

REPORT FOR CENTRAL REGION
DHBS

HOME SUPPORT PURCHASE AND
CONTRACTING MODELS

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PURPOSE

It is a widely held view across the sector that a different approach to the purchase of home and community support services is required to address some of the critical issues currently faced by the home support industry.

This report was commissioned to analyse and report on contracting and purchasing models for home and community support services that will assist the Central Region DHBs to address the current issues facing the sector. In particular:

- Stability & sustainability of the industry
- High worker turnover
- Inflexible & inappropriate services
- Cost blowouts
- Need for a rehabilitative approach to service delivery

The existing industry has developed as a result of historical funding and contracting approaches and services have evolved within a narrowly defined framework. However, the health and disability environment is changing rapidly, and the needs of clients receiving home based support services are significantly different to what they were when home based support services were established.

The report describes current needs and service frameworks. It identifies inappropriate and inadequate service responses and looks at the anticipated future needs of clients and the services that will be required to meet them.

The report draws extensively on international and national research to identify current industry issues and their relationship to the current purchase framework. It outlines national and international approaches to different purchase and contracting approaches.

It identifies purchase model options and contracting approaches appropriate to the NZ context and makes recommendations for an approach to purchasing home and community based support services by Central Region DHBs. The report:

- Outlines benefits and implications of the recommended option
- Outlines the impact on the industry and the industry capacity to adapt
- Identifies potential implementation issues.

EXECUTIVE SUMMARY

“The extent to which older people, if they become more frail and physically and mentally impaired, are supported within their own homes is a fundamental litmus test for the achievement of community care. Moreover, the contribution of such support to enabling individuals to remain within their own homes impacts in turn on the capacity to shift the balance of care between institutional and domiciliary settings” (Report of the Scottish Executive 2005). In other words, establishing an effective, viable home support service is essential for an integrated continuum of care.

There are significant risks to the management of health funding if cost-effective and sustainable home and community support services are not established in the near future. DHBs potentially face significantly increased costs of residential care when asset testing legislation changes come into effect on July 1 2005, as residential care costs are currently being subsidised by private payers. This risk will be exacerbated over the next 10 to 20 years as the percentage and number of people over 75 and over 85 increases markedly.

Cost containment approaches to the development of Home Based Support Services have in the past been characterised by a lack of understanding that a strong community-based sector, including HBSS, is essential if DHBs are to meet their goals of assisting older people to stay in the community while also meeting budgets. This is particularly so in the face of changing population needs, when the evidence is becoming clear that a strong community-based sector can be a cost-effective option, with the potential to reduce expensive hospitalisations and institutional care.

Current Services

However, as they are currently contracted and delivered, home based support services (HBSS) in NZ are inadequate to meet the needs of the community, are not viable long term and are not structured to fit within an integrated continuum of care. The commissioning and contracting of HBSS is unsophisticated, poorly related to outcomes and has little regard for levers that might raise service quality. It is characterised by purchasing decisions that severely limit flexibility; cost management techniques that are poorly targeted and have a negative impact on quality of care; and a lack of regulatory systems and monitoring. HBSS are currently neither contracted nor managed in ways that have sufficient regard to their complexities.

These problems have resulted in issues of:

- Service stability & sustainability
- Service gaps
- High worker turnover (Difficulties in recruiting and retaining support workers having reached crisis point)

- Inappropriate services
- Quality and safety. (Poor supervision, and training approaches that vary from provider to provider in general fail to address service requirements and also fail to meet the needs of support workers)
- Cost blowouts
- Consumer dependency

Current home based support services also completely lack a rehabilitative approach, and, in fact, can work against rehabilitation by providing formal services that undertake activities of daily living for a person, thereby limiting their opportunities for exercise.

HBSS are currently limited in scope and flexibility and the industry that has developed around them is characterised by workforce instability, management immaturity and financial issues. Performance measurement in HBSS services has been virtually non-existent, and there is limited evidence of a culture of quality improvement and organisational development throughout the industry. Many providers may lack the infrastructure and knowledge to support quality improvement and workforce development.

A ratio of low numbers of coordinators to large numbers of workers combined with the delivery of services across wide geographic areas affect providers' ability to support staff and to monitor or improve the quality of service delivery. Thus, support workers are delivering services in isolation, with minimal orientation, very limited training, and inadequate monitoring and supervision. While this is the way HBSS has operated historically, the increasing acuity and complexity of need among older people remaining in the community has exacerbated the risks of this situation. It now means that workers are delivering services to frail, vulnerable people, and increasingly this results in a situation where, in some cases, workers are carrying out tasks outside their scope of practice, and in other cases, are failing to meet consumers' needs for adequate support.

Action Required

In the immediate future, DHBs are faced with the dilemma of addressing the critical issues, stabilizing the industry and improving support services to enable older people to remain at home, while controlling and containing overall costs.

However, it is not simply a question of funding. While it is generally accepted that HBSS are historically under funded, the issues that need to be resolved are complex and are unlikely to be resolved merely by increased funding within the current purchasing framework of task specific per hour funding.

To create appropriate and sustainable home and community support services for older people that are integrated with other health and disability services within a continuum of care, DHBs must significantly alter their approach to the services, which will include reviewing service goals and outcomes, and

developing purchasing approaches and service structures that will deliver on the government's strategic goals for older people.

The challenge lies in developing a purchasing approach that embodies the government's strategic intent and gives expression to it through service shape and content while aligning it with cost containment. To achieve this, current HBSS service specifications, contracting, pricing and funding approaches need to change.

International evidence is emerging that shows home based care to be cost effective if designed and delivered properly. This report draws on research that shows that a wide variety of successful approaches to maintaining support services in the community are possible, indicating that DHBs have a significant degree of discretion in meeting local needs.

The report recommends a purchasing approach that is in line with international and national research. It can be implemented within the current assessment structures and funding levels, but can easily be adapted as the existing environment changes.

Recommended Approach

The proposal is to move to outcome focused service specifications and a purchase framework involving the purchasing of services by packages based on client assessment and client goals, rather than the current task defined per hour basis.

The new structure proposes that:

- The initial needs assessment and service coordination process assess the consumer's needs and define the consumer's desired outcomes, and determine resource allocation based on the Support Package Allocation Tool. ('SPA Tool' see page 20 for more detail.)
- Entitlement for the consumer be expressed and monitored within the DHB's payment systems in care levels or classification bands rather than in hours
- Services be purchased as a package
- A wider menu of services be available under HBSS to meet the individual needs of consumers
- The service package that flows from the assessed entitlement be determined initially by a team approach involving, as appropriate, the consumer, their family/whanau, the needs assessor/service coordinator and the service provider.
- Subsequent changes to the package, within the overall resources allocation, will be determined by the consumer and service provider in consultation (and may also include others who are significant in the individual consumer's service delivery, such as a health professional, service coordinator, support worker, allied worker, client advocate, etc).

These adjustments can be made *without* the need to return for a further formal reassessment of needs.

- The package include any combination within a broad menu of services
- The service delivery package include a co-ordination role to assist in accessing other services both formal and informal if appropriate
- Monitoring and accountability be a key aspect

Thus the provider has the flexibility to provide the most appropriate mix of services as the consumer's needs change. Some providers may elect to provide a comprehensive range of services themselves, while others may offer a core group of services and provide access to other services under MOU or partnership arrangements.

Monitoring & Accountability:

It is important to ensure that the comprehensive costs of providing the service packages are calculated by detailed examination. The system of devolved provider responsibility embodied by this model requires greater payer-provider collaboration, implying an active role for the purchaser which goes beyond the traditional claims payment role. A significant change in monitoring and reporting methods will be required with the move away from funding specific hours of input, to ensure quality of service and accountability for public funding. The proposed model requires a climate of mutual trust and responsibility, but must be backed by robust and comprehensive reporting mechanisms.

DHBs would need to develop a monitoring mechanism for providers, which would entail:

- Providers reporting on specific service provision for clients
- Providers reporting on the total volumes of each category of service delivered in a given period
- DHB analysis of this data by number of clients supported
- DHB developing benchmarks of levels of input required to meet levels of assessed need
- DHB reporting to providers on their performance against benchmarks
- DHB undertaking a wash-up of funding with providers in the event that less than say 90% of the benchmark level of inputs was delivered

This approach will have benefits for long term service planning, as data analysis will make it possible to compare community based services packages with the cost of residential care. However, economic evaluations cannot be merely concerned with the cost of different models of service delivery, but must consider the outcomes for older people and their caregivers and family/whanau. In the longer term, mechanisms for the measurement of outcomes will need to be developed.

Benefits of the Proposed Approach:

- Facilitates an integrated approach to service planning and management
- Facilitates a flexible management approach that develops services that are responsive to both individual consumer need and reflects the culture and needs of the community it serves
- The range of services is expanded, with more appropriate use of services
- Allows providers to address issues and develop innovation in all dimensions of the service including management, workforce and service development
- Supports flexibility of workforce structure and promotes an enhanced support worker role
- Supports improved service viability of the HBSS sector
- Increased service breadth & depth can be introduced while maintaining traditional services
- Provides conditions for a more cost effective service structure

Risk Management:

Barriers to introducing this approach can be addressed through developing programme guidelines, prioritising human resource development, coordinating an appropriate series of developmental activities, and introducing reporting arrangements and accountability systems designed to relate to programme objectives.

Implications:

Moving to the new model requires significant changes in needs assessment and coordination processes and in the way services are structured, contracted, delivered and monitored.

- Assessment will need to become more explicitly directed to assisting an older person to determine their goals. Better assessment tools, such as the InterRAI MDS-HC, will be needed to enable the assessor and the DHB to get better information about the physical, social and mental factors that mean the older person needs assistance to meet their goals.
- Revised service specifications will be required that reflect a holistic, goal oriented outcome focus and a habilitation/rehabilitation approach. Service providers will carry a greater responsibility for the delivery of services that successfully meet the consumer's needs and achieve the consumer's goals.

- The flexibility and continuity in purchasing offers a way of addressing recruitment and retention issues, by improving the ability of providers to develop long-term business and workforce plans, improved conditions of employment, career prospects for support workers, and enhanced job satisfaction.
- Purchasing service packages assessed in \$\$, care levels or classification bands will promote the integration of services, which will provide the basis for new services to develop to fill gaps.

The recommendations are focused on developing effective partnerships between funders, providers and consumers within a quality and accountability framework. Research shows that this requires funding and decision making to be devolved close to the consumer, and requires a genuine shift of power and control to be established and maintained within a climate of mutual trust and responsibility.

The proposed purchase framework is designed to provide a flexible structure for purchasing, coordinating and facilitating services that are highly responsive to the individual support needs of clients. It aims to achieve the best outcomes for clients by addressing the quality and workforce issues that encumber the development of HBSS, promote a more sophisticated approach to service planning and development and facilitate strong quality and financial monitoring processes by funders. The goal is consumer driven services that present older people with genuine and sustainable opportunities to remain living in the community.

BACKGROUND

Historically, HBSS have developed in isolation from other health services, as a response to people with stable levels of need for practical support, and separate from any health or medical needs they might have. However, the rapid increase in the numbers of people who need support to remain in the community has put funding for these services under considerable strain.

In particular, the increasing numbers of frail older people who remain at home require a very different style of service from the traditional service for a person with a permanent life long disability who needs someone to perform certain functions for them - ranging from one or two visits a week of house cleaning to complete personal and household management services.

The range and volatility of need of an older population is poorly accommodated by the current purchase approach and narrowly defined services. Older people often require HBSS due to health needs and require the support worker to be linked in with the health system supporting that person. HBSS is therefore part of the management of health conditions. Defined service culture for older people has also moved from a replacement approach, and a 'do for' culture, to a re-enabling approach with a rehabilitation focus.

Evidence shows that ignoring relatively simple physical and social needs can lead to older people deteriorating unnecessarily, resulting in preventable admission to residential care, while a service structure that addresses both the range and changing nature of people's needs contributes to reducing unplanned hospital admissions and residential care admissions. (Joseph Rowntree Foundation 1997; Landi et al 1999; Sinclair et al 2000)

Overall, the history of HBSS has been marked by incremental and ad hoc service development and has lacked significant policy reform. While the HBSS service specification did adapt to deliver more intensive levels of support for personal care, the need for an integrated health and disability support approach for older people, while they remained living in the community, has not been addressed. The structural approaches to the services have not adapted to the changing population. The way the services are regulated, purchased and monitored and the way the workforce is recruited and managed does not reflect the nature and extent of the services the community currently needs.

INTRODUCTION

The sustainable delivery of community based support services, including what is currently termed home based support services (HBSS), is fundamental to the aims of government strategies. Perhaps more than most services, Home Based Support Services must work with the implications of the establishment of community based continuum of care, as they operate across a number of boundaries of care, blending medical with social and personal needs, and formal with informal and family care needs.

While DHBs are working intensively towards shifting the funding and delivery of their services into the community, it is something of an irony that the already community based long term HBSS devolved in October 2003 should be raising such serious concerns across all DHBs.

The commissioning and contracting of HBSS is currently unsophisticated, poorly related to outcomes and has little regard for levers that might raise service quality. It is characterised by purchasing decisions that severely limit flexibility; cost management techniques that are poorly targeted and have a negative impact on quality of care; and a lack of regulatory systems and monitoring. HBSS are currently neither contracted nor managed in ways that have sufficient regard to their complexities. This has resulted in issues of:

- Stability & sustainability
- Service gaps
- High worker turnover
- Inappropriate services
- Quality and safety.
- Cost blowouts
- Dependency

The recruitment and retention of support workers has reached crisis point, with the sector showing an overall turnover of support workers of 39%. (NZ DSS Surveys 2004) Recruitment difficulties are escalating rapidly and the figure of 39% does not represent the true extent of the issue. Providers consistently report that current levels of turnover for recruits in the first year are 50% to 80%. Service gaps are increasing nationally, and are reaching critical levels in some regions.

Costs:

There are significant risks to the management of health funding if cost-effective and sustainable home and community support services are not established in the near future. DHBs potentially face significantly increased costs of residential care when the asset testing legislation changes come into effect on July 1 2005, as currently residential care costs are being subsidised by private payers. This risk will be exacerbated over the next 10 to 20 years as the percentage and number of people over 75 and over 85 increases markedly.

Supply of workers:

Numbers of older people are expected to rise sharply during the first half of this century, with significant increases in the number aged over 75 expected after 2011. At the same time, middle-aged women (the main informal care providers) are more likely to be in employment, family members tend to be geographically dispersed and there are rising numbers of single, divorced and widowed people without children. With supplies of informal carers uncertain, there is likely to be an increase in demand for care from professional services (Joseph Rowntree Foundation, 1997.) US research shows that in 2000, the ratio of women aged 25-54 to the total population aged 65 years and over was 1.74:1. By 2020 it is estimated to fall to 1.15:1. (Dawson and Surpin 2001).

