Supporting vulnerable older people in the community:

Positioning Wesley Community Action (WCA) to meet emerging challenges through setting and achieving best practice

A report prepared for
Wesley Community Action
by David Pickens

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wesley community action

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Naku te rourou nau te rourou ka ora ai te iwi

With your basket and my basket the people will live

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Executive summary

Review background

WCA was established by the Methodist Church in 1952 to promote social justice and help create just and caring communities in the Wellington region. Among other things, WCA provides Supported Independent Living (SIL) services to high needs older people living in the community. These services are provided under contract to Capital Coast and Hutt Valley District Health Boards.

WCA has sought a review of the Supported Independent Living Social Work (SIL) services it provides to older people. The purpose is to identify opportunities for improvement, and to identify additional services WCA might offer. The review framework defines that purpose as to review existing services and identify changes which are the most beneficial possible for high needs older people, having regard to the cost of those changes. Achieving this objective serves the interests of older people, WCA, the DHBs and government more widely.

In undertaking the review, issues were considered relating to the strengths and weaknesses of WCA service delivery, existing and potential WCA clients, competitors/collaborators, and the WCA and DHB relationship. Key stakeholders were interviewed and a literature review conducted, including relevant internal WCA documents.

Thinking about care for older people in a changing environment

The review sketches a picture of changing demand for and supply of elder care services against an evolving view of best practice. Best practice is an evolving concept based on what is best for the community overall and must be tailored to the specifics of each situation. In the case of care for older people, it is a system that works hard to make best use of existing resources; that automatically evolves to eliminate waste and deliver innovation and variety. It recognises heterogeneity between individuals and their circumstances, and the importance of tailoring solutions to the individual. It has the client at the centre of decision making.

An imagined future of elder care

It is envisaged that both demand for community support services and the complexity of that demand will increase strongly over coming decades. The share of funding from the government sector will fall, supplanted by both private funding of social services and direct private purchases as government retreats to areas of greatest need. Government funding will follow the client.

Technology will satisfy a growing proportion of demand. Also, private rest homes will start offering SIL services as a way of linking earlier to potential clients. Lower cost retirement

villages will become available, perhaps located close to towns (in preference to cities). For an increasing proportion of older people they will offer a preferable option to SIL.

A greater proportion of SIL supply will come from private sector commercial and non-commercial entities, increasingly collaborating with and resembling each other. These providers will take on increasingly complex cases over DHB providers, the effect of which will be to better drive innovation and choice. For low skill SIL services, the informal sector will increasingly be called upon, with some financial inducement from government if efforts to grow social capital prove insufficient.

The market will be highly competitive for suppliers and empowering for clients. As the size of the market increases, niche providers and services will evolve. Providers who base their decisions on the value of evidence based innovation will be increasingly rewarded while laggards will be penalised. Current divisions between elder and young SIL will dissolve to allow provider synergies and efficiencies to be realised. Incapacitation will come to be thought of and managed more as a continuum rather than in discrete "care boxes". In the event government regulators are too slow to respond to the changing nature of demand and supply, industry will seek the establishment of private standard setters and certifiers (overseen by government to manage competition risks).

Findings and recommendations

The review found that WCA has a proud and respected tradition of care in the community. It has a cooperative and collaborative culture. It has financial resources in reserve, social capital from the community and good will with government to draw upon. It is strongly evidence based. WCA is ideally placed to define and lead best practice in the care of older people. But within this context, there are opportunities for improvement, to contribute greater value. To this end, the review has put forward the following broad challenges to WCA:

- Strengthen the foundation for its strategic planning;
- Play a greater role in defining and leading the elder care system towards best practice;
- Identify and assess opportunities for meeting the needs of fee paying clients;
- Work with others in the elder care system to increase the supply and quality of short term care outside the hospital system;
- Make greater use of volunteer resources;
- Reduce the financial vulnerability of clients;
- Improve the interface between GPs and the elder care sector; and
- Review its communications strategy against its key risks and opportunities.

A complete list of the recommendations is provided in the next section.

Summary of recommendations

Taking time for big picture thinking: guided by a public interest touchstone

Recommendation no. 1: WCA annually review and amend Part II of this review "thinking about care for older people in a changing environment", on demand, supply and best practice to produce a common understanding of the environment within which WCA operates for strategic planning purposes.

Recommendation no. 2: WCA adopt as its decision making touchstone a public interest objective, its precise form to be determined through consultation internally and with key external stakeholders.

Recommendation no. 3: WCA establish a formal programme of engagement with leading and innovative thinkers to challenge and invigorate WCA and others as appropriate operating in the elder care sector.

WCA meeting the social challenge through setting and exceeding best practice

Recommendation no. 4: WCA review its vision and related strategic planning documents to ensure they are consistent with WCA leading best practice in the elder care field.

Recommendation no. 5: WCA advocate with government and other stakeholders as appropriate to move the elder care system towards best practice.

WCA meeting client need through growing and competing

Recommendation no. 6: WCA commence an environmental scan to identify fee paying clients to whom it might offer services, in the first instance leveraging off the strong base provided by its SIL activities.

Meeting the need for short term residential care

Recommendation no. 7: WCA (Wesleyhaven and SIL) co-ordinate a meeting with representatives of the relevant DHBs, MoH, and rest home representatives with a view to exploring the nature and magnitude of the need for short term residential care, and the practicality of rest homes better meeting this need.

Social bonds: can WCA catch the wave?

Recommendation no. 8: WCA follow closely the Ministry of Health trials with respect to social impact bonds, and commence informal discussions with potential funding partners, for example, ANZ.

Taking advantage of being a charitable organisation: Leveraging volunteer effort

Recommendation no. 9: WCA write to the Institute of Directors, Law Society and the Chartered Accountants Australia and New Zealand as a first step to gauging these organisations' willingness to:

- A formal arrangement with Volunteer Wellington or a grouping of charities to bring together professionals with projects in the charities sector requiring professional help; and/or
- Trialling such an arrangement in the first instance with WCA.

Recommendation no. 10: WCA review its activities to identify what roles might be undertaken by volunteers, and how best to add value to the contribution they make.

Reducing client and carer risk: Sensible shopping

Recommendation no. 11: WCA take preliminary steps to test, with the head offices of the two supermarket chains, their willingness to provide home delivery services that reduces client financial risk and the need for social workers to spend time shopping..

