

The Changing face of the Aged Care Sector in New Zealand¹

by

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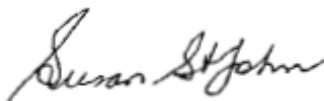
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¹ This is a revised version of a paper first published on the RPRC website in 2006.

The Retirement Policy and Research Centre

The Retirement Policy and Research Centre is pleased to publish this revised working paper on the aged care sector. We believe this is an important contribution to the knowledge of a fast changing industry, whose development and evolution will have a major impact on the wellbeing of an ageing population.

The Centre acknowledges the assistance of the University of Auckland in providing a summer scholarship to enable the research to be conducted. The assistance of the Ministry of Social Development, the Office of the Retirement Commission and the Ministry of Health, as well as helpful comments from industry advisors, in particular, Martin Taylor and David Renwick, are also acknowledged. The views expressed here however are those of the author Annette Lazonby.



Dr Susan St John

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Michael Littlewood

1. Introduction

The aged care sector has been described as a sector in crisis. Recent years have seen a rash of closures of charitable aged care providers, constant calls to raise the Residential Care Subsidy, and frequent strikes amongst nurses and informal carers due to poor pay and conditions. This report investigates the ‘Aged Residential Care’ market, examining its origins, present structure, and the issues it currently faces. It then conjectures a possible future for the market, and presents insights from people within the industry to inform the analysis.

2. Glossary and definitions

In this report, ‘Aged Care’ is taken to mean any products and services available to those over 65 years of age designed to improve or maintain their health and wellbeing, for example, personal alarms, companionship services, retirement village units, rest home beds and private hospital facilities. Aged Care (AC), therefore, has a broader meaning than Aged Residential Care (ARC). ARC refers to the range of services provided to older persons who are resident in the facility of the service provider and who require assistance on a regular basis because of chronic conditions, physical and mental disabilities (Johnson & Ucello, 2005). ARC institutions comprise Retirement Villages (RVs), Rest Homes (RHs) and Private Hospitals (PHs)².

The Retirement Commission (2006) defines RVs as encompassing the other two care providers; however these organisations are very different. Not only do they offer different services, but they are covered by different legislation, are eligible for different types of subsidies, and involve different types of care. That said, a RV complex will typically comprise multiple tiers of care, including several independent units, a building containing serviced apartments and very often a number of medium- and high-dependency beds, perhaps encompassing some dementia facilities. If a facility defines itself as a RH, however, it generally does not have any independent units and usually only facilities for medium-dependency care.

² Ancillary retirement complexes, such as eco-villages and serviced apartments, can be included in this definition of ARC, though they are not covered in any detail in this report.

The following lists the types of ARC institutions referred to in this report:

- 1) **Retirement Villages (RVs)**. Multi-tiered complexes providing independent residential units, medium-dependency and possibly high-level rest home beds (though DC and PH levels of care will be separately specified).
- 2) **Rest Homes (RHs)**. Facilities which provide medium-dependency RH beds and possibly high-level PH and DC beds (which will be specified).
- 3) **Private Hospitals (PHs)**. Facilities which only provide PH (DC) beds
- 4) **Ancillary Retirement Complexes**. Groups together other providers, such as serviced apartments and eco-villages, primarily (but not exclusively) catering to the older population.

Glossary of Abbreviations

AC - Aged Care

ARC - Aged Residential Care

ASPIRE – Assessment of Service Promoting Independence and Recovery in Elders

DC – Dementia Care

DHB - District Health Board

GP - General Practitioner

HWAC – Health Workforce Advisory Committee

LC - New Zealand Law Commission

LTO - Licence to Occupy

NZNO – New Zealand Nurses Organisation

NZPAS - New Zealand Positive Ageing Strategy

PH - Private Hospital

RCS - Residential Care Subsidy

RH - Rest Home

RN - Registered Nurse

RV - Retirement Village

SA - Securities Act

SC - New Zealand Securities Commission

3. Background: the Market for Aged Care.

Prior to the 1980s, corporate Retirement Villages (RVs) were unheard of and, although Rest Homes (RHs) had been in existence for some time, they were primarily run by charities and/or religious organisations. Provision of 'old-people's homes' (RHs) was the way the church looked after its frail old people. However, around 30 years ago, charitable organisations began some RV-type initiatives, following models in place in the US and Australia.

Rest Homes.

RHs were generally funded by a mix of charitable donations, active fundraising and a small government subsidy which was introduced in varying forms in 1951 (Shiple, 1996). Typically residents were younger in age than today and had a higher degree of functionality. They tended to enter RHs when they felt they could no longer cope with running a house, or so that they could have some companionship and to diminish the sense of vulnerability from being alone.

The streamlining of hospital care in the 1990s meant long-term rehabilitation was moved to nursing homes rather than hospitals, and this was the original rationale for the Residential Care Subsidy (RCS) (Shiple, 1996). The income and asset test for the RCS was applied in 1993 across all forms of long-term institutional care to remove the bias towards hospital care. During the 1990s, this means test was stringent, with low threshold levels, joint assessment and other features which made it anachronistic and punitive (St John, 1994).

Over the past decade, those entering RHs have become older and typically of severely limited capability to perform activities of daily life (washing, dressing, feeding), often needing 24-hour care.

As people are living longer and are healthier, they are able to stay in their own homes longer and so this is one of the reasons for the increase in the average age of those entering RHs. Continuing advances in medical technology involving both life-saving and life-prolonging techniques has increased the number of people surviving falls, heart attacks and other age-related afflictions. This has enabled people to live with disorders which, even a decade before would have been fatal. Despite some

improvements to the means test, an increased emphasis in-home care or ‘ageing in place’ has seen the more functional elderly remain in their homes longer while only those with severely diminished capabilities and/or dementia are cared for in RHs.

Retirement Villages.

The 1980s saw the advent of the corporate Retirement Village (RV), an idea imported from the United States and emerging in Australia at the time. RVs were specifically designed apartment and town-house complexes tailored toward the ‘retired’ market. They usually catered for a small spectrum of functionalities in their target market, such as serviced apartments for the more limited capability residents and independent units for those who are fully functional. Nowadays RVs typically include RH beds³. The complexes generally include recreational facilities built in, for example swimming pools, bowling greens, billiard tables and lounges for relaxation. The corporate structure of RVs tends to involve either leasing or outright purchase of the RV unit as well as maintenance fees for the upkeep of the village. Therefore they are targeted toward the wealthier individual, or couple, that has sufficient assets to be able to purchase or lease these facilities and sufficient income to pay ongoing building and maintenance fees.

From the 1990s up to the present, the structure of the ARC market has been changing considerably as larger corporate RVs, comprising more than five or so RV complexes, emerged and competed alongside the previously dominant charitable organisations and smaller one-home operations. The impact of these recent changes in the market for ARC is discussed in more detail in section five.

4. Current Picture of the Aged Care Market.

4.1 What is the Aged Care Market?

Most people think the aged care market comprises just the service sector, that is, ARC facilities such as RHs and RVs. As mentioned in section 2, AC is taken to mean the broad range of products and services that are tailored towards older people. Figure 1 identifies the products and services that make up the AC market.

³ Stand alone RHs tended to be built by charitable organisations, or by owner-operators who might have built the facility specially, or converted a house into several rentable rooms to provide RH-level care.

Figure 1 The Aged Care Market



4.2 What is the Aged Residential Care Market?

Section 2 also highlighted the distinction made in this paper between RVs and RHs/PHs. In a RH unit, the person receives a room in a RH complex that they have to themselves. They do not pay any capital sum for this room; rather it is rented (who pays depends on the nature of the particular individual's finances and the agreement with their provider) and in that weekly sum the person also receives a number of services such as meals, pharmaceutical and other health products, and a level of care and supervision (such as assistance to the toilet if required and 24-hour presence of a registered nurse). PH beds are high-dependency, hospital-type beds and are separate again from RH beds (these are not covered in any detail in this paper).

A RV unit is quite different. The person pays a capital sum to obtain the unit itself and typically a number of services may be provided (such as laundry and cleaning) but usually not *care* as those entering RVs are intended to be of a higher level of

independence. RVs and RHs are often part of the same complex in order to facilitate a seamless care continuum as the resident ages.

