CASE STUDY: AGED RESIDENTIAL CARE

PREPARED FOR THE NEW ZEALAND PRODUCTIVITY COMMISSION
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SECTOR BACKGROUND

The aged residential care industry is a privately provided health service funded through regulated prices, often subsidised

1. Aged residential care is part of the continuum of health services available to people over 65.[1] The services generally situate between and overlap with home support/community nursing and public hospital care. Currently, over 35,000 New Zealand residents live in around 670 private facilities around the country (Appendix: Figure A.1). Aged residential care combines health services with accommodation and daily living services (social interaction).

2. In 2017/18 expenditure on aged residential care expenditure was around $1.9 billion per year, with District Health Boards (DHBs) spending around $1.1b and residents through a legislated financial means test of income and assets contributing $0.8b (excluding extra charges)[2]. DHBs are responsible for ensuring sufficient supply for people they have assessed as requiring long term care indefinitely. There are four defined levels of care (rest home, dementia, continuing hospital, and psycho-geriatric) with differences in funding, certification requirements, and contractual obligations. After negotiation between DHBs and providers, regulated prices for services are set. [3] The prices are intended to cover both operating and capital costs across the facility. Providers are responsible for determining inputs (i.e. workforce, buildings) and allocating resources (i.e. care, food, beds) across residents.

3. There is no limit on the number of providers[4]/facilities but the facility must be certified under the Health and Disability Services (Safety) Act 2001 by the Ministry of Health (HealthCERT), meet all normal business regulatory requirements, and have a contract with a District Health Board. Certification and the contract incorporate a range of obligations, including some staffing requirements, on providers.

4. Since 2000, changes to the aged residential care system (care models, funding structures, regulation) have been incremental rather than fundamental.

Demand for services is expected to continue to grow, somewhat reflecting New Zealand's ageing population

5. While population ageing (Appendix 1: Figure A.2) is the main driver of demand, it has not and is not expected to be a fixed determinant. Moreover, while the oldest age groups are growing faster than the rest of the population, they are and will still be a relatively small part of the overall population with only a percentage of them using aged residential care, generally towards the end of their life

6. Over time, there have been developments that have increased the age of entry into care (Figure 1) and changes to the type of care required (Figure 2) such as that while numbers requiring care increase, the percentage of people over 75 requiring aged residential care has decreased. Most people entering care now are over 80 with a median stay of 18 months[5]. There is, however, significant variation in both the entry age and stay (between a few days to over 10 years) which impacts on what is appropriate care for an individual.

[1] With a few exceptions for people under 65

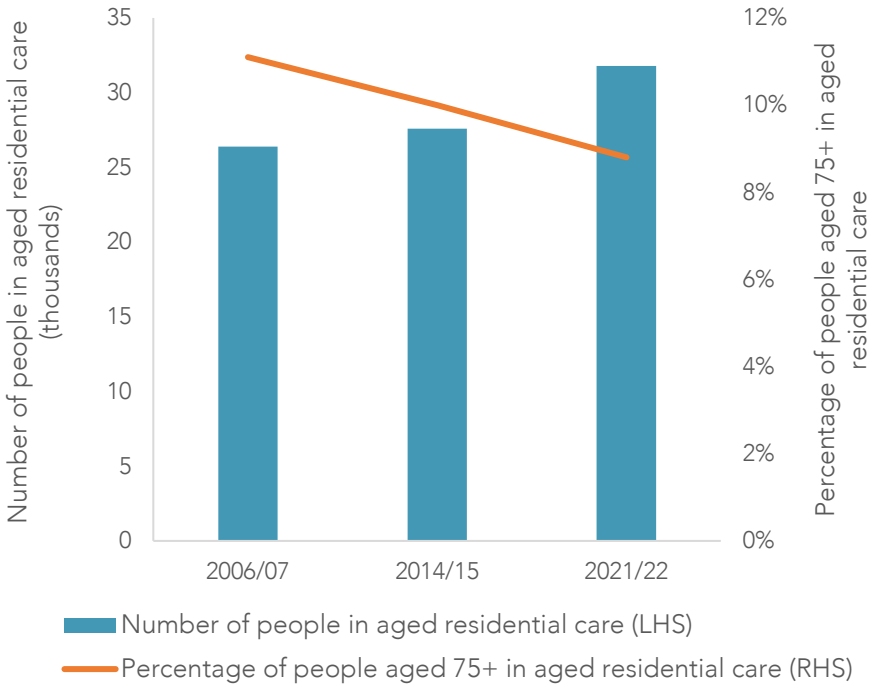
[2] Ernst&Young. Aged Residential Care Funding Model Review. Ernst&Young, New Zealand 2019, p63

[3] To opt out of the system, the entire facility must opt out which makes it infeasible for higher levels of care.

[4] Provider is the term used for the entity which has the contract and certification which can be a subset of a firm.

[5] Ernst&Young. P 9

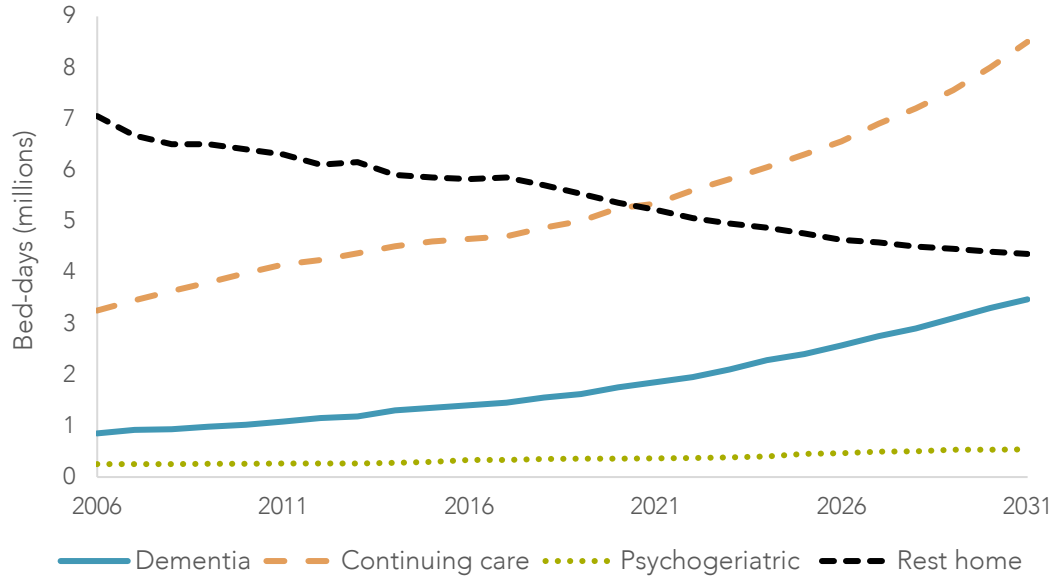
Figure 1 **Aged Residential Care Demand Planner, Central Region's Technical Advisory Services (TAS)**



Source: Ministry of Health. DHB Spending on services for older people. www.health.govt.nz/nz-health-statistics/health-statistics-and-data-sets/older-peoples-health-data-and-stats/dhb-spending-services-older-people

7. Whether residential care is needed (even if assessed as an option), depends on the individual's circumstances (such as family support or possible home renovations), and other local services (such as prepared food delivery, community nursing, home visiting, or home personal care). As more alternative services have been developed, most older people entering residential care, have some form of cognitive limitation and/or multiple co-morbidities. The result is increases in the more complicated caring areas associated with continuing hospital care and dementia care and decline in the lowest level of care (ie, rest home). This trend is expected to continue (Figure 2). The average caring task now compared to 2000, and into the future, is requiring higher skill levels in the workforce.

