiring 24 hour supervision with 'activities of daily living' (ADLs), with additional security provided for individuals who are at risk of wandering and becoming lost due to memory loss and confusion.

Clients may also have associated inappropriate behaviour's, including verbally inappropriate outbursts and/or inappropriate toileting.

Providers delivering dementia level care must have a separate secure environment for dementia clients. Staff caring for dementia clients must be appropriately trained to deliver dementia level care.

### **3.1.4 Psychogeriatric Care**

Psychogeriatric level care is for individual's requiring 24 hour supervision or care for more complicated medical conditions, plus psychologically related behavioural problems. These require Registered Nurse (RN) input and a more intense level of nursing for management of both medical and psychological conditions. Psychogeriatric care is also known as Specialist Continuing Care or Dementia (D6).

Generally clients in psychogeriatric level care have similar medical requirements to people in hospital level care, requiring total assistance with all ADLs, and may also be non weight bearing, incontinent, and require feeding/prompting. Psychogeriatric clients also have inappropriate behaviours e.g. calling out, aggression etc, that require they be kept in a safe and secure environment to protect the client and other people.

Providers delivering psychogeriatric level care have a separate secure environment for dementia clients. Staff caring for psychogeriatric clients must be appropriately trained to deliver psychogeriatric level care.

### **3.1.5 Additional Services Delivered by ARC Providers**

Age related residential care facilities also deliver services outside of the four service specifications for ARRC. Both the Ministry of Health (MoH) and the Accident Compensation Corporation (ACC) also fund clients for other services, which can be delivered in ARRC facilities. Additionally the DHBs funds a number of short-term services, including respite care, carer support and Community First in Otago.

#### **3.1.5.1 Respite care**

A client may enter an age related residential care facility for short-term care to assist in their rehabilitation from an acute episode. There is an expectation that the client will make enough progress to return to their normal place of residence (with or without further assistance in the community).

#### **3.1.5.2 Carer Support**

A client may enter an age related residential care facility for short-term care to provide 'time out' for family, whanau and caregivers. It is expected that clients will return to their normal place of residence.

#### **3.1.5.3 Community First**

Otago DHB is funding the Community First programme to enable clients assessed as requiring a move to residential care the opportunity to remain in their own homes with a level of support much higher than is traditionally delivered by home based support services (HBSS). Presbyterian Support Otago (PSO) receives funding for sixty clients in the Dunedin area.

### ***3.2 Certification of Age Related Residential Care Facilities***

District Health Boards can only contract with rest homes or hospitals that have achieved Certification under the Health and Disability Services (Safety) Act 2001 and comply with the Health and Disability Sector Standards 2001. Certification of age related residential care providers is undertaken by HealthCERT, an arm of the Ministry of Health. District Health Boards are not involved in the certification of any ARRC facilities.

The Health and Disability Services (Safety) Act aims to improve provider accountability using approved independent auditing to ensure compliance with the health and disability standards. Providers have to demonstrate that the services they provide are safe, focussed on patient services and outcomes and compliant with the standards.

## 4.0 The Needs Assessment and Income and Asset Testing Process

A client in ARRC may be fully subsidised, partially subsidised, or non-subsidised. The level of subsidy and client contribution is determined by a standardised income and asset test process. A client may elect to not have the income and asset test, and will be responsible for all costs associated with their care.

Every subsidised client of an age related residential care (ARRC) facility has to undergo an assessment to determine the level of care required. This is undertaken by the DHB Needs Assessment and Service Coordination (NASC) Service. ARRC facilities may accept any potential client; however they will not be eligible for any subsidy unless assessed by NASC. Most ARRC facilities insist on a NASC assessment before accepting a non-subsidised private paying client. A non-subsidised private paying client may only potentially become a subsidised client in the future if they have been assessed by NASC as needing residential care.

To enter DHB contracted age related residential care the person must be:

- Needs assessed by a DHB or DHB NASC as having **high, or very high needs** which are indefinite (i.e. the person's condition cannot be reversed)
- Determined by the DHB or NASC that the person cannot be safely supported within the community
- Aged 65 or over, or assessed as close in interest. A person close in interest must be aged between 50 and 64, unmarried and with no dependent children
- Eligible for publicly funded health and disability services (a New Zealand citizen or permanent resident, or eligible under the Eligibility Direction made under the New Zealand Public Health and Disability Act 2000).

### 4.1 Choosing a Facility

All people who have been assessed as requiring age related residential care have the option of accepting a vacancy in any appropriate ARRC facility within their DHB boundary. If a person wishes to enter an ARRC facility within another DHB boundary, they must be assessed by the relevant DHB NASC service. The entry criteria differ between DHBs and assessment for ARRC in one DHB is no guarantee in another DHB.

As of 1 July 2007, all certified age related rest home, hospital level care, dementia and psycho-geriatric beds in Otago and Southland can accept and will be funded for subsidised ARRC residents. This provides any prospective resident with a choice from any of the available rooms in any certified facility in which to live. The location, capacity and occupancy of ARRC facilities influence the choice potential clients have, especially in the smaller communities.

There will be cases where a resident will not be able to move into their preferred choice of facility. In this instance, they have the option of entering another facility in the interim until an appropriate room becomes available in their preferred facility.

### 4.2 Residential Care Subsidy

Once it has been established that an elderly person is in need of long-term care in a rest-home or hospital, they can apply for government funding through the *Residential Care Subsidy*. To qualify for the *Residential Care Subsidy*, a person must satisfy the following eligibility criteria.

- Be eligible for publicly funded health or disability services
- Be aged 65 or older, or aged 50-64 and single with no dependent children

- Receive contracted care services provided by a certified rest home or hospital
- Have a *financial means assessment* which is commonly referred to as income and asset testing.

### 4.3 *Income and Asset Testing*

Not everyone is entitled to funding under the Social Security Act 1964. A person must first have a needs assessment from a DHB or DHB funded Needs Assessment and Service Co-ordination (NASC) agency. If the needs assessment determines that the person requires long-term residential care indefinitely and the person wishes to apply for a Residential Care Subsidy, then the NASC will provide the person with a financial means assessment application form to complete.

The Ministry of Social Development (through Work and Income) then carries out a financial means assessment that considers the person's assets and income, and any gifting that has occurred.

The financial means assessment has two components:

- An asset test
- An income test

The *financial means assessment* is performed by Work and Income, and is based on an individual or a couple's assets and income. To qualify for the *Residential Care Subsidy*, the resident must have income and assets below the set thresholds. Residents who qualify for the *Residential Care Subsidy* may be required to contribute towards their cost of care.

A *financial means assessment* shows:

- If the assets that are equal to or below the applicable asset thresholds
- How much income will go towards the cost of care

If the person's assets are equal to or below the applicable asset threshold, they may qualify for Government funding (the residential care subsidy) to pay for some or all of the cost of their care.

An income test will determine how much a person must contribute to the cost of their care. Factors included in the income test are variable, and depend on income source, partners and their living circumstances, and whether the partner works.

The level of subsidy will depend on the type of care the person is assessed as requiring. A weekly personal allowance and an annual clothing allowance are paid separately to the person

An assessment review can be done at a time when a resident or their family thinks that the eligibility criteria may be satisfied to receive the *Residential Care Subsidy*.