4.3 Paying for Aged Residential Care

Currently, those entering a RH either pay privately or are subsidised by the Government through District Health Boards (DHBs). If the resident pays privately, the rate they pay is that negotiated between themselves and the RH provider, and comes out of their personal income. To access the Residential Care Subsidy (RCS), they must be a NZ citizen or resident, aged over 65 years of age or 50-64 and single with no dependent children, and undertake a healthcare needs assessment to judge the necessary level of care in a certified RH or PH (Ministry of Health, 2005). A financial means assessment will then determine the size of the subsidy if any.

Under the Social Security (Long-term Aged Residential Care) Amendment Act 2004, which came into force on July 1, 2005, new asset thresholds for the subsidy were introduced. The maximum allowable income earned from any assets is \$805 per person per year. The asset threshold changes are detailed in Table 1 below.

Table 1 The asset test for the Residential Care Subsidy.

	Previous asset threshold	Threshold from July 1 2006
Single person	\$15,000	\$160,000
Married couple (both in long-term ARC)	\$30,000	\$160,000
Married couple (only one in long-term ARC)	\$45,000 of assets plus house and car	Either: \$65,000 plus house and car, Or: total asset level of \$160,000
Single people 50-64, need ongoing care, no dependent children.	\$15,000	No longer require asset testing

Source: Ministry of Health (2005, updated)

It should be noted that the individual often enters the RH unexpectedly, after having had a major health event such as a fall, when they are more likely to find this process cumbersome and intrusive. While the assessment is being processed, the individual or their family must meet the full cost of the RH fees. These will be reimbursed but this process can take up to a month (there is a 30 day time-frame for the eligibility decision to be made).

Another point of interest is that the significant increase in the asset threshold from 2005 increases the number of individuals eligible for the RCS (Table 1). This will see escalating demands for ARC provision unless the already tight needs assessment criteria are constricted further⁴.

4.3 Legislation Protecting those in Aged Residential Care

Protection for those in Retirement Villages: The Retirement Villages Act

Until recently, there has been a dearth of appropriate legislation giving protections to those purchasing and providing RV services. The lack of protection, particularly surrounding disclosure of terms and conditions, complaints and disputes procedures and exit arrangements, highlighted the need for legislation specific to the ARC sector to be drawn up. In 2003 the Retirement Villages Act ('the Act') was passed, with some of its provisions coming into force that year and the remainder coming into force in 2006.

Background to the Act

When RV-type arrangements were being replicated in New Zealand during the 1980s, there was no legislation to govern this area and therefore little protection for those who bought into RVs. One particular problem surrounded the buy-back provisions when a resident wanted to exit a unit. Anecdotal evidence suggests that these could be quite unfair. The freedom that operators of RVs had to dictate the buyback provisions meant they could stipulate, for example, that the resident remained in the unit until a buyer could be found, that they sold the unit to the RV management who could then on-sell it to the buyer, and that the sale price would be set by the RV management who then kept the gain from on-selling the unit. Such inflexible

⁴ For a more detailed discussion of this see Ashton and St John, 2005.

arrangements which so heavily favoured the RV complex could severely diminish the asset base of the elderly client.

RVs were covered by legislation; soon after their introduction, the New Zealand Securities Commission (SC) brought them under the jurisdiction of the Securities Act 1978. This applied to offers of securities to the public, and in the RV sector it applies solely to the financial side of making an investment in a RV unit. Protection was via disclosure of information, so as to limit information asymmetries for those buying into RVs. By the beginning of the 1990s, however, it became apparent that the SA was providing inadequate protection for those in RVs as exemptions under section 5(1)(b) were used extensively and enabled a significant proportion of RV providers to avoid compliance with disclosure requirements under the SA (New Zealand Securities Commission, 1993).

In addition to frequent use of this ‘out’ clause on disclosure, the SA made no provision for anything other than investments in RV units. Thus, there remained the issue of complaints procedures, entry and exit rights and responsibilities of residents and other financial aspects of disclosure to the resident entering an ARC facility. Both the SC and the New Zealand Law Commission (LC), in 1993 and 1999, respectively, published proposals for reform of the law. Since no other legislation was applicable to the ARC sector, for some considerable time the RV sector was a relatively ungoverned area of ARC provision.

In 2003 the Retirement Villages Act was passed into law, with a small number of its provisions coming into force on February 1st, 2004. The provisions regarding complaints and disputes resolution came into force on October 1, 2006 and the remaining provisions will come into effect in May and September of 2007.

Features of the Retirement Villages Act 2003

One of the key characteristics of the Act is its broad definition of a RV; in particular, section 1 of the Act defines a RV as:

“any premises that contains two or more residential units that provide residential accommodation together with services or facilities or both, predominantly for persons in their retirement and for which the residents pay, or agree to pay, a capital sum as consideration”

The Act particularly applies regardless of the ownership structure of the unit, which can be a unit title or leasehold title, a lease, license to occupy or residential tenancy; so there is no method of changing the ownership structure to avoid compliance with the Act.

It also tightens up the disclosure requirements. The RV providers must present the intending resident with a copy of their specific agreement, the disclosure statement, the Code of Practice (expected to come into effect in 2007) and the Code of Residents' Rights. The level of disclosure aims to enable the intending resident to examine and compare a number of agreements from different RVs, which will specify the on-selling procedures, and choose accordingly. In addition to this provision of information, the 'informed choice' intention of the Act requires potential residents to consult a lawyer before they enter into any sort of agreement with the RV. There is also a 15-working day "cooling off" period which enables the resident to change their mind and negate the occupation agreement *post-signing*, and does not have to be preceded by any wrong-doing on the part of the provider.

The Act introduces a formal disputes resolution process, and a procedure for dealing with complaints must be set up by the RV with unresolved disputes to be mediated through a disputes panel.

The strength of the 2003 legislation lies in broad coverage, under the Act's definition, of a RV. This prevents slight changes to an organisation's structure that might preclude coverage by the provisions of the Act.

Recognising that he could not speak for other companies, Managing Director of Guardian Healthcare David Renwick sees the new legislation as "nothing that they [Guardian] weren't already doing"; in particular, and given the import that a large investment into a RV will have, it is also nothing that investors were not already doing and is likely to "cut the cowboys out of the industry".

There are, however, several significant flaws that can be identified with the Act. In particular, the Act does not outline a template disclosure statement; rather this is at the discretion of the RV provider, which is similar to the provisions of the SA 1978. The size of the disclosure statement might also be an issue. The intention is for the prospective resident to thoroughly examine the disclosure statements of multiple organisations and make their decision accordingly. However these documents are

typically quite long and involved. The assessment of several of these may be a daunting exercise for a potential resident whose average age is 80 years.

While disclosure under the Act may make a potential resident sufficiently *informed*, there still may be little real *choice* in the RV market, particularly in certain regions where there are few RVs available. Under such conditions, whether there is negotiability of the terms and whether the prospective resident has any real bargaining power are debatable.

Protections for those in Rest Homes: Health and Disability legislation.

As discussed above, although RH and RV functions often coexist in the same complex, these two areas are covered by different legislation. There is no single, or standalone, piece of legislation covering RH residents and operators; rather they come under the umbrella of Health and Disability legislation. In particular, RH operators are bound by the Health and Disability Services (Safety) Act 2001 (HDSS Act) which replaced the Old People's Homes Regulations 1987 and the Hospitals Regulations 1993 on October 1 2004 (Ministry of Health, 2006). The HDSS Act sets minimum standards that a resident in a RH or hospital can expect to receive. Those are governed by certification and monitored through an independent auditing process. The Ministry of Health reviews the audit reports, issues the certification, administers and enforces the legislation and pursues the legal process in the case of safety breaches.