Figure 2 Actual use of ARC (2006-17) and projected demand for ARC (2019-31), by care category



Source: EY analysis; ARC Demand Planner, using the past 10-year trend.

8. The sector estimates that over a 10 year period, resident numbers will grow in the range of 12 – 16 thousand which at a 95% occupancy would require an average of 10-14 new large 120 bed facilities each year.[6] Roughly speaking, there is approximately a 1-1 resident-employee ratio taking the entire workforce into consideration meaning they would be looking for about 12-16 thousand people with a range of skills.

Trend in industry structure and Investment has been towards larger and groups of facilities which are driving economies of scale, new management systems, and flexible use of labour within limits

9. There are a range of ownership structures and facility sizes. Providers can be commercial for profit (77%), charitable (21%), owner-operated, publicly listed, or foreign owned (by aged care multinationals or equity firms). In this sector, a non-profit status does not mean small or stand alone. Large groups[7] control 49% of facilities in different locations (either within or across regions) and have 60% of the sectors beds. The trend since 2000 has been away from a single owner-managed rest home facility to larger facilities that provide all levels of care, except specialised psycho-geriatric care, and that individual providers are part of a group of providers (for example: Ryman, Oceania, BUPA).

10. Larger and multiple facility groups allow for economies of scale in workforce and operational overheads. It also facilitates more flexible use of workforce, particularly, skilled workforce. Many providers are adopting the concept of dual-use beds which represent an increase from 19% in 2013 to 36% in 2020 of total bed supply. The traditional system has been to designate a bed / wing of a facility as either residential care or hospital care. A dual-use bed is available for either rest home or hospital level care depending on the needs of the resident. Having dual service beds requires the provider to have a workforce, particularly Registered Nurses (RNs), that can be flexibly used across units to reflect the makeup of the residents at a time. It also benefits residents in that they are less likely to have to move if their care needs change. Facilities with dual service beds must be able to meet the regulatory, audit, and contractual obligations for both levels of care.

11. The larger organisations are also able to introduce new management systems (including clinical and human resource overhead roles covering multiple facilities). Their size also allows them to undertake more inhouse training, and have a wider range of roles and enhanced career progression. Historically, independent

[6] New Zealand Aged Care Association. *Submission to the Productivity Commission's Issues paper on Immigration, Productivity and Wellbeing.* 5 October 2021

[7] The NZAGA has defined a large group as a situation of a number of connected via ownership facilities which collectively control more than 200 beds

care homes often had nurse manager/owners which reduced RN turnover but provides fewer career options for employees.

12. Analysis undertaken recently by EY on costs[8] found that it was difficult to earn an adequate return from either small or very large facilities. Inputs are lumpy, and up to a certain size they benefit from increasing economies of scale but then need additional lumpy inputs

13. The trend to attach aged care facilities to retirement villages, i.e., alternative housing for older people able to live independently with capital to invest, has resulted in spare bed capacity. In 2020 sector occupancy was less than 90%[9]. This is a change from the previous decade when many facilities were fully occupied. Attaching care homes to villages has been in response to consumer preferences, they sell better. The aged residential care facility and the village have business links but are managed and funded separately. Many residents in a retirement village's care home, particularly when first developed, have never lived in the independent units. More recently the management/care provision distinctions are being blurred as some older people are buying rooms or units that become part of the certified aged residential care services. The financial returns from these developments are not about the return from aged residential care but from housing developments (land and capital).

14. Aged residential care facilities (and their staff) may also provide alternative services to people not usually resident such as respite, day care programmes, rehabilitation which are funded separately.

WORKFORCE

Registered nurses and caregivers/Kaiāwhina[10] are the critical workforces for aged residential care, each with their own supply tensions

15. The NZACA[11] estimate that there are 36,000 people employed in aged care homes, with 72% (25,920) being caregivers/Kaiāwhina and enrolled nurses, 19% (6,840) registered nurses and 5% (1,800) activity coordinators. The remainder are non-care workforce including chefs/cooks, cleaners, nonclinical managers.

16. While there is some potential substitution of tasks, registered nurses (RNs) and caregivers/Kaiāwhina operate in different labour markets. RNs are tertiary qualified, regulated health practitioners and must be accredited to practice. Besides direct care, RNs often perform management (and at least supervisory) roles. Critically, they are professionally responsible and accountable for meeting specific regulatory and contractual roles in the facility, including that there is sufficient staff to meet the needs of residents.

17. Enrolled nurses (low numbers) can perform specific but not all nursing tasks and cannot be allocated the specific regulatory and contractual roles. With the recent changes in the competency framework for caregivers/Kaiāwhina, the potential for overlaps in roles with enrolled nurses has increased.

18. Caregivers/Kaiāwhina are part of the unregulated health workforce performing tasks focusing on individual personal supports (those requiring touching or behavioural encouragement) and where trained, take on additional tasks (medication, health tests). While no training is required to be employed as a caregiver/Kaiāwhina, providers have to ensure a minimum level of inhouse induction training on facility procedures, care expectations and close supervision to ensure resident safety. With the pay-equity settlement, providers also have to take reasonable steps to provider workers with the opportunity to attain qualifications (see paragraph 42).

[8] Ernst & Young. Interpretation from page 163

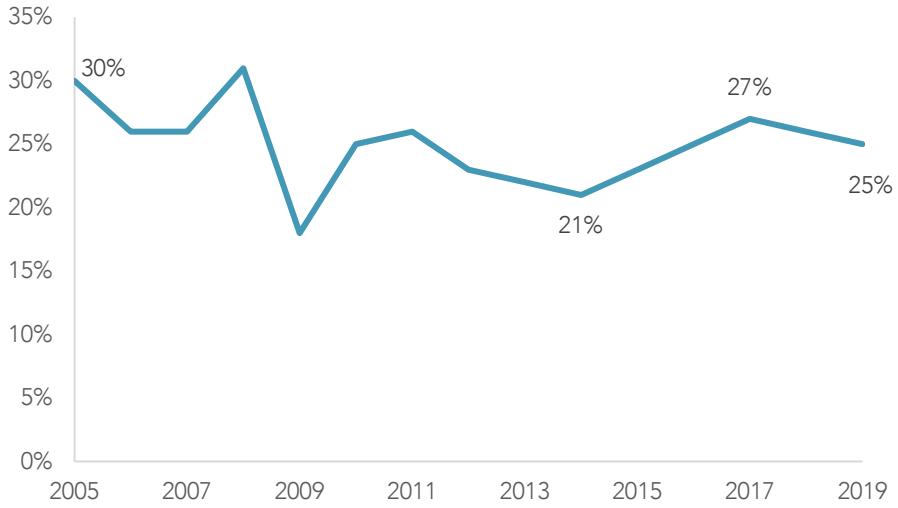
[9] McDougell John. Aged Residential Care Industry Profile 2019-20. New Zealand Aged Care Association, Wellington. P 3

[10] Kaiāwhina is the over-arching term to describe non-regulated roles in the health and disability sector. The term does not replace specific role titles such as healthcare assistant, orderly, mental health support worker.

