

Submission on:

Inquiry of care that older New Zealanders experience

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July 2010

Elder Family Matters is a small company providing homecare services for the elderly for 10 years. Services are offered in Wellington, Hutt Valley, Wairarapa and Kapiti. Elder Family Matters does not hold contracts to government agencies (ACC, MoH, or DHB)

Thank you for the opportunity to provide a written submission into the Inquiry of care that older New Zealanders experience. This submission is related to the home based care provision in the Wellington, Porirua basin, Hutt Valley and Kapiti regions. This submission covers 6 areas of concern, 3 suggestions for alternatives and 3 recommendations.

Areas of concern

1. Identification of needs

The semantics of “needs-based care” is problematic. The aged person benefits from a range of care along a care continuum. “Needs-based care” firmly places power into the hands of a health agency (the DHB, and in Wellington and Hutt Valley the NASC agency - Nurse Maude) to define where the level of care provision will occur along that care continuum. The decision of where “needs” are on that care continuum is arbitrarily defined by fiscal constraints and externally defined tools (InterRAI). Therefore, the defining of “needs” is based on meeting DHB policy, MoH policy, and inherently, government policy. An alternative semantic is “wants-based care”. A change in semantics from “needs” to “wants” would truly be consumer-centred, client-centred, patient-centred, or older person-centred.

2. Quality of service provision

The process of contracting is limited to few providers. This decision is driven from a motive of reduced transactional costs for the DHB rather than quality of care. Fewer providers = fewer transactional costs. This policy motive therefore limits the contracted providers to large organisations driven from a profit motive. This profit motive is irrespective of whether that profit is a) to shareholders or b) to retained earnings and growth orientation which is common in the poorly and incorrectly labeled “not-for profit” sector.

All contracted providers see their role as solely to meet the terms of the contract. Their complaints about (a) insufficient funding and the flow-on negative effect on caregiver training and quality of service, and (b) insufficient financial returns, are directed at the contracting agency (DHB, ACC). It would be more valuable if the contracted providers focused their energies on improving internal processes and demonstrating greater willingness to operate with fiscal frugality.

3. Equity of care

A key premise is that elder care is available for all the elderly based on a health system that provides for all needs through a single process. The difficulty is that equity of care as the predominant modus operandi promotes standardised care rather than personalized care, and therefore reduces the emphasis on quality of care. As a result of standardised care contracted home-based care agencies spend more energy on retaining contracts and market share than seeking to improve the quality of their service. The process of retaining market share is being able to be in the single process and preventing other capable organisations from getting into the process.

The single process in home based care in Wellington and the Hutt Valley is

- a) a referral, often from a GP or hospital, to the Care Coordination Centre (Wgtn), Service Coordination Centre (Hutt Valley) as a NASC (Needs Assessment and Service Coordination),
- b) the allocation of a package of care from the NASC to a contracted provider,
- c) the provision of care to the health consumer by the contracted provider as per their contractual requirements with DHB.

In this process the individual health consumer does not have any choice in their care provision.

The GPs as the primary referral agent are protected from being informed about any alternative care providers. We continually find barriers to informing GPs of the services that private care agencies offer. It could be argued that there is concern that by raising the opportunity for private care the inadequacy of current funded care arrangement may be spotlighted.

The Care Coordination Centre assesses health consumers against the InterRAI tools and can only refer health consumers to contracted agencies. The contracted agencies provide the specific tasks (e.g. showering).

4. Anti-competitive practices

The contracted agencies are in a privileged position. They offer health consumers (who are referred to them) with additional care services e.g. making beds, cooking a meal, doing the laundry and ironing in addition to the funded care. The consumers pay for these additional services privately. This means that other companies providing private services are inhibited from competing. We would expect that a Commerce Commission complaint directed at the DHB over uncompetitive practices would likely be upheld.

5. Ineffective accountability

The contracted agencies are not held to account because:

- health consumers don't easily complain about poor service;
- the DHB does not wish to remove a contract because this requires a new tendering process involving time and cost;
- the DHB and the contracted providers have a close and ongoing working relationship (which non-contracted agencies are not party to) which they would not wish to have jeopardised.

6. Multiple carers and poor coordination

There are usually several different players in an older person's home at different times responding to their needs/wants. This includes: Family, friends, neighbours, voluntary agencies, contracted agencies, and private companies. Under the current contracted provider arrangement (where only defined tasks are completed) there is often a lack of coordination about the actual care for the consumer, with multiple carers blaming each other. This situation is described in greater detail in our presentation to the Institute of Policy Studies Aged Care forum on May 21st 2010. Paper and presentation is accessible from www.elderfamilymatters.co.nz/Articles/Elder+Family+Matters+influencing+aged+care+policy.html

Alternative options for care

Alternative 1

Replace contracted agencies with approved agencies. Consumers can choose any agency that is registered as an approved home care provider. We believe that registration should, at a minimum, require the agency to be maintaining the NZ Standard 8158 Home and Community Support Standard which requires external audit.

Alternative 2

Consumer feedback becomes a role rather than service co-ordination. Annual results of health consumer feedback are published and provided to any potential health consumer when selecting a care provider.

Alternative 3

A voucher model. Consumers access a voucher for care services that can be taken to any registered care provider (NZS 8158) for the care services identified.

Recommendations

Recommendation 1

Change the semantics of “needs” to “wants. Replace “needs assessment” with “wants assessment”.

Recommendation 2

Remove the alignment of Needs Assessment and Service Coordination (NASC). They are two distinct processes. We recommend one process being “wants assessment” and the other process being “service information” including publication of consumer feedback.

Recommendation 3

Replace contracted agencies with funding towards packages of care. The elderly (or their representative) can then choose the amount and type of care they want depending on both the funded resource available (DHB fiscal position), personal resources available (savings and investments), and willingness to contribute personal resources towards their own well-being.

Results of these recommendations

As a result of implementing these recommendations for home based care service the government will realise the following advantages:

1. Fiscal management. The government can more accurately budget for home care support allocation.
2. Elderly citizens retaining independence and being valued. Independence is not about doing everything yourself but being in control of what is being done with you. This independence can only occur when health consumers take a share in the responsibility for their own care.
3. Political risk management. The combination of both public and private partnerships reduces the risk on government accounts and government perception in meeting the needs and wants of the burgeoning elderly population.