Residents of RHs are also protected, under the Health and Disability Commissioner Act 1994 (HDC Act). The Health and Disability Commissioner hears complaints regarding breaches under the Code of Health and Disability Services Consumers' Rights (the 'Code') as laid out in Part 2 of the HDC Act. The Code sets out the following patient rights:

- The right to be treated with respect
- The right to freedom from discrimination, coercion, harassment and exploitation
- The right to dignity and independence
- The right to services of an appropriate standard
- The right to effective communication

- The right to be fully informed
- The right to make an informed choice and give informed consent
- The right to support
- Rights in respect of teaching and research
- The right to complain

The Health and Disability Commissioner (2007).

4.4 Structure of the Aged Residential Care Market

Providers of ARC vary in size from those which own over twenty different facilities and have capacity for more than 2,500 residents to those which comprise just one RH. The major ARC facility providers are all for-profit organizations and are represented in Table 2. The ‘mid-size’ facilities are all around a quarter of the size of the above facilities, the largest having capacity for around 500 residents. These tend to be predominantly the charities and non-profit organisations and are listed in Table 3.

There are also several ‘satellite’ operators, who have one or more low-capacity facilities. These are not listed due to their number and variability.

4.6 Trends in the Aged Residential Care Sector

The ARC market is a market in transition. Of the mid-range providers, the for-profit organisations are expanding their capacity whilst the not-for-profit organisations are in the main part exiting the market. These are usually bought by the larger providers; so the market structure appears to be flattening, coming to consist of a small group of large providers and numerous satellites.

Table 2 The Structure of the Aged Residential Care Sector: Large providers

Provider	Number of (completed) RVs	Number of (completed) Residential-Care Facilities	Total Number of Beds
Guardian Healthcare Group	7	25 Hospitals (21 of which are also RHs)	Approx 2,200 Aged care beds 379 Independent units
Ryman Healthcare Ltd.	14	13 RHs 13 Private Hospitals	Over 2,500

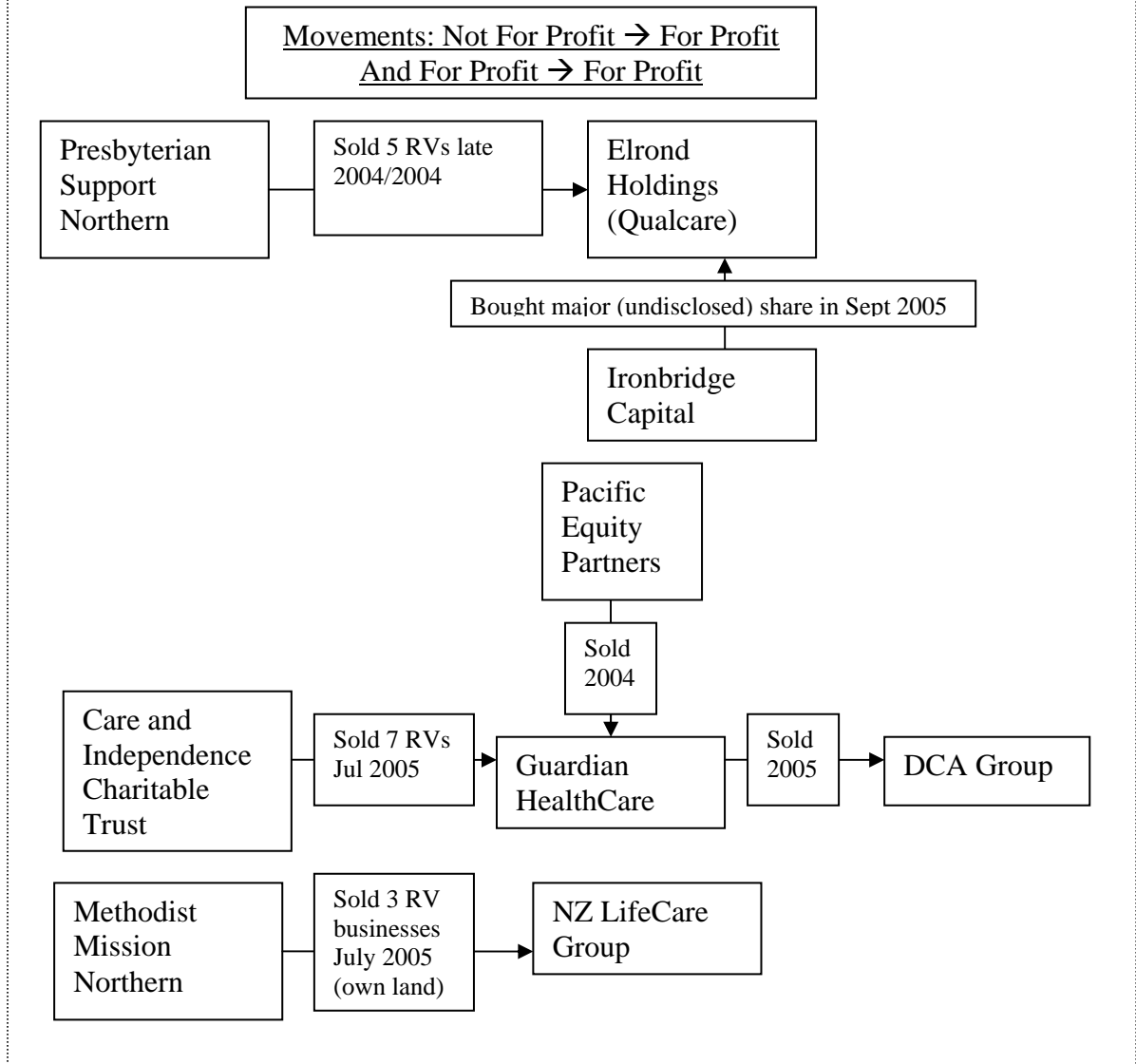
Metlifecare	13	9 RHs 6 Private Hospitals	Over 2,000
Eldercare	25 RH and Private Hospital Facilities, 2 of which also comprise RV Complexes		1,800 RH and Hospital Patients 227 Retirement Unit Dwellers
Radius Health Group	20 Facilities comprising: 16 RHs, of which 12 are also Private Hospitals and 2 have lifestyle units; 4 Private Hospital Only facilities		Over 1,300
Summerset	10 RVs some including RH and Private Hospital Beds		327 RH and Private Hospital Beds 800 Independent Units