HBSS face a double potential risk from this demographic change. While it reduces the supply of informal carers and increases the amount of formal care that will be required, at the same time it significantly reduces the formal workforce pool. The informal family carers and the formal support workers are the same demographic pool. The quality of the workforce pool is also being affected. In a high employment market, people who are 'work ready' with residual skills can easily get higher paying jobs with better conditions than HBSS can currently offer. Those that have very few skills tend to be what's left for an industry that cannot compete.

Changing Needs:

If we add to this scenario the increasing acuity and complexity of need that is becoming evident in the consumer base, home and community support services face a high risk collision course of several factors - Increasing volumes, increasing acuity and complexity, decreasing informal supports, decreasing work pool volume and decreasing work pool quality and work readiness.

Action needed:

When services are in such a state of crisis, funders have historically been tempted to shift the responsibility for solving the issues on to providers, or to limit the type of services, or reduce access. However, limiting services or targeting particular populations in order to stay within funding levels will not only fail to address the fundamental issues facing these services, but will simply result in cost shifting to other service areas and will not contain overall health and disability costs.

While it is generally accepted that HBSS are historically under funded, funding is not the only issue these service face. The issues that need to be resolved are complex and are unlikely to be resolved merely by increased funding within the current purchasing framework of task specific per hour funding. The implementation of an integrated continuum of care is dependent on co-ordination, and increases the requirement for flexibility. In the community the needs of older people must be met by different health and social services and by a combination of formal and informal, public and private care. This situation calls for an overall purchase approach that supports 'tailored packages' of care and case management.

CURRENT PROFILE OF HBSS

Note: Data for this and subsequent sections on the current NZ model has been drawn from the 2004 Auckland Uniservices surveys undertaken on behalf of the Ministry of Health Quality and Safety Project. These are:

Disability Support Services in NZ: Part 1 Service Provider Survey
Disability Support Services in NZ: Part 2 Service Provider Survey
Disability Support Services in NZ: Service User Survey
Disability Support Services in NZ: Workforce Survey

These surveys are referred to collectively throughout this report as the NZ DSS Surveys.

Service Profile

The current contracts for home based support services cover:

Ministry of Health & DHB Home Based Support Services Contract
Household Management (also referred to as home help or domestic assistance)
Personal Care
Night Sitting Services (also referred to as sleepover services)

Personal Care is defined as assistance with activities of daily living that enable a person with a disability to maintain their functional ability at an optimal level. These activities include but are not limited to:

- Personal hygiene and grooming
- Toileting
- Dressing
- Transfers and mobility
- Feeding

Sleepover is defined as assistance with personal care and household tasks for an overnight period of stay where there is facility for the caregiver to sleep.

Household Management is defined as services which assist a person with a disability to maintain, organise and control their household/home environment, enabling them to continue living within their own environment. This includes but is not limited to:

- Cleaning
- Laundry
- Meal preparation

Consumer Profile

- ❖ Consumers over 65 years receiving support in a home and community based setting account for approximately 70% of disability funding.
- ❖ Of those 65 to 75 years 32.4% are male and 60.9% are female
- ❖ Of those 75 years and older 24.9% are male and 68.9% are female
- ❖ The largest proportion (75%) is of European descent, while approximately 10% of consumers are Maori.

NOTE: A summary breakdown of data from the Disability Services in NZ: Service User Survey covering the Central DHBs is attached as Appendix 3.

Increasing Acuity and Complexity of Need

The needs of frail older people are significantly different to the needs of people with a life long disability. For some time, HBSS providers have reported for some time difficulty meeting the increasing acuity and complexity of need in the community. Acuity and complexity of need in home and community support services are the result of a combination of multiple factors. In sum, the range of factors may be broken down into factors related to the consumer and his or her needs, the living situation and associated family and whanau needs, and the provision and coordination of services. Research identifies specific factors as:

Client factors:

- Specific health or support needs (eg: medication management)
- Stability of health or support needs
- Behaviour, personality problems, service refusal
- Cultural or language needs
- Financial situation
- Level of health or support risks
- Social risks for client

Living situation factors:

- Carer, family, whanau support needs and/or
- degree of involvement
- Poor housing
- Geographical location and degree of physical and/or social isolation

Service provision factors:

- Cultural and gender dimensions of care
- Frequency, intensity and/or duration of support services
- Specialised tasks required: e.g., procedures, equipment, supervision
- Degree of risk for the organisation and staff
- Capacity of provider to support care needs (staff availability & training levels)
- Co-ordination of services

It is important to note that degree of complexity may be a function of factors within each group and/or between groups. In addition, balancing client right of self determination, client needs and safety, and staff safety is a complex situation in itself. (Kirk & Glendinning, 1998; Marks, 1991).

Both the increasing level and the interrelationship of these factors represent a significant risk factor when coupled with workers who are inadequately trained and supported. From the available data it is not possible to estimate the proportion of current consumers who have high and/or complex needs. However, in a recent survey undertaken by the Ministry of Health (2003) to assess this issue, participants report that less than 10% of current consumers fall into this category.

This number is consistent with international figures shown by a literature search undertaken as part of the MoH survey. The difficulty that providers face however, is the large amount of resource such consumers absorb. This is also consistent with international findings that in terms of resource allocation, providers can expect 10% of the highest users of services (consumers with high and /or complex needs) to take up nearly 50% of available resources, and 40% of lowest users of services to take only 10% of available resources.

Industry Structure

Currently, long term DSS funded home based support services (HBSS) are delivered by independent providers under contract to multiple funders - DHBs, Ministry of Health and ACC. They number about 110 nationally, and are a mix of both not-for-profit and for-profit agencies within a largely unregulated industry. The mix differs from DHB to DHB. Providers deliver intermittent services over a 24-hour 7 day period, and vary in size from large national providers, to small owner-operated local enterprises.

Services must meet a diversity of type and level of support needs for consumers across a broad age range. Few provider organisations deliver a single service, and many cater for a wide range of needs and ages. A number also deliver services across a mixture of home-based and residential settings.

Workforce Structure

Note: A more in depth discussion of workforce issues is included under Workforce Issues.

Number of support workers:

The estimated total number of support workers in NZ is around 40,000 – 50,000. It is very difficult to gage numbers of home support workers as many providers of support services supply across a number of services, including home support. But around 18,000 to 25,000 of these workers may work in a home and community setting.

Workforce turnover:

The recruitment and retention of support workers has reached crisis point, with the sector showing an overall turnover of support workers of 39%. Recruitment difficulties are escalating rapidly and the figure of 39% does not represent the true extent of the issue. Providers consistently report that current levels of first year turnover are 50% to 80%. This has led to service gaps nationally. Service gaps are most evident in rural areas and larger cities. Regions with particular workforce competition issues, such as tourism and seasonal work have the greatest difficulty.

Demographic characteristics:

Approximately 75% of all support workers in NZ are over the age of 40. They are largely women between 40 and 60; while for HBSS the greatest number (32.1%) are between 50 and 59 years.

Ethnic profile:

Internationally, the literature shows that support workers are often from ethnic minorities. NZ data indicates the majority of support workers here are NZ European (82%) or NZ Maori (approximately 8%). (The DSS in NZ: Workforce Survey looked at the 25% of workers who don't identify as of European descent and reports on primary languages **other than English**. Of these workers, the survey identifies that they are made up of Maori 4%, Pacific 37%, Asian 24%, other 35%) While providers report anecdotally that support workers have difficulty communicating in verbal and written English, the NZ DSS Surveys show only very small proportions of such workers amongst the Central Region DHBs, ranging from 0% to 3%.

Contracting Mechanism:

Support workers are considered to be employees for tax purposes, but providers use a wide variety of employment contracts for their workers. Most employ their support workers under individual contracts. The majority are casual with very few full-time permanent support workers. Most workers work part-time with no guarantee about the number of hours they work in a week and very few providers guarantee even a minimum number of hours in a week.

Hours worked:

Over half of home-based support workers are employed for ten hours or less per week, with just under 75% working less than 25 hours a week. The DSS in NZ: Workforce Survey reports home based support workers working a median value of around 12 hours per week, with 26% working less than 5 hours, 25% working 6 to 10 hours and 26% working 11 to 20 hours.

A number of workers work for more than one organization, with most of these working for two. 20-30% of workers were involved in paid work other than that of support worker. These workers were more likely to undertake cleaning, but also included were hospitality, gardening/farm work, clerical and small business/self employed.

Type of Work:

Over half of support workers undertake both domestic assistance and personal care. Of the rest 28% do only domestic assistance and 16% do only personal care. In the DSS in NZ: Workforce Survey, 20% of workers stated that the service they provided included 'medication – administration/monitoring/diabetes injections' and 'wound care eg. changing dressings'.

The median length of time workers spend with a consumer is 5.5 hours per week. (This compares to 4.4 hours per day for residential care support workers.)

Remuneration:

The median salary for support workers is \$10.82 an hour. Based on this hourly rate and a median weekly workload of around 12 hours, the salary for support workers is around \$7,500.00 pa. When this is extrapolated to a full time workload, the annual median salary is potentially \$22,000.

Travel:

About half of providers reimburse workers for travel costs, and very few reimburse for time traveled. Most of these payments activate after a designated distance traveled (20 – 40 Ks). The NZ DSS Surveys show that 79% of workers travel up to 2 hours between clients, with the median number of kilometers traveled being 20. Reimbursements for support workers use of their own vehicle varies considerably and can range from 28 cents to 62 cents a km, or be made up of such things as petrol allowances or a tank of petrol each week.

Interestingly, over a third of workers surveyed in the DSS in NZ: Workforce Survey had incurred travel costs as part of the service delivery – such as for shopping or taking consumers for treatment etc, but the majority of these workers stated they were not reimbursed for these travel costs. Almost two thirds of workers said they were also not paid for the time to undertake these tasks.

This suggests that this travel may not be part of the formal service delivery, although the workers and consumers may perceive it to be. 20% of workers stated they were paid by consumers to complete chores for them involving

travel, such as taking them shopping. These figures indicate an area of cost for services that are currently being undertaken outside the formal framework.

Training:

Orientation and lifting and handling are the most common training provided for home support workers, and this training is provided by coordinators in an orientation session or by 'buddying' with another worker.

It appears from the DSS in NZ: Provider Survey and Workforce Survey that virtually the only training that home-based support workers attend is the compulsory orientation and, in the current recruitment and retention crisis, even this episode of training is often compromised. The average attendance rate of workers at training was stated to be 40%. Although most providers stated they deliver some form of orientation, only 55% of providers in the survey said they always provided orientation before support workers commence seeing clients.

When providers were asked how many of their support workers had recognised and adequate training 62% said that fewer than 40% of their workers had completed training.

Process:

When an older person requires disability support services, they access them by being referred to a NASC for a needs assessment. Services are then delivered on the basis of need not entitlement. A person is assessed as having from very low to very high needs, in five bands as detailed in the Support Package Allocation Tool (SPA Tool) published by the Ministry of Health in 2002. The SPA Tool proposes that where necessary a package of care be offered, costing from \$0 to \$30 for low need, \$0 to \$180 for medium need, \$0 to \$360 for high need, and at the manager's discretion for very low and very high need.

The packages can differ because a person's social and personal circumstances differ. For instance, some people have plenty of family assistance; others have no family; some communities have active volunteer services, others have very little. Service co-coordinators have been restricted in their ability to use the full flexibility inherent in the SPA Tool approach by narrow service specifications for available services and limited flexible funding for alternatives.

The HBSS service provider receives a referral from NASC that amounts to an allocation (prescription) of service, defined as specific tasks which are estimated to take a certain amount of time to complete, adding up to fixed-length visits for each consumer. Based on this assessment providers are funded on a per hour fee-for-service basis for individual clients.

ISSUES

The issues for these services divide into two areas:

1. Service definition issues
2. Industry structure and quality

HBSS are currently limited in scope and flexibility and the industry is characterized by workforce instability, management immaturity and financial issues. Performance measurement in HBSS services has been virtually non-existent and there is limited evidence of a culture of quality improvement and organizational development throughout the industry. It appears that many providers lack the infrastructure and knowledge to support quality improvement and workforce development. The causes of these issues are multifaceted and stem from the complexity of providing cost-effective community based services to support a wide variety of needs for a diverse population across a large geographic area.

SERVICE DEFINITION ISSUES:

Current services are not meeting consumers' needs. The range and volatility of need of an older population is poorly accommodated by the current purchase approach to home based support, and by the narrowly defined services. The long term cost implications of an increasingly older population mean that a purchase approach for HBSS should aim to support older people to stay at home by providing services that prevent deterioration and promote informal support.

Rehabilitation:

The current purchase approach and service structure supports dependency on the part of both the consumer and the provider. Current services completely lack a rehabilitative approach, and, in fact, can work against rehabilitation by providing formal services that undertake activities of daily living for a person, thereby limiting their opportunities for mobilisation and problem solving.

Current purchasing also encourages provider dependency on the funding for each client. Providers currently have an incentive to maintain services to those they serve rather than reduce services as they successfully encourage the older person to become more independent, enabling the provider to then take on new clients. This has significant cost implications for the funding of these services long term. In future, purchasing needs to incentivise and support providers to respond to the needs of consumers in a manner that promotes rehabilitation.

Flexibility and Responsiveness:

In NZ, disabled people have indicated that what they desire from support workers and service agencies is somewhat different from what is currently offered, and they express dissatisfaction with many aspects of support

services, especially in regards to the flexibility and responsiveness of services (Gunderson-Reid 2004).

Currently, the HBSS service specification is largely aimed at purchasing help which is considered necessary for basic physical survival – eating, elimination, cleanliness and domestic mobility. The service specification does not focus on the wider issues of supporting older people’s social needs, morale, quality of life or connection with their community. Service elements that older people may see as essentially making daily life ‘a life worth living’ are not included, e.g. assistance with going for a walk, writing a letter, keeping a pet, connecting with family and friends.

Evidence shows that ignoring relatively simple physical and social needs can lead to older people deteriorating unnecessarily, resulting in preventable admission to residential care, while a service structure that addresses both the range and changing nature of people’s needs contributes to reducing unplanned hospital admissions and residential care admissions. (Henwood et al. 1998; Landi et al 1999; Weissert W 2001)

For instance, on average, people with chronic diseases have been shown to be 1.5 to 2 times more often depressed than those without such a condition. Thus support services that address mental and emotional needs are likely to assist older people to maintain healthy lifestyles, stopping a possible downward spiral of depression, unhealthy lifestyles, and deterioration of chronic disease.