Making bulk funding work better

Recommendation no. 12: WCA review its practices to ensure an appropriate balance is being struck between providing appropriate support to a high number of clients and investing in innovation.

General Practitioners: helping an essential group under pressure

Recommendation no. 13: WCA consider whether there would be value in co-ordinating the efforts of elder care stakeholders to improve the interface between GP practices and the elder care sector, and if so, how this might best be done having regard to the tremendous competing demands made on GPs time.

Targeting greatest need with the best tools

Recommendation no 14: WCA senior management consider whether the perception that clients could be placed at risk by privileging client autonomy over obvious threats to clients health and safety could apply to WCA and, if appropriate develop an external communication strategy with regard to this perception with key stakeholders

Recommendation no. 15: WCA continue to develop staff competency in best practice clinical decision making and risk mitigation in determining client autonomy versus living at risk with respect to elder care in the community.

Political risk, is it being managed?

Recommendation no. 16: WCA, together with other stakeholders as appropriate, ask the question as to whether they are appropriately prepared for managing the risks and controversy that comes with a strategy of caring for older people in the community.

Protecting and building effective relationships with accurate, timely and appropriate information

Recommendation no. 17: WCA review its external communications strategy and give a senior member of staff oversight responsibility for that strategy.

Part I - The review: who, why, what and how

Introduction

Wesley Community Action (WCA), among other things, provides services under contract to the Capital Coast and Hutt Valley District Health Boards to support vulnerable and high needs older people to live independently in the community. WCA have sought a review of these services and on future opportunities for related services. An overview of WCA is provided in Appendix 2. An outline of the purpose of the review, the review scope and the approach taken is provided below.

Purpose

The purpose of the review is to:

- Identify whether WCA's existing services are providing the greatest value reasonably practicable in support of older people;
- Identify what might be done to add value where the services are not providing the greatest value reasonably practicable in support of older people;
- Identify new opportunities to provide services to older people living in our communities; and
- Provide a foundation for advocacy work with government and other stakeholders.

To achieve this purpose, the review looked at the environment within which WCA operates and considered how that environment is changing. Opportunities for WCA to strengthen existing and offer new services were then identified.

Scope

The review focus is mainly on high needs older people living or capable of living independently in the community, with appropriate support, in the Hutt Valley and Capital Coast DHB regions. However, the review also recognises the importance of considering the flow of older people into and out of high needs community living, as this helps to identify related services WCA might provide. Consistent with government funding and service provision criteria, "older people" is defined as 55 and above for Maori and Pacifica peoples, and 65 years and above for everyone else.

Review recommendations are for WCA alone. However, those recommendations encompass:

1. Change where WCA has the mandate and ability to make changes to the services and potential services it provides;

2. Change which is dependent upon third parties accepting the need for that change, for example, DHBs and other providers of services to older people;
3. Any other change identified in the course of the review deemed by the reviewer as likely to be of net benefit; and
4. Areas where further work is needed to determine the need for change.

This approach recognises that WCA is one part of a complex system of support provided to high needs older people.

Review framework

Aligning interests for the public good

Achieving the purpose of the review is in the interests of WCA and its staff. Where successful, it will promote WCA becoming better able to retain existing contracts for service, win new contracts, and to identify gaps in service provision for which it might then become the provider of choice. This was anticipated by the Ministry of Health, DHBs and other government funding agencies as they moved to a more contestable social service provision model, a model intended to apply equally to government and private (commercial and non-commercial) providers.

To the extent WCA improves its performance, it is also serving the interests of the agencies that fund it, by better meeting the objectives of those funding agencies, and at less cost per 'unit' of service delivered.

But most importantly, achieving the purpose of the review will better serve the interests of WCA clients and potential clients. It will also result in flow-on benefits of lower costs elsewhere in the elder care system, for example; hospitals and rest home care, and to the informal care sector (mainly family and friends). This will free up resources to achieve benefits elsewhere in the system.

Touchstone objective

Consistent with the interests outlined above, the touchstone objective for the review is:

To identify changes which are the most beneficial possible for high needs older people, having regard to the cost of those changes.[1]

In other words, this review is seeking to find improvements in economic efficiency; that is, over time providing services most valued by the elder community and at less cost.

[1] This objective is equivalent to the government's regulatory reform objectives as contained in the Regulatory Impact Assessment and Business Case guidance material available on the Treasury website.

To give this objective greater definition and provide more focus for the review, the touchstone objective has been broken into the three types of economic efficiency:

Productive efficiency: achieving more for a given level of resource. Doing 'more with less' or reducing waste frees up resources to achieve benefits elsewhere.

Allocative efficiency: ensuring the resources received by WCA are going to where they will produce the greatest benefit. Often (but not always[2]) this means targeting greatest need.

Dynamic efficiency: innovating to improving performance over time, for example:

- learning from success and failure, both within WCA and elsewhere;
- being aware of evolving practices and the supporting evidence base; and
- anticipating and preparing for change, including technological, economic and social.

Issues reviewed

Within the construct provided by economic efficiency, the review looks at the following issues, their likely consequences (where a problem is identified) and possible solutions:

For Wesley Community Action

- Whether there is a clear and shared understanding of WCA's purpose in delivering services to older people in the community, and if not, a strategy to improve this.
- Whether there are gaps between what WCA says they do and what they actually do, and if so, the nature and magnitude of any gaps.
- Whether WCA culture supports achievement of its vision and objectives, working constructively and effectively with its key stakeholders / others, and doing the best possible for clients with the resources available.
- Whether staff capability appropriately matches the skills required to provide SIL services, and if not, a strategy to improve this.
- Whether WCA has achieved the correct balance between specialisation and generalisation in staff skills.
- Whether there are opportunities for delivering existing services for less, for example, the extent to which volunteer efforts is being leveraged and the scope for increasing this input.

For existing clients

- The extent to which clients are being supported in the community when residential or hospital care would be a better option.

[2] For example, if the cost of satisfying the specific "greatest need" is disproportionately high.

- The extent to which the risk of favouring low cost/easier clients and services is appropriately managed.
- Whether WCA clients' most important needs are being met and given priority over lower value needs.
- The scope for earlier intervention with clients, having regard to type one errors (intervening when it is unnecessary), type two errors (not intervening when it would have been beneficial to the client and other stakeholders) and expected cost.