#### **Asset Thresholds (published March 2007)**

	Allowable asset level from 1 July 2006	Allowable asset level from 1 July 2007
Single person 65+	\$160,000 of assets	\$170,000 of assets
Couple 65+ [where both are in long-term residential care]	\$160,000 of assets [per couple]	\$170,000 of assets [per couple]
Couple 65+ [where	EITHER	EITHER

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Review of Age Related Residential Care – Otago & Southland

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only one is in long-term residential care]	\$65,000 plus house and car, OR a total asset level of \$160,000	\$75,000 plus house and car, OR a total asset level of \$170,000
Single people 50-64 requiring care [and with no dependent children]	No longer require asset testing [but are income tested]	No longer require asset testing [but are income tested]

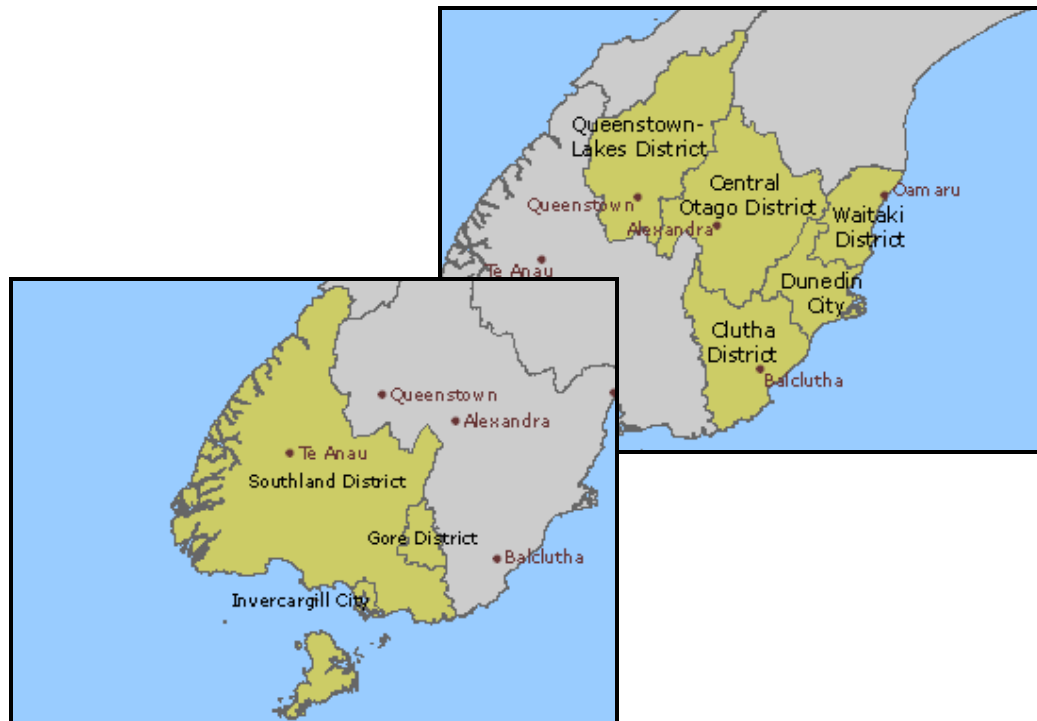
Source: Looking at Long-term Residential Care in a Rest Home or Hospital  
Ministry of Health, March 2007.

The asset thresholds to receive the *Residential Care Subsidy* are increased by \$10,000 on 1 July each year.

## 5.0 Population Analysis

The Southland and Otago District Health Boards service a combined population of 286,224<sup>5</sup>, with 179,388 in Otago and 106,821 in Southland. For the total region, over 13.9% of the population is aged 65 and over.

The territorial local authorities are shown in the diagrams below.



### 5.1 Total Population

The population profiles of the eight territorial local authorities (TLAs) show there is significant variability across the Southland and Otago region.

Dunedin City has a very large cohort of young adults attending tertiary institutions. Queenstown Lakes has a very large portion of its population in the 20 to 45 year age range. Conversely Gore, Rural Southland, Clutha, Waitaki and Central Otago show a drop in population in early adulthood which would be consistent with net migration out of the region.

The age profiles of each of the TLAs changes significantly as the population grows older. Central Otago, Queenstown Lakes, and to a lesser extent Clutha, have an increase in people aged 55-59, which would be consistent with an influx of “baby boomers” into the respective regions.

Waitaki has a higher portion of people over the age of 65 than elsewhere in the Otago Southland region. This is possibly due to the migration of younger people out of the region and the migration of older people into the Waitaki region to retire. The Queenstown Lakes area has a very low number of people over the age of 65 for the size of the population. Rural Southland also has a low number of older people, especially over the age of 75.

<sup>5</sup> Census Usually Resident Population Count, 2006 Census

## 5.2 Population Over 65

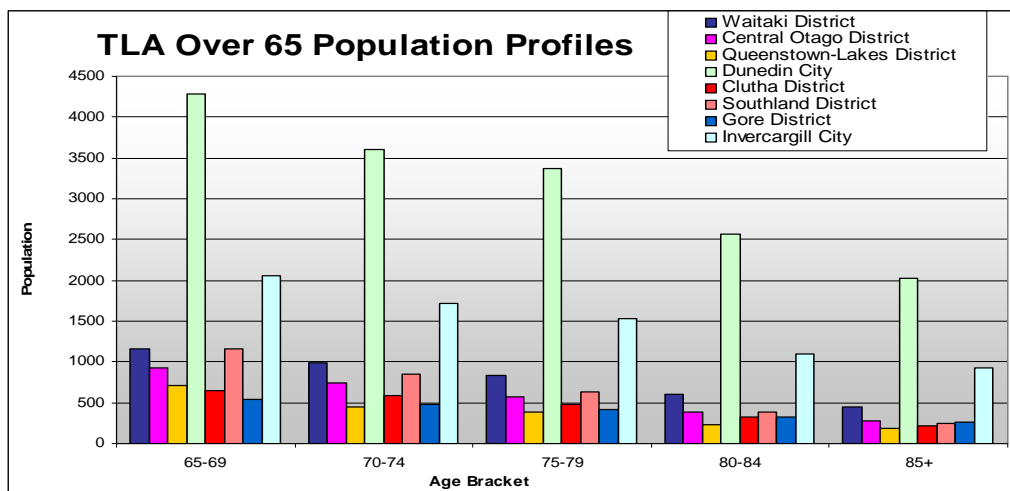
Despite the large variability in local area over 65 populations, the ratio of older people across both districts is very similar. There are nearly 40,000 people aged 65 and over across the Otago and Southland regions.