The promotion of social inclusion is a neglected issue within the current purchasing of home based support. It is well established that social inclusion is a key factor in preventing functional deterioration (Netten et al 2002). Evidence shows older people report one of the significant benefits of home care to be the emotional and social support it provides.

Research suggests limitations on the range of services underestimate other areas of life also regarded by older people themselves as important. Empirical research has shown that alongside psychological well-being and good physical functioning, older people value having relationships with others, health and social activity, and that they struggle with loss of independence. Netten et al 2002 found that older people receiving assistance from health and disability support services measure the outcome of the support against its usefulness in assisting them with their control over daily living, safety, personal care, food and nutrition, and social participation. Rowe and Kahn 1998 describe the predictors of successful ageing as:

1. avoiding disease and disability
2. maintaining physical and mental function
3. continued engagement with other persons in productive activities.

Support for ‘a life worth living’ is an established and acceptable approach in services for young disabled people or people receiving mental health services. Extending this concept to older people is the challenge embodied

by current government strategies aimed at ageing in place. If older people are to successfully remain at home, these issues will need to be addressed in the wider context of organising support both formally and informally.

Current service response:

While current HBSS goes some way towards addressing such issues, the narrow focus on meeting physical needs, the limitations of the restrictive service specification and the inflexible purchasing approach mean the services cannot address the extent or changing nature of older people's needs. Nor is there a good mechanism in place for putting together a package of care that combines HBSS with other needed services. While impairments in mental, physical and social functioning are often taken account of when assessing older peoples' needs, the current HBSS service specification is not designed to respond to this assessment and address these needs.

In fact, analysis of the match of current needs and services suggests that the current HBSS services are applied inappropriately. While the purpose of 'personal care' services is fairly specific, the application of 'domestic assistance' (or 'home help) is less clear. Many consumers are assigned 'two hours of home care a week' without a clear analysis of what function this service is performing. There is the possibility that this is actually functioning as social support or a 'keeping an eye on' service masquerading as 'housework'. The appropriateness of meeting an older person's social needs through the provision of an untrained worker who is supposedly there to do housework needs to be questioned. As the current purchase approach does not support regular monitoring of service delivery and assessment of need, inappropriate services continue to be delivered for long periods of time.

As stated in the Scottish Executive review of community support - "From a preventative perspective, it would be possible to argue that the total operation of community supports for older people is a 'counterproductive system' when viewed against the original community care goal of promoting independence, with a large component being the inability to integrate health and social goals holistically." ('Over the Threshold' 2005).

The current task-based model of care minimizes the opportunities for 'added value' in home and community support services. In the long term, this limited approach will not support the significant advantages to be gained in both quality and cost containment by providing services that help older people achieve the outcomes they want. As the research indicates, there appears to be a fortunate conjunction between the factors that help an older person to age well so that they do not need or can limit their need for health and disability support services, thereby reducing health cost per capita, and the factors that have been identified as those that older people want from a health service. That is, the things that can be done to reduce health costs are also the things older people want (Kennedy 2003; Netten et al. 2002; Rowe and Kahn 1998; Grundy and Bowling 1999).

KEY NOTES - SERVICE DEFINITION ISSUES:

What we Know:

1. Task based HBSS lack flexibility and are not meeting consumers' needs
2. Current services lack a rehabilitation approach and support dependency
3. Evidence shows that ignoring relatively simple physical and social needs can lead to older people deteriorating unnecessarily, resulting in preventable admission to residential care
4. It is well established that social inclusion is a key factor in preventing functional deterioration

What We Need To Do:

1. Establish a service structure that addresses both the range and changing nature of people's needs. Evidence shows this will contribute to reducing unplanned hospital admissions and residential care admissions.
2. Introduce a rehabilitative approach into service delivery
3. Establish packages of care that are based on consumers' assessed needs and goals, are outcome focused and combine HBSS with other needed services.
4. If older people are to successfully remain at home, support for 'a life worth living' will need to be addressed in the wider context of organising support both formally and informally

SERVICE QUALITY & INDUSTRY STRUCTURE ISSUES:

Monitoring:

The current service structure does not provide for an overall care plan or link support services to other care plans that may be in place for the consumer. This issue often begins with the referral from the NASC agency. Home support provider agencies often receive extremely limited information from the NASC about the consumer's support needs, their wider health and social needs and their living situation. Referrals will merely state the number of hours of personal care or domestic assistance a consumer has been 'allocated' to meet their assessed needs. The provider will often receive no further information on the consumer.

The current service package does not fund the establishment of a care plan or a visit by a coordinator to the consumer's home for a risk assessment. Consequently, many providers don't establish a care plan for the service or undertake a risk assessment for either the consumer's service needs or for OSH purposes. In most situations, the support worker is sent to the consumer's home without the provider assessing the service delivery context at all.

In 2003 the Ministry of Health and ACC jointly conducted an audit of a national, representative sample of providers of home based support services against the voluntary NZS 8158 (Home and Community Support Sector Standard), in order to assess the gap between current practice and the Standard. Between June and November 2003, 39 audits of providers were completed of 29 mainstream, eight Māori, and two Pacific providers, across the country.

25% of providers showed high risk/critical risk findings against criteria in the Standard. One of the significant areas of high risk was described as: Evidence of insufficient risk assessments undertaken prior to service delivery and limited evidence of documented risk management plans in place for any risks identified.

Providers state that issues of ensuring that consumers' homes comply with Occupational Safety and Health (OSH) and Accident Compensation Corporation (ACC) standards are of great concern. (NZ DSS Surveys 2004) However, providers exhibit a poorly developed knowledge of how to manage safety issues in the community. This, coupled with lack of information from the NASC agency, can lead to significant risks for both consumers and workers. There was a sense of desperation among participants in the NZ DSS Provider Survey; as one stated: "We have no good basis to make a care plan, and no workforce to meet the needs of the plan".

There is currently little, if any, ongoing monitoring or review by either the provider or the NASC until there are substantial changes in the circumstances of the person receiving the service.

Supervision:

Providers struggle to set and maintain quality and safety standards in the community setting. While the risks generated by poor supervision were not considerable in the past, consumers' increasing acuity and complexity of need has raised these risks considerably.

A major problem reported by providers is the difficulty of detecting and managing changing consumer needs. If a consumer's health deteriorates significantly after the initial needs assessment, the support worker will often take on more support responsibilities without consulting with agency coordinators, putting herself and the consumer at risk. Additionally, other home health providers (eg: district nurses), consumers or families often pressure the support workers to perform support tasks that they are not qualified to do. Providers state that support workers are often not assertive enough to refuse to take on extra tasks. The lack of supervision contributes to support workers isolation when this occurs.

The high risk findings among 25% of providers in the 2003 MoH audit against the Home & Community Support Sector Standard largely related to workforce issues, including:

- indications that, in some instances, support workers are assisting service users when the level of assistance required is not clearly defined in individual service plans and the support worker has not been assessed for competency to provide the level of care required
- indications that, in some instances, systems to determine and monitor the competency of support workers are not adequate, especially where providing for clients with high care needs

The delivery of services across wide geographic areas combined with the fact that workers operate in isolation, with a ratio of low numbers of coordinators to large numbers of workers provide significant challenges for supporting staff and monitoring or improving the quality of service delivery. The current pricing level, coupled with the high staff turnover, leads to a significant strain on resources, which exacerbates this situation. Providers do not currently employ enough coordinators to maintain the functions of constant recruitment and ongoing training of new workers, as well as adequate supervision of a widely dispersed workforce.

In the NZ DSS Surveys 2004 providers state that they cannot provide satisfactory supervision and do not always ensure that regular performance appraisals take place. Some providers run performance appraisals for their support workers, usually on a yearly basis, but these are often unsuccessful. Since most providers can't afford to run interviews in the community they ask the support workers to come to the agency office for the review. Many workers simply don't show up at the performance review meeting and the coordinators do not have the time to follow this up. Providers cannot afford to link the performance review to a pay rise, so there are few incentives for the

workers to participate in a performance review. Many workers also do not stay in the position long enough for an annual performance review. Providers expressed the view that safety is compromised because society does not consider home support as health services, with a consequent requirement for quality standards.

Providers relied more on training and orientation rather than ongoing supervision to ensure that the support workers understood their roles and responsibilities. Coordinators stated they often didn't see the support workers after the training and orientation were over, and the position had begun, so they tried to make this orientation as thorough as possible to minimise safety and quality risks.

Some organisations employed nurses or other coordinators who would visit support workers on the position but most providers did not have the resources to pay for these roles. Providers took a reactive approach and relied heavily on consumer feedback to detect problems in the services. Most providers surveyed their clients once a year to check on their satisfaction (although some providers did not survey their clients at all) and some providers made annual visits to all of their clients in their homes.

Service Gaps:

Significant service gaps are increasingly evident. These are both geographic and time related. The recruitment and retention issues this sector faces has meant it is has become very difficult for providers to service difficult times of the day and weekends and public holidays. The Holidays Act legislation has exacerbated this already existing issue. The current purchase approach is focused on maximum flexibility in workforce management – a per hour, task defined, specific worker/consumer allocation. However, such an approach generates weakness in overall workforce structure and responsiveness; such as lack of commitment on the part of workers, high turnover and recruitment difficulties. A purchasing approach needs to maintain a degree of flexibility while moving to support a reliable and consistent workforce response to the complex delivery requirements of these services.

Standards:

The HBSS industry is largely unregulated. The Health and Disability Services (Safety) Act 2001 does not currently apply to community services, although there is the possibility that this will be extended in the future. Thus, the Health and Disability Standards 2001 that cover residential care do not apply to home based support services. NZS 8158:2003 The Home and Community Support Sector Standard (H&CSS Standard) was jointly commissioned by the Ministry of Health and ACC in 2003, and was developed by Standards NZ supported by an expert group of industry representatives. The Standard is currently voluntary, and will not become mandatory until the Health and Disability Services (Safety) Act 2001 is extended to cover community based services. Compliance with the Standard can also become mandatory if funders write it into contracts with providers.

The home based support industry is subject to Occupational Safety and Health regulations and general privacy and employment regulations including

the Employment Relations Act. OSH Guidelines for Home and Community Support Services were developed by OSH, in consultation with industry representatives, and published in 2003.

The Future

Evidence of good quality and poor quality service is to be found across the range of providers, and size is no guarantee of quality. (MoH audit 2003) However, the Introduction of a Standard that mandates higher levels of training and supervision will require significant provider capability and capacity development, including significant workforce development. Merely making the H&CSS Standard a contractual requirement in the future, without stabilising and restructuring the workforce, will not only be a difficult and expensive exercise, but risks having a significant destabilizing effect, exacerbating the risk of further service gaps.

The current high turnover of support workers, particularly in the first year of employment, make it uneconomic for providers (and funders) to significantly invest in this workforce. Workers who undergo training are likely to leave in large numbers, using their training to gain better paid and more secure jobs elsewhere, representing a negative investment for providers and funders. If workforce turnover is not controlled, the implementation of NZS 8158 will have an unnecessarily serious cost impact. (See **Workforce Issues** for further research and discussion.) Greater investment in the workforce will be necessary, including both the support workforce and the wider workforce of educators and coordinators/supervisors.

The implementation of training standards and requirements needs to be accompanied by an overall workforce development approach that addresses the issues that have been shown to generate high turnover of support staff, such as remuneration and working conditions, job enrichment and opportunities for promotion.

There are currently low numbers of the senior workforce that would be required to facilitate standards development. If the new H&CSS Standard is imposed in the current environment, management resource that is at present fully occupied with managing the high turnover will need to be released to conduct training. There are currently not sufficient workers in the industry at a senior/coordinator level to conduct the existing supervision requirements to maintain safety. Providers would not be able to achieve the required training and supervision for the new H&CSS Standard without significant workforce development at this senior level.

In summary, the existing structure of a largely part time and casualised workforce is in conflict with the emphasis on training in NZS 8158. The greater the number of individuals who need to be trained to a standard, the more resources are required and the greater the cost. The two major issues that need to be addressed before the H&CSS Standard is implemented are:

- the structure of the workforce

- controlling turnover

If improved standards are to be achievable and affordable, workforce structure needs to be changed at both support worker and coordinator levels to enable both agencies and workers to make more permanent commitments and investments.

KEY NOTES - SERVICE QUALITY & INDUSTRY STRUCTURE:

What We Know:

1. There is poor information flow between NASC and provider agencies
2. Support services lack adequate care planning, risk assessment and linkages to other services the consumer is receiving. There is currently little, if any, ongoing monitoring or review by either the provider agency or the NASC until there are substantial changes in the consumer's circumstances.
3. The delivery of services across wide geographic areas, combined with the fact that workers operate in isolation, means that providers struggle to set and maintain quality and safety standards in the community setting.
4. The ratio of coordinators to support workers is low and senior staff are currently too fully occupied managing the impact of recruitment and retention issues to adequately train and supervise support workers.
5. While the risks generated by poor training and supervision were not considerable in the past, consumers' increasing acuity and complexity of need has raised these risks considerably.
6. Significant service gaps are increasingly evident. These are both geographic and time related.
7. Merely making the H&CSS Standard a contractual requirement in the future, without stabilising and restructuring the workforce, will not only be a difficult and expensive exercise, but risks having a significant destabilizing effect, exacerbating the risk of further service gaps.

What We Need to Do:

1. A purchasing approach needs to maintain a degree of flexibility while moving to support a reliable and consistent quality and safety response to the complex delivery requirements of these services.
2. The Introduction of a Standard that mandates higher levels of training and supervision will require significant provider agency capability and capacity development, including significant workforce development.
3. The two major issues that need to be addressed before the H&CSS Standard is implemented are:
 - workforce structure
 - workforce stability and turnoverWorkforce structure needs to be changed at both support worker and coordinator levels to enable both agencies and workers to make more permanent commitments and investments.

WORKFORCE ISSUES

INTRODUCTION

The demographic profile of the support worker that has emerged from the NZ DSS Surveys 2004 paints a very diverse picture of the workforce, in terms of ethnicity, age, employment contracts, number of positions held and work undertaken.

Support workers are delivering services in isolation, with minimal orientation, very limited training, and a lack of monitoring and supervision. While this is the way HBSS operated historically, the increasing acuity and complexity of need among older people remaining in the community has exacerbated the risks of this situation. Workers are now delivering services to frail, vulnerable older people with volatile needs.