[11] New Zealand Aged Care Association Submission to the Productivity Commission. 5 October 2021

19. The sector's turnover between 2005 and 2019 ranged between 21 and 30% excluding 2009 (Figure 3 below).[12] The turnover is higher than for the DHB health workforce (around 16%) and the New Zealand workforce. In December 2019, turnover for RNs at 33% is higher than for caregivers/Kaiāwhina at 23%.

Figure 3 Twelve-year trend in annual turnover of the ARC workforce



Source: ARC industry profile 2019/20.

20. In the October 2018 NZARC RN Vacancy and Turnover Survey, only 22% of RNs ceasing employment with an aged residential care provider stayed in age care; 49% moved to a DHB, and others to new fields, overseas, or retirement.[13] Most caregivers/Kaiāwhina (75%) ceasing employment with a provider leave the New Zealand aged residential care sector and 11% (9% being migrants) went overseas[14]. Further information on what these workers do after working in the sector wasn't identified.

21. The sector's survey on Vacancies in December 2019 highlights the relative difficulty of recruiting RNs: 7.5% of RN and 6.2% of Clinical Manager positions were vacant compared to 3.2% for caregivers/Kaiāwhina[15]. This is not unexpected, as there is a significantly wider pool of potential candidates for the latter role.

22. The contracts and standards establish minimum staff to resident ratios. As a result, with a few exceptions, facilities can operate with some positions being vacant. The immediate response to a staffing constraint would be to not admit new residents, followed by reducing activities which do not affect clinical safety but which can reduce the breadth of services to residents. However, without a minimum level of RN/Clinical manager coverage, a facility would need to close. In the short term, these positions may be filled by agency staff or through support from a DHB.

23. A number of groups, particularly unions and consumer advocates, have had an ongoing concern over whether the sector is using sufficient labour to ensure quality and safety for residents. They argue for increases in minimum staffing requirements relying on studies which have shown a positive relationship between higher levels of staffing and quality & safety for residents. The difficulty with prescribed staffing to resident ratios is that they do not reflect actual resident needs in a particular facility. The DHB contracts and the Health and Disability Standards instead focus on obliging clinical managers to ensure staffing meets actual resident needs which can be independently assessed through audits. This allows innovation and recognises that the mix of residents can have very different needs at any given time while providing an avenue for accountability through professional obligations.

[12] McDougell John. P 38

[13] New Zealand Aged Care Association. *Submission to the Review of Essential Skills in Demand List 2018: Submission on moving registered nurse (aged care) to the Long Term Skill Shortage List*. October 2018.p 9

[14] McDougell John. P.41

[15] IBID p.40

The migrant workforce[16] (short term, skilled, and permanent) are a large source of the aged residential care workforce by 2019

24. The NZACA has estimated almost 40% of RNs and some 40% of caregivers/Kaiāwhina are on visas[17]. This is significantly higher than the sector leadership, 17 % of clinical managers and 5% RN facility managers are on visa (very few being temporary). Some 14% of the remainder of the ARC workforce are also migrants on visas. This includes workers on permanent resident visas (noncitizens)– many of who are long run residents. Information from 2019 immigration data identified that 20% of the aged residential care workforce were recently arrived with 12% on temporary visas and 8% on resident skilled migrant visas. RNs are more likely to be on resident tracks than caregivers/Kaiāwhina. The aged residential care sector is not only a significant employer of recent migrants but long-term immigrants. This has also been found in other studies[18].

25. The sector became more reliant on new migrants by 2019; while the sector's workforce grew by 11% between 2012 and 2019, the temporary visa workforce doubled and the skilled resident migrant visas workforce increased by 54%[19].

26. The aged residential care workforce is overwhelmingly female, greater than 90%, and above average labour force age (54% are between 45 and 64 and it is not unusual to have staff over 65). Males, however, represent a higher portion of essential skills visas averaging 23% for RNs and 24% for carers/Kaiāwhina over the 2013/14 to 2017/18 period. Migrants on these visas were also younger (most are between 25 and 34)[20].

Registered Nurses are largely on resident-focused visas

27. To practice as a RN, migrants have to be accredited by the New Zealand Nursing Council. It assesses a migrants education equivalence and work experience to New Zealand trained nurses. Most international nurses in aged care need to complete a competence assessment programme (CAP) before being registered. There are about 20 programmes available across the country, generally in the polytechnic sector, who work with hospitals and some aged care providers for the practical components. As part of recruitment, aged care providers may offer placements to CAP studies, make direct offers to those already in CAP training, and offer to meet the cost of a nurse's CAP course. Foreign fee for CAP typically ranges from 6-9 thousand.[21]

28. The breakdown of visa types in aged residential care for RNs is outlined in the following Table 1. [22]

[16]Migrant encompasses all workers in New Zealand on visas regardless of their nature

[17] IBID p.42-25 provides data on migrants used in this paper unless otherwise noted. This includes the DHB related tables.

[18] Two studies are: Twaddle Shaun and Masrur Khan. *Health and Disability Kaiāwhina Worker Workforce 2013 Profile.* Berl April 2014. www.berl.co.nz and Badkar Juthika, Paul Callister, and Robert DIdham. *Ageing New Zealand: The growing reliance on migrant caregivers.* Institute of Policy Studies, July 2009.

[19] Information came from a matching of Migrant Employment Data to IRD data by Productivity Commission

[20] Collins, F., & Pawar, S. (2021). Temporary migration, employment and income inequality. National Institute of Demographic and Economic Analysis. University of Waikato. Hamilton. P.6

[21] New Zealand Productivity Commission. Notes of meeting with the Nurses Organisation on 22 September

[22] McDougell John. Page 42

Table 1 Breakdown of RNs on visas by type of visa

Visa type	RNs on visas	Clinical nurse managers on visas	Facility managers on visas
Long Term Skill Shortage List or other Work to Residence visa	39%	56%	29%
Long Term Skill Shortage List Resident visa, Skilled Migrant Category Resident visa or other Resident visa RNs	23%	34%	57%
Essential Skills work visa or other temporary visa that is not Work to Residence	24%	6%	7%
Is an IQN but no information on visa type or residence status available	6%	0%	7%
Other	8%	4%	0%
Total on visas	100%	100%	100%

29. Majority of RNs are on resident focused visas. The RNs can (and do) once any visa and contractual commitments are met, use their qualifications in other parts of the health sector. Of the RN migrant group, the largest numbers are Filipino and Indian. These ethnicities are also significant in the DHB hospital sector workforce. In 2018/19, the Nursing Council identified that 61% of all employed registered nurses in New Zealand are of New Zealand/Māori/Pacific ethnicity and 45% of other ethnicities with largest being Filipinos and Indians[23]. Respondents are allowed multiple answers. The proportion locally trained is higher at 72.5%, with 9.3% have been trained in the Philippines, 4.9% in India, 7% in the United Kingdom and the rest elsewhere.[24] As New Zealand's citizenry becomes more ethnically diverse, this could reflect a second-generation training, but at this point, it is likely associated with local training of an immigrant workforce.

30. The Philippines has been particularly strong avenue for nurse recruitment as under the ASEAN-Australia-New Zealand Free Trade Agreement, New Zealand agreed to offer a streamlined path to registration for Philippine nurses. They need to meet the relevant English language requirements and attend a short bridging course.

31. Antidotally, aged care providers are currently finding it rare to receive applications from New Zealand qualified nurses when recruiting.