Otago and Southland Population Details [Over 65]

Territorial Local Authority	Age Bracket					Total 65+
	65-69	70-74	75-79	80-84	85+	
Southland	4173	3319	2818	1942	1547	13798
Otago	7311	6116	5420	3980	3046	25874
Region	11484	9435	8238	5922	4593	39672

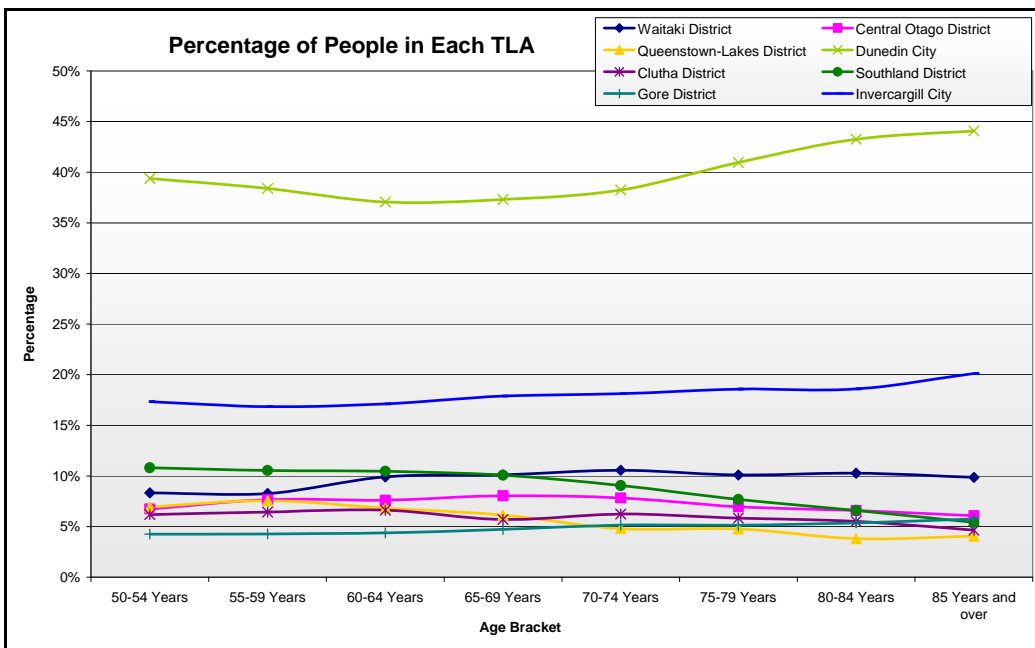
### 5.2.1 Territorial Local Authority

There are eight territorial local authorities [TLAs] in the Otago Southland region. Four of the TLAs, Waitaki, Dunedin City, Clutha, and Central Otago, are exclusively in the Otago DHB region and three TLAs, Gore, Southland District and Invercargill, are exclusively in the Southland DHB region. The Queenstown Lakes TLA is split between Otago and Southland DHB's; the Wakatipu area in the Southland DHB region and Wanaka in the Otago DHB region.



As the population ages, analysis shows that the proportion living in both Dunedin and Invercargill increases, whereas there are significant decreases in Southland district, Central Otago, Queenstown Lakes, Clutha and Gore. The observed patterns could be caused by a number of factors, and these may be different between each TLA. Two possible causes are migration to the two larger cities, and population growth in certain TLAs for people in the “baby boomer” and early retirement years.

Review of Age Related Residential Care – Otago & Southland



## 6.0 Aged Related Residential Care Facilities

There are a total of 74 age related residential care facilities across the Southland Otago region; 24 ARRC facilities in Southland and 50 ARRC facilities in Otago. There a large variety of facilities, with some offering a single type of service e.g. rest home, to others that offer all four service specifications. Facilities range in size from 6 beds to 123 beds.

### 6.1 Location of Age Related Residential Care Facilities

The number of age related residential care facilities increases with the size of the local population. The larger population centres have more ARRC facilities and the smaller centres have fewer ARRC facilities.

There also appears to be a correlation between the size of the local population and the size of the ARRC facilities. The larger urban areas of Dunedin and Invercargill have on average ARRC facilities nearly twice the size of the rural/remote regions of rural Southland, Central Otago and Queenstown. ARRC facilities in Clutha, Gore and Waitaki are on average smaller than the regional average.

#### Location of ARRC Facilities

TLA	Number of ARRC Facilities	Average Facility Size [Beds]
Dunedin	30	47
Invercargill	13	52
Waitaki	9	33
Central Otago	6	25
Gore	5	36
Clutha	4	37
Southland	4	31
Queenstown Lakes	3	24

### 6.2 Location of Age Related Residential Care Beds

Southland has half the number of ARRC beds as Otago, or 33.3% of all regional beds. This is close to the 34.8% ratio of the regional population over 65, but indicates that Otago has slightly more capacity based on the size of the over 65 population.

Location of Aged Related Residential Care Beds by DHB										
DHB	Service Specification								Total	
	Rest Home		Hospital		Dementia		Psychogeriatric			
Southland	624	31.7%	258	36.2%	101	37.0%	37	33.3%	1020	33.3%
Otago	1343	68.3%	455	63.8%	172	63.0%	74	66.7%	2044	66.7%
<b>Total</b>	<b>1967</b>		<b>713</b>		<b>273</b>		<b>111</b>		<b>3064</b>	

As discussed earlier, ARRC beds tend to be concentrated around the two larger urban centres of Dunedin and Invercargill.

Location of Aged Related Residential Care Beds by TLA					
TLA	Service Specification				Total
	Rest Home	Hospital	Dementia	Psychogeriatric	
Dunedin	885	332	131	74	1422
Invercargill	399	189	63	25	676
Waitaki	227	45	24	0	296
Gore	102	45	28	4	179
Clutha	116	26	7	0	149
Central Otago	97	40	10	0	147
Southland	86	18	10	8	122
Queenstown Lakes	55	18	0	0	73
<b>Total</b>	<b>1967</b>	<b>713</b>	<b>273</b>	<b>111</b>	<b>3064</b>

There are fewer specialised ARRC beds (hospital, dementia, and psychogeriatric) in the smaller areas. Psychogeriatric beds in Otago are only found in Dunedin.

### 6.3 Providers of Aged Related Residential Care Beds

It is important to recognise that there are a variety of providers that operate age related residential care facilities. The sector is dominated by both commercial and not-for-profit providers. The not-for-profit sector in Southland has a much higher percentage of ARRC beds compared to Otago. Not-for-profit organisations include social services organisations, rural trusts and community trusts.

Location of Aged Residential Care Beds by DHB				
DHB	Type of Provider			Total
	DHB	Not for Profit	Commercial	
Southland	6	453	561	1020
Otago	0	710	1334	2044
<b>Total</b>	<b>6</b>	<b>1163</b>	<b>1895</b>	<b>3064</b>

There is only one facility operated under an alternative mechanism. Southland DHB operates a six bed continuing care (hospital level) unit in the Queenstown Lakes Hospital.

Location of Aged Residential Care Beds by TLA				
TLA	Type of Provider			Total
	DHB	Not for Profit	Commercial	
Dunedin	0	494	928	1422
Invercargill	0	336	340	676
Waitaki	0	73	223	296
Gore	0	80	99	179
Clutha	0	42	107	149
Central Otago	0	71	76	147
Southland	0	0	122	122
Queenstown Lakes	6	67	0	73
<b>Total</b>	<b>6</b>	<b>1163</b>	<b>1895</b>	<b>3064</b>