In this situation safety issues relate to worker competency and commitment, inadequate training, poor supervision and monitoring and workers ignoring safety procedures and boundaries. Workers are carrying out tasks outside their scope of practice and training or providers are refusing to undertake support for consumers with high needs, thus creating service gaps.

RECRUITMENT

Providers in the NZ DSS Surveys 2004 report great difficulty retaining staff, and state they spend a great deal of time and resources recruiting new support workers. This difficulty is evident nationally, but varies from region to region, with smaller provincial centres faring best. Rural areas, larger cities and regions with particular workforce competition issues, such as tourism and seasonal work, have the greatest difficulty.

Newly recruited support workers are often new to the workforce or have not worked for some time. The NZ DSS Surveys 2004 show the minimum standard for employing support workers is good spoken communication (92%) and good written communication (71%). However, 74% of providers stated they have no minimum education criteria, though 77% see relevant life experience and previous experience as a caregiver as important (61%).

In spite of these minimal employment criteria, providers state that the competencies required of their workers are much greater than in the past. The changes in consumers' circumstances over the last ten to twenty years mean that workers not only need competency in performing basic tasks, but the many different levels of need now being supported in the community mean there is a requirement for workers with varying levels and types of competency, including interpersonal relationship management and the ability to manage boundaries of care.

In contrast to the rising levels of competency required, providers report a reduction in the quality of the support workers who are looking for work compared to ten or twenty years ago. The current services were developed

during a period of a relative labour surplus, which allowed the home support providers to build their workforce cheaply, with little regard to job quality. At that time, there was a good supply of middle aged women with life experience and excellent practical skills. However, the current high employment environment in NZ means the available workforce pool is not only reduced in number, but also has lower skills and work readiness.

Providers state that many workers have literacy problems and most workers have low confidence in their own ability to learn. While many workers with these problems still have excellent practical skills and abilities, providers are finding an increasing number of workers who are unable to perform even basic domestic tasks such as food preparation or cleaning the floor. Providers struggle to provide the resources to adequately train their support workers in these tasks. The NZ DSS Surveys 2004 show that training workers to perform basic tasks sometimes occurs in an ad hoc way if clients make complaints about the quality of their support.

In summary, providers cannot be selective about who they hire because they have severe staff shortages. As home-based support workers have poor working conditions, such as low pay, lack of guaranteed hours & a requirement to travel at their own cost, they are difficult to employ in the first place. Providers invariably end up employing less experienced workers who have low skills and experience barriers to learning. These workers in turn need significant support and training to achieve an adequate level of communication and skills.

WORKFORCE STRUCTURE

Casualised workforce:

Home based support services in NZ are characterised by a casualised and limited workforce structure. The majority of support workers are working part-time, on individual, casual employment contracts. Over half work under 10 hours a week, with another 25% working 11 to 20 hours per week, with most having no guarantee of the number of hours they will work. Coordinators tend to be employed full time on permanent contracts.

Providers choose to structure the support workforce this way because of the highly variable client base and the funding constraints of the current purchase framework. Workers are largely hired to match clients geographically, to limit travel as much as possible. Client choice and geographic location impacts significantly on the viability of the support worker's position, as the worker can't be redeployed easily if there are no other available clients in their area. As well as this, clients' needs are always changing and providers state they cannot afford to carry the risk of having to pay the workers for hours unless they are assured of receiving funding for that time.

Individual contracts are also seen to be more flexible and responsive to the needs of the workers as support workers are attracted to home-based support work because of the flexible hours and the possibility of part-time work. Many

support workers prefer to work fewer hours, or to have flexible work schedules because of family commitments or other work commitments

Career path:

The industry also lacks a culture of advancement. Providers in the NZ DSS Surveys 2004 were concerned at the lack of career path for support workers, and believed that creating opportunities for advancement would help to address the high turnover. However, such a solution is deceptively simple. The NZ DSS Surveys 2004 also show that most workers do not start the position with a career in mind. Workers are attracted by the part time, flexible work, and do not generally envisage remaining in the position for a long period, nor do they necessarily have the qualities that would make them good coordinators. Providers believe that this negative attitude towards career advancement is reinforced by the low status of home-based positions.

Another issue that hampers the development of a career structure for support workers is the limited choice of levels for advancement. For most providers, staff are organised into one of three “tiers”: (a) domestic workers; (b) personal care workers, or; (c) coordinators. The NZ DSS Surveys 2004 show that most support workers feel there are few opportunities for promotion in their current employment. The difference in skill level and competence between the support workers and coordinators is so great it is a disincentive for workers to move from one position to the next. Very few workers currently advance from being a support worker to a coordinator.

TRAINING

Current situation:

Training approaches vary significantly from provider to provider, in general fail to address service requirements and also fail to meet the needs of support workers. The NZ DSS Surveys 2004 show that a large proportion of the HBSS workforce has little training beyond brief orientation.

As there is usually only one opportunity to train workers, providers often try to make the orientation as comprehensive as possible. Providers report that a large volume of information is given out during the orientation session, and the workers sometimes struggle to take it all in, becoming bored or discouraged. Providers state that agencies are so desperate for staff that they sometimes send workers out into the community after providing only an hour of orientation to the position.

To improve basic safety providers state the need to train their workers to communicate effectively, develop rapport with consumers and their families, and understand their roles and responsibilities as support workers. There has been much discussion about ‘professionalising’ support workers in order to improve the status of home and community support services, thus attracting workers with better skills who would be more easily trained to provide safe services.

However, achieving an adequately trained workforce involves a complex interrelationship of issues. While workers are now inadequately trained for the work they are being required to do, providers face significant difficulties in addressing these issues. They face the double complexity of an extremely difficult training environment (low skill workforce pool who experience learning barriers, part time employees spread over a wide geographic area, low staff/trainer ratio) combined with severe recruitment difficulties.

Geographic area:

Providers struggle to accommodate ongoing training due to the nature of community based work. It is difficult to bring workers in to the agency office for training sessions, as the current funding level does not cover the worker's time when they are not directly providing a service, or a replacement worker for the client. Thus most providers don't pay workers for time spent training, or for travel time to get to training. This disincentive is exacerbated in rural communities where many workers live a great distance from the office.

Part-time workers:

The part-time nature of the workforce is another barrier to a centralised training approach, as part-time workers usually have outside commitments or other positions that make it difficult to attend training sessions outside their hours of work. The NZ DSS Surveys 2004 show that a number of workers have other employment in order to increase their income, and are reluctant to attend unpaid training sessions if it prevents them from undertaking paid employment opportunities.

Age related issues:

The age of support workers has a significant impact on their willingness and ability to undertake training (Wilner & Wyatt 1998). As support workers are largely between the ages of 40 to 60 with a history of low educational attainment with low levels of confidence in their ability to learn, they find it particularly difficult to self manage learning tools.

Existing training packages:

Existing training packages that could be adapted for home based support workers rely on a trainee managed approach, using video and workbooks. These packages are used for support workers in residential care facilities, but have been shown to be difficult for these workers to achieve. The workers require a large amount of help, encouragement and supervision to be able to complete the programme.

Future training package:

Training standards for The Foundation Level Training for Home Based Support Workers were established by the Community Support Sector Industry Training Organisation (CSSITO) in 2004. CSSITO are currently developing a delivery system for this training, and state that it will focus on an 'on the job' approach in order to accommodate the difficulties faced by community based services. However, as stated earlier, providers will need to greatly increase the numbers and competency levels of their senior workforce to enable them to deliver on the job training to support workers individually.

Worker resistance:

Apart from the practical difficulties and the cost implications of accessing training, the most significant barrier to an adequately trained workforce is the fact that workers don't see any value in undertaking training, as it does not currently result in more pay, improved conditions or promotion. The NZ DSS Surveys 2004 show that even when training programmes are offered by providers, attendance is very low. Both providers and workers report that this is because:

- workers don't see any value in training as it does not result in more pay, improved conditions or promotion.
- there is no payment for the time to attend training
- there is no payment for the travel costs to attend training
- workers have difficulty finding the time because of other commitments
- workers lack confidence in a learning situation

workers lack language abilities

The NZ DSS surveys indicate that most support workers have family responsibilities that not only make it difficult for them to make extra time available for training outside working hours, but also that family is the number one priority for the majority of support workers. They work to make money for their family, so ultimately their major incentive to undergo training is to earn more money. Since providers cannot afford to link training with an increase in remuneration, they struggle to motivate their workers towards training.

Training Summary:

The two things that have the most impact on the retention of support workers are low pay and poor working conditions (Angle & Newman 2002; Bratesman 2000; Dawson & Surpin 2001). These two aspects can be seen to be impacting significantly on the NZ HBSS sector.

The NZ DSS Surveys 2004 reveal an apparent paradox in relation to the training of support workers. Support workers' attitudes and current actions in relation to training are not consistent. In the NZ DSS Surveys 2004, the majority of support workers state they were offered the opportunity to undertake training and felt it was very important that they be given that chance.

Providers in the surveys were also very clear about the value of having a trained workforce. However, workers did not feel that providers supported them to train and stated that they wanted more support from management for them to undertake training. Yet when providers offered training, very few workers responded to the opportunity.

This suggests that the issues of a lack of payment for training time, no increased remuneration when training is achieved, no improvement in working conditions and advancement when trained are strong disincentives to undertake training. These, coupled with the workers' lack of confidence in a learning situation, and competition from other responsibilities, results in a workforce that does not respond to training even when it is offered.

It appears that training is just one aspect of a very complex picture, and an adequate training programme offers only one part of the solution. Merely introducing a training course and requirements for minimum qualifications will not contribute to overcoming the training resistance that currently exists in this workforce. Without the appropriate changes to the service model in place, it is unlikely that a training programme will alter current practice, and if workers' contributing needs are not met, the introduction of training requirements could result in the exacerbation of the current workforce supply crisis.

HIGH TURNOVER

Causes

The findings of the NZ DSS Surveys match those of a wide range of international research which has consistently shown that the combination of

- poor salaries and benefits
- poor working conditions
- lack of adequate training
- lack of support and supervision
- lack of opportunities for advancement

lead to high workforce turnover rates in home based support services.

Internationally, workers express dissatisfaction with pay, benefits and opportunities for advancement. As in the NZ DSS Surveys 2004, workers internationally describe the considerable satisfaction they derive from taking care of people who need them. Support workers want good relationships with clients, guaranteed hours of work, more predictable schedules, more recognition and support, and safe, clean working conditions. (Sinclair 1998; Patmore 2001)

Impact of purchasing approach:

Providers in NZ have consistently identified the 'per hour per client' purchase model, with its attendant volatility and uncertainty as a barrier to service

sustainability. They see it as leading to casualisation and inefficient use of the workforce, which in turn generates staff turnover. This view is borne out by international research which links a 'pay per hour' purchasing approach to a low skills/casualised approach to the workforce. (Bratesmen 2000; Dawson & Surpin 2001) Research also indicates that a 'pay per hour' approach incentivises a high turnover as there appear to be lower costs to the provider in replacement. Although this has been shown to be an illusion as health and disability providers often fail to calculate the true cost of replacing workers. (Seavey 2004)

Impact of turnover:

While many direct turnover costs are borne by providers, others are borne directly or indirectly by support workers themselves, by consumers and their families, and by public sector funders. (Seavey 2004). They have been shown to detrimentally affect consumers and workers at the service delivery level.(Netten 2004) It can be argued that turnover-induced problems are especially detrimental in human service organizations where productive capacity is concentrated in the knowledge, skills, and abilities of employees, and is in turn directly linked to service quality.

Furthermore, research indicates that costs at the service delivery and funder levels are not necessarily integral to the provider's cost/benefit calculus regarding turnover. NZ providers show evidence of this in the lack of innovation they exhibit in addressing their high staff turnover issues. In other words, providers may determine that it is not cost effective for them to make the investments needed to reduce turnover, but by not making those investments, substantial "downstream" turnover costs may be incurred by other stakeholders in the system --- consumers and their families, workers, and public sector funders. (Paraprofessional Healthcare Institute 2003; Seavey 2004)

Causes summary:

The NZ DSS Surveys 2004 looked at people who had not worked as a support worker in the last month. It's interesting to note that 20% of these support workers reported poor health as the reason they discontinued employment as a support worker. The fact remains that while support workers express enthusiasm for the work, and often planned to remain doing it, the industry has a 39% turnover rate. Providers report a turnover of 50 – 80% of workers in the first year of recruitment and most workers have been in their positions for less than a year. These findings, and the reasons given by workers for taking up the position, suggest a somewhat vulnerable and volatile workforce who are attracted to the work and want to do it, but are significantly impacted by factors outside their work and by the current working conditions.

Solutions

To ensure quality support services, it appears that support workers must receive adequate remuneration, guaranteed hours of work, sufficient training,

good supervision, peer support and opportunities for upgrading and promotion. (Wilner & Wyatt 1998)

Banaszak-Holl & Hines 1996 found that increased training did not decrease turnover, but involvement in care planning, work autonomy and better career opportunities could be linked to lower turnover. Respondents in the NZ DSS Survey 2004 report that training is more important to them than promotion. For some support workers, training is related to recognition, support and increased contact with management, all of which are important to their satisfaction levels.

Bowers, Esmond & Jacobson (2000) report that one reason for a decrease in job satisfaction for support workers, is a feeling of disrespect from management. In the NZ DSS survey 2004, support workers cite limitations on their time and poor communication with coordinators as factors affecting the quality of their work. When this is linked to research that shows that 'being valued' is a significant issue for support workers, and that involving support workers in care planning could reduce turnover (Banaszak-Holl & Hines 1996), a picture begins to emerge that has significant implications for a purchasing approach.

Research also consistently shows that workers have a sense of responsibility towards consumers, and if they are unable to provide the appropriate quality support, this leads to an increase in stress and overall job dissatisfaction. (Bratesman 2000; Dawson & Surpin 2001; Angley & Newman 2002; Davis & Dawson 2003) Research also shows that the support worker's relationship with the client is a central determinate of quality of care (Sinclair et al 2000; Patmore 2002).

In the NZ DSS Surveys 2004 the most common reason given by workers for staying in their positions was that they enjoyed looking after their clients. 44% of workers continued working in the position because of the difference they made in the lives of consumers. A further 28% remained working because of personal satisfaction, or because they enjoyed the job. This is supported by the international literature, which reports that support workers enjoy caring for people and that the quality of the relationship with consumers is a significant factor in the support worker remaining in the position (Joseph Rowntree Foundation 1998; Wilner & Wyatt 1998; Dawson & Surpin 2001).