For potential clients

- The nature and extent of populations of unmet need in the community
- The extent to which potential clients are in hospital or residential care when they would be better supported in the community.
- The ability to realise synergies with other services, for example, with mental health support services for older people through WCA successfully tendering for those clients.

For competitors/collaborators

- The opportunities to improve services through merging with competitors/other service providers.
- What WCA knows about the things competitors/potential competitors do better/worse than WCA, and what if any changes WCA intends to make as a consequence.

The WCA and DHB interface

- Whether funding is sufficient to best meet DHBs' objectives.
- Whether contracts appropriately enable and support WCA innovating in the provision of services, both in the care provided to individual clients and in the overall delivery of services.
- The appropriateness of the existing market structure, that is, competition "for" versus competition "in" the market.

Approach

The review employed a number of tools to uncover the key performance risks and opportunities, and to develop options. Those tools included:

- Meeting with stakeholders (clients, staff, funders, other service providers, academics).
- Reviewing New Zealand and international literature.
- Reviewing internal WCA documents.

Part II - Thinking about care for older people in a changing environment

There are a number of ways to think about the environment shaping the demand for and supply of support services for older people. Two approaches, the vertical market and the four sectors approaches, are discussed briefly below.

A vertical market for elder care services and products

Vertical market continuum:

1. **Aging well and staying well** - these older people are operating independently of the main specialist elder government and NGO (Non-Government Organisation) support services, although they will be enjoying access to *standard* supports such as superannuation, subsidised GP visits and pharmaceuticals and accommodation, for example.
2. **Living well with one or more long term conditions –** these older people have a known and serious mental or physical condition that needs to be managed, requiring some ongoing support or adjustment to their living arrangements, for example, medication, house alterations, or ongoing therapy. However, their ability to operate independently is high, as is their life enjoyment. There may be a small number of specialist support providers involved in their care; otherwise the support is from mainstream providers, for example, physiotherapists.
3. **Some compromise to quality of life, complex co-morbidities/frailty issues –** these older people have a range of serious ailments requiring ongoing management which is beyond the capacity of informal support networks. Often a number of specialist agencies and services are being provided to maintain life enjoyment and independence. This group will fall within both home supported care and residential care (including retirement villages).
4. **Acute care** – these individuals have experienced an extreme event for which highly specialised support is needed: on a short term basis, for example, many types of heart attacks; or on an ongoing basis, for example for some types of cancer, or mental illness. The support needed might be provided in the home, short term residential care or in a hospital.
5. **Post discharge support including 'rehabilitation and re-ablement'** – these older people have been through acute care and have returned or are in the process of returning to the community, either to independent, supported independent living or residential care.
6. **Support, control and choice at the end of life** – this comprises supporting older people to make informed choices about quality of life and medical intervention and includes advance care planning.

Rest homes would tend to offer services from level 3. on. Increasingly, retirement villages are spanning 1 through to 6 above, offering independent living through to hospital services and short stay respite accommodation. WCA is primarily involved in providing supported

independent living services at level 3. and also in residential care although, appropriately, they have some involvement across all six levels.

The main focus of this review is supported independent living (SIL). That said, there are clear links across all groups which need to be taken into account in deciding where WCA should target its resources to the greatest benefit of older people in or potentially in SIL.

The four sector model

There are broadly four sectors involved in care across the six levels identified above. The author offers below a broad and informal description of these sectors based on work he has done previously for government on the application of economic principles to education and in mental health. The sectors are as follows:

The informal care sector: made up of family, friends, neighbours, clubs providing tangible social support to older people. Informal care is provided across all six stages, but declines relative to the contribution made by other sectors and as the complexity of client need increases. This sector tends to be driven to meet need by formal and informal social bonds with older people (social capital[3]). This is the oldest and probably largest sector involved in elder care (by value of works contributed). It is the view of the author that the informal care sector will have been declining relative to the other sectors as those sectors have increased in size, reducing the need for informal care.

The commercial sector: supply from commercial entities depends on financial demand for services, that is: from older people and their families who can afford the services; and/or increasingly in recent years, from government funding the purchase of services on behalf of older people. The commercial sector operates retirement villages and provides supported independent living services. Increasingly, retail service providers (for example supermarkets, taxi service, insurance companies and banks) are tailoring their services to cater for older people, as the demand from this group increases and their needs become better understood. This sector tends to be driven to meet need by the prospect of earning profits. This is the second oldest sector, possibly the smallest sector, but now probably growing the most rapidly. Growth is being driven by increasing government funding and contestable (non-government supply); the growing gap between peoples' expectations and what the government can reasonably provide; and the mainstreaming of old age services.

Voluntary sector: this sector tends to be driven by the desire to support vulnerable members of the community and to provide services based on need. That drive might be based on a shared belief in the value of particular work by its members, whether religious, ideological or value based. This sector is the second oldest operating in elder care, and has been in relative decline with the increase in the role of the state over the last 100 years, although there is perhaps some resurgence in recent decades as governments move to formally acknowledge and work with welfare pluralism.4

[3] Social capital is based on notions of duty, loyalty, love etc.

[4] Welfare pluralism formally recognises the complementary role the four sectors listed can contribute to meeting society's objectives. It can be contrasted with the Scandinavian welfare model, for example, where the state is given primacy for achieving certain social objectives.

Government sector: While the newest, the government sector has grown enormously over the last 100 years, and may today even exceed the informal sector (depending on where the boundaries of the elder care sector are drawn). The government features strongly in the areas of income protection which contributes to older people being able to fund support services themselves, and in funding for specialist services that require a high level of skill for example, hospital and acute mental health care. This is also where poor performance can have the greatest impact. As well as providing many services itself, the government also purchases services from both the voluntary and commercial sectors. Some of the services provided are income and wealth tested. In addition, the government sets the rules and oversees the performance of the elder care support system and is accountable to the public for its overall performance.

The four sectors cannot be considered in isolation from each other, and the boundaries are not always clear.

WCA works across all four sectors and must remain acutely aware of the stakeholders, their strategic direction, and capabilities and emerging changes to operate effectively on an ongoing basis.

The balance of care provided by each sector across countries and over time depends on a mixture of factors. These include tradition, legal responsibilities, health and social policy, national budgets and wealth and epidemiological and demographic trends relating to population growth and life expectancy.[5] It is to these factors the review now turns.