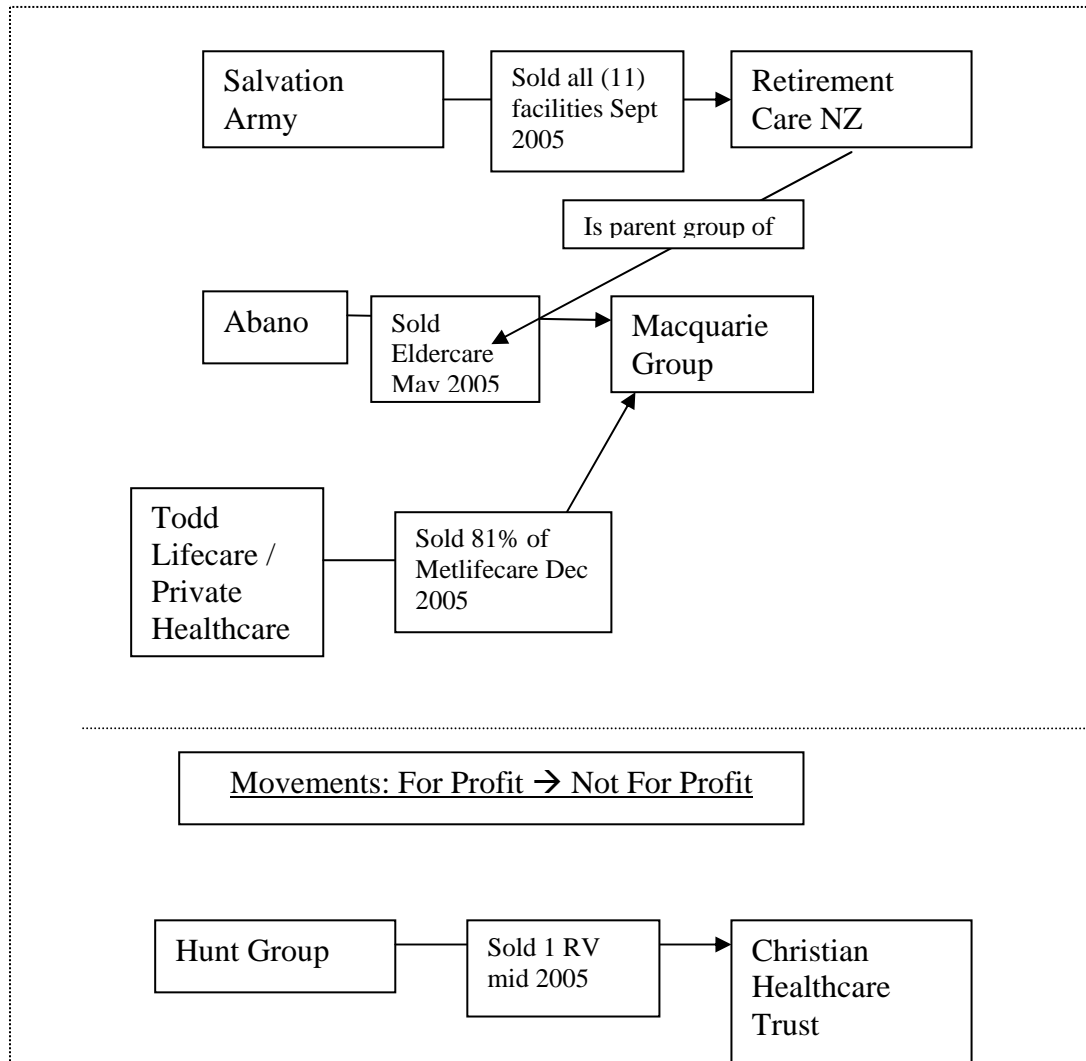
Table 3 Mid-size providers as at 2006

Provider	Number of RVs	Number of Residential-Care Facilities	Total Number of Beds	Organisation type / Notes
Lifecare New Zealand	2	9 RHs		For Profit
Presbyterian Support	None	5	Approx 500	Not-for-profit (religious) / No longer owned by PS but continues under same name.
Vision Senior Living	5 Resorts 2 of which are not yet completed		Approx 500 and expanding	For Profit
Christian Healthcare Trust	None	7	Approx 400	Not-for-profit (religious)

Figure 2 illustrates the movements in the market just over the two years up to March 2006. In early September 2005, the Salvation Army sold all 11 of its ARC facilities to Retirement Care NZ, the parent organisation of Eldercare NZ (The Salvation Army, 2005). In 2004 Presbyterian Support completed the process of transferring ownership of its ARC facilities to Elrond Holdings (Stretch, 2004) though the facilities retain the same name.

Figure 2 Recent Trends and Moves in the Retirement Sector up to March 2006





The CEO of Presbyterian Support noted that the charitable organisations “reluctantly” exited the market which was increasingly dominated by “large national and multinational providers” (Presbyterian Support East Coast, 2005). 2004 also saw the sale of facilities belonging to the Auckland Methodists and Hastings St John of God (Presbyterian Support East Coast, 2005). Charitable providers seemed to find the government’s then \$80 daily subsidy⁵ made their business unsustainable (“No budget money for providers of residential care”, 2005).

In contrast to the charitable providers, the large for-profit providers are expanding within the market. The Macquarie Group recently purchased Eldercare NZ with the

⁵ This subsidy cap has increased since the time this amount was calculated and varies between districts.

Salvation Army facilities and gained an 81% share in Metlifecare as RVNZ⁶, giving them a controlling share in two of the largest residential aged care providers in the New Zealand market.

In the last two decades, the trend has been away from provision of solely ARC. Large organisations, such as Guardian and Metlifecare, as well as the midsize organisation Radius Health Group, have moved into provision of more multi-faceted healthcare services such as personal alarms, companionship programmes, home-help, maintenance, medical and even financial services. More than one industry representative has suggested that this may explain why owning ARC facilities is viable for the larger organisations, as some of the more lucrative services may subsidise the less financially viable operations (such as provision of RH care). The Presbyterian Support CEO believes that it is precisely this cross-subsidisation along with economies of scale available to large corporate providers that enables them to prosper in a market which has seen the smaller charitable providers forced out (Presbyterian Support East Coast, 2005).

5. Issues Facing the Aged Residential Care Market.

There are several emerging issues that will affect the future of ARC. These include the ageing population, effects of changes in the family structure of future cohorts of elderly people, changes in consumer tastes, issues with funding the aged-care workforce and the emerging market structure of ARC providers. This section will discuss each of these issues with particular reference to their possible impact on the provision of ARC.

5.1 The Ageing Population

Projections suggest that by 2051, the population in New Zealand will increase from 3.88 million in 2001 to 4.81 million on the following assumptions: fertility levels decline then stabilise at 1.85 children per New Zealand woman; a net migration gain of 5,000 people a year from 2007 onwards and life expectancy from birth increasing to 86.5 years for females and 82.5 years for males (Statistics New Zealand, 2004a).

⁶ RVs New Zealand, a joint venture between Macquarie Group and Australian property investment company FKP. RVNZ owns 81% of Metlifecare as of 15 Dec 2005 and 100% of Eldercare as of 13 July 2005.

Along with other developed countries New Zealand's ageing population will see an overall increase in the median age. Assuming the population follows the trends listed above, the median age of the population is projected to be 45.1 years by 2051, increasing from 34.7 in 2001 (Statistics New Zealand, 2004a).

New Zealand's post-war baby-boom was followed by a decline in the number of children born per woman. The percentage of the population over the age of 65 is expected to rise from just under 12% in 2001 to 25% by 2051 (Statistics New Zealand, 2004a).

There is also ageing within the 65+ cohort, with the number of people over 85 years of age predicted to increase six-fold by the middle of this century (Organisation for Economic Cooperation and Development, 2005). In 2001, the percentage of people over the age of 85, considered the older-old, was 10% of those over 65. This is projected to rise to 24% by 2051 (Statistics New Zealand, 2004a). This 'older-old' group has the highest incidence of morbidities such as degenerative diseases and disabilities, and a higher prevalence of co-morbidities (having two or more diseases and/or disabilities at once) (Statistics New Zealand, 2004c)

Ageing of the population has implications for dependency ratios. Statistics New Zealand (2004b) estimates show the proportion of the population aged under 15 was 23% in 2001 and this number is expected to fall to 16% by 2051. The total dependency ratio (which represents the ratio of the dependent population, those aged under 15 and over 64, to the working age population, those aged 15 to 64) rise from 35% in 2001 to 41% by 2051. Note that this assumes those 65 and over are 'dependent' (do not work). Actual dependency ratios may not rise by quite as much depending on the labour force participation rates of those aged over 64.

These population trends are significant for how the aged care sector will function in the next half-century. Not only will there be more people than ever before in the over-65 and over-85 cohorts, but there will be a higher proportion of the population than ever before in these groups. This places a larger burden on the working-age population to support them, shown by the increased dependency ratios. Furthermore, there is ageing within the aged population, with an increasing proportion entering the older-old cohort. This may present an additional burden to the working age population because the older group tend to have much higher health needs.

5.2 Impact of Ageing on Aged Residential Care

The above-mentioned trends in the ageing population will place significant strain on aged-care services, including the ARC services. Cornwall and Davey (2004) identify the two perspectives that appear to pervade the literature regarding coping with the ageing population which they term the 'crisis' and the 'manageability' viewpoints. The former predicts that population ageing will place an unsustainable burden on the health system which will therefore require a major structural overhaul. The latter proposes that while it is important not to underestimate the impact of an ageing population on the health system, with attention to funding, planning and delivery issues, the current system can cope without necessitating any kind of grand reformation.

