Case study: aged care regulation

Issues for future regulatory design

Complaints mechanisms

- Multiple complaints mechanisms within a single regulatory regime may confuse the public, dissuade people from lodging complaints, lead to duplicative complaints, and make it harder to use complaints data to identify system-wide issues. These issues can be managed by having a common contact point, a clear division of labour between the complaints bodies and policies for referring complaints between them, and clearly-allocated responsibility for collecting and analysing complaints data.
- Multiple complaints avenues can make sense where there are efficiency gains in specialisation. However, any efficiency gains need to be weighed against the benefits that would arise from consolidating services, sharing assets, and reducing customer confusion.

Delegating regulatory functions to non-government organisations

- There can be good reasons to delegate regulatory functions (such as compliance and monitoring) to non-government organisations, including:
  - a desire to see greater innovation in the achievement of regulatory objectives,
  - recognition that the expertise required to monitor compliance lies outside government and it is more efficient to make use of existing capability, or
  - the interests of the external monitoring parties are aligned with the objectives of the regime.
- Delegation to non-government organisations can, however, create real or perceived perverse incentives, which may undermine a regulatory regime's credibility. Delegation should be accompanied by robust oversight processes that directly control sources of perverse incentives or collect data to assess whether they are posing a risk.

Incentives for performance improvement in regulatory systems

- Where quality improvement is a desired outcome from a regulatory regime, clear signals can be provided about the impact of performance improvements on regulatory decisions. Examples of such signals include:
  - publication of the decision-making framework used by regulators;
  - communication with providers after regulatory decisions have been made, to outline how improvements in specific areas would translate into more favourable decisions in future;
  - higher grades awarded in the decision-making framework for top performance.
- However, it is important to test that the public benefits of having more providers achieving top performance levels outweigh the costs.

Performance reporting and transparency

- Regular public reporting on the performance of a regulated sector can help promote confidence in a regulatory regime and identify systemic issues, regardless of whether the information drives consumer behaviour. Ideally, performance reporting systems should be introduced at the same time a regime is being implemented.

Regulating public services

- In establishing a regulatory regime for public services, it is helpful to think through the relative

roles of the funding and regulatory arrangements. Funding arrangements may permit faster enforcement action, but can be less useful for raising performance across the whole system in the absence of substantial failures, or for revealing information to consumers about relative performance.

1.1 Introduction

As part of its inquiry into regulatory institutions and practices, the Commission has been tasked with preparing case studies to identify "broader insights into the design and operation of regulatory regimes." This case study describes the regulatory regime covering the delivery of aged residential care and discusses five main regulatory design issues:

- The benefits and disadvantages of multiple complaints mechanisms;
- When to delegate regulatory functions (e.g. monitoring compliance) to non-government parties;
- Developing incentives for performance improvement in regulatory regimes;
- The role of performance information and transparency; and
- The roles of regulation and funding in enforcement of public services.

1.2 The aged care sector

In 2011, there were just under 31,000 New Zealanders in institutional long-term residential care: 5.1% of all people aged 65 and over, and 11.6% of all people aged 80+ (OECD 2012).

Residential care is provided through rest-homes, dementia units, long-stay hospitals and psycho-geriatric facilities. The majority of facilities provide a mix of services (e.g. rest home and hospital services). Only providers that are certified by the Ministry of Health may receive public funding for aged care services, which is delivered through regional District Health Boards (DHBs). As at 7 November 2013, there were 663 accredited aged care providers, the majority of which were privately-owned (Ministry of Health 2013; New Zealand Aged Care Association 2013).[1]

The Government subsidises residential care for people aged 65 and over, who meet both a needs and financial means assessment. The needs test is performed by DHBs and assesses an individual's eligibility for residential care. To enter DHB-funded residential care, an individual must be assessed as:

- having "high, or very high needs which are indefinite (ie, the person's condition cannot be reversed)"; and
- being unable to be safely supported within the community. (Ministry of Health n.d.)

The financial means assessment applied depends on the individual's circumstances, in particular whether the person in question has a spouse or partner and whether the spouse or partner is also in long-term care. In the 2012/13 financial year, $928 million was spent on aged residential care and $269 million was spent on home-based support services (Goodhew 2013).