Demand for and supply of elder care services: Emerging challenges and key trends

Demand for elder support services

Increasing numbers of older people

The most obvious factor impacting demand for elder support services is the number of older people. Worldwide, the number of people aged 65 or older is projected to grow from an estimated 524 million in 2010 to nearly 1.5 billion in 2050, a three-fold increase.[6] Similarly, the number of New Zealanders aged 65 and over is expected to nearly double by 2031, reaching about 1.1 million[7]. In turn this is being driven by:

- Increasing life expectancies - since 1840 life expectancy has increased by about two years every decade.
- The baby boomer bulge, that is, those born in the “baby boom” following World War Two reaching their 70s and 80s.

However, changes in the number of people over the age of 65 is a rather bald measure of expected demand and needs to be discussed alongside other factors impacting demand.

[5] Mestheneos E and Triantafillou J (2005) *EUROFAMCARE - Pan-European Background Report: Services for Supporting Family Carers of Elderly People in Europe, Characteristics, Coverage and Usage*, Eurofamcare
[6] World population aging report, 2013, United Nations, New York.
[7] MoH, 2014b.

Incapacity rates amongst older people

Amongst the over 65s, the disability rate is approximately 60 %, increasing significantly in later age cohorts[8]. This compares with 28% for people between 45 and 64. WCA typically provides services to older people experiencing high levels of incapacity.

Increasingly, policy makers around the world are encouraging a greater focus on prevention (including pharmaceutical treatments) and rehabilitation as strategies likely to yield government savings and reduce the incidence of incapacitation in the over 65s. There is mounting evidence from cross national data that—with appropriate policies and programmes—people can remain healthy and independent well into old age and can continue to contribute to their communities and families.[9]

What is less clear, however, is whether these approaches are reducing the average length and severity of older disability, or merely postponing it in line with increasing life expectancy. Further, poor lifestyle choices around food and drink, exercise and recreational drug use are starting to manifest in the age groups approaching 65. At this point it is difficult to anticipate what impact this will have on both longevity and the nature and extent of incapacitation in old age.

More dramatically, it is difficult to forecast the timing and extent of advances in treatments for diseases affecting older people. For example, more than 40 million people worldwide are estimated to be living with Alzheimer's disease and other forms of dementia. At this point there are no totally effective drugs to cure or slow its progression, although a number of drugs are in their final stages of testing. It was commented by Tim Earl, the chief operating officer of TauRx, that the first drug to successfully target the disease could be worth as much as NZ$10 billion in sales.[10] With such a prize, alongside the exponential growth in scientific understanding, significant breakthrough treatments here and for other conditions affecting older people appear likely over the next thirty years.

Further, newer technology (for example, robotic house cleaning and automated pill dispensers) and moves towards "mainstreaming" services to better meet the needs of older people (for example, building houses with elder-friendly features and increasing home delivery services) could also see a reduction in demand for elder support services, in particular for lower needs clients. In the USA, the number of older people with disabilities living in the community who received care from family, friends, or paid caregivers has changed little over time, despite a large growth in the elder population, while the use of assistive devices has grown substantially.[11]

[8] MoH statistics, 2014.
[9] National Institute on Aging, National Institutes of Health; World Health Organization (2011) *Global Health and Aging*.
[10] "A 30 year quest for Alzheimer's remedy nears the finish line", 18.3.16, stuff.
[11] *Centre for Policy on Ageing – Rapid review July 2014* The care and support of older people – an international perspective

On balance, it is suggested that the projected increase in the rate of incapacitation of older people in coming decades (as people who made poor lifestyle choices age) will in part be balanced by the uptake of technology solutions and a greater focus on prevention and rehabilitation. The main unknown is the extent and timing of medical advances which might lead to a step improvement in treating the main conditions leading to incapacitation in later life.

Unmet demand

Two years ago the author prepared a report on severe mental illness in the community. In preparing the report a strong impression was gained that the needs of significant and distinct pockets of people with severe mental health issues were going unmet.

With this experience, there was some expectation that significant pockets of demand untouched by formal support providers might also exist in the care of older people space. There was at least a "smoking gun". According to Ministry statistics, close to 50% of the population of New Zealanders with high and complex needs entitled to government assistance do not access it (although only a proportion of these will be older people).

However, for the most part stakeholders spoken to (WCA staff, health officials, service providers and academics) to did not believe there was significant unmet need in the elder care sector. It was felt that family, neighbours and GPs were, for the most part, identifying high needs individuals and ensuring the relevant authorities were notified. It was noted approximately 96% of people over 65 were visiting their GPs at least once a year, and that GPs were getting better at identifying and referring high needs older people to the relevant organisations. Further, if there is unmet demand remaining in the community, one person spoken to felt that demand was likely to be relatively evenly spread across the different groupings of older people, and therefore not easily targeted.

Private demand: Income and wealth, and community expectations

Higher incomes and wealth allow older people more scope to purchase support services themselves. Overall, incomes for older people have been rising, significantly in the 1970s with the introduction of National Superannuation, and since then indexed to wages (which in turn have increased significantly since the 1970s). Looking forward, Kiwisaver may also increase the assets held by older people, although it will be quite some time before there is a noticeable impact. Also, if overseas experience is any guide, government backed savings schemes tend to crowd out significant savings elsewhere leaving overall savings rates (and wealth) little changed.[12]

Perhaps a more important trend is the move away from home ownership as houses become less affordable. Home ownership is often used by older people to fund access to retirement villages. With a reduction in home ownership, together with people living longer and

[12] Attanasio, O., Banks, J., Wakefield, M. (2007) *Encouraging Savings through Tax-Preferred Accounts*; Attanasio, O. and Banks, J. and Wakefield, M. (2004) *Effectiveness of tax incentives to boost (retirement) saving: Theoretical motivation and empirical evidence*.

eroding their asset base over a longer period, it appears likely older people will be less well equipped to meet their own costs in later life, meaning a greater role for the informal sector and government.

Finally, basing estimates on average incomes perhaps understates demand in the market where WCA operates – high need users. High need users often have few accumulated assets as a consequence of their conditions (for example, drug and alcohol addictions), which may have become more acute over time, eroding earning ability and increasing expenses as they head towards retirement. As commented above, there are groups on the verge of entering the cohort of older people who may present with comparatively higher levels of impairment as they age, and consequently be facing more challenging socio-economic circumstances.