### 6.4 Occupancy of Age Related Residential Care Facilities

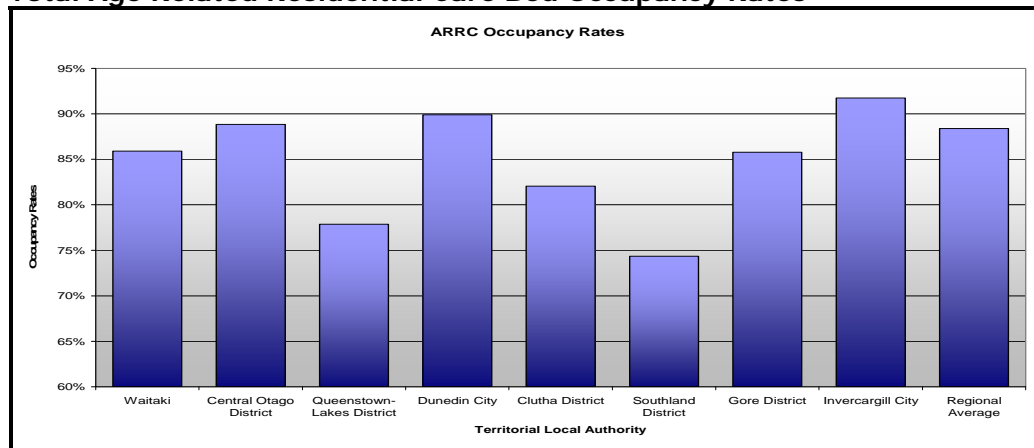
The occupancy rates of age related residential care facilities are important for a number of reasons. ARRC revenue is directly linked to occupied beds through a fee for service payment mechanism, and profitability of a facility is linked to occupancy rates. As occupancy fluctuates, the fixed costs associated with running the facility do not change.

A profitable ARRC sector also creates an environment of upgrading and investment amongst current and new investors. This leads to an ongoing improvement in services and facilities for ARRC residents. This has resulted in a vast improvement of standards of ARRC facilities and now resident expectations are also much higher than just a few years ago.

### 6.4.1 Occupancy Rates by Location

Analysis of occupancy rates for all forms of age related residential care shows that there is a large variance amongst the eight TLAs. The areas with the highest occupancy rates are in the two largest population urban areas of Dunedin and Invercargill. The areas with the lowest occupancy rates are the two smallest population areas, Queenstown Lakes and rural Southland.

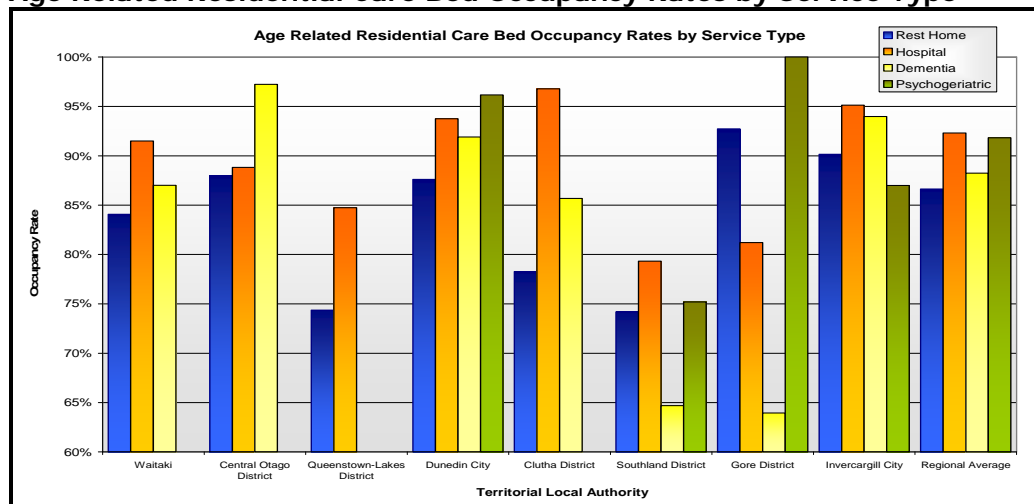
#### Total Age Related Residential Care Bed Occupancy Rates



A more detailed analysis of the TLA occupancy rates by service type shows that occupancy rates between the service types can vary considerably. Examples include:

- Gore has a 100% occupancy rate for psychogeriatric, but a very low occupancy rate for dementia.
- Clutha has a very high occupancy rate for hospital level care, but a much lower occupancy rate for rest home level care.

#### Age Related Residential Care Bed Occupancy Rates by Service Type



## 7.0 Utilisation of Age Related Residential Care

A DHB strives to have equitable access to ARRC, but there are many factors that influence the utilisation rates of age related residential care. This makes determining and measuring the levels of access challenging, as many of the variables that affect utilisation are difficult to quantify.

Clients will present with different levels of complexity and support need. This will be reflected in the service user's Care Plan and whether they stay in the community or enter residential care. A number of measures are used to highlight the differences observed in the utilisation of ARRC. These measures assist in making a judgement on the levels of access to ARRC.

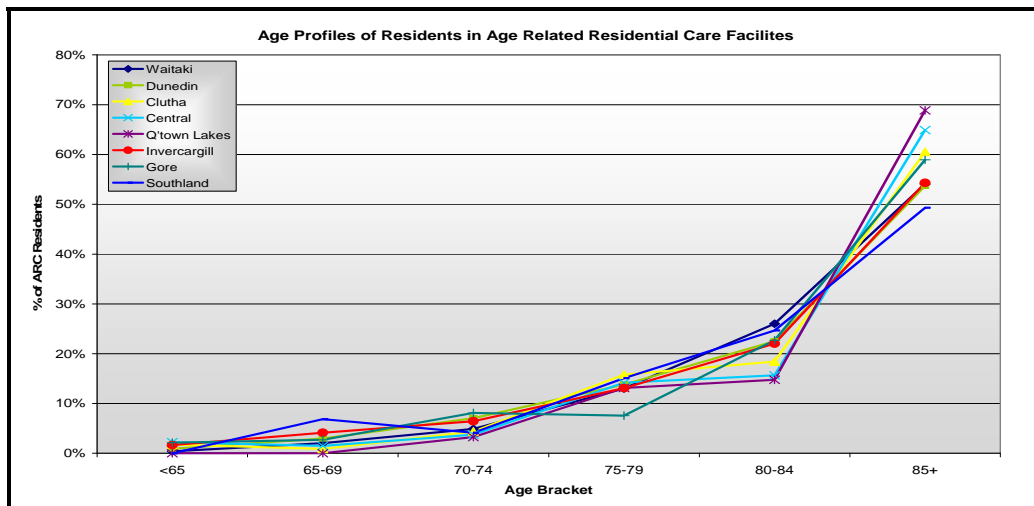
### 7.1 Profile of Population in Age Related Residential Care

There is a strong relationship between age and utilisation of aged related residential care. As the population ages, a greater proportion of people move into residential care facilities. In July 2007, there were 895 people in Southland and 1765 people in Otago living in an age related residential care facility. Analysis of the population, and occupancy data of ARRC facilities, shows there are some distinct differences between the:

- Ages and location of people in age related residential care
- Ages of people in the four ARRC services; rest home, hospital, dementia and psychogeriatric
- The proportion of the population in age related residential care.

#### 7.1.1 Ages and Location of People in Age Related Residential Care

All things being equal, it could be expected that the age profiles across the region would be similar. As can be seen in the graph below, there is a very noticeable difference between TLAs on the age profiles of ARRC residents. The ARRC residents are much older in Queenstown Lakes and Central Otago with a much higher proportion of residents over the 85 in ARRC facilities. Nearly 70% of all ARRC residents in Queenstown Lakes are aged 85 and over. Conversely Southland TLA, Dunedin and Invercargill ARRC residents are younger, with a higher proportion up to age 85, but especially in the 80-84 age bracket.