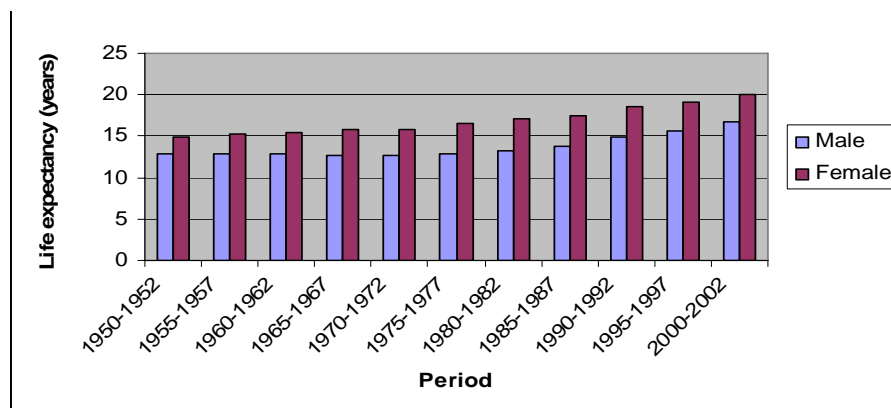
There are several aspects of population ageing which will have significant and differentiated impacts on the provision of aged care:

Life Expectancy, 65 and over.

Over the past 50 years, life expectancy of both males and females has been increasing. This is likely to lead to both a nominal and proportional increase in the demand for ARC services

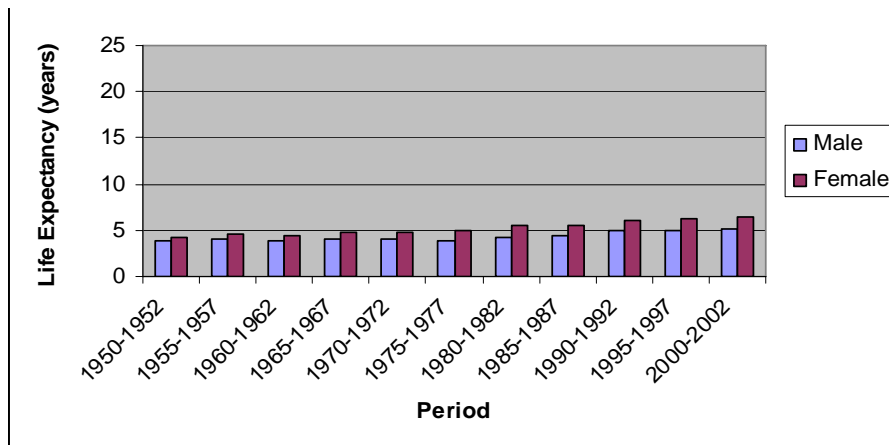
Statistics New Zealand (2004b) found that, over the period 1951 to 2001, female life expectancy at 65 has increased by 5.2 years, males' by 3.1; and at age 85, females in 2001 lived on average 2.3 years longer than they did in 1951 and males 1.3 years. The following figures illustrate these increases.

Figure 3 Female and male life expectancy at 65.



Source: adapted from Statistics New Zealand (2004b).

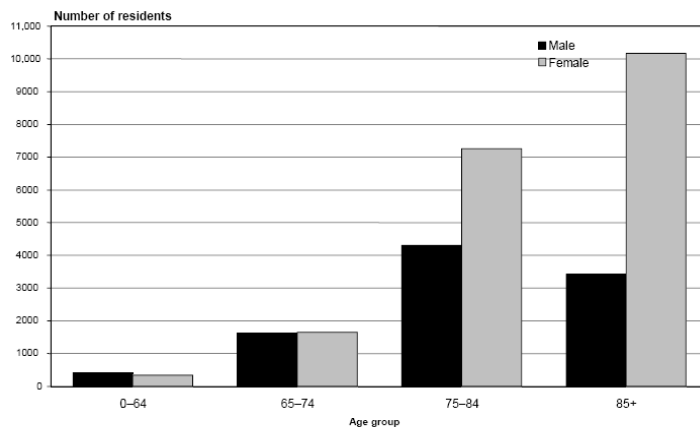
Figure 4 Female and male life expectancy at 85.



Source: adapted from Statistics New Zealand (2004b).

These life expectancy figures have several implications for the demand for ARC. First of all, the overall increase in life expectancy of males and females will have an impact on the numbers of individuals requiring ARC. Demand for RH and PH beds increases steeply with age, particularly for women. Of women over the age of 85, 31% were in an ARC facility compared with 24% of men over 85 (Cornwall & Davey, 2004). Figure 6 illustrates this.

Figure 5 Demand for ARC by age and gender.



Source: Cornwall and Davey (2004)

As can be seen, females aged between 75 and 84 in ARC outnumber males by just under two-to-one and once they reach over 85, they outnumber males by more than two-to-one. The predominance of females over 85 in ARC reflects their higher life-expectancy and that men are more likely to be cared for by a younger spouse at home.

Overall increases in life-expectancy may or may not draw out the length of time each individual spends in ARC, depending on the assumptions we make regarding the trend in age-related morbidity.

Ageing of the Health Workforce

Along with the ageing population, the average age of the health workforce is increasing and in this New Zealand follows international trends as well. In particular, New Zealand's General Practitioner and nursing workforce is increasing in average age.

Ministry of Health (2002a) highlights a trend toward later entry into the nursing profession as contributing to the increasing number of nurses over the age of 40. The modal (most common) age bracket in 1990 was 30-34 and in 2000 was the 40-44 age bracket, which follows the general trend of the baby-boomer population bulge that is making its way through the workforce. The other implication this has for the aged-care sector is that these staff will exit the supply side of the market and enter its demand side, along with other baby-boomers, thus stretching nursing resources for aged-care.

A second and similar issue is the trend toward ageing of the General Practitioner (GP) workforce. GPs are of particular importance in providing primary health care. This is the frontline of health service provision and the first point of call for members of the community when they require treatment. A well organised and resourced primary health sector enables appropriate and timely delivery of health care to those in need, thus preventing ill-health and unnecessary hospitalisation. With the move toward more in-home care under the 'Ageing in Place' model, the GP workforce will play a significant part in making this model work. New Zealand Medical Association (2004) notes that along with the increase in numbers of GPs exiting the workforce, there is a reduction in the number of medical graduates entering general practice. So, as was the case with nurses, the modal age-bracket of GPs is increasing with the most common age-bracket for GPs being 35-39 in 1998 whereas by 2002 the 40-44 year age-bracket had the majority of GPs. Therefore, ageing of the GP population and declining numbers of medical graduates entering general practice will have a significant impact on the ARC sector.

5.3 Impact of Changes in Family Structure

Marriage dissolution and de facto partnership

Like many of its developed counterparts, New Zealand has seen an overall increase in the number of marriages being legally dissolved and an increase in the number of those who live in de facto partnerships (Statistics New Zealand 2004a). These trends have significance for managing aged care and potential demand for ARC for a number of reasons. The first has to do with support: there are economies of scale when two people live together, both in a financial and practical sense. Statistics New Zealand (2004c) notes that, although the difference between unpartnered and partnered individuals not having enough income to meet their needs is small (12% and 10%, respectively), a more marked difference exists between unpartnered and partnered individuals in reported health status, particularly mental health and well-being. The percentage of unpartnered individuals reporting feeling sad, blue or depressed was twice as high as for coupled individuals - 12% compared with 6%. Problems with sleeping (insomnia or hypersomnia) were more than twice as prevalent among unpartnered individuals than couples with 11% of the former reporting they had trouble with sleeping compared with only 5% of couples (Statistics New Zealand, 2004c).

If the decline in formal partnerships (by way of declining marriage rate and increasing marriage dissolution rate) is not matched by the increase in de facto partnerships, we can expect a larger proportion of the over-65 population to be unpartnered in future years, which will have an impact on the ARC sector because demand for ARC increases in unpartnered status.