Aged care facilities are increasingly located in retirement villages. A 2012 survey of New Zealand Aged Care Association (NZACA) members found that 38% of aged care facilities were co-located with a retirement villages, and that these facilities provided 47% of all aged care beds. Compared to 2011, the number of aged care beds located in a retirement village had increased by 18% (NZACA 2013).

[1] The 2012 survey of NZACA members found that 76% of facilities were privately owned, with the remaining 24% owned by charitable/religious/welfare organisations. The privately-owned share had increased from 68% in 2005.

1.3 The legislative framework

Health and Disability Services (Standards) Act 2001

The main statute governing aged care is the **Health and Disability Services (Standards) Act 2001 (HDS Act)**. The Act's purpose is to:

> (a) promote the safe provision of health and disability services to the public; and
> (b) enable the establishment of consistent and reasonable standards for providing health and disability services to the public safely; and
> (c) encourage providers of health and disability services to take responsibility for providing those services to the public safely; and
> (d) encourage providers of health and disability services to the public to improve continuously the quality of those services (section 3).

Other relevant legislation

Other relevant statutes are the **Health and Disability Commissioner Act 1994**, which establishes the Health and Disability Commission (HDC) and the **Health Practitioners Competence Assurance Act 2003**, which sets out the occupational regulatory framework for health professions. The purpose of the Health and Disability Commissioner Act is to:

> to promote and protect the rights of health consumers and disability services consumers, and, to that end, to facilitate the fair, simple, speedy, and efficient resolution of complaints relating to infringements of those rights (section 6)

If an aged care resident is unable to make or communicate a decision themselves, decisions may be taken on their behalf, through an enduring power of attorney, a personal order or a Court-appointed welfare guardian or property manager. These powers and protections are provided through the **Protection of Personal and Property Rights Act 1998.**

Aged care providers that are also retirement villages are subject to the **Retirement Villages Act 2003**. The primary purposes of the Act are to:

> (a) to protect the interests of residents and intending residents of retirement villages:
>
> (b) to enable the development of retirement villages under a legal framework readily understandable by residents, intending residents, and operators (section 3).

1.4 Key components of the aged care regulatory system

The key components of the regulatory system are presented graphically below in Figure 1.

Certification

Aged care providers must be certified by the Ministry of Health. Certification periods can range from six months to five years, and are determined by the Ministry using a matrix. The matrix scores the provider's performance on a 0-5 scale against eight 'high-risk areas', seven 'general' factors, and three 'other' matters. The cumulative score determines the provider's certification period. Certification is based on information provided through the audit system and from other key parties such as the relevant DHB and the Health and Disability Commissioner (HDC).

Audit

As part of the certification process, a provider must be audited by a Designated Audit Agency (DAA). DAAs are private organisations, which have been approved ('designated') by the Ministry of Health. DAAs must carry out their audits and prepare their reports in accordance with rules laid down in the DAA Handbook, which is prepared by the Ministry of Health. Providers choose which DAA carries out their audit.

Every provider must go through a full audit at the end of each certification period. Certification audits check all criteria in the Health and Disability Service standards, and generally take 2-3 days. Performance against each of the criteria is rated on a four-point scale.[2] Audits are also used to assure DHBs that the provider in question is complying with the Aged-Related Residential Care Services (ARRCS) funding contract. At the midpoint of their certification period, providers are also subject to surveillance audits. These focus on known risk factors of the provider, are generally carried out in one day, and are unannounced (i.e. take place without prior warning). A surveillance audit may trigger further audits if significant issues are identified. Additional audits are triggered when the ownership of a facility changes, or a provider seeks to offer a new health and disability service. The Ministry and DHBs may also carry out unannounced inspections of providers, generally in response to complaints.

Standards

The Minister of Health approves the Health and Disability Service Standards (the Standards), which providers are audited against in order to gain certification.[3] The Standards also form part of the ARRCS funding contract. The Standards cover such matters as consumer rights, organisational management, continuum of service delivery, provision of a safe and appropriate environment, restraint minimisation, safe restraint practice, seclusion, infection control management and infection prevention and control.