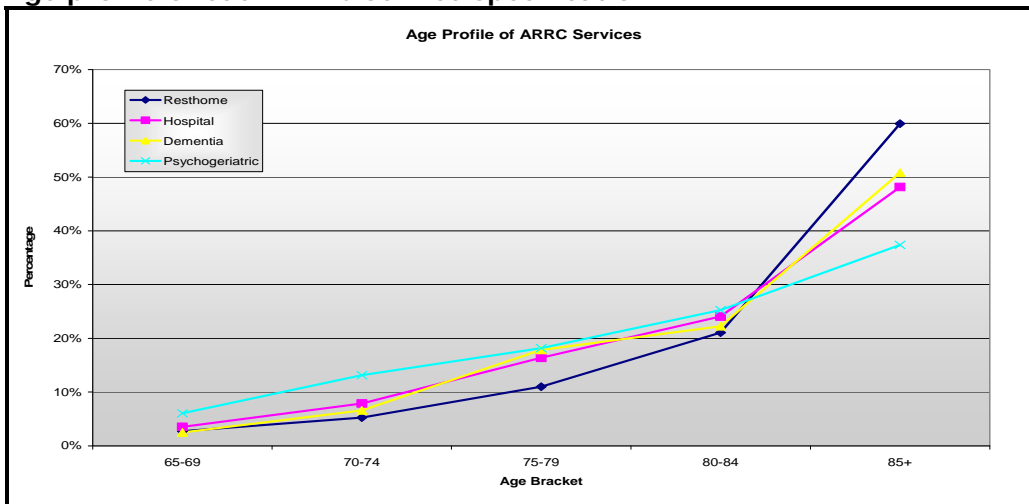
#### 7.1.2 Age Profile within the Four Age Related Residential Care Services

This measure looks at the ages of people who are utilising each of the four ARRC services. As would be expected, the percentage of residents in all four services

increases with age. Of the total number of people in age related residential care, there are a small number of people aged between 65 and 69 (3%). Nearly 56% of all ARRC residents are over the age of 85.

However there are significant variances in the age profiles between each of the four service specifications. The majority (59.9%) of rest home level care is utilised by people over the age of 85, but a much greater proportion of hospital level care, dementia and especially psychogeriatric care is utilised by people below the age of 80.

### Age profile of each ARRC service specification

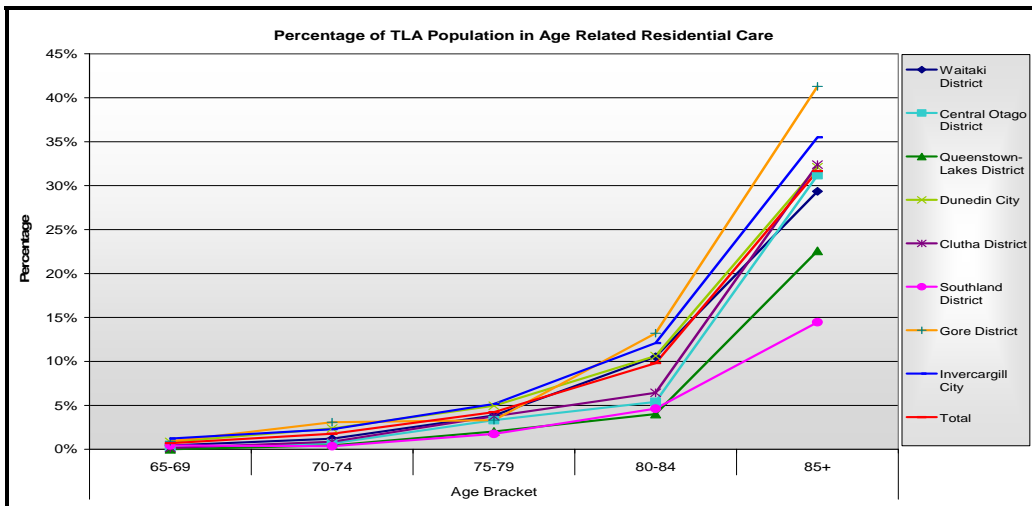


Age Profile of ARRC Services (Southland & Otago)						
Service	Age Bracket					Total
	65-69	70-74	75-79	80-84	85+	
Resthome	2.7%	5.3%	11.0%	21.1%	59.9%	100%
Hospital	3.6%	7.9%	16.4%	24.1%	48.1%	100%
Dementia	2.5%	6.6%	17.9%	22.3%	50.8%	100%
Psychogeriatric	6.1%	13.1%	18.2%	25.3%	37.4%	100%
All Services	3.0%	6.2%	13.2%	22.0%	55.6%	100%

Psychogeriatric care has the youngest age profile with nearly 63% of psychogeriatric residents under the age of 85. People with age related psychogeriatric needs usually have complex multiple requirements, and therefore may potentially have a shorter life expectancy than the population average.

#### 7.1.3 The Proportion of the Population in Age Related Residential Care

This measure looks at the proportion of a particular age group utilising ARRC. As would be expected the proportion of the population utilising ARRC increases with age. However there are large variances in the percentage of people utilising ARRC within each territorial local authority (TLA).



Percentage of TLA Population in ARRC					
Territorial Local Authority	Age Bracket				
	65-69	70-74	75-79	80-84	85+
Waitaki District	0.43%	1.20%	3.85%	10.51%	29.36%
Central Otago District	0.22%	0.68%	3.32%	5.38%	31.18%
Queenstown-Lakes District	0.00%	0.44%	2.04%	4.00%	22.58%
Dunedin City	0.84%	2.36%	4.95%	10.62%	32.10%
Clutha District	0.15%	0.85%	3.75%	6.42%	32.39%
Southland District	0.43%	0.35%	1.74%	4.62%	14.46%
Gore District	0.92%	3.09%	3.31%	13.21%	41.29%
Invercargill City	1.22%	2.28%	5.16%	12.08%	35.50%
Total	0.69%	1.76%	4.22%	9.79%	31.66%

Analysis of the proportion of the population utilising age related residential care shows there are significant differences between areas. This review has not investigated the reasons for the differences in ARC utilisation between areas, but there are a number of possible reasons.

Reasons for the large observed differences in each area may include:

- A population ageing faster (or slower)
- Migration of older people to urban centres
- Different attitudes towards ageing and accessing age related residential care
- Levels of independence
- Availability of ARRC capacity
- Cost of living
- Topography – older people tend to cluster in flat areas
- Climate
- Community Culture
- Population Density

Some populations may age faster than others due to:

- Ethnicity of population, with Maori and Pacific People populations observed to age up to ten years earlier than the total population.
- Socio-economic status of the population
- Lifestyle choices
- Workplace environment.

An older person may also elect to shift to another town or city once they require ARRC, especially for the more specialised services. Reasons for shifting to another location may be because of:

- The desire to be closer to family
- Requiring greater access to secondary and tertiary health services
- The necessary ARRC services are not available in their area.

There has been discussion about some people not having the option to remain in their preferred location due to either no suitable ARRC facility, or the preferred ARRC facility is fully occupied. This discussion is currently occurring in Queenstown, but has also occurred in many other locations over the years.

It is planned to undertake more analysis on the movements of residents between different locations. At this time we are awaiting external contractors to complete software modifications to extract the necessary data for analysis.