Only 15% of workers in the NZ DSS Surveys remained working because it was a source of income. This seems inconsistent with the most significant reason for not doing the work being 'low pay'. However, this can be seen as an indication that there is a certain sustainable level of remuneration required to attract/keep workers, and beyond that, people do the work because they want to do that particular work. This suggests that if the 'floor level' income can be achieved, (this would involve addressing the issue of guaranteed hours) there could be a fairly committed workforce supply for these services.

Solutions summary:

This sector faces the paradox of provider agencies with severe workforce shortages and great difficulty recruiting workers, being unable to guarantee workers hours of employment. This appears to point strongly to problems in the funding of services.

Evidence shows that support worker roles can be structured to attract quality workers who do the job because they 'want to care for people', without requiring excessive increases in salary levels. If working conditions are satisfactory, these workers have been shown to be a stable and committed workforce in both service trials and long running service structures.

A purchase framework needs to be established that supports providers to stabilise the current workforce turnover before training and standards development can be undertaken. This will need to include measures that introduce some certainty and stability of funding to allow providers to move to employment practices that guarantee hours of work for support workers.

Purchasing that promotes flexibility also appears to be an essential element in addressing both quality issues and workforce turnover. Purchasers have been shown to have an impact on service quality with regard to the time purchased and the flexibility allowed. The time allowed to undertake identified tasks and the flexibility workers have to respond to consumers' needs has been shown to impact on quality of service and on both the consumer's and the worker's satisfaction levels (Sinclair et al 2000).

The Community First model being trialed in Waikato, Otago and the Bay of Plenty utilises a bulk purchasing service model which works on the basis of some guaranteed hours and places considerable emphasis on the 'team'. The Waikato Community First model is currently undergoing evaluation as part of the ASPIRE project and the results will be available in 2006. However, recent informal reports from these trials indicate the turnover of support workers is significantly less than in normal home support programmes.

In order to address workforce turnover levels in the long term, support worker remuneration will need to be improved by addressing base pay rates, payment of travel time and costs, and recognition of qualifications gained.

Nearly two thirds of the workers surveyed by the NZ DSS Surveys 2004, who had previously worked as support workers, stated they would consider returning to this type of work if the pay rate and work conditions improved. This suggests that there is a work pool to be tapped if conditions improved. Because of its complex nature, the vulnerability of consumers and the resources at stake, support worker turnover is a pressing issue that all stakeholders will need to work together to solve.

Government needs to recognise the genuine requirements of these services and correct their historical underfunding. Providers have a responsibility to recognise the true cost of turnover and initiate innovative recruitment &

retention strategies. DHBs also have a responsibility to recognise the downstream costs of turnover for consumers, workers and funders and act to purchase services in a way which maximises flexibility and incentivises stability & sustainability.

KEY NOTES - WORKFORCE ISSUES

RECRUITMENT

What We Know:

1. Providers have great difficulty retaining staff, and spend a great deal of time and resources recruiting new support workers.
2. Because of severe staff shortages providers employ less experienced workers who have low skills and experience barriers to learning. These workers in turn need significant support and training to achieve an adequate level of communication and skills.

WORKFORCE STRUCTURE

What We Know:

1. Home based support services in NZ are characterised by a casualised and limited workforce structure. The majority of support workers are working part-time, on individual, casual employment contracts. Over half work under 10 hours a week, with another 25% working 11 to 20 hours per week, with most having no guarantee of the number of hours they will work. Providers choose to structure the support workforce this way because of the highly variable client base and the funding constraints of the current purchase framework.
2. The industry lacks a culture of advancement and suffers from the perceived low status of home based support work. This is reinforced by workers' low pay, lack of guaranteed hours and the requirement to cover their own travel costs between clients.

TRAINING

What We Know:

1. A large proportion of the HBSS workforce has little training beyond brief orientation. Approaches to training vary significantly from provider to provider, in general fail to address service requirements and also fail to meet the needs of support workers.
2. Provider agencies face an the double complexity of an extremely difficult training environment (low skill workforce pool who experience learning barriers, part time employees spread over a wide geographic area, low staff/trainer ratio) combined with severe recruitment difficulties.

3. The Support Workers Foundation Training Programme package has been developed by CSSITO. However, even when training programmes are offered by providers, attendance is very low. Merely introducing a training course and requirements for minimum qualifications will not overcome the training resistance that currently exists in this workforce.
4. The most significant barrier to an adequately trained support workforce is the fact that workers don't see any value in undertaking training. The issues of a lack of payment for training time, no increased remuneration when training is achieved and no improvement in working conditions and advancement when trained are strong disincentives to undertake training.

PURCHASE FRAMEWORK

What We Know:

1. In NZ and internationally, research links the 'pay per client per hour' purchase model to a low skills/casualised approach to the workforce.
2. The true costs of support workforce turnover are much higher and more comprehensive than is usually perceived.
3. The support worker's relationship with the client is a central determinate of quality of care. Workers have a sense of responsibility towards consumers, and if they are unable to provide the appropriate quality support, this leads to an increase in worker stress and impacts on both the consumer's and the worker's satisfaction levels.
4. Research shows that ensuring quality support services and lowering workforce turnover is linked to workers 'being valued' which have been shown to relate to:
 - adequate remuneration
 - guaranteed hours of work
 - adequate training
 - good supervision
 - peer support
 - opportunities for upgrading and promotion
 - involvement in care planning
 - work autonomy

KEY NOTES 2 - WORKFORCE SOLUTIONS

What We Need To Do:

1. A purchase framework needs to be established that supports providers to stabilise the current workforce turnover before training and standards development can be undertaken. This will need to include measures that introduce some certainty and stability of funding to allow providers to move to employment practices that guarantee hours of work for support workers.
2. Purchasing must allow sufficient time and the flexibility for workers to respond adequately to consumers' needs. Purchasing must also facilitate providers to raise the value of support work by:
 - providing an adequate 'base-rate' of remuneration
 - some guaranteed hours of work
 - adequate training
 - good supervision
 - involvement in care planning
 - peer support
 - opportunities for upgrading and promotion
3. In order to address workforce turnover levels in the long term, support worker remuneration will need to be improved by addressing base pay rates, payment of travel time and costs, and recognition of qualifications gained.

INTERNATIONAL PURCHASING MODELS

World wide there is a move from the 'replacement' model of home support which primarily aims to support the older person in the performance of tasks that they are now unable to perform alone but which are necessary to daily living (the current NZ model) to a 'rehabilitative' model which aims to intervene to restore maximum functioning and quality of life. Such a model encompasses both the goals of supporting daily living and maximising independence within the aspiration of promoting social inclusion throughout the life course. (Sinclair 2000)

Research shows that purchasing policies impact directly on whether providers can meet consumers' changing needs adequately. The research also shows there is no one model, but a number of approaches that will deliver successfully, depending on local circumstances. However, 'flexibility' is a key concept when considering future models of support. Flexibility applies across a number of aspects of service delivery, all determined by the funding framework. To deliver quality services to successfully meet the needs of consumers flexibility needs to apply to 'what, when and how'.

Consumers need choice around what options are available for services to meet their individual needs and goals, and to address individual risk factors. There also needs to be flexibility built into the purchasing to facilitate a flexible response to the time frame the services are delivered in and the way they are delivered.

These approaches fall into 3 categories:

Intra-task time assessment - adequacy of the time allocated for a visit

The estimate of time allowed for the tasks required to meet the assessed need makes the difference between a worker delivering the service in a consumer-friendly way that is safe and acceptable to the consumer, and having to rush through a task in inadequate time. In a home and community context, a 'cookie cutter' approach to estimating the time it takes to perform a task can lead to service delivery that is unacceptable to the consumer, upsetting and scaring them, or, in some cases, can lead to service delivery that is unsafe for the consumer and/or the support worker (Patmore 2003). The time required to perform simple tasks can be consumer specific and context specific, and it can change from day to day depending on the consumer's physical and emotional state. In general, the original time estimated to perform tasks needs to be realistic and the approach flexible so that the consumer's needs can be taken into account, e.g. when a consumer has had a recent fall, they may be weaker and more easily scared, and dressing and showering may need to be approached more gently and take longer than when the consumer is feeling more robust.

Ability to provide extra time on a one off basis in response to episodic changes in need

A more significant amount of time may be needed either performing the same tasks, extra tasks, or attending to tasks more often for a consumer for a limited period due to episodic changes in their physical and/or emotional condition, e.g. when a consumer has the flu, a 'flare up' of their condition, or is discharged from a short term hospital admission.

Ability to change the tasks performed

The provider needs to be able to respond flexibly to needs identified in consultation with the consumer, e.g. if a relative who normally provides transport for essential needs is away, a consumer may prefer to forego cleaning time for transport for shopping or a doctor's visit.

There are a number of international approaches that exhibit these aspects of flexibility. Comprehensive reviews of the literature investigating practical models for organising home care services and responding to older people's individual needs showed that service flexibility and budget management benefits could be achieved by the bundling of services together. The reviews examined a wide variety of purchasing approaches that promoted both service responsiveness and workforce management. (Dumont-lemasson et al 1999. Sinclair 2000. Bratesman & Saucier 2002. Patmore 2003.)

Service Responsiveness

Early trials of intensive home support for people at risk of residential care in Britain were considered successful but failed to translate into long term purchasing:

Thanet Community Care Project, Kent:

Staff deployed a decentralised budget which could be spent on a variety of services not normally available through the existing social services system. Staff were required to cost the overall packages of care which they organized, taking into account both the cost of existing services such as home help and meals on wheels, and also their additional expenditure. They were free to organize the most appropriate packages of care according to the needs of clients and their caregivers within an overall constraint of two thirds of the cost of a place in a residential home. Expenditure beyond this level was permissible at management discretion. The staff also had to keep more systematic and structured records than was commonly the case. These formed the basis of accountability and monitoring of the scheme by management, and covered the assessed needs of clients, the activities of field workers and the costs of care.

Outcomes for consumers: Assessments became more wide ranging and problem focused , and were no longer concerned narrowly with service

eligibility. It was found that a number of problems which frequently prove to be associated with the breakdown of community care, such as severe stress on carers, risk of falling and confusional states, were much more effectively managed at home than is normally the case. Overall, the model reduced the need for institutionalization, improved the levels of satisfaction and well-being of older people and of their carers and achieved this at no greater cost than is normally expended in the care of such clients.

Darlington Community Care Project:

This was a multidisciplinary model designed to discharge frail, elderly people from long stay geriatric wards to their own homes. Consumers received extensive levels of home support provided by multi-purpose care workers who spanned the role of home help, nursing aide and paramedical aide, supported by a multidisciplinary geriatric team which referred, assessed and reviewed. They were supervised by case managers who deployed an overall budget.

Outcomes for consumers: The programme resulted in improvements in client well-being and lower levels of carer stress than patients in long stay hospital at no greater cost. The strengths of this model lay in promoting the continuity of worker/client contact and the combination of the meeting of practical needs with helping with emotional or psychological needs. (Challis 1999)

Gateshead Community Care Project:

This was similar to the Thanet model with support from a multidisciplinary case management team and support for informal carers. While the scheme was geographically & socially different to the Thanet model, it produced even lower rates of residential care admission at the same cost as conventional care for the consumer group.

Other approaches described in the reviews:

- Providers where the line-manager to care workers assessed each referral, then devised and, if needed, revised care packages. Control by Purchasers occurred via a weekly panel of senior managers who had to ratify every new care package and every major change to a care package – often using their overview of resources available.
- The line-manager to care workers could adjust care in the light of overall consumer needs at the time. Instead of set lengths for each visit, staff were assigned tasks only and told to spend as long as these tasks required, which varied with consumer's health. 'Task-centred, not time-centred' was how this arrangement was sometimes described.
- In another service, if a consumer seemed to suddenly need more care, the provider could count on funding to temporarily increase the time supplied for up to a week, to allow for delay in re-assessing the case. Payment was assured to them whether or not an increase was eventually agreed. Currently in NZ, home support is provided for increasingly

unstable consumers. If providers observe a change in a consumer's circumstances that creates a distinct need that is not met by the initial assessment, providers often provide any such emergency increase above initial time specifications. Even if increased time is eventually approved, the provider can receive no back-pay for increased care prior to re-assessment. There have been lengthy delays for re-assessment reported.

- In other models described in the reviews providers were allowed, at their own discretion, to increase the time budget for a consumer. In one case, visit lengths could be increased by up to 15 minutes. In another, total weekly care could be increased by up to three hours per consumer. Greater increases required Purchaser approval. At other providers, while Purchasers initially indicated timed amounts of care, provider staff had some flexibility to work in a 'task-centred' way, vary the amount of time. The charging system was sensitive to the way in which visit lengths could change day-by-day in response to consumers' circumstances. Further approaches allowed supplemental payments to be made to providers for additional contractual obligations, such as care coordination or achievement of specific performance goals.

Other suggestions made by the researchers, based on evidence, would allow provider responsiveness while maintaining purchasers' control over the use of public money. For instance an independent provider could be allowed to increase daily care time at its own discretion for up to a week, if a consumer required it, or the purchaser could allow an agency a finite monthly budget of unallocated hours on which it could draw for any extra time required. A purchaser representative could discuss each use of this time budget retrospectively with a provider's manager at a monthly meeting and thus illustrate what use was permissible in future. The monthly time budget could be adjusted as circumstances warranted – increased, decreased or terminated. Purchasers could thus maintain significant control. Purchasers would face strictly limited claims for extra resources, no higher than all the unallocated hours. This approach would also allow benchmarking and comparison of providers' claims from these time budgets.

Workforce Management

Other aspects of models described in these reviews described different approaches to managing the workforce. These services were much less affected by the problems of recruitment and retention and safety and quality issues than other services in the same area that followed the conventional casualised approach to workforce management.

In some services home support staff were employed for a guaranteed number of hours per week – for instance 10, 15 or 20 hours. On top of this they often also worked many additional hours, if the service needed it and a worker was willing. If demand for a worker fell however – for instance through a worker's regular client being admitted to hospital – and if managers could not find them fresh work, workers would still be paid for their full number of 'guaranteed hours'. Pay also covered time spent traveling between consumers and for training and staff meetings.

In other services that followed this 'guaranteed hours' workforce management model, each worker was committed by contract to work a fixed number of hours per week, somewhat more than their hours of guaranteed pay, if managers required this. Extra hours on top of this were optional for both parties.

Each worker's hours and income usually fell into three categories. Staff were often paid on banded hours like '10 -15' or '15 - 25'. For a worker with, say, '15 - 25' banded hours, these three categories would be:

- Pay for at least 15 hours per week was guaranteed, whatever happened. If a major customer had been admitted to hospital, management had to either fill these hours with other work or pay the worker for doing nothing.
- The worker was obligated to work for at least 25 hours each week, any week that management desired this.
- On top of this, the worker might work extra hours if management desired this and the worker was willing.