Under the ARRCS contract, aged care facilities must have a Code of Residents' Rights, which is consistent with the Code of Health and Disability Consumers' Rights (the Code). The Code is drafted by the Health and Disability Commissioner and reviewed at least every three years. The Code lays out the rights of those using the health system and the corresponding duties of providers, including the rights to be treated with respect, to make an informed choice and give informed consent, and to freedom from discrimination, coercion, harassment and exploitation. The duties on providers created by the Code are mirrored in the Standards.

Complaints

Residents or their families can make complaints through a number of avenues. Each aged care provider must, under the terms of the ARRCS agreement, have an internal complaints procedure. Residents can also complain to the HDC for potential breaches of the Code, or to their local DHB or the Ministry of Health regarding the quality of their care. For issues regarding the costs of service, complaints can be made to the Disputes Tribunal. There is not a formal division of labour about the treatment of complaints between the Ministry, DHBs and HDC, but there is close communication between the organisations. Investigations into incidents in aged care facilities can also be conducted by the police, Accident Compensation Corporation or coroner.

Enforcement

The Ministry of Health has the primary responsibility for enforcement. Where audits identify weaknesses in the provision of care, the Ministry may require the provider to take corrective action or add conditions to the provider's certification. The Ministry can also require more frequent audits, where there are concerns about a provider's performance. The Ministry may impose fines for offering health services without certification, or for obstructing or misleading an audit or inspection.

District Health Boards do not have regulatory enforcement powers regarding aged care providers, but do have a number of levers they can use through the ARRCS funding contract, such as the ability to appoint a temporary manager to a facility or cancel its funding.

Where an HDC investigation into a complaint indicates that there may have been a serious breach of the Code, the Commission may lay a disciplinary charge with the Health Practitioners Disciplinary Tribunal (where the medical professional is registered under the Health Practitioners Competence Assurance Act) or Human Rights Review Tribunal (for other health service providers).

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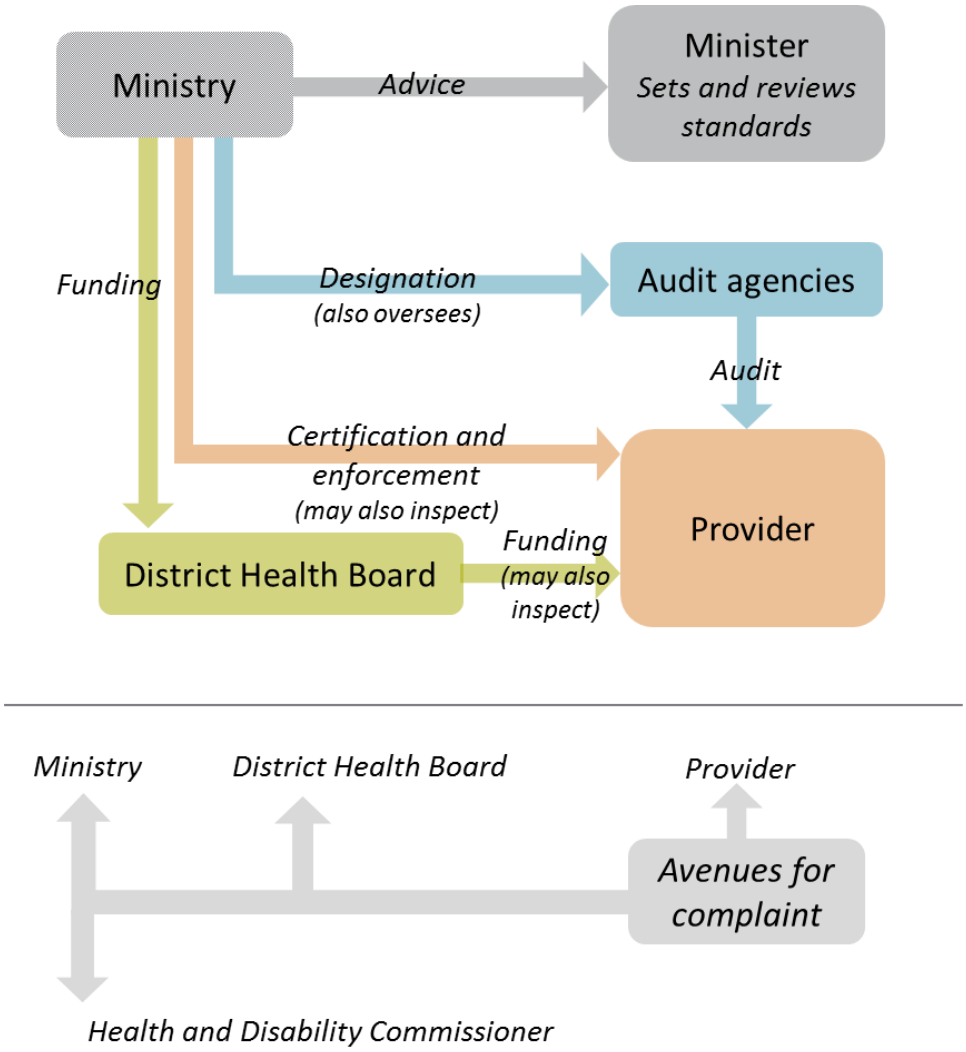
[2] 'Continuous improvement', 'fully attained', 'partially attained' and 'unattained'.