Caregivers/Kaiāwhina migrant workforce are employed from a range of non-skilled base visa categories, often temporary visas

32. The caregivers/Kaiāwhina migrant workforce has grown from around 20% in the 1990s [25] to around 40% by 2019. The NZACA survey of providers indicated that around 64% were on temporary work visas, 19% on resident visas and 17% unknown visas[26]. Those on resident visas will have entered New Zealand through avenues such as permanent family, refugee, Pacific, partner categories and then found employment in aged residential care. An examination of immigration-IRD data base shows slightly more than a third of the temporary visas are essential skills (employer sponsored) and the other two thirds are family, post study and other visas finding work in the sector.

[23] Nursing Council of New Zealand. (2019). *The New Zealand Nursing Workforce: A profile of Nurse Practitioners, Registered Nurses and Enrolled Nurses 2018-2019.* Wellington: Te Kaunihera Tapuhi o Aotearoa/Nursing Council of New Zealand. P. 22

[24] Ibid. p. 41

[25] Badkar p.12

[26] McDougell John. P 46

33. The ethnicity of the migrant workforce has also changed from the Pacific and United Kingdom towards the Philippines and India.

34. Short term migrants that are being directly recruited from overseas by providers would be expected to have some form of training/experience that benefit the provider even though it is not a job requirement for local purposes. The Ministry of Health has identified 1000 migrants with foreign nursing qualifications working as Health Care Assistants. While it is not automatic, there is a training and competency pathway that a migrant can pursue to progress/return to nursing. The health sector has been working on making the pathway more attractive/usable to migrants that are in the country.

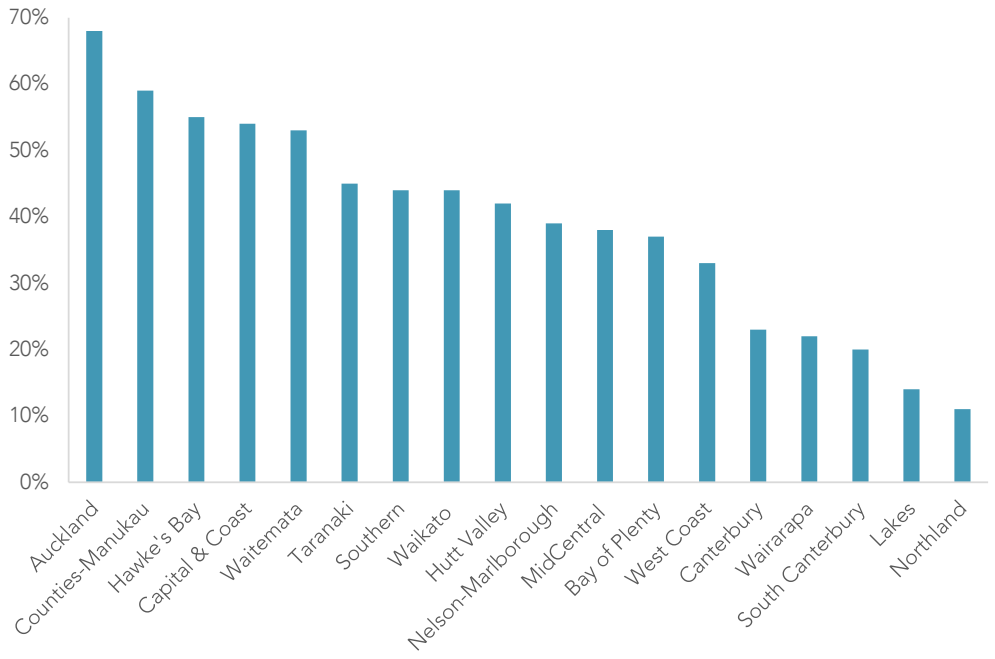
35. Temporary migrant worker visas (even for 3 years) are often not the preference of either the employer or migrant. The jobs being filled are not temporary.

The migrant workforce is located unevenly across New Zealand regions and varies over time across regions

36. The sector's migrant workforce is not evenly distributed across New Zealand. Two sources of locational information have been identified: an NZACA survey of their workforce and the immigration-IRD data set. They are not directly comparable because they treat migrants residing in New Zealand over 5 years differently. The NZACA identifies workers on visas regardless of time in New Zealand and the immigration-IRD data only distinguishes migrants in New Zealand less than 5 years. This is a significant difference and means that the results cannot be directly compared. They both, however, show significant regional variation.

37. The NZACA's survey of their workforce showed that the percentage of registered nurses on visas[27] (Figure 4), ranged from 11% in Northland to 68% in the Auckland DHB area and over 50% across the Auckland region. This percentage was also greater than 50% in Hawke's Bay and the Capital and Coast (Wellington) DHBs. For large DHBs, in 2019, the providers in the Canterbury DHB were distinctly less reliant on RN migrants at 23%.

Figure 4 Percentage of RN workforce on visas by DHB region



38. For caregivers/Kaiāwhina (Figure 5 below), employees on visas were 7% in Northland and 62% in the Auckland DHB with the rest of the Auckland region DHBs and Whanganui DHBs being greater than 50%. Many DHB regions caregivers/Kaiāwhina on visas were in the range of 20-40%[28].

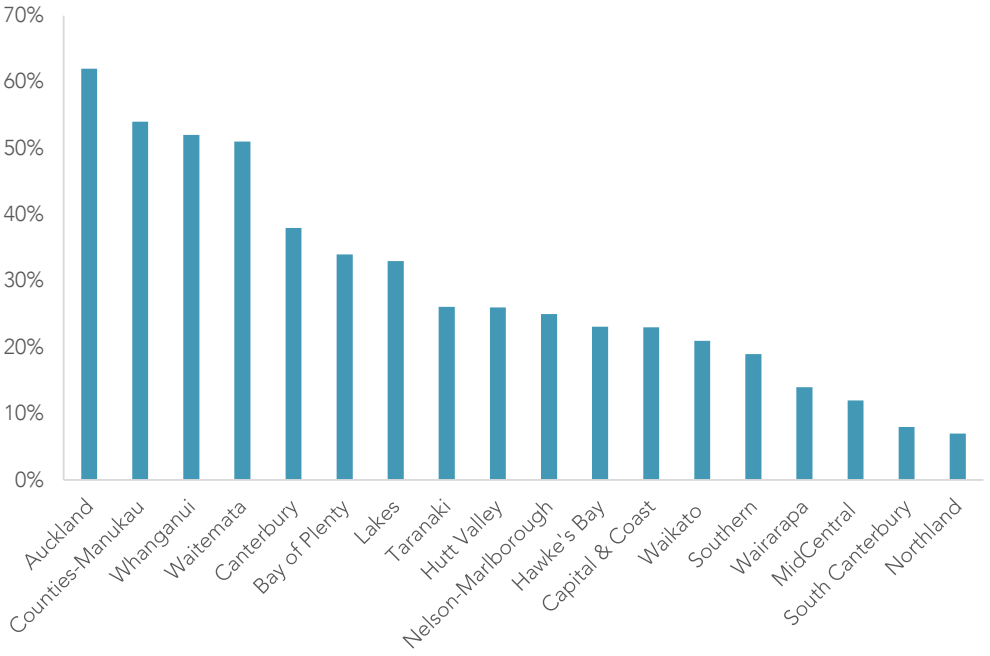
[27] McDougell John. P.43

[28] Ibid. p.44

39. The immigration-IRD information highlights that employment of migrants is also variable over time. For recent skilled migrants (mostly RNs), 41% of the migrants went to Auckland and 12% to Canterbury DHB in 2012 but in 2019 25% went to Auckland and 29% in Canterbury. Variation over time is also observed in respect of the temporary essential skills visa.