Government (buying services on behalf of older people)

During 2013/2014 District Health Boards (DHBs) spent approximately $217 million on home support services, comprising over 10 million hours of support.[13]

There are a couple of points to note in introducing this section. First, government spending can just as easily be viewed as demand or supply. At least in part, government spending (demand) is the inverse of private demand – the more generous public provision, the more it will crowd out private spending. As this review is being conducted from the perspective of WCA, government spending on elder care is being characterised as demand (it purchases these services from WCA). Also, increasing government spending for older people is not the same as increasing the generosity of funding. If funding increases 10%, yet the client group population increases by 20%, the scheme becomes less generous.

The ability of government to fund social spending is closely tied to the strength of the New Zealand economy. Increasingly, governments around the world have been faced with a reduced capacity to raise revenue as their economies continue to battle the fallout from the global financial crisis. Demand for government help goes up during economic downturns as incomes and jobs suffer, leaving more people unable to fund their needs. In the area of health spending, this is against a backdrop of continued medical advances offering new and expensive treatments demanding to be funded.

In response, governments are increasingly turning to cheaper support options such as SIL, focusing on prevention of disease and incapacitation, and turning away from universal provision in favour of targeted spending - where the need is the greatest and individuals are unable to fund the services directly themselves. A threefold increase in spending on SIL (to match the increase in the number of older people) would take spending to approximately $600 million, and like spending on superannuation and mainstream health services, would likely come under pressure from policy makers. In England, for example, central government funding for older support **dropped** by 36 % over a three year period in response to difficult economic conditions.

Since the beginning of the financial crisis New Zealand has been spared the worst of the cold winds; our economy is more diversified in favour of markets so far less impacted (in particular Asia). Away from Europe, the commodity cycle has worked in our favour (until

[13] More Effective Social Services: Final Report, New Zealand Productivity Commission, 15 September 2015, Wellington.

recently) and an increase in government spending - related in particular to the Christchurch earthquake (enabled by high government borrowing off a base of low debt) - has kept demand high.

But New Zealand is not immune to the factors that led to a slashing of social spending in England. Growth remains fragile in Europe, North America, Australia and Japan. Importantly, there are worrying signs coming out of China, in particular relating to unprecedented debt levels and speculative asset prices. Should this market fail, New Zealand can expect to face the same difficult funding choices faced by so many of the European and North American countries.

In New Zealand, for many years health spending as a proportion of GDP has continued to increase. This is unsustainable. (The recent controversy over melanoma treatments is a typical example of technological drivers at work.) Even more significantly, however, the number of older people will increase enormously over coming decades and with it the demands on health and related social spending. The risk of pandemics and other significant health risks remains (Zika was identified by one interviewee as a relevant emerging risk).

Not only is it difficult to anticipate how these future challenges will unfold, it is difficult to anticipate how government policy will change in response. What appears likely is total government spending will increase, but per capita spending will fall. At least in part this will be through greater efforts to means test, potentially for all SIL-eligible. This could lead to an increasing *proportion* of high needs older people being required to fund their own home support.

Supply of elder support services

Informal carers

There are a number of factors likely to result in a falling supply of informal carers for older people in coming years, including:

- Traditionally women have been the primary carers in the home. With a strong trend to both partners working there is less capacity to directly support older people. However, with two incomes and often fewer children to support, families will be better equipped to fund support for their parents from the formal care sector.
- Over the last 100 years the government has greatly increased its role in providing social services – at the expense of care that was previously provided by the informal and voluntary sectors. There is now an expectation by many that government has the primary role in social support, and with this culture shift, families are increasingly reluctant to incur the expense of supporting older people when that cost can be met collectively.
- Further, there are now fewer families where older people live with their children. Work, for instance, sees children moving away from their older parents, meaning physically they are limited in the direct support they can provide.

- With the trend towards smaller families there are fewer children across whom to spread the cost of caring for older parents. Today, across developed economies, around 20 percent of women do not have children.

There are, however, a number of factors which could see an increasing contribution from the informal sector, including:

- Single parent households are on the increase.[14] In some situations it makes sense for a single parent to move in with grandparent(s). Through the child minding services provided by the grandparents, this more easily allows the single parent to return to work, and it means opportunities for cost savings through sharing accommodation and household costs. Importantly, it also provides an opportunity for establishing strong family bonds perhaps resulting in greater reciprocal support for the grandparents in later years.
- Governments are increasingly seeing the opportunity to cost effectively increase supply from the informal sector by, for example, providing financial incentives. For example, two-thirds of OECD countries for which information is available provide a statutory right for leave to care for the chronically ill and approximately half provide for paid leave, but at a nominal amount. It is notable these costs fall to the employer rather than the government[15].
- Increasingly government and non-government stakeholders are looking for ways to rebuild social capital. Examples of these include as Sam Johnson (social entrepreneur), neighbourhood watch, the encouragement to check on older neighbours, and not turning a blind eye to domestic violence. On a systems wide basis, it is obvious that strong social capital will better allow a community to withstand and manage the social consequences of large negative shocks to the system, and cope, in this case, with a significant upward swing in elder dependency. What is less clear is how effective the initiatives will be.

Private supply (formal sector)

Currently 70 non-government organisations provide home-based and community-based support services for DHBs. Thirty seven of the providers are not-for-profit (NFP) organisations and 33 are for-profit (FP) organisations.16 Non-commercial organisations are better able to access volunteer resources (it is noted the volunteer intermediary Volunteer Wellington does not offer volunteers to commercial entities, for example), and have a more favourable tax status. In contrast, commercial entities perhaps have greater access to capital and would tend to apply a greater range and depth of professional expertise to their activities.

[14] 2013 Census Quickstats about households, November 2014, Statistics New Zealand, Wellington.
[15] Better practices - Organisation for Economic Co-operation and Development (2011) *Help Wanted? Providing and Paying for Long-Term Care*, OECD.
[16] New Zealand Productivity Commission, September 2015.