[3] Although the Minister of Health does have the power to exempt providers from complying with the Standards, where exceptional circumstances justify it and where exemption does not compromise the safety of affected customers: s.23 of the Health and Disability Services (Standards) Act 2001.

Where a HDC investigation finds a breach of the Code, the Commissioner publishes the name of the provider, "unless it would not be in the public interest or would unfairly compromise the privacy interests of an individual provider or a consumer."[4]

Figure 1 The aged care regulatory system



1.5 Issues for future regulatory design

Complaints mechanisms

The aged care system is relatively unusual for having a number of complaints mechanisms within one regime. From one perspective, having a range of complaints avenues is positive. Residents or their families can choose the path that best suits them, and the available data suggested that residents were making use of the avenues. 111 complaints were lodged with the Health and Disability Commissioner about rest homes in the 2012/13 financial year, and 156 were logged with the Ministry of Health (HDC 2013; communication with the Ministry of Health).[5]

However, multiple avenues may confuse the public about where they should complain. This may either dissuade people from lodging complaints, or lead to multiple, duplicative complaints.[6] Dividing responsibility for complaints amongst other bodies can make it harder to collect and use complaints data to

[4] Health and Disability Commission (2008). *Policy document – naming providers in public HDC reports*. The Commission may publish the name of individuals (e.g. medical professionals), where there is "flagrant disregard for the rights of the consumer or a severe departure from an acceptable standard of care, such that the provider poses a risk of harm to the public", where the individual has refused to comply with recommendations, or where it has been found to have significantly breached the Code three times in the past five years.

[5] Not all complaints logged with the Ministry were managed by the regulator.

[6] The Ministry of Health noted that it was not unusual for the same complaint to be made to several organisations.

identify system-wide issues. Under current arrangements, there is not systemic collection and analysis of complaints from the four main aged care complaints avenues. Multiple complaints mechanisms may also lead to people in similar circumstances being treated "in a materially different way procedurally or substantively" (Australian Productivity Commission 2008).

When do multiple complaints avenues make sense?

Multiple complaints avenues within one sector or regulatory regime may make sense where there are efficiency gains in specialisation (Australian Productivity Commission 2008). For example, it may be more efficient to have a dedicated service for customers with special needs, or to manage complaints dealing with complex and technical issues. However, any efficiency gains would need to be weighed against benefits from consolidating services and sharing assets, and better accessibility resulting from reduced customer confusion (APC 2008).