Thus staff had part of their income guaranteed, and managers had a significant amount of guaranteed, predictable labour for planning the workload. Familiarity has been a significant factor in effective support services. (Wilner & Wyatt 1998; Patmore 2004; Sinclair 2000) Many providers strove to create for every consumer one support worker who was clearly that person's main worker. Some agencies provided a consumer's support wholly through this main worker, backed by one or two other familiar regular workers - who could also replace the main worker when ill or on holiday.

These agencies would attempt to supply twice daily visits, seven days a week, through only two different staff. A number of providers strove to create for each consumer a small group of staff (eg: three) who became their familiar support workers. This increased the chances that, when a scheduled worker was absent, a familiar person could always be found to substitute. Other providers believed that, as long as consumers received their weekday morning service from a single main worker, they could accept several different workers for evening and weekend visits.

Weekend & 'After hours':

When approaching the difficult weekend and 'after hours' work, rather than relying on all workers to fill these hours, some agencies formed a 'volunteer group' of specific workers from the general workforce that they could rely on to work these hours. Others went further and created some weekend care positions with guaranteed hours, where workers could fill gaps in weekend service if other staff did not volunteer. Some Purchasers funded a specific new high pay rate at weekends which improved the supply issues dramatically.

In remote geographic areas where it had been almost impossible to supply workers, purchasers resolved the supply issues by providing for higher wages plus mileage costs for workers servicing these particular areas,. Purchasers also funded some new posts, which had guaranteed hours of work, for stand-

by workers who could serve new customers from these hard-to-serve areas till other workers could be found.

Other purchasing approaches supported models that focused on service responsiveness and the most efficient and effective distribution of skills within the workforce. For example:

Example A: A service made up of specialist teams:

- An Intake Team for new home support referrals. For up to six weeks it would assess them and undertake rehabilitation and enablement work to establish what service was strictly necessary. Then, if needed, they would be transferred to an appropriate longer-term provider.
- A team which provided a four week programme to assist hospital discharge, and then transfer if needed to a longer-term provider.
- A team of 'generic care workers' who could work jointly with Health staff. They were being trained by District Nurses.
- A specialist support team for people with mental health problems.
- A support team for people with physical disabilities, people with learning disabilities, and for children.

Example B: This was divided into four specialist teams:

- A short-term service for assessment, rehabilitation and enablement work, like Provider 'A'.
- A support team for people with complex needs - like sufferers from MS, Parkinson's Disease, or strokes.
- A service for people with dementia
- A team of mixed Health and Social Services support staff serving people needing a mix of Health and social care

Conclusion

The reviews and demonstration projects show there is no one delivery model that determines success. (Sinclair 2000) identifies some elements of an 'ideal type':

- care management with devolution of budgets
- multidisciplinary assessment (especially including health input)
- regular reviews and ability to respond rapidly to changes in need
- purchaser has access to services that can be responsive and flexible in terms of skills and times available

- overall co-ordination of health (hospital and community) and social care
- good communication with older person and carer and between all contributing providers of service
- all involved professionals work as if one team, centred on the older person
- access to health monitoring and medical and nursing support
- locality management that can maximize use of local resources
- seamless delivery through generic workers
- named worker or small team of named carers
- role of informal carer (if applicable) supported
- rapid delivery of appropriate equipment and adaptations
- goals focused on independence and wellbeing and not merely survival
- attention paid to maintaining family and community links
- availability of suitable workforce carers trained for practical tasks, caring relationships and delivering support in the home.

Current NZ Trials of New Purchasing Models

Ageing-in-Place requires services to have a rehabilitative approach, that is, to be committed to the idea that older people can recover function, and to provide a service that encourages the older person to maintain control over their daily life. This requires a flexible service with well-trained and committed staff. Funders and providers are cooperating in a number of areas throughout NZ to undertake new initiatives in service delivery, or implement changes to current practice to improve service outcomes for clients. In general, one of the observed impacts of these approaches is improvements in workforce recruitment and retention.

Community First Ageing-in-Place Pilot, Presbyterian Support Services, Dunedin

Issues triggering this initiative included clients being unwilling to enter residential care or wanting to exit residential care, and recognition by the provider and the funder that developmental work was required. The setting is home based and targeted to people aged 65 and over.

The service focuses on providing flexible, rather than prescriptive and task oriented, services and on improving client function and health status. The service is also funded as a “package of care” rather than on a fee-for-service model, which has allowed the provider to be more flexible both in meeting the needs of clients, which for these older people with complex needs can vary from day-to-day, and the needs of care staff, who have been able to be offered permanent employment rather than being employed on a casual basis.

The client receives rehabilitation from a team directly employed by the organization that includes physiotherapy, occupational therapy, and nursing staff. Service planning is viewed as a dialogue with the client and the support package is agreed on a case-by-case basis. A case management, rather than service coordination, approach is used.

The team of staff is split geographically. This reduces travel time and mileage costs. Clients are formally reassessed three-monthly to re-examine funding levels. The service has a low coordinator to client ratio of one coordinator to 30 staff. Workers have regular scheduled contact with their coordinators and a handover meeting when the three-monthly client review occurs. Having a central headquarters for the service ensures a close connection between coordinators and workers.

Attendance at in-service training and a weekly team meeting is compulsory. Workers are employed on permanent employment contracts, at agreed hours.

The service aims for a mix of 85% of hours covered by permanent contract and 15% by casual contract. Workers are paid at a standard rate irrespective of training completed and there is provision for paying mileage. Travel time is incorporated into the salary.

A broader group of applicants was attracted to apply for the support positions by differentiating the role as a 'support worker' as opposed to caregiver. Being part of a pilot that may influence how a future service develops was also attractive to these recruits.

Outcomes of the pilot to date include people staying in their homes longer and lower levels of admission to residential care and hospital. The ability to recruit and retain support workers is favourable with the service demonstrating no recruitment problems and low staff turnover.

Community First Ageing-in-Place Pilot, Presbyterian Support Services, Waikato

This initiative was triggered by research by the provider indicating that clients were seeking services that were client-centred, goal oriented, and which maximised their independence and enabled them to remain in the community. The service is home based. However, the provider has a relationship with another provider to offer transitional residential beds to assist people needing higher support before going home.

The service is targeted to people 65 and over whose needs indicate eligibility for residential care but who choose to remain in their own home. The primary objective is to give the person a real choice of remaining in their own home and to support restoration of, and improvement in, their health function.

A funding package is allocated to each person and used flexibly according to the changing needs of the person. The client is involved in determining how their needs will be met within the allocated package. The level of funding is linked to the contribution that Vote Health would make to the person's care if the person were to enter residential care. Overseas evidence would suggest that the overall cost of the service would be approximately 80% of the cost of residential care. This project is being evaluated as part of the Assessment of Services Promoting Independence in Elders (ASPIRE) project, which is a meta-analysis of three randomised controlled trials being undertaken by the University of Auckland under contract to the Ministry of Health. The report from this project will be available in June 2006.

The service is configured into teams. Key workers have primary responsibility for a group of clients, with other team members providing back up. Each key worker has a defined work schedule. The coordinator (a registered nurse) is readily accessible to clients and to the team and interfaces with primary care. A case management approach is used and the multidisciplinary team assesses all clients and their home situations before the service commences. This team includes a registered nurse coordinator, physiotherapist and an occupational therapist.

All workers are required to complete a training programme involving one hour's attendance every fortnight over 26 weeks. This programme has been newly developed in conjunction with Auckland University and is based on the Foundation Certificate with additions for dementia and the restorative model of support.

The service has a low coordinator to worker ratio, which the provider finds assists with worker isolation, improves camaraderie, and enables training and support for workers. Workers are employed on a permanent contract for set hours within a fortnight and receive incremental adjustments to their wages in line with on-the-job experience and completion of training. Trained staff can become part of the casual pool. Workers are paid for their full working day including travel time, and are provided with cars. Valuing the workers is demonstrated by investment in worker conditions and training, and their involvement in how the service operates.

The service has been operating for 24 months and appears to be going well. It has had much less difficulty recruiting staff in comparison to the provider's previous experience in home care, and has very low turnover.

Initial review by the provider suggests good outcomes for clients, with some very positive success stories. Indices measured support the possibility of maintaining or improving functional ability bringing the associated benefits for clients' quality of life.

Community First Lite

Presbyterian Support Northern are currently developing an adapted approach for clients with less intensive need for support. A version of Community First Lite is currently used as part of the 'drop down' process within Community First, and Presbyterian Support Northern are considering trialling this less intensive approach in other areas.

Slow Stream Rehabilitation Pilot, Masonic, Horowhenua

This service was developed to meet a need in the community for more comprehensive rehabilitation services for older people after illness or injury. It was believed that this two-year pilot for slow stream rehabilitation would prevent some older people were being admitted into residential care prematurely and that if they received more rehabilitation they could make sufficient improvements to return to live in their own homes.

The service targets people aged 65 and over, and most referrals come from the public hospital for people that have completed their rehabilitation there but are identified as having the potential to make further gains with more rehabilitation. Some referrals come directly from the community and from general practitioners. To be accepted there must be a realistic expectation that clients will be able return to their own homes at the completion of rehabilitation.

Clients receive rehabilitation services as inpatients for up to 12 weeks or as outpatients for up to one year, in a unit within the rest home wing of a large

retirement village. A multidisciplinary rehabilitation team including physiotherapy, occupational therapy, registered nursing, and rehabilitation consultant input, provides services. A needs assessor from the local Needs Assessment and Service Coordination agency is an integral member of the rehabilitation team. Support workers are called “rehabilitation assistants”, receive specialised training as part of the team, and assist with implementing the rehabilitation plans created by professional staff.

Workers are required to undertake training within six months of joining the initiative. Course fees are reimbursed on completion of training and the education officer gives individualised training assistance as necessary.

The provider has no difficulties recruiting and retaining staff. The environment is characterised by professionalism and effective teamwork, which is perceived to be a significant factor in the low turnover.

Outcomes of the service for clients are yet to be analysed. A similar programme being operated in the Hutt at Woburn Masonic is being evaluated as part of the ASPIRE project.

Coordination of Services for the Elderly (COSE), Christchurch

The Coordinator of Services for the Elderly (COSE) model of care is the result of an ElderCare Canterbury initiative based in a primary health care environment, which evolved out of community consultation over many years. The service is run through Canterbury DHB and includes control groups to enable comparison between the Needs Assessment and Service Coordination agency and COSE models. This service is one of the three services being evaluated through the ASPIRE project.

The service targets people 65 and over living in home and community settings with medium, high, and very high needs, and aims to ensure that people can be integrated (or re-integrated) into the community and to improve the social networks of clients as well as providing health support.

A one-stop-contact case manager approach is used. The case manager (a nurse or allied health clinician) liaises with a cluster of general practitioners in a given area, is responsible for all care for the registered clients, and is trained in needs assessments.

Evaluation of the model to date has shown that locating a “key worker” in a primary health care environment has assisted timely access for older people to primary and community health services that proactively improve and maintain their health and independence.

Although statistics show similar workloads as in existing service models, the COSE service has clearly shown decreased waiting times and resulted in fewer hospital admissions, which has had a positive impact on costs. General practitioners are supportive because their workloads have been reduced, they can delegate some of the tasks they previously did, and they have a key contact person to ask about their own patients.

CONCLUSION

Ultimately it is well accepted that community based support requires a significant investment at central government level. However, in the immediate future, DHBs are faced with the dilemma of addressing the critical issues, stabilizing the industry and improving support services to enable older people to remain at home, while controlling and containing overall costs. While these things may appear incompatible, evidence suggests otherwise. The challenge lies in developing a purchasing approach that embodies the government's strategic intent and gives expression to it through service shape and content while aligning it with cost containment.

While the current picture for these services is bleak, the outlook is positive. Although policy issues remain to be resolved, in many ways, the timing is right for DHBs to achieve the results needed. International evidence is emerging that shows home based care to be cost effective if designed and delivered properly. (Landi et al 1999; Weissert et al 2001; Challis et al, 1990:88; Chappell N. L 2004.) There are strong indicators of the essential elements needed for successful, cost effective home based support services from long running international examples, and promising service trials are currently being carried out in NZ.

Home Based Support Services can now 'come in from the cold' and be developed and integrated as part of the package of health and disability services based in the community. The government's strategic intent aligns closely with service elements that research has shown to be essential for the successful delivery of home and community support services.

Evidence indicates that the significant workforce issues will also be addressed by developing a new community based service structure and design. There can be synchronicity and alignment in addressing the needs of consumers and support workers that delivers improvements for both while controlling and containing both the direct service costs and the overall health and disability costs. (Wilner & Wyatt 1998; Sinclair 2000) **

Research suggests that establishing a sustainable approach that improves the quality and safety of services, stabilizes the workforce and effectively maintains people in the community will involve moving to a purchasing approach that:

- Is based on consumer's assessed needs, goals and risks
- Is outcome focused
- Maintains consumer choice and control
- Promotes habilitation/rehabilitation
- Enhances service responsiveness
- Promotes service flexibility

- Is relationship based
- Promotes family/whanau and community involvement
- Enhances coordination and collaboration
- Supports monitoring and supervision
- Promotes a competent and stable workforce
- Requires accountability from workers, providers and funders

Evidence shows that to address the high workforce turnover, support workers roles must maintain a level of flexibility, but provide an adequate base remuneration rate, a guarantee of hours, and an enriched working environment. This must include adequate training, supervision and support from managers, and the opportunity to deliver responsive quality services and maintain good relationships with clients and their families.

In addressing government strategies, DHBs have a plethora of choice in determining specific goals for a purchase approach to HBSS - promote efficiency and quality, maintain or enhance client outcomes, contain overall costs, increase access, match services to needs, prevent the progression of disability, concentrate public resources on those with greatest need, stimulate development of home and community based services, promote reasonable division of labour between informal systems and publicly financed care, reduce residential care usage, etc. Clarity about goals and consensus among participants will be necessary to enable community support services to achieve their intended outcomes (Patmore 2003).

To create appropriate and sustainable home and community support services for older people that are integrated with other health and disability services within a continuum of care, DHBs must change their approach to the services, including reviewing service goals and outcomes and developing purchasing approaches and service structures that will deliver on the government's strategic goals.