However, it is suggested in this review that the distinction between commercial and non-commercial providers of social services will become irrelevant. This is because government funding is becoming an increasingly dominant feature of both sectors. To successfully win and hold contracts requires compliance with the government's accountability model. This in turn is promoting convergence. Further, development along the lines of social impact bonds (discussed below) is expected to blur any distinction in future years as 'for' and 'not for' profit entities increasingly work together on the same projects. Finally, entities are increasingly working to adopt the advantages of entities operating in the other sector, for example, voluntary entities are adopting professional approaches and reducing traditional constraints on their activities, and commercial entities are funding community-based causes and in some cases taking advantage of voluntary labour inputs.[17] For these reasons, the two sectors are considered together in the section below.

Where demand leads, supply will follow. It appears very likely demand will increase, significantly, over the next twenty to thirty years. This demand will, it is suggested, be proportionately greater from private funded compared to public funded sources.

Perhaps as interesting as the increase in demand for support services is the increase in the range of services that will be sought. Older people are a heterogeneous group. As the number of older people increases, so too does the practicality of meeting demand for people presenting with different conditions. Three groups specifically identified by stakeholders were the visually impaired, heavy users of recreational drugs, and hoarders.

Further, a sizeable gap in the market for mid to low cost residential accommodation was identified. This is a likely growth area as potential operators seek to meet the demand for company and security by many older people, while breaking down stereotypes relating to residential care.

Further, synergies available through vertical integration could see residential operators increasingly reach out through offering SIL services to possible future clients of their residential facilities. Ryman Healthcare is an example of an operator expanding in both directions along the vertical market for elder care services.

Another trend likely to impact supply is the move toward more qualified care givers. This should see an increase in the quality of care giver services, and it will see an increase in costs.

While there has been some consolidation of private suppliers funded by government (and in the case of the mental health contract WCA used to hold, nationalisation), this is inconsistent with international trends and the growing consensus on best practice. That is, in the medium to long term it is likely multiple private providers will be funded to deliver social services, which in turn should see a wider range of client older groups receiving tailored services and facilities. Already there is a wide range of private providers (commercial, government funded, charitable and mixed) operating in the elder care space. Together, these entities provide a wide range of services, possess differing capabilities and motives, and will potentially provide significant choice for clients as the government moves

[17] The author is aware of a vineyard using volunteers to pick grapes in exchange for a contribution to community based causes.

towards best practice (discussed in the following section). The assumption is that the environment will continue to evolve towards best practice, and that WCA needs to both anticipate that environment and itself adopt best practice if it is to best contribute to meeting the needs of older people.

International trends and evolving best practice

The concept of "best practice" is easily misunderstood and misapplied, and for this reason a pause is taken here to explain how it is being used in this review. Best practice is:

- *Firmly based on what is best for the community overall*. That is, it is not what is best for older people alone. The consequences for other stakeholders must be taken into account. Most typically with government programmes, this means there are limits to the extent to which government will increases taxes on the community to fund support for people in need.
- *Situation specific.* Policy makers do not have the luxury of starting with a clean slate when designing policy regimes. They will have inherited a unique set of community values, institutions (with differing capabilities and incentives), rules and arrangements/relationships. This means it is often not possible to simply pick up a regime that is working well overseas and expect it to work just as well in New Zealand. To achieve best practice, New Zealand must be a discerning consumer of international practices.
- *An evolving concept.* As knowledge and the environment changes, so to must best practice if it is to continue to best serve the community's interests. Elder care operates in a dynamic environment. With a growing emphasis on evidence based policy, knowledge can be expected to increase rapidly.

Client centric support

"It is more important to know what sort of person has a disease than what sort of disease a person has." – Socrates

It has become widely regarded as best practice to focus support around the "client". This has come to mean a number of things. First, for many years there have been calls for government (and other providers) to provide their services in a co-ordinated and seamless way to each client. To achieve this usually means someone having the responsibility to holistically identify the full range of needs of the client, and ensuring they receive the best package of support from the different agencies. Older people will often have complex medical, mental and social issues to manage. Clients can struggle to navigate through the system of support which may make sense from a provider perspective, but is disconnected from the client, especially if the client has some cognitive impairment. This has been a strong driver of the whanau ora programme which, besides more strongly addressing the coordination role, also takes into account the wider context provided by the family. It is also a role that WCA has taken on for itself with respect to SIL, and a role that leads to increased quality of care.

It is increasingly recognised that clients are heterogeneous, in their needs, preferences and capability, and therefore in what services will work best for them. This requires the system to have available a range of options to match the specifics of their circumstances, and the capability to recognise the different circumstances and match them to the best option.

Finally, a client centric approach also means a shift to empowering client decision-making. This contrasts with the traditional medical model whereby medical professionals essentially make the decisions on behalf of the client based on the professional's superior knowledge of treatment options and consequences. Interaction with the client is limited to explaining the rationale behind those choices. The alternative approach recognises, borrowing from market economics, that the "consumer is king". The client, better than anyone, knows their values, preferences and capabilities into which any intervention must fit. It also recognises that client buy-in to the goals sought, and the approach being taken to get there, will increase the likelihood of the client achieving those goals.[18] To quote from the Productivity Commission "More client choice is generally better, but needs to be accompanied by systems that provide guidance and information for older people exercising choice, and that guard against abuse".

There is considerable challenge to the elder care system to achieve the correct balance between providing for autonomous decision making by the client and appropriate client risk management. This came up a number of times in discussions with stakeholders . Examples of erring too far on the side of client autonomy might include:

- Where a client has not expressed any anxiety over managing their money, a social worker might spend little effort identifying and managing financial risks, even though these risks, if they eventuate, could significantly threaten future care options (for example, SIL).
- Even though a client could manage some routine cooking, cleaning and shopping tasks, because they would prefer not to, these services are provided to the client. A concern expressed a number of times was that such an approach could lead to a more rapid loss of independence and transfer to residential care than would otherwise be the case.

In contrast, achieving the correct balance requires the carer gaining a deep understanding of the client and their circumstances, and proactively identifying risks and opportunities to improve their quality of life. The worker then brings these insights with them to the client when exploring client goals, and the best options for achieving those goals. While ideally the client is in control of this process, they should be proactively aided and guided by the worker's insights and specialised knowledge.

And here lies a key difficulty with best practice. Social workers will have considerable sway with clients. Some decisions being faced by clients will be difficult for workers to engage with (advance care planning is one example). How far to "encourage" versus "enable" client decision making will not always be clear. To succeed with different clients requires the social worker to possess a high level of skill, judgement and character, and apply considerable

[18] For a discussion of some of the studies supporting this point, refer "A study of biomechanical basis for behaviour", Ivan Pickens, chapter 11.

effort. Getting the right balance can be resource intensive, but it can reduce systems costs elsewhere, for example, reducing demand for rest home care.