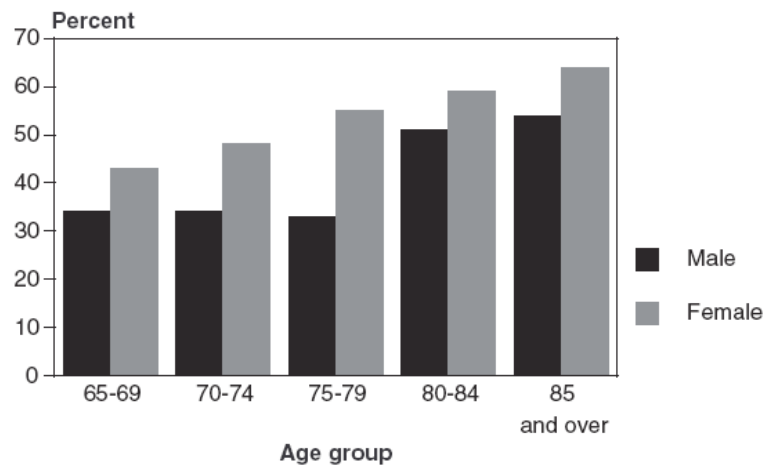
Statistics New Zealand (2004c) projections up to 2021 expect an increase in those over 65 living in one-person households. As of 2001, 42% of those in one-person households are over 65 and this is projected to increase to 47% by 2021.

5.4 Support from family

Statistics New Zealand (2004a) estimates that, under mid-range projections, the birth rate will continue to decline from 1.90 per female as measured in December 2000 to 1.85 by 2011 from which date it will remain stable at this lower level. This has implications for the aged care market. Currently, children play an important role in

providing informal support for the elderly. Statistics New Zealand (2004c) notes that the most important form of assistance that family members provide for the elderly is in-kind assistance. They highlight the outcomes of the 2000 Survey of Older Persons which investigated the percentage of elderly receiving in-kind support such as: major home and/or car maintenance; purchase or provision of a car, major household appliance, holiday, haircut, clothes or shoes; and help with cooking, cleaning, lawn-mowing or gardening. The survey found that women tended to receive more in-kind care than men in every age group, and that, as expected, need for care increased with age, as illustrated in figure 6 below.

Figure 6 Receipt of in-kind support by people aged 65 +



Source: Statistics New Zealand, Survey of Older People, 2000

Source: Statistics New Zealand (2004c)

The authors point out that older people living alone must bear the burden of household chores by themselves which might lead them to get support from family members if they cannot cope with these alone.

5.5 Changes in Consumers' Tastes

In public hospitals today, it is common to see signs listing patient rights and the complaints process. Publicity about consumers' rights has served to increase awareness of what is acceptable and what is not, and has reduced tolerance for inappropriate treatment and sub-standard conditions. Media and advertising, including via the Internet, has also impacted on healthcare consumers' tastes by vastly

increasing the information and knowledge about procedures, products and services available to them.

Evidence of the impact of advertising on demand for healthcare can be seen in the Direct-to-Consumer Advertising (DTCA) of pharmaceutical products in the US and New Zealand. While there is considerable debate around DTCA, Mansfield et al. (2005) show that DTCA unequivocally results in increased demand for pharmaceutical products and medical consultations.

The impact on demand for aged-care as the elderly become more, if not better, informed about the options available to them is hard to tell. However, the choice over how to manage the ageing process, including choice of ARC facility, is not to be taken lightly, given the person will spend a significant amount of time living with the consequences of those choices. So it might be hoped that the benefits of increased knowledge via advertising, media and the Internet will outweigh any perceived costs.

5.6 Workforce Issues

Increased demand for aged (and other) healthcare impacts on workforce recruitment, training and remuneration. With staff shortages and recruitment issues, patient choice may be severely reduced. The problem is perhaps worse in the home-care sector where low pay results in recruitment, retention and turnover problems. Home-care services range from general housework to showering and dressing. The personal nature of the latter makes it all the more important that staff members are appropriately trained and sensitive to clients' needs and deliver services in a way that maintains their dignity. In its first objective, the Health of Older People Strategy outlines that:

“the Ministry of Health and DHB...will place greater emphasis on skills needed to work alongside older people, their families, whanau and caregivers in community and home settings [and] develop the health care and home support workforce to focus on home-based rehabilitation (home support) services.”

(Ministry of Health, 2002b p.19).

Contractors with the DHB must pay staff and fund their administration costs out of a limited fee. This reduces the hourly rate available to in-home carers and also limits scope for pay increases.

In December 2005 the NZ Nurses' Organisation and the Service and Food Workers Union went on strike over pay parity for ARC nurses and pay increases for service workers in the ARC facilities of Guardian Health Care and Healthcare Providers NZ. This was followed a few days later by the Service and Food Workers' Union members of Radius Residential Care.

The numbers of trained Registered Nurses (RNs) in New Zealand appear to be sufficient to meet the need but there appears to be a chronic shortage of RNs actively in the workforce due to pay and conditions (Department of Labour, 2005). Managing Director of Guardian Healthcare Group David Renwick notes that DHBs tend to be the "gatekeepers as well as the poachers" of ARC workers. The size of the DHBs' subsidy to ARC providers keeps down the wage rate that can feasibly be paid to nurses working in the ARC sector. However, they always have the option of going to work in a DHB-run hospital, where pay rates are higher. The impact of this could be chronic shortages of nursing and other staff in private ARC facilities.

In a snapshot survey of 40 ARC sites, the NZNO discovered staffing levels fell well below the recommendations of the Standards New Zealand staffing indicators with staffing levels sometimes falling as low as little more than 50 per cent of indicator levels (New Zealand Nurses Organisation, 2005).

Staffing levels are also a problem for healthcare support workers. Brown and Duncan (2001) estimated that there are about 25-30,000 caregivers in ARC, though there have been no formal data collected on these. The typical wage of these unskilled workers in 2006 is \$10.50- \$11.50 per hour and results in massive staff-turnover, some sources putting it as high as 50% per annum (New Zealand Nurses Organisation, 2005).

Mileage is an issue as in-home care workers may often service more than one client in a day, necessitating travelling between homes. The DHB does not fund travelling therefore paying for mileage must come out of the capped rate for the number of hours allocated to the person, and so many providers do not pay travel costs. In 2005, 77 years after the first petition, a delegation of homecare workers returned to Parliament to deliver an 18,000 signature petition for the reimbursement of travel costs for homecare workers ("Call for extreme makeover of homecare sector", 2005).

In the intervening decades, there had been no action undertaken to provide for these expenses.

Training is another issue with homecare workers (Health Workforce Advisory Committee, 2006); if undertaking training is at the expense of the homecare worker, there is no incentive to up-skill if that training will not lead to a higher wage.

High turnover and retention problems were identified by the Health Workforce Advisory Committee (2006) as affecting the support workers' sector. A lack of service workers conflicts with the client's right to choose from whom they receive service. This issue affects individuals receiving in-home care as well as those in an ARC facility. If there is a problem with a staff member, the contractor to the DHB or the ARC facility will be unable to change that staff member if they cannot find a replacement.

5.7 Changes in the Market Structure of Aged Residential Care Providers

As discussed in Section 4.4, the market for ARC is characterised by increased market power on the supply-side as the mid-sized, mainly charitable, ventures have exited the market while the for-profit organisations make plans to expand. The demand side of the market must be separated into two parts: the demand for retirement village units and the demand for rest home care. These two are not independent: consumers of retirement village dwellings are likely require rest home care services during their time and, depending on various aspects of their retirement village unit, including the level of in-home care they can receive in it, demand for rest home care will increase or decrease. The demand side for retirement village units is competitive: there are numerous individual purchasers of retirement village dwellings. Excluding services supplied to private paying residents, the government purchases services from RH providers for eligible elderly residents through contracts with DHBs. Therefore the demand side for the rest home component of ARC is characterised by significant market power on the part of the major buyer.

Increased market power on the supply side means that the (more powerful) firms can have an impact on price depending on the production decisions they make. Since expanding production drives down price, an increase in market power of some firms tends to be associated with smaller quantities than would be supplied in a market that

is more competitive. The smaller firms, being individually too small to affect price, must accept the price prevailing in the market.

In the market for rest home care, increased power on the supply side is counterbalanced by power on the demand side, which means we would expect the price of rest home care to be kept lower than it would otherwise be if the demand side was competitive (which would be the case if there was no government involvement and all individuals had to purchase their own rest home services). In the market for retirement village dwellings, there is no such power on the demand-side, so the increasing market power on the supply side suggests conditions could become less favourable for consumers.

The fact that the buyer can elicit a discount on price of the factor for the same amount of input means the overall cost of providing individuals with residential care is lower. The government's increased buying power enables lower government expenditure.