RECOMMENDED APPROACH TO A SERVICE STRUCTURE & PURCHASE FRAMEWORK FOR HOME BASED SUPPORT SERVICES

These recommendations are focused on developing effective partnerships between funders, consumers and providers within a quality and accountability framework. Research shows that this requires funding and decision making to be devolved close to the consumer, and requires a genuine shift of power and control established and maintained within a climate of mutual trust and responsibility. The goal is consumer driven services that present older people with genuine and sustainable opportunities to remain in living in the community.

The proposed purchase framework is designed to provide a flexible structure for purchasing, coordinating and facilitating services that are highly responsive to the individual support needs of clients. It will achieve the best outcomes for clients by addressing the quality and workforce issues that encumber the development of HBSS, promote a more sophisticated approach to service planning and development and facilitate strong quality and financial monitoring processes by the funder.

Aims

The proposed service delivery approach and purchase framework has the objective of:

- Supporting clients to live independently, enhance their quality of life and prevent premature or inappropriate admission to residential care.
- Providing a greater range of services
- Providing flexible, integrated and responsive services.
- Providing a seamless continuum of care through cooperative working arrangements with other services.
- Integrating with improved NASC processes.
- Making effective use of the total resources for HBSS.

The essential elements are a move to:

- Consumer outcome focused service specifications
- A purchase framework involving the purchasing of services by packages rather than by hours based on, client assessment and client goals

Current HBSS service specifications and contracting, pricing and funding approaches will need to be changed. Research studies show that a wide variety of successful approaches are possible, indicating that DHBs have a

significant degree of discretion in meeting local needs. The recommendations should therefore be seen as generic elements of a broadly defined approach. The proposed model is in line with the international and national research, and aligns with the approach to HBSS embodied within NZS 8158:2003 (Home & Community Support Sector Standard). It can be implemented within the current assessment structures and funding levels, but can easily be adapted as the existing environment changes.

The new structure proposes that:

- The needs assessment and service coordination process define the consumer's desired outcomes and determine a resource allocation based on the SPA Tool (In future the case mix utilization groups from the InterRAI MDS-HC will be used.)
- Entitlement for the consumer be expressed and monitored within the DHB's payment systems in care/resource levels rather than in hours
- Services be purchased as a package
- A wider menu of services be available under HBSS to meet the individual needs of consumers
- The actual mix of services to be provided within the package of resource allocated be determined in consultation with the consumer within a team approach involving the consumer, needs assessor and HBSS provider
- The package include any combination within a broad menu of services
- The package include a co-ordination role to assist in accessing other services
- Monitoring and accountability be a key aspect

Discussion of Issues

Assessment

Needs assessment will need to reflect a holistic view, focus on consumer goals and risks, and take a habilitation/rehabilitation approach. The consumer and the assessor will agree on the outcome that can be aimed for. A resource allocation for achieving this will be determined. At present this can be based on the SPA Tool. In future the implementation of the InterRAI MDS-HC will be a significant aid in facilitating a more comprehensive approach to assessment and care planning. The MDS - HC has a more objective and validated method of determining social and clinical needs. The MDS-HC resource utilization groups (RUGS) will provide more detailed information for casemix purchasing for home support to be implemented.

In the proposed model, service coordination will not, as at present, specifically define the hours of input or tasks/services that may need to be delivered to

achieve the outcome. The support package will be expressed in levels of resource.

Purchase of Service packages

The services needed to achieve the assessed outcomes for the client will be purchased from HBSS providers as a package. The package may include, but will not be limited to elements such as:

- Household management
- Personal care, including Complex care (Advanced Personal Care)
- Community Nursing
- Day programmes
- Social support
- Transport
- Allied health care
- Home visiting/monitoring
- Medication management
- Childcare
- Respite (In home, in facility, for consumer or caregiver)
- Education/training
- Community rehabilitation

Service packages could include any combination of these services. The contracted service package may include some of these services (funded by the DHB) while also asking the provider to perform a co-ordination role in accessing other services available from allied service agencies, community groups or informal caregivers.

Process

The service package that flows from the assessed entitlement will be determined initially by a team approach involving the consumer, their family/whanau and the service provider (and possibly initially the needs assessor). Subsequent changes to the package, within the overall resources allocation, will also be determined by this team approach (and may also include others who are significant in the individual consumer's service delivery, such as a health professional, service coordinator, support worker, allied worker, client advocate, etc). These adjustments can be made *without* the need to return to NASC for reassessment.

Thus the provider has the flexibility to provide the most appropriate mix of services, as the consumer's needs change. Some providers may elect to provide a comprehensive range of the services themselves, while others may

offer a core group of services and provide access to other services under MOU or partnership arrangements.

Monitoring

It is important to ensure that the comprehensive costs of providing the service packages are calculated by detailed examination. A system of devolved provider responsibility requires greater payer-provider collaboration, implying an active role for the purchaser which goes beyond the traditional claims payment role. A significant change in monitoring and reporting methods will be required with the move away from funding specific hours of input to ensure quality of service and accountability for public funding. The proposed climate of mutual trust and responsibility must be backed by robust and comprehensive reporting mechanisms.

Monitoring needs to occur at several different levels:

- Provider volume and mix reporting.
- Quality Audit of services delivered
- Evaluation with the consumer by NASC in regular review sessions re the extent to which their desired outcomes have been achieved and risks managed
- Client feedback to service provider/funder through client satisfaction surveys, etc

DHBs would need to develop a monitoring mechanism for providers, which would entail:

- Providers reporting on specific service provision for clients
- Providers reporting on the total volumes of each category of service delivered in a given period
- DHB analysis of this data by number of clients supported
- DHB developing benchmarks of levels of input required to meet levels of assessed need
- DHB reporting to providers on their performance against benchmarks
- DHB undertaking a wash-up of funding from providers in the event that less than say 90% of the benchmark level of inputs was delivered

This approach will have benefits for long term service planning, as data analysis will make it possible to compare community based services packages with the cost of residential care. Economic evaluations however cannot be merely concerned with the cost of different models of service delivery, but must consider the outcomes for older people and their caregivers and family/whanau. In the longer term, mechanisms for the measurement of outcomes will need to be developed.

The InterRAI suite of assessment tools, including the MDS-HC are very valuable in this respect as they have been shown to be both valid and reliable over time, i.e. if a person shows change over time, then their condition has in fact changed in the direction shown by the assessment. InterRAI have developed 22 Home Care Quality Indicators using MDS-HV data. In New Zealand terms, these are actually community-based care quality indicators. These can be combined with other key performance indicators, such as outcomes for the family caregiver and modified for New Zealand to enable planners and funders to receive standardized and valid information about the effectiveness of the services they are purchasing, and improvements they need to make.

Past and current performance measurement in health and disability services has concentrated on the performance of a service rather than an assessment of its effectiveness - a concentration on the quality of inputs rather than the outcome achieved. Measures of performance have also concentrated on the immediate rather than the long term. The concern has been to ensure that consumers' houses were clean, they achieved personal cleanliness, they did not spend all day in bed, etc.

Funding for outcomes requires that the longer term outcomes of service delivery be part of the monitoring framework, such as the need to enhance older people's mental health or that of their family caregivers, or preventing the need for hospital admissions or the need to enter residential care.

Benefits of the Proposed Approach

- Facilitates an integrated approach to service planning and management
- Facilitates a flexible management approach that develops services that are responsive to both individual consumer need and reflects the culture and needs of the community it serves
- The range of services is expanded, with more appropriate use of services
- Allows providers to address issues and develop innovation in all dimensions of the service including management, workforce and service development
- Supports flexibility of workforce structure and promotes an enhanced support worker role through:
 - allowing workers to respond to individual consumer needs
 - promoting involvement of workers in decision making
 - enhancing the relationship between support workers and clients
 - promoting increased supervision and greater contact between workers and management
 - promoting interdisciplinary work practices
 - expanding opportunities for professional development
 - creating opportunities for training
 - supporting a team approach to staffing
 - reducing isolation

All of these aspects have been shown to contribute to improving retention.

- Supports improved service viability of the HBSS sector
- Increased service breadth & depth can be introduced while maintaining traditional services
- Provides conditions for a more cost effective service structure

Impact

Risk Management

Barriers to introducing this approach can be addressed through introducing programme guidelines, prioritising human resource development, coordinating an appropriate series of developmental activities, and introducing reporting arrangements and accountability systems designed to relate to programme objectives.

- Programme guidelines – detailed guidelines will be necessary to provide a baseline for programme development and operation
- Funding – clarity will be needed in the relationship between the funding model and financial accountability
- Programme accountability - Performance indicators & reporting systems need to be cogent to be able to quantitatively & consistently assess performance against the specified objectives
- Data recording – there needs to be a standardised framework for data reporting.

Implications for NASC

Moving to the proposed model requires a change in needs assessment and service coordination. These changes are in line with the New Zealand Guidelines Group “Assessment Processes for Older People” Guideline published in 2003.

Assessment will need to become more explicitly directed to assisting an older person to determine their goals. Better assessment tools, such as the InterRAI MDS-HC, will be needed to enable the assessor and the DHB to get better information about the physical, social and mental factors that mean the older person needs assistance to meet their goal. The sharing of the service co-ordination role will need to be clearly defined for each client so that responsibilities and accountabilities are clear.

Implications for Service Provision/ Providers

Service provision will be defined by revised service specifications that reflect a holistic, goal oriented outcome focus and a habilitation/rehabilitation approach. Providers will have the opportunity to deliver an expanded range of services. In consultation with the consumer and their family/whanau, the

provider will determine the service package, deliver and coordinate the package, and, with the consumer, continuously assess whether the package is achieving the consumer's goals.

Providers will carry a greater responsibility for the delivery of services that successfully meet the consumer's needs and achieve the consumer's goals. These changes will need to be achieved through a service development period that may result in revised management and service delivery structures, and will certainly require the up-skilling of management, coordination and support staff.

Implications for Industry Structure

Purchasing service packages assessed in \$\$ or classification bands will promote the integration of services, which will provide the basis for new services to develop to fill gaps.

Management and service delivery structures will be enhanced, with improved governance, improved workforce recruitment and retention, and improvement in service viability.

The future industry could take a number of forms. Providers could:

- Become larger in order to deliver across the spectrum of services
- Form coalitions with other providers or allied agencies
- Develop subcontracting arrangements with larger providers

Implications for Workforce:

In the current environment of severe workforce recruitment and retention issues, the increasing pressure for improved standards, training and qualifications for support workers may further destabilize the services. Increased requirements will lead to further demands from workers for continuity of work, work satisfaction and career pathways. The proposed model offers a way of addressing these issues:

- More flexibility and consistency in purchasing will improve the ability of providers to develop long-term business and workforce plans, rather than relying on extremely short term approaches such as the hiring of part time workers by the hour
- Providers can offer improved conditions of employment and career prospects for support workers. (e.g. guarantee of hours, continuity of work, ability to move up through a team.)
- The promotion of interdisciplinary work practices and expansion of opportunities for professional development inherent in the proposed approach has the potential to lead to a higher level of staff satisfaction, and result in greater staff retention
- Consumer driven, responsive services create an environment that enhances the support worker role and provides more job satisfaction for workers

The refocused service specifications will place new requirements on both management and support staff. As the NZ Aging in Place trials have shown, recruitment policies need to put emphasis on 'attitude' as much as skills. The ability of support workers to 'work with' rather than 'do for' clients will need to be identified and developed.

Improved standards mean there will be an increase in costs per worker in order to remunerate a more highly skilled and qualified workforce. Improvements in recruitment and retention of the workforce on implementation of the proposed model and the resulting decrease in staff turnover will help to counter this increase. Better deployment of the workforce will result in a reduction of the numbers of workers needed. Greater retention of workers and a more consistent funding approach will also assist workforce capacity building in the sector, as the proposed model both requires and allows providers and workers the flexibility to invest in training to meet nationally endorsed competencies.

There are currently approximately 45,000 support workers in NZ, working across community and residential care services. (Auckland Uniservices survey 2004) At present the workforce drain is significantly biased towards movement of workers from the community into residential care services. International research and interim reports of minimal staff turnover within the NZ Aging in Place trials suggest that implementing a model that supports and enhances the support worker role will not only increase recruitment opportunities for new workers, but may make home based support more attractive to existing workers from throughout the support workforce.

Workforce Development required:

- Improvement in recruitment approaches and processes
- Better deployment of the current workforce under altered contracting and purchasing approaches
- Changes in management structure and processes to increase supervision, training and contact with workers
- Development of management approaches to better manage the employment and deployment of the current workforce
- Reallocation of funding to different workforce costs
- Structured involvement of workers in decision making and care planning
- Targeted, modular, workplace based training for current & future support workers
- Nationally recognised and transferable qualifications
- Defined career pathways for support workers

APPENDIX 1

CURRENT PROFILE OF HOME BASED SUPPORT SERVICES IN NZ

The data has been drawn from the 2004 Auckland Uniservices surveys undertaken on behalf of the Ministry of Health Quality and Safety Project. These are:

Disability Support Services in NZ: Part 1 Service Provider Survey
Disability Support Services in NZ: Part 2 Service Provider Survey
Disability Support Services in NZ: Service User Survey
Disability Support Services in NZ: Workforce Survey

Consumer Profile

It is difficult from available data to establish a consumer profile. The Disability Support Services in NZ: The Service User Survey (2004) undertaken for the Ministry of Health by the University of Auckland gained a snapshot of disability support consumers by using data from the Client Claims Payment System (CCPS) which captured the invoicing of support services delivered in NZ in July 2004. It included invoicing for age related support services, support services for disabled people and mental health residential support services. In this 'snapshot' nearly half a million hours of home support services (HBSS) for all ages were invoiced nationally.

It appeared in all DHBs that the largest group of service users was those aged 75 or older, with a national average of around 61%. When those aged 65 and older are included, this national average grows to just over 73.

Consumer Profile:

- ❖ The majority of services invoiced were for older consumers receiving home based support or carer support services
- ❖ Around 56% of all consumers had a primary age-related impairment
- ❖ Of those 65 to 75 years 32.4% were male and 60.9% were female
- ❖ Of those 75 years and older 24.9% were male and 68.9% were female
- ❖ The largest proportion (75%) were of European descent, with approximately 10% Maori.

Non-residential settings

- ❖ Around 70% of consumers received support in non-residential settings (home based support)
- ❖ Two service categories accounted for 96% of the invoicing: Home Support 79.9% and Carer Support 16.1% of all non-residential services invoiced.

- ❖ Of consumers 65 to 74, 85.% received home support and 12.0% received carer support
- ❖ Of consumers 75+ 92.5% received home support and 5.7% received carer support

NOTE: A summary breakdown of data from the service User Survey covering the Central DHBs is attached as Appendix 3.