Supported Independent Living (SIL)

In New Zealand about 75,000 older people receive home and community support services through the health system. This compares to 31,000 older people who are in aged residential care.

The traditional approach to providing care for older people has been to transition them to institutional settings, either in residential care (rest homes) or hospital care, depending on the nature and severity of their needs. More recently retirement villages financed by clients have become popular. These offer high quality accommodation options from independent living through to high needs users requiring significant specialised support. They are funded both independently and by government depending on the circumstances.

Increasingly, governments around the world have moved to try to support older people remaining in their own homes for as long as possible - even high needs older people. There are a number of drivers for this new strategy:

- It is what the majority of older people say they want;
- It is often cheaper to support older people in their own homes than in residential or hospital care; with aging populations, financial considerations have become increasingly important;
- It has been shown, overall, to produce superior life quality outcomes for older people. Similar effects have been shown with community based care for mental illness over the institutional based care common through into the 1960s; and
- New technology has made it easier. For example, WellAware uses a suite of sensors that non-intrusively monitor the health status of older people living in care facilities or in their own homes.

Parsons et al. (2012) evaluated three New Zealand programmes to support older people to remain in their homes. They found that such programmes reduce the risk of a frail older person being permanently institutionalised.[19]

Again, it is important to qualify best practice. Just as markets do not operate perfectly, nor can administrative systems of support for older people. There will, be times when an older person will be in SIL when they would have been better in residential care, and vice versa (sometimes the judgement can only be made in hindsight).

The question of systemic bias in the system (whether there are too many people in community based, residential or hospital based care) was tested with stakeholders. No-one identified a systemic bias. However, this does not mean stakeholders, in even the best operated systems, can afford to be complacent or dogmatic. The system will continue to evolve over time as the environment changes, mistakes will be made, boundaries tested and the risk of systemic failure will be ever present.

[19] Quoted in New Zealand Productivity Commission, September 2015.

It is often claimed that people with dementia would prefer to live at home for as long as possible cared for by their family, that this option is associated with better quality of life, and that care at home is cheaper than care in a care home. None of these rationales is fully supported by evidence. Care in care homes is a preferred option for a significant minority of older people, particularly when presented with a scenario of dementia with complex intensive needs for care. Currently available evidence suggests that subjective quality of life is similar for those with dementia cared for in care homes and those cared for at home, and may even be better in care homes for those in the advanced stages of dementia. Societal costs of care in care homes and care at home are found to be similar when an appropriate cost/value is attached to the unpaid inputs of family carers.[20]

Rightly or wrongly, there will be occasions when the appropriateness of the SIL provided, and the system itself will be brought into question. WCA and others need to have confidence that when these circumstances arise, they are appropriately managed, for the benefit of the community in general, and older people in particular.

An increasing proportion of older people now live in their own home, reflecting the change to SIL. While 28% of people aged 85 years or older lived in aged residential care in 2006/07, this number dropped to 23% in 2013/14. Going forward, the trend towards SIL is expected to continue; increasingly higher needs individuals can be accommodated through new technology and improved practices. The main threat to this trend is perhaps the development of low cost residential care options that provide the security and companionship many older people say they need, while breaking down the negative connotations of residential care. It cannot be assumed that SIL will remain the preferred option for older people.

Prevention and early detection

The government makes important choices in funding SIL for older people versus pursuing early detection and prevention strategies – the fence at the top of the cliff versus the ambulance at the bottom.

There is evidence of a change in favour of prevention and early detection. In particular GPs are being brought into the system of elder care through identifying possible high risk older people and referring these on to appropriate agencies. In the context of GP expertise, their links within the health system, and with approximately 96% of older people visiting their GP each year, this appears a logical place to focus future efforts. While stakeholders commented on the continuing improvements of GP performance in this area, a number considered the potential gains to be considerable.

Prevention programmes have historically focused on younger or working age adults, but there is increasing recognition of the value of prevention programmes aimed at older people. Among the key ways of managing demand are improving health literacy, targeting physical activity, exploiting new technology, encouraging best use of medicines, and

[20] Prince M, Prina M and Guerchet M (2013) *World Alzheimer Report 2013 - Journey of Caring: an analysis of long-term care for dementia*, Alzheimers disease International.

delivering services focused on increasing functionality and self-management. Innovations are arising in each of these areas.

International reviews of specific programmes suggest that important improvements to the health and welfare of older cohorts *seem* possible from *some combination* of: delaying retirement, increased community activities, improved lifestyles and better age-adapted healthcare systems, particularly where these are combined with more emphasis on cost-effective prevention. However, while there is evidence that certain interventions can help improve the health status of older people, it remains unclear as to which are the most (cost) effective.[21]

Prevention of incapacitation for older people is in an initial state of development only, at research, policy and practice levels. While a growth area, little conclusive can be said about costs, benefits and relative effectiveness of different measures. It is not known whether prevention efforts reduce, or simply postpone, a loss of independence. Further, the prevention agenda must broaden if it is to tackle social isolation, engage communities more widely, adapt or develop homes, and make cities more age-friendly places. Innovations in each of these areas are available and scalable. With this sector growing significantly as an area of social need around the world, and with the trend to stronger evidence based government policies, it can be expected that significant progress will be made to close this research hole in coming decades.

It is positively noted the Ministry of Health is working with other agencies to produce better information on New Zealand's aging population, and is strongly focused on improving its evidence based approach to policy making. Clearly the Ministry and other stakeholders must make decisions on where to allocate their limited resources despite existing information gaps.

An evolving consensus on welfare pluralism?

Welfare pluralism is on a continuum representing a shift towards needs being met from multiple sources rather than a single source (for example, government or informal carers). It involves deliberately deciding which sector (for example, government, informal, commercial, non-commercial or some combination) is best placed to meet which need.

For many of the more developed economies like New Zealand, welfare pluralism means moving away from the government providing welfare services to encouraging private (commercial and non-commercial entities) and informal carers.[22] It involves:

- Encouraging and enabling voluntary action;
- Decentralising in favour of a community focus;
- Placing service users at the centre; and
- Government monitoring and funding third party service providers.