Where the establishment of multiple complaints avenues does make sense, their pitfalls (e.g. public confusion, duplicative complaints, and inconsistent treatment) can be managed through some of the following tools:

- *A shared contact point (e.g. a common 0800 number and/or website):* a common contact point, with appropriate mechanisms to refer complainants on to the right organisation, can help improve accessibility. They can also help with the collection of complaints data for surveillance purposes (see below).
- *Clear roles and responsibilities for each party, and shared protocols for referring complaints to the appropriate organisation*: this helps ensure an efficient division of labour, and fair and consistent treatment of complainants.
- *Clearly-allocated responsibility for collecting and analysing complaints data:* complaints are an important source of information on how well a regulatory regime is performing and where interventions may be required.

Regardless of the number of complaints mechanisms proposed, there are some core characteristics that any new system can be assessed against (see Box 0.1 below).

Box 0.1 **Characteristics of effective complaints systems: the Benchmarks for Industry-based Customer Dispute Resolution Schemes**

The Benchmarks for Industry-based Customer Dispute Resolution Schemes (the Benchmarks) are set by the Australian Government's Commonwealth Consumer Affairs Advisory Council and "act as an objective guide to effective practice" in sectors that run customer dispute resolution schemes (Australian Government 2013). The Benchmarks are used in Australia and New Zealand where dispute resolution schemes are required by law. In New Zealand, this has included schemes in the financial services, electricity and gas industries.

The Benchmarks and their underlying principles

- **Accessibility:** the scheme makes itself readily available to customers by promoting knowledge of its existence, being easy to use and having no cost barriers.
- **Independence:** the decision-making process and administration of the scheme are independent from scheme members.
- **Fairness:** the scheme produces decisions which are fair and seen to be fair by observing the principles of procedural fairness, by making decisions on the information before it and by having specific criteria upon which its decisions are based.
- **Accountability:** the scheme publicly accounts for its operations by publishing its determinations and information about complaints and highlighting any systemic industry problems.

- **Efficiency:** the scheme operates efficiently by keeping track of complaints, ensuring complaints are dealt with by the appropriate process or forum and regularly reviewing its performance.
- **Effectiveness:** the scheme is effective by having appropriate and comprehensive terms of reference and periodic independent reviews of its performance.

Source: Ellison 1997, Australian Government 2013

Delegating monitoring functions to third parties

The aged care regulatory system delegates responsibility for compliance monitoring to non-government organisations (the designated audit agencies) and creates competition between these organisations. While there can be good reasons for delegating regulatory functions, there are some issues and criteria that should be considered first.

Types of regulatory functions

For the purposes of this Inquiry, the Commission has identified six main functions involved in operating regulatory regimes.

Table 0.1 Types of regulatory functions

Function	Description / examples
Make rules or standards (under legislative or delegated authority)	Set standards, guidelines or rules to which regulated entities, individuals or activities must comply, reflecting the regulatory objectives set out in in statute.
Inform and educate	Provide general or targeted information to firms and individuals subject to regulation about compliance.
Approve / prohibit activities	Provide approval to carry out regulated activities (e.g. issue consents, approve mergers, license individuals to practice in regulated profession), refuse to provide approval, or prohibit activities which are contrary to the objectives of the regulatory regime.
Promote and monitor compliance	Actively seek information from regulated entities and / or collect market intelligence to assess compliance levels and identify potential risks.
Handle complaints from the public	Receive and process complaints from the public about the performance of regulated entities and their compliance with regulatory requirements. Where appropriate, require regulated entity to make amends.
Enforce compliance where breaches suspected	Investigate cases where entities or individuals are suspected of having breached regulatory requirements, assess whether breach has occurred and impacts of any breaches. Where appropriate, issue penalties or enforcement action.

Notes:

1. This model is adapted from a framework from Victorian State Services Authority 2009

These functions can be consolidated within one agency, or distributed across several organisations. Arguments can be made for both consolidation and distribution. The Victoria State Service Authority (2009) has recommended that regulators should "undertake a full range of regulatory operations", on the grounds that this will "allow regulators to develop and shape the appropriate balance between regulatory tools, create opportunities to develop regulatory expertise and provide for greater consistency in the implementation of regulation." Consolidation can also support effective feedback loops from the 'coalface' (e.g. enforcement officers and complaints processes) to those setting the regulatory strategy.