40. Identifying reasons for the variation requires further investigation. It is likely to be influenced by type of provider (smaller providers in rural areas), whether there is a new facility, and alternative employment opportunities for females in a region. There has also been commentary that once residence is achieved and contract terms completed, migrants staying in the sector prefer to move to urban centres [29].

Figure 5 Percentage of caregivers on visas by DHB region



Wages are determined through a mix of employer, DHB, and Government decisions at different times

41. The aged residential care sector is a low pay sector in the economy and compared to DHBs. While wages are determined by each provider either on an individual contract or through a union contract, since 2000, government intervention (contractually and legislatively) directing specific funding to the workforce (to RNs and/or caregivers/Kaiāwhina) has occurred a number of times.

42. The most significant initiative has been the legislatively-provided pay-equity settlement for caregivers/Kaiāwhina in 2017 covering aged residential care and home support. The pay-equity settlement's expectation was that wage increases together with a sector-wide career progression and training framework would change the perception of caregiving as a minimum wage-minimum skill sector. The pay schedule applied between 1 July 2017 to 1 July 2021 starting at $19 per hour for no qualifications and no experience to $27 per hour for L4 qualifications or more than 12 years of experience (Appendix: Table A.1). The experience component of the settlement is for existing employees, and new employees' wages will be determined by their progression through the career framework qualifications. This settlement was funded at $2.2 billion for aged residential care and home support sectors through to 30 June 2022[30]. This included funding for employers to facilitate training. Employers are required to take reasonable practical steps to ensure the workers can attain qualifications. The length of time will depend on individual circumstances with the expectation that fully

[29] Ibid. p 46

[30] Ministry of Health. 2020. *Care and Support Workforce Qualification Attainment*. Wellington: Ministry of Health page 3

completing qualifications could take 6 years while working. Employers are allowed to have higher wages than required by the settlement.

43. The training and career progression framework relates to the New Zealand Qualifications Authority's *Certificate in Health and Wellbeing* or its equivalent recognised by the Industry Training Organisation (ITO). Nurses working as caregivers/Kaiāwhina (regardless of their registration/enrolment status) are paid on the level of service with their current employer and when they have achieved two "culturally focused unit Standards" are deemed to be at Level 4[31]. A simple summary of the levels is:

- Level 2 is entry with a focus on providing person-centred tasks in a health setting and being able to recognise and report changes in a person
- Level 3 includes increased skills in recognising vulnerability or abuse and working under direction of a health profession to respond to changes in a person's situation and supporting their independence
- Level 4 focuses on working with people with complex needs and taking a leadership role.

44. As part of the New Zealand Work Research Institute study evaluating this change, providers responded that they had not observed a significant increase in New Zealanders applying for caregivers/Kaiāwhina positions as a result of the settlement. Instead, it was noted that they received an increase in applications from migrants (often on short term visas)[32]. Providers also argue that they have been underfunded for the agreement, particularly if they have relatively more long-term employees who were automatically at the top of the scale. There was a positive response from a number of workers choosing to undertake training. However, with the recent minimum wage increases to $20 in 2021 and $21.20 in 2022, the beneficial wage gap for recruitment has declined.

45. In December 2017, aged care RNs had a median salary of $58,240[33] which was close to the bottom of the DHB RN salary range of 52,460(graduate) to 70,820(top scale). While DHBs funded a pay increase, the sector argues that as of December 2020 their nurses are paid on average $10,000 less than in DHBs.

46. These initiatives appear to be associated with a reduction in turnover in 2019, particularly through the caregivers/Kaiāwhina Pay Equity Settlement restricting the experience benefit to the 'current' employer.

47. NZACA identified 30% of their workforce as unionised; 60% for nurses, 39% for caregivers/Kaiāwhina 39%, and 5% for noncare workers. Unionisation is highly variable across facilities.[34] The sectors two key unions - E Tu (caregivers/Kaiāwhina) and Nurses Organisation- seek significant wage increases for their members. They (and providers) have directed their efforts on targeted funding increases from Government and DHBs. Unions have had some success with this approach. Both Unions agree that there are workforce shortages for the sector and accept that a migrant workforce is part of the current picture. They have expressed concern that migrants are less likely to join a union than the local workforce.

48. While not confirmed, it is quite feasible that migrants are being paid less than locally trained staff at same experience levels. This occurs in the pre-registration period for nurses (as their scopes of practice are restricted) and where overseas caregiving experience or training is not matched to the new caregiving competency framework. There have also been concerns about internationally trained nurses being able to meet language requirements to complete registration.

[31] Douglas Julie and Katherine Ravenswood. The Value of Care: Understanding the impact of the 2017 Pay Equity Settlement on the residential aged care, home and community care and disability support sectors. New Zealand Work Research Institute, Auckland, New Zealand. 2019. P. 9

[32] Ibid. p. 16.

[33] New Zealand Aged Care Association. *Submission to the Review of Essential Skills in Demand List 2018: Submission on moving registered nurse (aged care) to the Long Term Skill Shortage List*. October 2018.p 6

[34] McDougell John. P. 52Table 11.2

ATTRACTING LOCAL WORKFORCE

Alternatives to migrant workforce would require attracting local workers from other sectors (both health and the wider economy) and an increase in the number of RNs being trained

49. No documentation/commentary has been identified that indicates that the hiring of migrant workers is pushing out local workers in the 2000-2020 period. The significant use of a migrant workforce in aged residential care is not about bringing in unique specialised skills, but about filling workforce gaps. RNs and caregivers/Kaiāwhina raise different considerations when thinking about attracting local workers.

50. Training, prior experience and regulation are not constraints for employing caregivers/Kaiāwhina and they are recruited from the wider local workforce. Local unemployment rates across the wider economy would be expected to be a key factor. Therefore, given New Zealand unemployment rates, a significant lift in wages and conditions would be required to attract a replacement local workforce into this sector from other parts of health sector and the wider economy.

51. While various formal training initiatives can support more rapid adjustment to work and improve quality and breadth of services provided, they are not a requirement to being employed. The hiring of inexperienced caregivers/Kaiāwhina primarily requires increased supervisory input from experienced staff and nurses. However, the skill mix of the workforce has been changing and given the trend that residents will be frailer and sicker, there will be an expectation that the workforce is upskilling. For the caregivers/Kaiāwhina workforce, literacy becomes critical – need to be able to read and understand instructions, undertake formal ongoing training, and use information technology. As previously noted, a sector-wide career progression and training framework has been developed.

52. The New Zealand Aged Care association in its various submissions on government policies has noted that a number of their providers work with schools, training providers, and Work and Income NZ (WINZ) to find school leavers and other people in New Zealand with the interest and potential to work as caregivers/Kaiāwhina. They have training contracts with WINZ to train beneficiaries to become caregivers/Kaiāwhina. An initiative with Medcall Recruitment Company was mentioned as an initiative which was not particularly successful in that from an initial potential 531 applicants only 25 worked as caregivers/Kaiāwhina.[35] Some providers employ unqualified people in non-contact roles as home assistants or kitchen hands and then into caregiving positions. A few larger organisations have their own private training establishments to train caregivers/Kaiāwhina. It is not uncommon to see caregiving positions advertised on community social media pages.