As discussed before, the merging of the large firms and the removal of the mid-size firms means that a more powerful supply-side is emerging. What will be the impact on suppliers of this increased seller power? One outcome can already be observed which is the improved lobbying position of large firms to elicit an increase in the level of the government's subsidy for rest home care.

Guardian MD David Renwick sees additional impacts of the increased supplier power in the ARC market to be a more professional sector with more money for research and improved lobbying power. This can be beneficial for the sector if the increased expenditure on research results in improved care-delivery outcomes and/or lower costs. Conversely, a more powerful supply-side can also contract quantity (either actively, by using such techniques as bed-blocking, or passively, by not increasing capacity in line with demand) to increase price (that is, increase the size of the RCS). If improved lobbying power simply results in rent seeking this would result in a loss to society.

6. Ageing in Place Strategies.

'Ageing in Place' (AIP) is a broad concept to which different groups attach different meanings. Therefore, there can be debate over its scope, relevance and feasibility.

AIP is commonly perceived as taking place in one's *own* place (i.e. one's own home) (New Zealand Institute for Research on Ageing, 2005); however the New Zealand Positive Ageing Strategy (NZPAS) explains that to "age in place" means to "be able to make choices in later life about where to live, and receive the support needed to do so" (Ministry of Social Policy, 2001 p10). It does not appear from this that the intention is for the process to take place in the person's own home. Marek and Rantz (2000) define AIP as being able to remain in the same place as the individual's care service needs change. They note that the key feature of AIP is the "separation of type of care [from] place of care" (Marek & Rantz, 2000 p2). Therefore AIP envisions that, as a person ages and service-intensity needs change, it is not necessary that the location in which they receive these services changes.

Different countries have different perspectives on AIP. The UK approach places emphasis on 'staying put', usually in the one's own home, as opposed to a 'nursing home', or RH (Means, 2007). US models of AIP have seen the development of a third branch of ARC, called an Assisted Living Residence (ALR), which provides more care than is feasible for one's own home, but a lower level of assistance than would be provided in a nursing home (Mitty, 2004). Australia's approach to AIP has been to adapt existing RHs into AIP-capable facilities, via the introduction of multiple levels of care in the one facility so the person may stay in the one place as their care needs change (Commonwealth Department of Health and Ageing, 2002). New Zealand's approach has placed more emphasis on ageing in the community, which tends to involve staying in one's home as opposed to going into residential care.

AIP initiatives are very attractive to governments and other funders of long-term care because they appear to offer cost savings. Up to a certain level of care intensity need, it is cheaper for the elderly individual to remain in their own home rather than be moved to a RH facility, even though the individual may require funding for in-home care support and installation of some facilities (such as hand-rails or ramps). However, there is some critical point where the level of degeneration, and bundle of services required by the individual, make it cheaper for them to be cared for in a long-term care facility. Shepperd and Iliffe (2006) performed an objective systematic review investigating the economic benefit of in-home care (or 'hospital at home') services and found insignificant evidence that there was any economic benefit. Marek

and Rantz (2000 p2) note that implementation of the AIP model has the most success “when provided to individuals living in congregate or geographically close locations”.

In October 2006, the University of Auckland reported on its economic evaluation of the Assessment of Service Promoting Independence and Recovery in Elders (ASPIRE) study. In this, they studied three AIP initiatives and compared their costs and benefits with “usual care” pathways (which involved a mix of residential and community care). Benefits were measured in terms of days of residential care avoided and days of deceased avoided. The findings were that all three AIP initiatives were more expensive⁷ (ranging from an ICER⁸ of \$20 per person for the lowest cost initiative to ICERs of \$271 and \$340 per person for the more expensive initiatives) than ‘usual’ pathways of care, but all three initiatives increased days spent in the community (by both reducing days spent in residential care and reducing days of deceased) (Parsons *et al*, 2006).

There are also social benefits to the AIP model which is one reason why it receives a significant amount of support. It has been promoted by the OECD since 1994 and represented in the NZPAS where goal five is for “older people to feel safe and secure and [able to] age in place” (Ministry of Social Policy, 2001 p1). Among the holistic aims of AIP are the following objectives. Prevention of isolation of the older person by enabling them to receive care in their dwelling within the community, rather than moving them to a ‘nursing-home’ where it is considered they will only receive contact with a narrow cohort within the community. Prevention of upheavals in the latter years of the individual’s life by discouraging the idea that the individual has to move every time their care needs change, (where evidence suggests that the health of a “frail” elderly person deteriorates with each move (Marek & Rantz, 2000)). Recognition of the preferences of the large majority of elderly people to remain in their homes; Marek and Rantz (2000) note that the wider public has a largely negative perception of nursing-homes and so too do the elderly, most of whom want to remain in their own home.

⁷ Sensitivity analysis showed that these results were sensitive to the time-period of evaluation - time spent in residential care settings increased the cost of care pathways.

⁸ ICER – an Incremental Cost Effectiveness Ratio. A method of cost-effectiveness analysis which subtracts from the total cost of the scenario at hand (i.e. the AIP initiative) the cost of the baseline scenario (i.e. the ‘usual’ pathway of care) and divides by the benefits of the new scenario minus the benefits of the baseline scenario.

In order to ensure safety and security of the individual while they are receiving devolved care, there are a number of aspects of care delivery that require attention. Care delivery mechanisms, workforce training, on-going education and feedback and complaint mechanisms would have to be well-developed and frequently evaluated.

Devolved care is not a new concept and care delivery in the primary setting has for long been an accepted model of care. However in order to make AIP initiatives work, development of what the Health Workforce Advisory Committee (HWAC) refer to as “non-regulated workforce” (including healthcare assistants, residential care support workers and in-home carers) is necessary. Health Workforce Advisory Committee (2006) found that pay, guaranteed work, training and potential for career advancement are all issues for staffing the industry.

With devolved care, it is easier for a person to ‘fall through the cracks’ unless soundly monitored. Complaints mechanisms will need to be stronger for those who receive care in their community because they can be more vulnerable to abuse. If neglect or mistreatment occurs in an ARC facility, it is arguably easier to pick up on because there are multiple people dealing with the person and more likelihood of someone observing the abuse. If elder-abuse occurs in a homecare environment, it is between the elderly person and the abuser, so they are more easily intimidated; this can mean the abuse is less likely to be observed and exposed.

An additional issue with AIP initiatives is the burden AIP places on the family of the elderly person, particularly their spouse. An elderly married couple will not generally become infirm at the same rate. This means that when one partner enters the frail, ‘very-old’ stage of life, the other partner is required to pick up the ‘slack’ or perform the duties that, had their partner been in a RH, paid staff would see to (for example, helping them to the toilet at night). For a person who is elderly themselves, this can be exhausting and take its toll on their own health.

In all, AIP is no panacea to resolve the burgeoning costs of providing long-term care, though it has merit in terms of its social objectives. In order to meet these holistic objectives, development of AIP delivery mechanisms, and in particular the workforce delivering the care, is necessary. The evidence on cost-effectiveness of AIP does not lend itself to the conclusion that RHs are a thing of the past, though the role of these and RV complexes are inevitably changing so that some of the functions performed

by RHs might disappear or be replaced with other functions which may include aspects of facilitating AIP.

7. The Future of the Aged Care Market.

So far we have examined the ARC sector, looking at a number of current trends that are likely to have an impact on the cost and delivery of care. This section discusses the possible future implications of the issues currently facing the ARC market. It is speculative to infer from present trends what the future will look like. Rather we offer conceivable scenarios arising in response to these trends.

7.1 Summary of Issues Facing the Aged Residential Care Market

Mushrooming Over-65 Population

Section 5.2 discussed the challenges presented by the ageing population on the ARC market. Along with the number of over-65s coming to represent 25% of the population by 2051, the largest change will be that occurring in the over-85 group (the older-old) who are projected to increase 600% by mid-century. The increase in the proportion of the population over 65, and the considerable proportional increase in those over 85, will significantly increase the demand-side pressure on government resources.