On the other hand, distributing functions may help promote efficiency and confidence in the system. For example, under a number of current regulatory frameworks in New Zealand, enforcement functions sit with the police and courts, rather than the agency which approves or prohibits activities. This helps minimise

duplication of effort and resources. Similarly, public complaints functions are often allocated to separate bodies, to provide assurance about the fairness and independence of the process.

When to delegate monitoring functions?

Aged care is not the only regulatory regime where compliance monitoring has been delegated to non-government bodies. Under the Education Act 1989, the New Zealand Qualifications Authority has previously delegated responsibility for the approval and accreditation of courses in tertiary education institutions to sector-owned bodies.[7] However, aged care differs from the tertiary education regulatory regime, in that aged care providers are able to choose which agency they use for their audits.

Delegation may be beneficial where:

- *There is a desire or potential to see greater innovation in the achievement of regulatory objectives*, such as new measurement technologies or auditing processes. Bodies closer to providers may have stronger incentives to introduce new technologies. In addition, replacing a monopoly with multiple agencies may create dynamic incentives to improve and innovate.
- *Specialised knowledge is required to carry out monitoring and compliance, and this knowledge resides outside of the government:* rather than duplicate or bid up the price of existing expertise by establishing a new agency, it may be more efficient to delegate functions to industry.
- *The interests of the external monitoring parties are aligned with the objectives of the regulation*: see below.

Delegation can, however, present challenges. Innovation may not be desirable is some circumstances (e.g. where the harm caused by non-compliance is high) and in some circumstances delegated bodies may face incentive to lower standards. Delegation to industry bodies can also increase the risk of capture of the regulatory regime. In the case of aged care, concerns were expressed about the incentives facing designated audit agencies and the degree of oversight. As a result, the Auditor-General recommended in 2009 that the Ministry consider alternative models for auditing and certifying rest homes (Office of the Controller and Auditor-General 2009).

Monitoring delegated authority

Even when they are not realised, perceptions of perverse incentives or capture can undermine confidence in a regulatory regime. Delegated regulatory functions therefore need to be accompanied by robust oversight and accountability processes. These should either directly control potential sources of perverse incentives or collect data to assess whether they are posing a problem. In the case of aged care, the Auditor-General noted:

- possible conflicts of interest, where audit agencies were offering consulting services to providers to resolve issues identified in audits;
- the potential for rest homes to select the cheapest or most lenient audit agency;
- risks that "commercial pressures might influence an auditor"; and
- concerns about inconsistent application of the Standards and insufficient capability within agencies (OAG 2009).

A follow-up report by the Auditor General in 2012 found that Ministry policy responses had reduced many of these risks, but that further improvements were needed (OAG 2012).

Incentives in the regulatory system to improve

A key objective of the aged care regulatory regime is to "encourage providers of health and disability services to the public to improve continuously the quality of those services". Providers are now on to their

[7] These delegations have since ended.

third audit cycle, and the regulator had been expecting to see more facilities reaching a 'continuous improvement' rating by now. This had not happened. There were a number of possible explanations for the slow rate of improvement, including staff turnover within rest homes, a cohort of residents that was entering later in life with higher levels of need, and tougher oversight by the Ministry of auditors.

Discussions with stakeholders also indicated that the regulatory system may not provide strong incentives to achieve 'continuous improvement':

- The process of establishing a new care system and collecting evidence to attest to its effectiveness could be costly and time-consuming.
- The benefits of achieving 'continuous improvement' may not be clear to providers. The Standards had different weightings in the Ministry's certification matrix, and a provider's certification period was determined by its total matrix score. Moving up to a 'continuous improvement' rating may not be enough to earn a provider an additional year of certification or may not be sufficient to outweigh a fall in a rating against another standard.

Where quality improvement is a key desired outcome from a regulatory system, clear signals can be provided about the impact of performance improvements in regulatory decisions, such as:

- Publication of the decision-making framework used by regulators;
- Communication with providers after regulatory decisions have been made, outlining how improvements in specific areas would contribute to more favourable decisions in future (e.g. longer certification periods); and
- Allocating significantly higher grades in the decision-making framework for the achievement of top performance levels.