53. On the other hand, RNs are tertiary qualified, requiring formal courses over 3 years and specifically approved practical experience. Economy-wide unemployment is a less significant factor for attracting New Zealand trained RNs in the medium term. Rather the options for attracting RNs to the aged residential care sector is about competing for RNs with the rest of the health sector. In 2022, the demand for RNs across the health sector is greater than the supply. Since 2019, Covid 19 testing, vaccination and staffing of managed isolation and quarantine facilities has required a significant amount of RN input and diverted this resource from other parts of the health sector, including aged residential care.

54. At a regulatory and contractual level, there are no special requirements of an RN to work in aged residential care. It would be expected and desirable, as a practical matter, that the clinical managers/most senior RNs in a facility would have had some sector experience and have chosen to focus their ongoing professional training in the care of older people. The RNs, like all regulated health practitioners are expected to meet ongoing training obligations.

55. One of the factors affecting the aged residential care sector's ability to attract RNs is the growth of alternative employment options for RNs. The role of nurses in primary care and community settings has been expanding. RNs, also, can specialise and become nurse practitioners who see clients directly to diagnosis and treat, including prescribing a range of medications which otherwise be undertaken by General Practitioners. Oceania, a large group of aged residential care providers, has employed nurse practitioners to support their

[35] New Zealand Aged Care Association. *A new approach to employer-assisted work visas and regional workforce planning Submission to the Ministry of Business, Innovation and Employment (MBIE).* 18 March 2019 p. 5

residents across a number of their facilities to address difficulties in getting General Practitioner support for their residents.

56. In the short term, aged residential care could employ all nurses graduating in New Zealand. Figure 6 below[36] identifies numbers of graduating nurses since 2010. There was a significant increase between 2010 and 2013 that has remained relatively flat since at around 1750 completions. In 2019, there were at least 2700 people with a skilled migrant visa working in residential care.

Figure 6 Annual completions of a bachelor level nursing programme in New Zealand, 2010-19

57. While numbers graduating in recent years have remained relatively steady, there has been a change in makeup of students enrolling in nursing such that there is now a relative increase from secondary school and reduction from workplaces and other tertiary study (figure 7)[37].

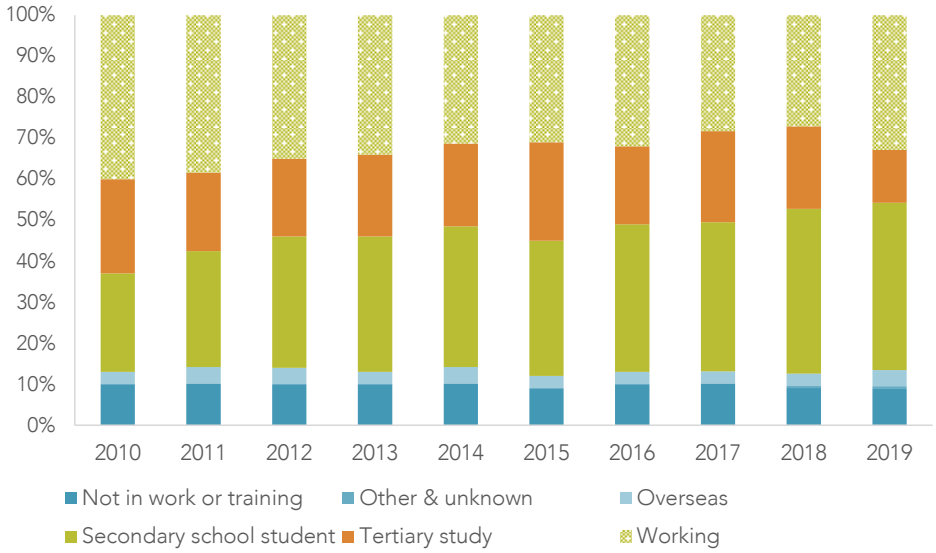
58. At a sector leadership level, aged residential care nurses are participating with Ministry of Health and DHBs on initiatives to increase the overall nursing workforce and for aged care. On 14 February 2022, the Ministry of Health announced[38] an initiative to fund former nurses to return to the healthcare sector. The funding would be available for approximately 200 nurses. They estimate that there are more than 20,000 New Zealand-trained registered nurses who are not practicing and more than 1,000 internationally qualified nurses working in aged residential care as health care assistants who may be eligible for this support.

[36] Pather Kamini. *The New Zealand Nursing Pre-Registration Education Pipeline.* TAS Kahui tuitui tangata, Wellington New Zealand. June 2021. P7-Figure 6.

[37] Ibid. P5 Figure 3

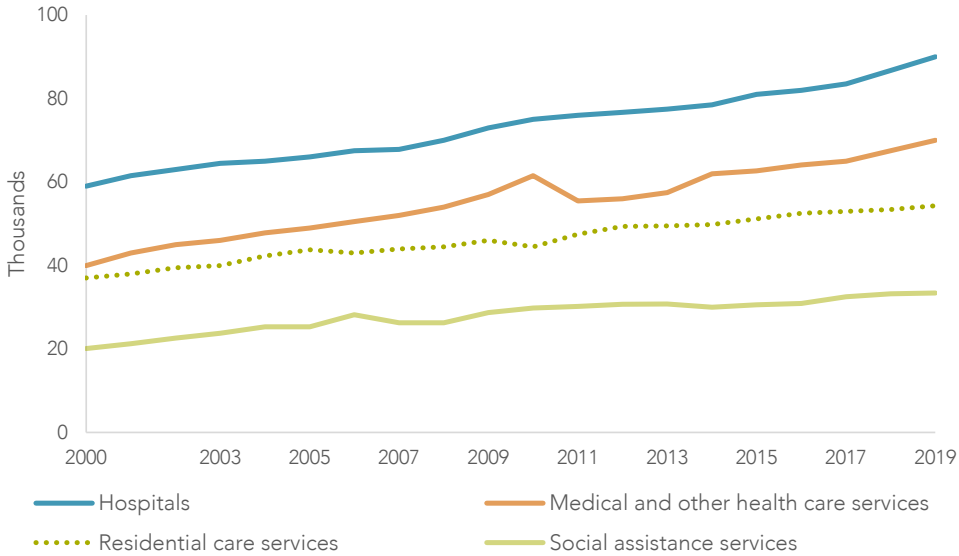
[38] Ministry of Health. 14 February 2022 Media Release: *Million dollar fund launched to help nurses return to practice*

Figure 7 Prior activity of students starting a nursing bachelor course by first enrolment year



59. The aged care sector is expected to continue to compete with other areas of the health and social services sector for workforce. Both RNs and caregivers/Kaiāwhina can work in other parts of the wider health sector. Health based and social based agencies, such as those providing disability services, employ caregivers/Kaiāwhina. Figure 8[39] shows that the residential care workforce has grown slightly less than the workforce in other parts of the health sector before 2020.

Figure 8 The number of people employed in the health care and social assistance sector, 2000-19



Source: Stats NZ.

60. New Zealand trained RNs also can work internationally. Various Australian states have regularly recruited from New Zealand generally offering higher rates of pay. The U.K. has also been a desirable work location for New Zealand trained RNs. The actual extent to which emigration of RNs is contributing to shortages was not identified and would need further investigation.