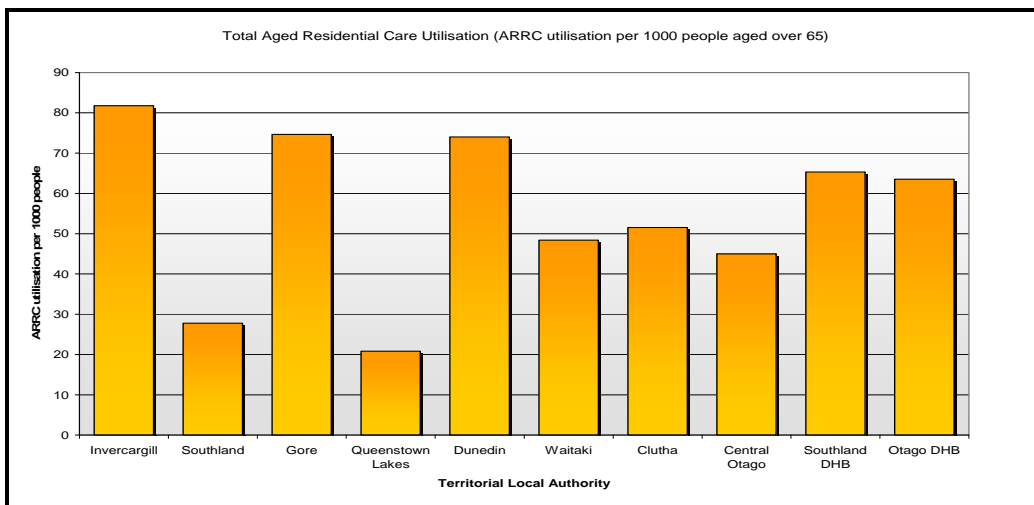
## 7.2 Current levels of service

It has been identified that there are differences between areas (TLAs) in the numbers of people utilising age related residential care and the stage in life at which they utilise it. This has a large impact on the levels of service available and provided in each area, but it is difficult to determine historically whether the needs of the population drive capacity, and hence utilisation, or if capacity drives demand. Both DHBs are continually developing their needs assessment and service allocation services to better meet the needs of clients through appropriate allocation of services based on the clients needs.

Based on the population in each area (TLA) and the services provided, the following analysis shows the utilisation of ARC services.

### 7.2.1 Age Related Residential Care Utilisation by the Over 65 Population

Analysis shows ARRC utilisation (the number of people in a given population using a service) is highly variable between the TLAs. The following graph gives an indication of the utilisation rate for all types of aged residential care for the over 65 population for each TLA.

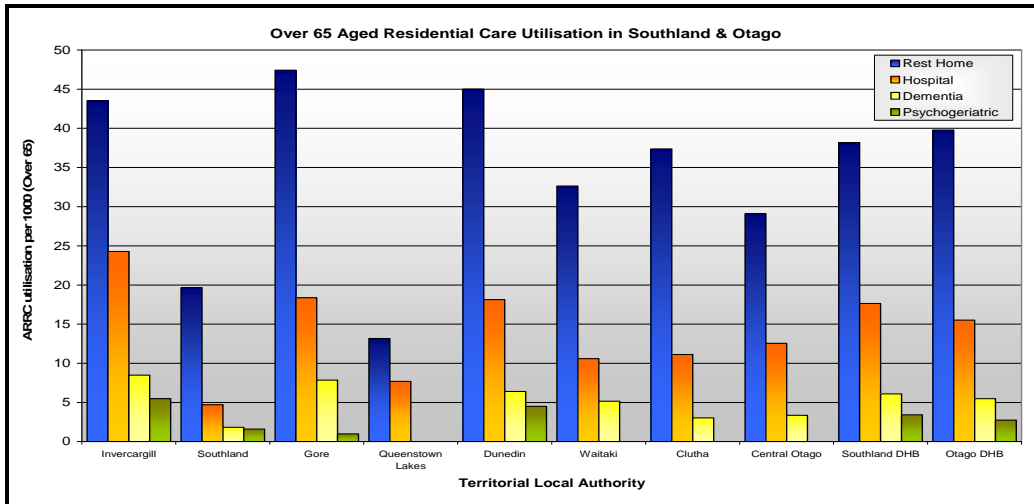


The utilisation rates for ARC are very similar between Southland (65.3 in ARRC per 1000) and Otago (63.5 in ARRC per 1000) DHBs. There is however very large variability between the two main centres of Dunedin and Invercargill, and the more provincial and rural areas.

Analysing the utilisation rates down to service type shows variability between the TLAs. This may reflect some of the differences in developing and contracting services, especially for more specialised services such as hospital level care, dementia and psychogeriatric care. Otago has a higher utilisation rate of rest home level beds.

Southland has a higher utilisation than Otago for Hospital, Dementia and Psychogeriatric care.

Analysis also shows that services are utilised by a much greater proportion of the over 65 population in Invercargill, Dunedin and Gore. Queenstown Lakes and Southland TLA have the lowest utilisation rates.



Utilisation rates are influenced by available capacity where a facility is full residents assessed as needing care will go to another location to receive care. However there is a high correlation between utilisation rates and occupancy rates in a particular area, with the areas having low utilisation rates also showing, in general, low occupancy rates.

Where occupancy rates are low, it is assumed that demand is being met. This is assumed to be correct with both high and low utilisation rates [percentage of people aged over 65 in ARRC].

Notable exceptions to this are the low utilisation rates and the high occupancy rates in the Queenstown Lakes TLA, specifically hospital level care in Queenstown, and rest home level care in Wanaka. These anomalies are no doubt a reflection of the rapidly growing populations in these areas and the inevitable lag between need arising and capacity being established. This lag and the mechanisms available to DHBs to address it are discussed later in this paper.

Further charts showing the utilisation for over 75 and over 85 are available in the Appendices [see page 25]. The utilisation rates increase with age, but the ratios of utilisation between each TLA are very similar.

## **8.0 Trends in Aged Residential Care**

### **8.1 Historical Trends**

As outlined earlier in this report, the aged residential care sector is dominated by private sector providers. The economics of this sector are highly impacted by occupancy rates as the cost structures of residential care facilities are largely fixed and revenue is only received for occupied beds and is therefore variable. This creates a competitive environment where providers strive to provide an environment that is at least as attractive to potential residents and their families as other providers and preferably more attractive so that their facility remains fully occupied. Over time this competitive pressure has driven an evolution in facility design with rooms with multiple beds and shared bathroom facilities making way for single rooms, often with separate ensuites. Technology and regulation has also influenced facility design, for example the introduction of lifting equipment as the norm has led to the need for bigger rooms to accommodate hoists for non-weight bearing residents.

In addition to changes in the physical requirements for accommodation there has been an evolution in the broader models of care provided. Facilities providing single levels of aged residential care are now faced with competition from large multi-level retirement villages providing a wide range of care including independent cottages, rest home care, long term hospital level residential care, psychogeriatric level care and dementia level care all within the same site. These facilities are proving very attractive to potential residents who anticipate a progression through several levels of care. It appears that residents can see the advantages of experiencing that transition in an environment where each step can be achieved within a constant and familiar environment and with a minimum of upheaval for themselves and their families.

It also appears that independent cottages co-located within facilities that also offer higher levels of care have the potential to allow residents to remain in independent living arrangements for longer as support services from adjacent facilities are more easily provided to them within their own homes. These facilities tend to be large and require an adequate population base to be sustainable. Historically they are located in the larger urban areas, but increasingly more supported living facilities are being built and planned in smaller retirement destinations such as Central Otago and Queenstown Lakes.