This could allow providers to make better-informed judgements about the relative costs and benefits of pursuing further improvements. It would, however, be important to test that the *public* benefits of having more providers achieving top levels of performance outweighed the costs.

Performance information and transparency

Aged care audit reports were not published when the regulatory regime was first introduced, and requests for copies of reports were refused on the grounds of commercial sensitivity (Consumer New Zealand 2009). Following a campaign by consumer and senior citizens' representatives, summary audit reports were published on the Ministry website in 2009 and the full reports were published (on a trial basis) in 2013.

The audit reports were not originally thought of as a consumer information tool. Rather, they were seen as inputs to the certification process and a means of encouraging provider self-evaluation and -improvement. In the course of the Commission's discussions with stakeholders, questions were also raised about:

- the usefulness to the general public of the full audit reports, given their technical nature;
- the extent to which consumer information actually affects resident decisions, given the circumstances in which people enter residential care and the sometimes limited options available (especially for those with high care needs);
- the degree to which audit reports allowed the public to track the long-term performance of the aged care system, or judge the performance of the system overall.

While all of these points have merit, it is clear from the ongoing press coverage of aged care issues that there is a strong public interest in information about the performance of the sector. Regardless of whether the information drives consumer behaviour, regular public reporting on the performance of a regulated sector can help promote confidence in a regulatory regime and help identify systemic issues. Ideally, performance reporting systems should be introduced at the same time a regulatory regime is being implemented.

Three issues of importance when developing performance reporting systems are accessibility, comparability and perverse incentives:

- *Accessibility:* the information provided should be readily understandable, or presented in a readily understandable manner, by the general public. In the case of aged care, the audit report summaries include a 'stoplight' diagram, which describes the performance of a facility pictorially against the Standards with colour-based ratings.
- *Comparability:* information should allow for performance to be tracked over time. Consistent and quantitative measures are particularly helpful.
- *Perverse incentives:* the publication of performance information can be used to strengthen incentives to improve on providers. But they can also generate less desirable behaviour, such as gaming. The potential for perverse incentives is strongest when the performance information is linked to high-stakes decisions (e.g. certification or funding levels). This implies using a range of information in making regulatory decisions, or using performance information for surveillance and monitoring purposes only.

The roles of regulation and funding in enforcement

Some aged care stakeholders and external commentators have highlighted the lack of graduated enforcement tools in the aged care regulatory system as a problem. A visiting US scholar recommended that new sanctions (including fines) be introduced to give the Ministry more levers over poorly-performing rest homes (Ferrino 2013).

Under current arrangements, the Ministry has levers at the top and the bottom of the Ayres/Braithwaite 'enforcement pyramid', but little in the middle. Under the Act, the Director-General of Health can order a provider to close, cancel its certification, or fine it $50,000 for operating without Ministry approval. The Ministry can also add conditions to a provider's certification and providers are sometimes required to report on their progress in resolving identified problems. However, the Ministry cannot vary the term of a provider's certification in the middle of the period, nor are there powers to issue fines for non-compliance.[8]

Most stakeholders interviewed by the Commission were not convinced that the addition of penalties as fines would improve compliance, and some believed they could actually harm the quality of care. In their view, the vast majority of breaches by facilities were accidental rather than intentional, and fines could take resources away from care services. The Ministry saw more frequent audits and inspections as a preferable tool, especially as reports from their unannounced inspections had reputational effects. This highlights the importance of identifying the key incentives on regulated parties, when designing enforcement tools.

Where publicly-funded services are being regulated, the government will have two levers to respond to problems – the regulatory system and funding contract. In establishing a regulatory regime for public services, it is important to think through the relative roles of the funding and regulatory arrangements. Funding arrangements may permit faster action: in the case of aged care, the Ministry was more likely to call on the DHBs to trigger the ARRCS funding contract for enforcement than use its own regulatory powers, in part because action through the contract required fewer legal processes and could therefore be taken more quickly.

Enforcement using the funding lever is also potentially more powerful, in that it can put the viability of a provider at risk. However, funding-based interventions tend to target individual providers and may therefore be less useful for raising performance across the whole system in the absence of substantial failures, or for revealing information to consumers about relative performance.

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