[39] Ministry of Health. *The cost and value of employment in the health and disability sector*. Wellington: Ministry of Health. October 2020. P.9

ALTERNATIVE CARE SERVICES FOR OLDER PEOPLE

Aged Residential Care is part of a spectrum of services with alternatives (with their own workforce and cost limitations) available

61. There are alternative formal publicly funded services (home support and public hospitals) which may also provide aspects of care provided by aged residential care. In addition, family or the older person can arrange and pay for supports they need. Informally (unpaid), family can also directly support the older person.

62. These alternatives are important when looking at productivity –both for capital and labour. Older people needing support do not necessarily require 24 hour care. Recognising that older people prefer staying in their homes as long as they possibly can, the health system has been focused on expanding home support services. Services provided in an older person's home will have lower physical capital requirements than an institutional setting. In many cases, these services would also require fewer workers and use the workforce differently. Technology is also more likely to be used for monitoring and facilitating selfcare in a home setting. A constraint is having the appropriated skilled workforce available to travel to people's homes. In addition, at some point, services provided in the home becomes more costly (and less flexible) than providing care in a facility.

63. The question that could be asked is whether the workforce issues for the formal home care sector are different than aged residential care. Home care providers face many of the same issues as residential care providers. Caregivers/Kaiāwhina, the primary workforce in the home support sector, also face many of the same issues as their residential care counterparts– with two additional characteristics: they need to be able to travel around to clients and it is more often part-time/split- shift work. Many of the initiatives focused on developing this workforce do not distinguish the two settings – residential and home. As home support has taken on more complex care, the requirements on providers in respect of managing their staff are also increasing. Expectations are that these providers will have more health professionals, often RNs, supervising and undertaking care coordination functions, and ensuring that the workforce meets the needs of the individual older person (such as ensuring different levels of skilled caregivers/Kaiāwhina for different complexities). This sector, while growing, is smaller than the aged residential care sector. The role of migrant workers in the sector is unclear.

64. If there were no aged residential care facilities, there would need to be an expansion of aged-related public hospital care. Care in an aged residential care facility rather than a hospital is usually cost effective and supports public hospital productivity by reducing the average length of stay, as older people often require longer stays. This allows more people to receive hospital services with the same inputs and/or requires less physical capital (from reduction in ward sizes). Hospital use often leads to entry into residential care. In 2016, 78% of people admitted to aged residential care had been previously admitted to a public hospital in either 2015 or 2016, and of these 8.4% had been hospitalised less than a week before entering residential care.[40] The average hospital-level ARC bed in 2016 was $238 per day compared with an average of $1,000 per day for stay in a DHB hospital medical ward[41].

NEW TECHNOLOGY

Technological developments are likely to reduce the rate at which demand for aged residential care grows

65. Adoption of new technologies is unlikely to disruptively reduce the demand for care workforce soon. Rather new technology and innovation is expected to continue to improve the nature of the work, support changes to workforce mix, and reduce expected demand for aged residential care:

- internationally, there are research programmes focused on preventing and/or slowing the progression of dementia (both behavioural and pharmaceutical); dementia is and expected to be increasingly a significant driver of entry into residential care

[40] Ernst&Young. Aged Residential Care Funding Model Review. Ernst&Young, New Zealand 2019 p.128

[41] New Zealand Aged Care Association. *Submission to the Ministry of Health on Health of Older People strategy Update*. 6 September 2016. New Zealand Aged Care Association website. P.3

- technologies such as respiratory supports, portable dialysis equipment can shift care into the residential care sector from public hospitals and also if sufficiently portable into people's homes
- equipment supports and design adaptations to beds and wheelchairs has reduced the importance of physical strength of carers (to lift people) so more older workers can be employed
- international research and development on using robots and artificial intelligence in care homes has had some success, particularly, in signalling which residents are having difficulties and in entertaining lonely residents.

INTERNATIONAL COMPARISON

New Zealand is not unique in the workforce and population dynamics it faces for aged residential care

66. New Zealand is not alone in facing an ageing population dynamic and difficulties in meeting the workforce required for aged residential care. It is of sufficient policy concern, that the OECD has a Long Term Care work programme to address related policy concerns.[42] Unattractiveness of employment in aged residential care appears to be an issue in most western industrialised economies. While formal care has been around for decades, caring for older people was traditionally unpaid and undertaken by families or, if necessary, as part of charitable activities. Furthermore, improved education and wider employment opportunities for women have contributed to a decline in available local workforces.

67. At a broad level, New Zealand's aged care services output and input structures (including employment of migrant workforce) are similar to those across many countries – including Australia, Canada, and United Kingdom.

68. The OECD review of long-term care identified Israel (71%), Ireland (48%), Canada (34%), Switzerland (31%) and Australia (29%)[43] as having the highest use of migrants in aged residential care. New Zealand did not participate in this survey. The OECD also found that most of these migrants would be considered overqualified for the jobs they are doing because of the nursing training they had undertaken in their home country.[44]

69. The dominance in recent years of migrants from the Philippines and India is also not unique to New Zealand but also reflected in Australia and Canada's aged care source countries[45]. These source-countries have developed processes (and training) that facilitate emigration.

COVID 19 CONSIDERATIONS

70. Covid 19 pressures has worsened workforce shortages, particularly for registered nurses, in the sector. This is not only because of border restrictions but because of increasing demand in other parts of the health sector (public hospitals, vaccinations, and MIQ facilities). The Council of Christian Social Services in their submission to the Productivity Commission's Immigration inquiry indicated that the 860 aged residential care RNs who have resigned or handed in their notice since March 2021 were departing to: 60% to DHB public hospitals, 30% to other aged care providers, 6% to MIQ, 8% to become vaccinators, and 12% elsewhere. [46] International demand for RNs is also high as all countries, including source countries, are responding to Covid. For example, the Philippines has restricted emigration to all countries of their nurses to 6,500 to assist in the Philippines's covid response.[47]

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[42] See www.oecd.org/els/health-systems/long-term-care.htm

New Zealand is not actively participating and rarely shows up in the comparison tables.

[43] OECD. *Who cares? Attracting and Retaining Care Workers for the Elderly. Chapter 2.3 LTC workers' profiles are unchanged.* OECD website: oecd.org/els/health-systems/long-term-care.htm . Figure 2.6.

[44] Ibid.

[45] Ibid.

[46] New Zealand Council of Christian Social Services. *Submission to the Productivity Commission on Immigration, Productivity and Wellbeing* inquiry (p.2)

[47] New Zealand Productivity Commission. *Notes of meeting with the New Zealand Aged Care Association.* 23 July 2021

71. For caregivers/Kaiāwhina, the Government's automatic extension of visas has been welcomed by providers. The post Covid recruitment picture is less clear. If the pandemic fundamentally changes the economy's structure (such as for tourism), there may be an opportunity to attract more local workers to caregiving and potentially nursing. For nursing, there are transition considerations including training constraints both for university level course work and practical placements within DHBs. In addition to DHBs, a few aged care providers, who can meet the training expectations of course providers, are participating in these practical placements. The situation for caregivers/Kaiāwhina is different: courses can be established on site and experience can be obtained via employment rather than placements.