The trends outlined above are consistent with the New Zealand Disability Strategy and are a positive development in the provision of age related residential care.

### **8.2 Trends Driving Future Demand for Capacity**

The recent change [1 July 2007] to the Social Security Act has resulted in a move away from DHB managed bed policies to a model that will now be largely market driven. DHBs are now obliged to subsidise any eligible ARRC resident in any ARRC certified bed. ARRC certification is independent of DHBs, and an ARRC facility can have an unlimited number of ARRC beds certified.

The development of capacity has always been largely dependent on the willingness of providers to commit capital. These decisions are heavily influenced by providers' analysis and projections for future demand. In areas where there is a growing population there is an inevitable lag between need arising for capacity and the sector providing the bricks and mortar as there are "critical mass" issues with the economics of building and operating ARRC facilities.

The trends towards "ageing in place" are leading to a decline in the number of residential beds per capita necessary to meet the needs of the population. These

trends are partially offsetting increased demand arising from an aging population. These trends include the increasing role of home based support and other non-residential services and the elderly population getting progressively younger and fitter on an age for age basis.

As more people remain in independent living for longer, there is an increase occurring in the average levels of acuity for people entering residential facilities. Over time this is likely to lead to a shift in the mix of rest home/hospital care required, with more emphasis in the future likely to be on hospital level residential care.

## **9.0 DHB's Role in Planning Future ARRC Capacity**

The market driven model for age related residential care places the responsibility for future investment decisions on private providers as they bear the risks associated with those decisions. The development of additional capacity does not present a funding risk for DHBs as the total number of subsidised residents, and therefore the level of funding provided by DHBs, is determined by the needs assessment process, not the number of available beds. However, inappropriately high levels of capacity do create a financial burden on the wider provider sector as this leads to lower occupancy levels and a resulting decline in financial viability for the sector.

Private providers base their decisions to invest on perceived current and future demand. A decision about how many beds to provide in a specific location is a key commercial decision for a provider as the development of too many beds in a specific location can lead to under-utilisation of the facility, low occupancy rates and therefore an unviable business.

DHBs can play a role in facilitating the development of additional capacity by helping providers to identify where it is needed and when it is needed. Providers' decision making processes can be enhanced through the provision of timely accurate analysis of population and service delivery trends. DHBs have access to detailed utilisation data which they can analyse and share with current and potential providers in an impartial way.

The six beds owned and operated by the Southland DHB in Queenstown are an anomaly in the sector for two reasons. First, the use of two shared rooms – four beds and two beds respectively – no longer meets normal sector standards, where there is now an expectation from residents of individual rooms, in many cases with ensuites. Second, the Queenstown beds are the only ARRC beds provided by both DHBs, and such an arrangement is now very uncommon in New Zealand.

If a private provider were to establish new ARRC hospital level capacity in Queenstown, it is inevitable that potential residents would choose the new facility over the current beds, resulting in the DHB beds becoming redundant.

## **10.0 Key Issues**

A number of key issues are raised by this report which highlights some historical anomalies that need to be rectified, and gives the ARRC sector some clear signals on where Southland DHB and Otago DHB view opportunities in the future.

### **10.1 Migration**

The data analysis shows that there is a higher proportion of the older population utilising residential care in the major urban areas of Dunedin, Invercargill, and to a lesser extent Oamaru and Gore. These centres are traditionally recognised as retirement destinations, but statistics are starting to show Central Otago and Queenstown Lakes are becoming more prominent retirement destinations.

At this stage it is not known exactly who, or how many older people move towns, but it is thought that older people move for a multitude of reasons to suit their own individual needs. Older people may possibly move:

- for lifestyle reasons [climate, flat terrain]
- to be closer to family
- for a reduced cost of living [including house prices]
- to be closer to community and support services
- to be closer to hospital and specialist health services
- to enter Age Related Residential Care

Work is underway to carry out detailed analysis of trends of people migrating within the region and out of the region to receive ARRC. It was hoped to have this analysis available for this report, however the contractor completing the data extraction from the DHB information systems was unable to complete the task in time for this report to be released in August. This work continues and this report will be amended to incorporate this analysis once it is completed. Given the public interest in this issue DHB management decided to proceed with the release of this version of this report.

While the additional data will potentially provide information for the sector, it will not alter the overall findings of this report. It may however enhance our understanding some of the reasons for the trends identified here.

### **10.2 Utilisation of Age Related Residential Care**

The main urban areas have a much higher utilisation of age related residential care than the provincial and rural areas. However deciding what the correct level of ARRC utilisation is very difficult. Demand is based on individual need

Since devolution of age related residential care [and other Health of Older People services], it is acknowledged that there are no standardised methods, criteria or application for the assessment of support services (inclusive of age related residential care), and therefore it is difficult to compare utilisation and access objectively.

Attempts have been made to benchmark ARRC utilisation, and both Southland and Otago consistently show higher than average levels of ARRC utilisation [based on the over 65 population] around New Zealand [possibly by up to 20%]. It is not known if the New Zealand average is the correct utilisation rate for ARRC, but the NZ average is essentially what Southland and Otago are funded for under population based funding [PBF]. Population based funding only provides funding based on the number of people, adjusted for varying population needs such as age and ethnicity. To continue to provide higher levels of access to ARRC than the funding provides means that the DHB must decide to under-spend on other services.

### **10.2.1 Areas of High Utilisation**

As a result of population based funding, both Southland DHB and Otago DHB are looking closely at potential areas of overspending for services. Areas of high ARRC utilisation have come under close scrutiny.

Ideally the Otago DHB would like to reduce rest home level capacity in Dunedin. However perceived demand for ARRC services will dictate capacity by the sector. The Otago DHB has implemented a demand management plan to ensure all other options are explored before an older person is entered into a residential facility. Early indications are that occupancy rates for rest home level beds are falling in Dunedin.

To date Southland has limited ARRC capacity through managing the number of new ARRC contracts. This will no longer be an option and greater emphasis will be on demand management similar to that used by Otago as mentioned above.

### **10.2.2 Areas of Low Utilisation**

Two areas of lowest ARRC utilisation are rural Southland and Queenstown Lakes. These two areas also have the lowest ARRC occupancy rates. This could indicate that the older people in these areas are:

- Healthier and do not require residential care
- Supported by family and friends to allow them to remain in the community
- Dying younger before they require residential care
- Leaving the area to access residential care [either by choice or because of a lack of options]

The observed occupancy rates in most areas tend to indicate that there is choice in most instances. However a couple of the smaller populated areas, especially Queenstown and Wanaka, appear to suffer from a possible lack of capacity in some services.

### **10.3 Ratio of Specialist Care Beds**

Southland has a much higher proportion of hospital level and specialist ARRC services than Otago. Indications are that the Southland DHB ratios are closer to the national rates. With evidence Otago [and Southland] has a much higher ARRC utilisation rate than the national average; this suggests Otago has too many rest home level beds.

A plan has recently been implemented in Dunedin to manage the access to ARRC as indications were that some people may have been entering residential care inappropriately. The goal of the plan is primarily to ensure that other options have been explored before a person enters residential care.

### **10.4 Projecting Future Age Related Residential Care Utilisation**

Anticipating demand has to be done on a population basis, but there are many variables that may have an influence. Ultimately it is the ARRC sector that will provide the capacity to meet demand. Increasing [or decreasing] capacity takes time, usually years, so clear signals and planning are required by entire sector including the DHBs.