Ageing of the Health Workforce

An additional implication of the ageing population concerns the ageing of the health workforce (summarised in section 5.2: Ageing of the Health Workforce). Both the GP and nursing workforce exhibited an increase in the average age of its members. This will place a strain on residential and other forms of elder care on the input-side; already it is difficult to attract and retain staff in the ARC sector.

Changing Nature of Long-Term Relationships

Section 5.3 investigated other demographic trends relating to family structure that could have implications for the ARC market. Section 5.3: Marriage Dissolution and de facto partnership, suggested that there was a decrease in the marriage rate, an increase in the divorce rate and an increase in numbers of people in de facto unions.. Due to the fact that demand for ARC seemed to be increasing in unpartnered households, partner status was significant for this analysis. Speculating on the evidence, the impact of changes in marriage and divorce rates is ambiguous,

depending on whether increased divorce rates are matched by increased rates of (re)marriage or entry into de facto relationships.

Declining Birth Rates

Declining birth rates are also significant. It was noted important role played by the family in providing in-kind care to the elderly person. It is therefore reasonable to expect that, with the decline in the number of children in the average family and more people remaining childless, more of the burden of care for the ageing person will fall to the government.

Changes to Consumers' Tastes and Preferences

Section 5.5 discussed changes in consumers' tastes and preferences regarding residential (and other health) care. In particular minimum acceptable standards of healthcare service have risen. This has implications for ARC providers and the government, such as an increase in the number of complaints regarding service levels they receive, particularly from subsidised clients. The government might find itself facing additional lobbying, this time coming from end-consumers of ARC, which could in turn create additional pressure on the government to raise RCS levels.

Industrial Action in the Healthcare Sector

Recently, there has been significant industrial action taken by nurses and carers in the ARC sector as well as in-home care workers in response to low pay and poor working conditions in this sector (section 5.6). In December 2005, members of the NZ Nurses' Organisation and the Service and Food Workers' Union took strike action against a number of ARC providers over pay levels for ARC nurses and other ARC workers. The pay parity issue is an important one, especially as the public and private sectors compete with one another for staff. This, in itself, is not a problem and in fact would be beneficial for the ARC market, however, due to the government's price-setting function, the "gatekeepers and poachers" problem as mentioned in section 5.6 arises.

Homecare workers seem to be the most under-represented and are perhaps the most under-valued group of workers in the aged care sector. Poor pay, unsubsidised mileage and a lack of financial incentives for undertaking training and up-skilling have left the homecare sector in a state of uncertainty and high turnover. These issues

will pose a significant challenge to the government if it aims to increase the numbers of elderly people who have their care needs catered for in their own home.

Emerging Structure of the ARC Market

Section 5.7 discussed the impact of changes to the market structure of ARC providers. Although there were many providers of ARC, there were a few large firms that would have significantly more market power than the smaller providers. On the other hand, the demand side for rest home care was characterised by significant market power held by the government.

The government's demand side power at present appears to exceed that held by the providers, and is effective for keeping the size of subsidies down. However if the supply side gets stronger, for example if the proportion of beds in the operated by the largest firms increases, this will increase provider bargaining power, both in terms of lobbying and possibly employing signalling tactics such as bed-blocking. It is important to note that the market is still in transition and so the power levels have yet to be worked out⁹.

Ageing in Place

This paper devoted a special section to AIP strategies, given their growing importance in New Zealand and the rest of the world. The section noted the different meanings of AIP, including those used overseas, particularly in Australia, where the implementation of AIP strategies does not signify the demise of the RH. The ASPIRE study was mentioned as showing that an AIP pathway was not the more cost-effective option compared with the 'usual care' pathway, but had more socially desirable outcomes.

AIP is affected by workforce issue discussed in section 5.6. In order for AIP to be a viable alternative to low-level ARC, resources need to be devoted to improving staff training and remuneration. Training of homecare nurses might be up to an acceptable level already; but for homecare workers who do not require formal nursing training but who provide personal care for elderly people, training seems absent, usually due to funding issues. Section 5.6 mentioned that it was not feasible for contractors to provide training for their workers at their own expense, nor was it worthwhile for

⁹ This paper has not examined the implications of such changes as the merging of existing large suppliers into one or two very large firms, or what might happen if a long term care insurer enters the market to compete with the government on the demand-side.

workers themselves to fund their training as this will not generally be accompanied by any significant increase in pay. These pay issues were another point of contention in particular for informal carers. Low rates of pay and lack of mileage payments results in very high turnover amongst these workers. If these conditions persist, it will undermine attempts to improve AIP. If homecare becomes chronically short-staffed then higher-need elderly people cannot be adequately or safely cared for in their own home and so will have to move to an ARC facility. In addition to adequacy, there is the matter of dignity as well to consider. High turnover may mean that the elderly patient is having their personal care needs attended to by frequently changing carers which can be uncomfortable and degrading.

The issues mentioned above by no means exhaustively cover those faced in the implementation of AIP; they merely represent some of the areas which will require resources devoted to them to make AIP a feasible alternative to low-level care in a RH.

7.2 Is the Sector in Crisis?

There are multiple perspectives on whether the ARC sector is in crisis. What we would expect to see, if the market for ARC were hopelessly inadequate, is a raft of shut-downs in the industry and little or no entry of firms, resulting in widespread shortages of ARC beds. That would precipitate what could then be termed a crisis. This section will discuss the analysis undertaken in this paper, drawing in commentary from various ARC representatives to provide an industry perspective to the discussion.

It is not the case that the sector is in crisis. The exit of charitable organisations has been more than matched by the entry of for-profit firms. There have been no bed shortages, and one industry representative suggested that it is this factor that informs the government's decision not to increase the subsidy to the levels proposed by providers.

Accusations that the sector is 20% underfunded have mainly come from charitable-providers. However Guardian Healthcare Managing Director David Renwick believes that these charitable organisations tend to “bury themselves in infrastructure”, having 15-20% more staff than the for-profit providers. That said, he notes that corporate entry into the market has not been to take advantage of the RH portion of

the sector. He suggests instead that the for-profit providers are entering the sector for strategic reasons, including the fact that, with an ageing population, the sector is going to get larger, not smaller, and that overseas precedent indicates subsidies cannot be arbitrarily maintained below what makes provision of certain services viable. Rather than seeing positive economic profits right now, they see the government as eventually having to respond to lobbying to raise the RCS up to viable levels. Otherwise, it may get to the point where RHs/PHs employ bed-blocking techniques because it becomes unviable to continue to take on clients.

Martin Taylor, CEO of Healthcare Providers New Zealand, offers the further possibility that, at current subsidy levels, providers will defer maintenance and upgrades, be unable to raise pay-levels of their staff and will eventually exit the market.

8. Conclusion

It has often been said that the ARC sector is a sector in crisis. Over the course of this paper, we have attempted to analyse the various components of the current debate; outlining the impact that characteristics of the industry such as its demographic environment, the support it gets from the government and other organisations, and the demand and supply issues facing the market, will have on the sector both now and into the future.

What we found was that the ARC sector is perhaps not a sector in crisis but it is definitely one in the throes of considerable transition. What we may therefore expect from such a sector is considerable *planning* - planning to meet the expected upsurge in demand resulting from the ageing population, the changing structure of the population, the evolution of consumer tastes and planning to manage this increased demand within the context of the pressures ageing will put on the input side of the market.

With the entry into the ARC market of the large for-profit organisations, both in the areas of rest home and retirement village provision, supply does not seem to be diminishing. It may therefore be said that the 'invisible hand' side of the market is working as expected. However, this market is made up of a significant visible hand component which is the government; the major buyer of rest home services. On this demand side, it is difficult to see the same level of planning that might be expected for

a growing sector such as this one. Rather, there appears to be heavy reliance on the presence of for-profit organisations as evidence that subsidies do not need to be increased and considerable faith that in-home AIP initiatives will be the future of aged care.

There is some danger in this lack of planning. As a society, we have the information before us; there is little doubt of what the future trends will be: the population *will* age, and with it the aged care workforce. These and other factors mean we will see pressure put on the supply side of the market when there is also pressure in the opposite direction on the demand side. Therefore, if there is not sufficient planning while we still have time, this sector might emerge from its transition straight into a crisis.

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