SUMMARY

72. Over the last two decades, the aged care sector has been growing with the ageing of New Zealand's population. While providers are private, the government and public entities influence or set many of the operating parameters. The sector has faced a relatively stable funding framework (centrally regulated prices with subsidies, DHB contracts) and certification system. Changes to frameworks have been incremental rather than fundamental. Industry structure and investment have moved towards larger facilities and being part of a group of facilities which have driven economies of scale, new management system and opportunities for more flexible use of workforce. Labour remains the critical input, particularly RNs and caregivers/Kaiāwhina. The sector is adapting to provide more complex care with expectations of increasing and differing skills. These trends are expected to continue.

73. Migrants, defined as employees on visas, are a significant source (around 40% in 2019) of the aged residential care sector's critical workforce. They are in New Zealand on a wide range of visas, both short and long term, skilled and unskilled work visas, as well as, other visas. While employees on short term visas have been increasing, the sector also employs noncitizens who have been in New Zealand for many years.

74. RNs are tertiary-degree trained and regulated health professionals. Those who are foreign trained need their qualifications accredited by the Nursing Council. Supplementary New Zealand based training is often required. The sector competes with other parts of the health sector for qualified RNs which also have had difficulties recruiting within New Zealand and are significant employers of migrants. Migrant nurses are currently critical to allowing various providers to operate. Furthermore, the aged care sector has provided information which identifies that their nurses often move to District Health Boards when their current employer obligations are completed. Addressing RN shortages is a health sector-wide concern. The numbers being trained are not meeting the increasing demand across health services. Nursing workforce shortages, particularly in aged care, are not unique to New Zealand with a number of countries, such as Canada and Australia, also seeking to attract nurses from abroad.

75. Caregivers/Kaiāwhina are unregulated with minimal entry requirements. As such, the sector can recruit broadly from the New Zealand labour force. The 2017 pay-equity settlement introduced a legislated minimum pay scale and a training-career framework for these workers with the aim of making the sector a more attractive employment option. At the time, the pay scale started above minimum wage In the future, workers are expected to have better communication and literacy skills to participate in training. Attracting local workers, however, continues to be difficult in certain locales. While requiring further analysis, the availability of alternative employment for women could be contributing to local recruitment difficulties.

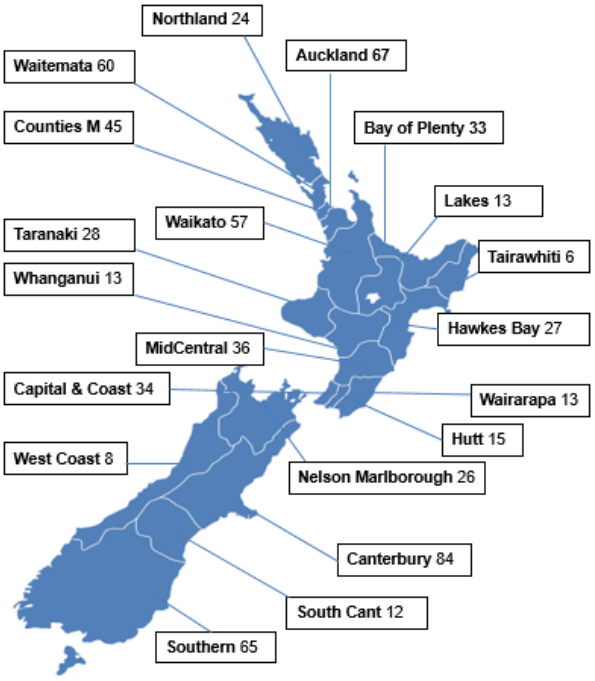
76. While a migrant Caregivers/Kaiāwhina workforce is important to the provision of these services, the employment of short-term migrants is not about the sector accessing specialised skills but addressing ongoing workforce shortages. The positions being filled are not temporary or seasonal. As demand for services continues to grow, the sector will continue to need more workers. The relative benefit to the New Zealand economy from increasing the employment of local workers rather than migrants in aged residential care will depend on where they are drawn from.

77. Difficulties in recruiting an aged care workforce is not unique to New Zealand. There is international competition for migrant aged care workers. Recent source countries, such as the Philippines and India, are often the same.

78. The sector's productivity has increased as it becomes more focused on providing complex care. Without the sector's services, this care would need to be provided through other means – such as within public hospitals, community nursing, or by family. As such, the sector also supports hospital productivity. While there will be opportunities to adopt new technology and innovative practice, for the foreseeable future, a care workforce will continue to be the critical input into the sector's services.

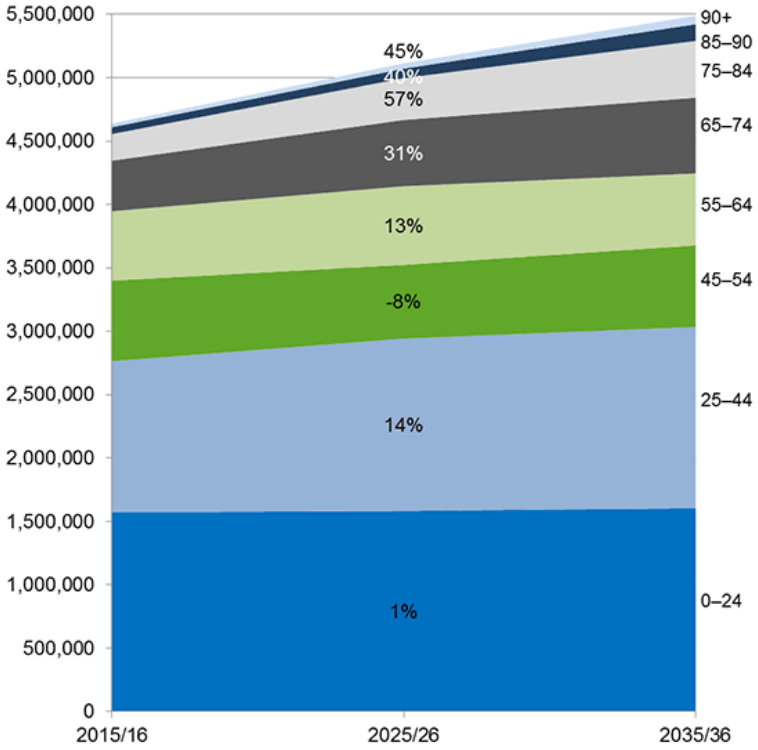
Appendix A

Figure A.1 Distribution of aged residential care facilities in 2016



Source: Central Region's Technical Advisory Services (TAS), Survey of Aged Residential Care Facilities March 2016.

Figure A.2 Projected population growth, by age group



Source: Ministry of Health website: https://www.health.govt.nz/nz-health-statistics/health-statistics-and-data-sets/older-peoples-health-data-and-stats/our-changing-population

Table A.1 Pay-Equity Settlement Pay Rates

Qualification or length of service	1 July 2017 Year 1	1 July 2018 Year 2	1 July 2019 Year 3/4	1 July 2021 Year 5
L0 or <3 years' service	$19.00	$19.80	$20.50	$21.50
L2 or 3+ years' service	$20.00	$21.00	$21.50	$23.00
L3 or 8+ years' service	$21.00	$22.50	$23.00	$25.00
L4 or 12+ years' service	$23.50	$24.50	$25.50	$27.00

Source: Ministry of Health website: www.health.govt.nz/new-zealand-health-system/pay-equity-settlements/care-and-support-workers-pay-equity-settlement/pay-equity-settlement-information-employees

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