Population forecasts clearly indicate that the number of older people is going to grow considerably over the next twenty years and beyond. However older people are also predicted to be healthier for longer, so in future the proportion of older people accessing services at a certain age will move out.

There is also evidence that “baby boomers” are moving into Central Otago and the Queenstown Lakes areas. As these people move into retirement, they will potentially increase the demand for age related residential care. However this significant increase in demand is realistically 20 years away.

### **10.5 Specific Issues**

There are a number of locations that have specific issues with the provision of age related residential care.

#### **10.5.1 Queenstown**

The unique characteristics of the Queenstown population make ARRC service planning for elderly challenging. Despite the large increase in overall population, the increase in people over the age of 65, and specifically over 85 is very moderate. The small number of older people means that there is currently very little increase in demand for ARRC services.

There are 37 rest home level beds and six hospital level beds in Queenstown. The rest home level beds have an average occupancy, indicating there is sufficient capacity to meet the demand for rest home level of care.

The Southland DHB owns and operates the six hospital level care beds in Queenstown. These are the only beds owned by either DHB and are a historical arrangement that has ceased elsewhere around the country. The six hospital level beds in Queenstown are outdated and inappropriate for ARRC by current standards. There are two rooms that are shared amongst residents. The four bed room is used by female residents, and two bed room is used by male residents. Occupancy data can be misleading because the facility can only accommodate up to four females and two males. This may potentially result in an empty bed even if there is demand by a fifth female or a third male, as it would be inappropriate to have male and females in the same room. In effect this facility is running close to 100% of available capacity. This is a key indicator that demand for hospital level care is not being met in Queenstown.

It is apparent that the current DHB beds no longer meet sector standards. If a private provider established a modern ARRC facility in Queenstown, the DHB operated beds would not be able to attract residents and would inevitably become redundant. Ultimately the market will determine the number of hospital level beds, and Southland DHB will work with ARRC providers through sharing data.

Providing more hospital level beds in Queenstown is not a funding issue. If there currently are people moving from Queenstown to access hospital level care, any new capacity will transfer the funding from one provider to another.

#### **10.5.2 Wanaka**

There are 18 rest home level beds and 12 hospital level beds in Wanaka. Occupancy rates are increasing rapidly and are very high. This is an indication that there will be a demand for increased capacity in Wanaka in the near future.

## **11.0 Options**

A number of options are continuing to be investigated by the Otago and Southland DHBs. From preliminary analysis possible solutions are:

### **11.1 Short and Medium-term**

It should be acknowledged that any interim option would potentially be for a period of between two-three years based on the ability for long-term options to be achieved.

#### **11.1.1 Queenstown**

- Option 1      Negotiate with an existing provider of rest home level age related residential care for additional hospital level capacity by converting some current rest home level beds to hospital level care. This requires agreement by all parties, including remodelling of the existing facility and re-certification to hospital level care.
- Option 2      Convert two acute beds at Lakes District Hospital (LDH) to long term aged related residential care. This would incorporate two beds in a single room. This may have major implications for other acute services within LDH and any new beds will require re-certification.
- Option 3      Relocate current age related residential care beds to single rooms within acute medical ward of LDH, and acute medical beds to current age related residential care beds. This will require major reconfiguration of the LDH.

#### **11.1.2 Wanaka**

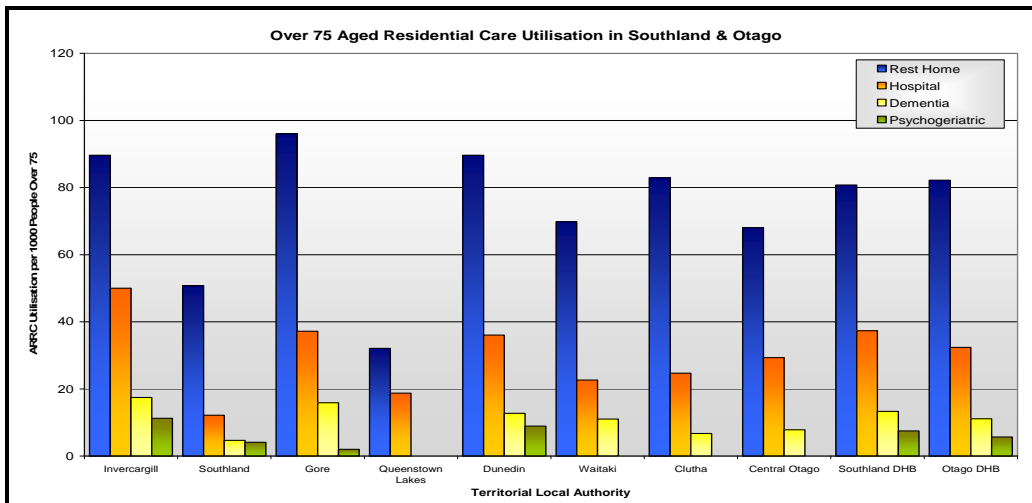
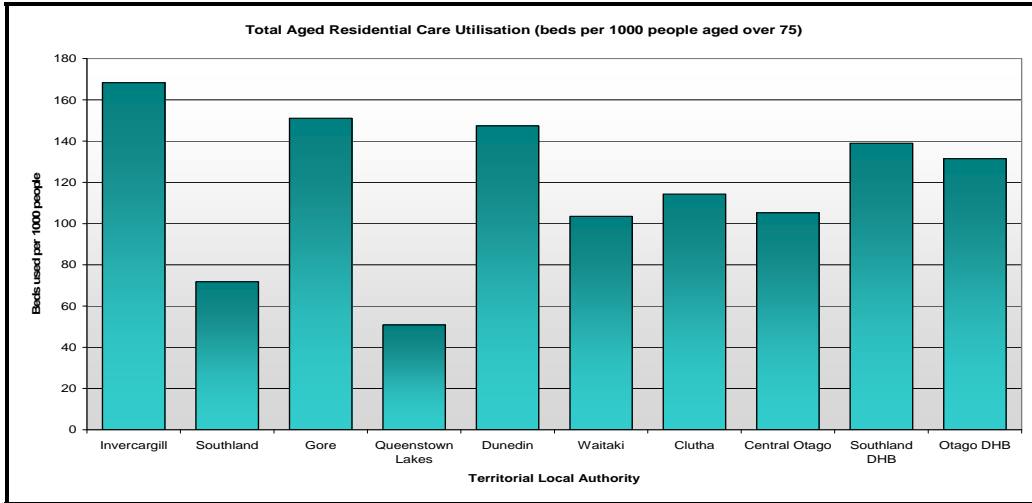
- Option 1      Negotiate with an existing provider of age related residential care for additional capacity within current facility. This could include 'flexi-bed' arrangement within current bed numbers or new capacity being built.

### **11.2 Long-term**

The long-term option for both Queenstown and Wanaka can be considered in tandem. It is the DHBs understanding that the sector is now aware of the capacity issues and has the expectation that the sector will now move to meet the demand for future provision of age related residential care. The DHBs will play a role in facilitating the development of additional capacity on an equitable and fair basis.

## 12.0 Appendices

### 12.1 ARRC Utilisation by the Over 75 Population



12.2 ARRC Utilisation by the Over 85 Population