Consumer's Views & Perceptions of the HBSS Service:

Survey participants were reasonably unanimous in their perceptions of what would make for quality support services. It would involve:

- ❖ Client centred and flexible services
- ❖ A back-up support system
- ❖ Access to quality information
- ❖ Appropriately trained support staff
- ❖ Monitoring of support staff and providers

Participants reported perceptions of risk to be:

- ❖ Risk of emotional and psychological distress
- ❖ Risk of unmet needs
- ❖ Risk of theft or abuse of consumer's possessions
- ❖ Cultural risks

Discussion: Consumers expressed considerable concern about the high turnover of support workers, and felt that this contributed to the quality and safety of the services they received. They thought that the underlying cause of much of the risk they perceived was:

- ❖ Poor communication between needs assessors, providers and support workers
- ❖ Lack of training for support workers
- ❖ Lack of commitment of support workers
- ❖ Lack of monitoring of both providers and support workers

Participants often reported feeling fearful and vulnerable. Perceived causes of this was the lack of preparedness and accountability on the part of support workers and a general feeling that the consumer was not regarded as being important. It was clear that many consumers had been significantly affected by the current high turnover rates in HBSS, and from their perspective there seemed to be a correlation between staff turnover, continuity and quality of care. Every participant voiced how vulnerable and anxious they became when they had changes in support workers, gaps in provision of support and support workers unfamiliar with the consumer's particular needs.

Consumers saw training of support workers as very important and thought that the current workforce was not trained and lacked many skills, including what they determined as basic, such as house cleaning and hygiene care.

Consumers expressed the view that needs assessment was not holistic, did not consider key issues and failed to take into account the consumer's family, including their culture and spiritual needs. Consumers thought that the needs

assessment should be less prescriptive, 'more thorough', and take more account of the needs of the individual consumer.

The issues of independence, autonomy, self determination, choice and control were very important to consumers who felt disempowered in relation to the HBSS services they were receiving. Consumers seemed to hold a very clear view they should be more involved in decision making regarding their needs and the way they were met, and to be shown more respect in their ability to do this.

The consumer's relationship with their worker was important in how they perceived the quality and safety of their services. Apart from the need to be assured of their skill levels, consumer's greatly valued the qualities of compassion, patience, gentleness and respect in support workers. Positive experiences were described as situations where, in the consumer's view, they and the support worker were working in partnership, where both respected and valued each other. Where consumers were unable to develop this relationship with their worker, it became and continued to be an unhappy experience.

Good information and communication with the service provider were also important to the consumers' feelings of safety and security and perception of quality.

The findings from the Quality and Safety survey of consumers are entirely consistent with international research on service performance, and organisation and staff performance in community based support services. Throughout the international literature the issues of self determination, autonomy and control, the need for adequately skilled workers, flexible services, continuity, good information and communication, and the values of gentleness and respect are all repeatedly reported as being necessary for the delivery of successful services. (Wilner & Wyatt 1998; Sinclair et al 2000; Bowman 2001; Patmore 2004; Netton et al 2004;)

APPENDIX 2

Anticipated Demographic Profile in Out Years

Numbers of older people are expected to rise sharply during the first half of this century, with significant increases in the number aged over 75 expected after 2011.

If current population projections hold true, by 2051 26% of the New Zealand population of 4.54 million will be aged 65 + (1.18 million people), 15% aged 75 + (708,000 people) and 5.3% aged 85 + (292,000 people). This is a total increase between 2001 and 2051 in the 85 + population of 485 percent, compared to a total increase in the 65+ population of 158 percent and the total New Zealand population of 20 percent. NZ data has shown that the key expense for the NZ health system comes for those 75-84 years of age and 85+ (Ministry of Health 2002). There is a concern that the ageing of the population will lead to an unsustainable increase in the cost of the health system. For example, if current costs per capita continue, then the cost to the health system of health care for people 85+ will be \$2.13 billion per annum by 2051, an increase of 560%.

Population ageing is not peculiar to New Zealand. (Grundy 2002) compares populations with high fertility, relatively high mortality, and young age structures with rapid growth with populations with low vital rates, older age structures, and slow or no growth. The former population pattern is characteristic of the developing world, e.g. sub-Saharan Africa; the latter population pattern is characteristic of the developed world, e.g. many European countries. New Zealand is seen to largely fit into the developed category in which the most pressing public health problem concerns the growing proportion of old – particularly very old – people. However, it can be argued that Maori and Pacific populations in NZ exhibit characteristics of the 'developing' category, and DHBs should also consider the implications of this in future purchase planning.

One assumption often made is that as people get older they become less healthy with increased functional disability and therefore require more costly assistance. New Zealand data would currently appear to confirm this assumption. However, different assumptions can be made about the usage older people will make of health and disability services, and it is these assumptions that are of interest when DHBs are considering purchase frameworks and service design in the immediate future.

Numerous researchers, (Chase 2001; Miller 2001; Jacobzone, Cambois et al.1998) actually anticipate that health care usage will be significantly lower than the 'crisis' perspective predicts. (Chase 2001) shows that whilst medical spending rises with age, old age itself is not associated with increased medical spending. The association is actually with disability and poor health related to chronic processes. The 'manageability' perspective argues that while ageing is important, its influence on the health sector will be able to be managed without placing an uncontrollable burden on either costs or service

provision. (Cornwall & Davey 2003) Research supports this view that the health and disability drivers of costs for the older age group are dynamic – that is, they are able to change or be changed. (Jacobzone, Cambois et al. 1998; Grundy & Glaser 2000).

APPENDIX 3

Disability Support Services in NZ: The Service User Survey. Auckland Uniservices (2004)

Summary of the Survey Data in Relation to Current DSS Home Based Support Services (HBSS) in the Central DHBs Districts

The Disability Support Services in NZ: The Service User Survey (2004) undertaken for the Ministry of Health by the University of Auckland gained a snapshot of HBSS consumers by using data from the Client Claims Payment System (CCPS) which captured the invoicing of support services delivered in NZ in July 2004. It included invoicing for age related support services, support services for disabled people and mental health residential support services. In this 'snapshot' nearly half a million hours of home support services (HBSS) for all ages were invoiced nationally.

Consumer Profile:

- ❖ The majority of services invoiced were for older consumers receiving home based support or carer support services
- ❖ Around 56% of all consumers had a primary age-related impairment

CCPS consumer data from invoicing for June 2004 was captured and broken down by DHB. The consumer profile that emerges from this 'snapshot' for the Central DHBs was as follows:

1. Service Users by DHB

DHB	Number	Percent	2001 census
Capital & Coast	4868	5.5%	6.5%
Hawkes Bay	3450	3.9%	3.8%
Hutt Valley	2682	3.0%	3.4%
Mid Central	4538	5.1%	4.1%
Wairarapa	908	1.0%	1.0%
Whanganui	2239	2.5%	1.7%

(The right hand column represents the percentage that each DHB contributed to the total number of people resident in NZ on census night 2001.)

It appeared in all DHBs that the largest group of service users was those aged 75 or older, with a national average of around 61%. When those aged 65 and older are included, this national average grows to just over 73%.

2. Age Groups by DHB

DHB	14 and under	15 to 44	45 to 64	65 to 74	75 & older	Total
Capital & Coast	2.1%	12.1%	14.3%	12.5%	59.1%	4867
Hawkes Bay	0.6%	12.7%	15.0%	13.2%	58.5%	3450
Hutt Valley	2.0%	9.7%	11.6%	14.0%	62.8%	2682
Mid Central	1.2%	13.0%	16.3%	12.8%	56.8%	4538
Wairarapa	2.5%	9.8%	15.4%	12.7%	59.6%	908
Whanganui	0.4%	8.1%	12.8%	17.5%	61.2%	2239

3. Age of Consumers Over 65 by Gender Across All DHBs

Age Group	Male	Female	Unknown	Total
65 to 75	32.4%	60.9%	6.7%	100%
75 & older	24.9%	68.9%	6.2%	100%

4. Ethnicity by DHB

DHB	Of European descent	NZ Maori	Pacific	Asian	Indian	Not stated	Other
Capital & Coast	75.0%	3.3%	2.0%	1.3%	0.6%	10.8%	7.0%
Hawkes Bay	71.8%	7.8%	0.5%	0.1%	0.0%	12.2%	7.5%
Hutt Valley	73.5%	4.3%	1.6%	0.9%	0.5%	11.0%	8.2%
Mid Central	78.5%	4.9%	0.4%	0.3%	0.2%	6.4%	9.3%
Wairarapa	84.4%	6.1%	0.8%	0.3%	0.0%	2.1%	6.2%
Whanganui	75.4%	7.2%	0.4%	0.0%	0.1%	12.6%	4.3%

Non-residential settings

- ❖ Around 70% of consumers received support in non-residential settings
- ❖ Two service categories accounted for 96% of the invoicing: Home Support 79.9% and Carer Support 16.1% of all non-residential services invoiced.

5. Non-residential services by age

Service	14 & under	15 to 44	45 to 64	65 to 74	75 & older	Total
Home support	30.2%	42.9%	64.1%	85.0%	92.5%	79.9%
Carer support	66.0%	41.9%	27.3%	12.0%	5.7%	16.1%
SIL	0.1%	7.6%	3.7%	0.4%	0.2%	1.2%
Ageing in place	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%
High & complex	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%
Respite	3.7%	2.6%	0.8%	0.3%	0.4%	0.9%
Day programme	0.0%	4.9%	4.2%	2.2%	1.2%	1.8%

Table 5 shows the breakdown of age groups into non residential services. Percentages refer to the proportion of consumers with a non-residential service within the total of that age group across all DHBs.

6. Non-residential service users by DHB

DHB	Home support	Carer support	SIL	Respite	Day programme
Capital & Coast	63.4%	30.4%	3.8%	1.5%	0.8%
Hawkes Bay	71.0%	24.8%	2.4%	0.6%	1.2%
Hutt Valley	74.9%	18.8%	3.1%	1.4%	1.8%
Mid Central	72.5%	24.1%	2.5%	0.7%	0.3%
Wairarapa	60.5%	28.4%	6.5%	3.7%	0.9%
Whanganui	68.8%	28.0%	2.2%	0.2%	0.8%

Table 6 shows the breakdown of all age groups into non-residential services across DHBs

7. Primary impairment by age

Primary impairment	65 to 74	75 & older
Age-related	13.1%	85.6%
Intellectual	4.4%	2.4%
Personal Health	17.5%	33.4%
Physical	16.0%	44.0%
Psychiatric	7.5%	8.8%
Sensory	10.5%	61.3%
Not known	15.1%	27.0%

Table 7 shows a breakdown of the 65+ consumers by primary disabilities ???

8. Age by primary impairment

Primary impairment	65 to 74	75 & older
Age-related	57.3%	79.4%
Intellectual	3.8%	0.4%
Personal Health	5.9%	2.4%
Physical	24.6%	14.3%
Psychiatric	1.5%	0.4%
Sensory	0.5%	0.6%
Not known	6.4%	2.4%

Table 8 shows a breakdown of the 65+ age brackets by primary disabilities ???.

9. Primary impairment by DHB

DHB	Age related	Intellectual	Personal health	Physical	Psychiatric	Sensory	Unknown
Capital & Coast	36.1%	13.2%	4.4%	26.5%	0.7%	1.9%	17.1%
Hawkes Bay	46.5%	11.4%	3.8%	18.6%	0.9%	1.8%	17.0%
Hutt Valley	64.8%	11.7%	1.0%	9.0%	0.5%	0.4%	12.6%
Mid Central	52.3%	8.7%	2.0%	15.2%	0.7%	1.3%	19.7%
Wairarapa	49.0%	15.0%	0.6%	16.7%	0.1%	1.1%	17.5%
Whanganui	57.3%	8.0%	0.5%	14.8%	0.4%	1.2%	17.7%

Note: There is no indication of reasons for regional variation in percentages from the survey.

10. Home support services by DHB

DHB	Domestic Assistance		Personal Care		Total	Total
	Number consumers	Number hours	Number consumers	Number hours	Number consumers	Number hours
Capital & Coast	1838	15193.6	708	15788.0	2546	30981.6
Hawkes Bay	1589	11954.3	752	20342.8	2341	32297.0
Hutt Valley	1097	7439.3	402	7715.3	1499	15154.5
Mid Central	1990	21174.0	698	12597.5	2688	33771.5
Wairarapa	296	2200.5	145	2814.5	441	5015.0
Whanganui	1098	8456.5	337	6573.5	1435	15030.0

Data is based on the number of service units delivered weekly for the month.

11. Average hours per week of home support services by DHB

DHB	Domestic assistance	Personal care	Total (Average hours per consumer)
Capital & Coast	8.3	22.3	12.2
Hawkes Bay	7.5	27.1	13.8
Hutt Valley	6.8	19.2	10.1
Mid Central	10.6	18.0	12.6
Wairarapa	7.4	19.4	11.4
Whanganui	7.7	19.5	10.5

Data shows the average number of hours of home support per consumer across all age groups. The total average hours per week ranged from a low of 4.1 in Canterbury to the high of 13.8 in Hawkes Bay. The national average was 7.2. The national average per service was 5 hours domestic assistance and 13 hours of personal care per week.

12. Total number of respite days by DHB and age group

DHB	14 & under	15 to 44	45 to 64	65 to 75	75 & older	Total
Auckland	16	83	564	57	-	720
Bay of Plenty	179	136	-	-	-	315
Canterbury	10	143	55	397	1592	2197
Capital & Coast	487	230	-	-	-	717
Counties Manukau	19	109	243	-	-	371
Hawkes Bay	76	148	-	-	-	224
Hutt Valley	143	341	-	-	-	484
Lakes	12	-	-	-	-	12
Mid Central	108	114	-	-	-	222
Nelson Marl	105	25	-	-	-	130
Northland	48	32	-	3	-	83
Otago	88	42	-	63	420	613
Sth Cant	8	26	9	29	26	98
Southland	55	-	-	56	254	365
Tairāwhiti	215	210	14	-	-	439
Taranaki	5	61	-	-	-	66
Waikato	12	86	-	-	-	98
Wairarapa	270	47	-	-	-	317
Waitamata	10	100	413	116	-	639
West Coast	-	-	-	34	77	111
Whanganui	5	24	-	-	-	29
Total	1871	1957	1298	755	2369	8250

Table represents the number of respite days invoiced in June 2004. All DHBs and all ages are included here as the variation across both is quite significant. Because consumers can claim for respite care at any time the invoicing is not necessarily related to the numbers of days used in the survey month. Therefore presenting the total number of days per DHB can be misleading and it must be remembered that the data is a representative 'snapshot'. However, the pattern of respite care most commonly used for consumers under 44 is very strong.

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