[21] Oxley H (2009) *Policies for Healthy Ageing: An Overview. OECD Health Working Papers 42*, Paris: Organization for Economic Cooperation and Development

[22] The Road to Welfare Pluralism, Old Age Care in Sweden, Germany and Britain, Mai-Brith Schartau, Sodertorn University, Stockholm, Paper presented at IPSA XXI World Congress of Political Science in Santiago, Chile, July 12 – 16, 2009.

While some countries (including New Zealand, the United States and the United Kingdom) have moved organically, over a long period of time towards social pluralism, others (such as the Scandinavian countries) have chosen this path more recently, driven by:

- Governments alone being unable to meet growing demand for social services. Health spending is a particularly strong example. Michael Cullen, for example, as Minister of Finance, sought to promote a debate on the need for significant reform in the face of an ever increasing share of GDP being spent on health (an unsustainable trend). Similarly, Bill English, as the current Minister of Finance, is leading the debate on targeting youth at risk in an effort to, among other things; reduce government spending on addressing social problems in later life. It is perhaps not a coincidence that it has been the Minister of Finance co-ordinating and driving these initiatives. Today in New Zealand social spending is approximately $34 billion, compared to $280 million in 1967.[23]
- Evidence that, at face value, government social welfare programmes do not appear to be working – drug abusers are not cured, older people remain isolated and in high need, domestic violence and other crime continues at high levels and poverty persists. For many observers and recipients of social services, a "one size fits all" approach imposed from above has failed. Recognising both the importance of innovation in service provision and the heterogeneity of needs (and therefore solutions), welfare pluralism becomes a natural choice.
- Increasingly, through a perception of failure, a centralised monopoly provider (government) of social services is losing credibility and political support thereby promoting change towards social (welfare) pluralism.

The three factors described above converge strongly in the area of elder care. A significant increase in demand for services is expected, placing not just funding for older people at risk, but also all the other areas of community need as the tax dollar is stretched further. These transparent pressures in turn help to build a constituency for change. A government centric approach to residential care for older people is viewed as neither financially sustainable nor in the best interests of older people. To properly deliver community based care requires contributions from the informal, commercial and non-commercial sectors.

An important part of social pluralism is social capital. Social capital was discussed with a number of stakeholders during this review. It is action based on "trust, a sense of being able to rely on other people and a duty and obligation built up over time, resulting in a strong sense of solidarity and communal obligation."[24] Some argue social capital is reinforced by the strengthening of the welfare state through itself strengthening a sense of solidarity. The findings of this report is the opposite. Social capital has been eroded through the expansion of the welfare state reducing the value of bonds that previously existed within supporting communities of interest – across families, neighbours, hapu, church groups, and other groups. The argument runs in parallel to that above for the decline in the informal sector - as other sectors have increasingly met need, both the supply of and demand for social capital has declined. Higher levels of social capital, it is argued, will better allow a

[23] New Zealand Productivity Commission, September 2015.

[24] The Road to Welfare Pluralism, Old Age Care in Sweden, Germany and Britain, Mai-Brith Schartau, Sodertorn University, Stockholm, Paper presented at IPSA XXI World Congress of Political Science in Santiago, Chile, July 12 – 16, 2009.

community to weather the negative shocks that may come, and to address gaps in service provision by the other sectors.

A particularly interesting part of this project has been speculating on the possible strength of social capital within Pacifica communities in comparison with the more individualistic migrants and their descendants from the United Kingdom. A tradition of socialising income and wealth across the wider family group and treating that family unit as an economic unit may help explain the comparatively small demand from these communities for government funded support for older people[25], in spite of their lower average incomes. While it might be argued these communities are disadvantaged - in the sense that they receive comparatively less of the government "subsidy" during the good times of increasing government support - the opposite is also true. More individualistic cultures will likely feel a contraction in government support more keenly than Pacifica and refugee groups with strong family and community bonds.

The conclusion from this tentative line of thinking is that social capital, if it can be reenergised or even remain a latent force until needed, will provide some insurance against the very real possibility of a significant and sharp contraction of per capita government funded support for older people. To this end, there may be useful learnings from efforts to generate a renaissance in Maori culture, a culture strong on social capital that might be able to be applied more widely. Similarly, the efforts of the 'voluntary armies' and in particular of people like Sam Johnson, point to both the gains and possibilities of strengthening social capital when strong need arises.

At the other end of the spectrum, welfare pluralism implies that those best placed (resourced) to fund purchase of the services they need in later life, should purchase those services from the private providers sector. This has a number of advantages:

- It allows limited government funding to stretch further in targeting greatest need;
- By promoting private supply, it builds depth into the market from which the government also purchases services on behalf of clients; and
- Politically, it might be argued it is not the place of taxpayers to subsidise what in essence is a wealth transfer from the elder rich to their children.

To most successfully meet coming challenges the sectors need to work in a synchronistic manner, where relative strengths and weaknesses (broadly, incentives, capability and capacity) for addressing each challenge determine which will dominate the response to that challenge.

A useful example is the "Shared Lives" programme found in the United Kingdom (refer Appendix three for description). Basically, people with low needs (they need not be older people) requiring supported accommodation are provided with government funding. People with surplus accommodation are encouraged to join the Shared Lives scheme in exchange for rent payments subsidised by the government. Depending on the circumstances, some government training can be provided to those making accommodation available.

Martin Knapp of the London School of Economics assessed the cost effectiveness of the Shared Lives programme and found that, compared with traditional residential placements, savings range from £46 to £995 per week, depending on the service user. Beyond this, the

[25] Even taking into account a younger population for Pacifica communities.

scheme has also been shown to build social capital, interconnectedness and social outcomes.

New Zealand would appear ideally placed to adopt this scheme or similar as a way of meeting SIL objectives (including for older people). Accommodation is becoming increasingly unaffordable and inaccessible, in particular for high needs individuals. At the same time it is likely that the number of unused bedrooms in dwellings is at an all-time high, driven in particular by the trends to:

- Single parent households. Increasingly families are being accommodated in two houses rather than one, with a resulting underutilisation of bedrooms; and
- With an aging population has come an increase in the number of houses with unutilised bedrooms, that is, older parents remaining in the family home long after the children have left.

Initially, building up a robust system of welfare pluralism may not reduce total cost, but instead shifts those costs around the system. However, after the one-off costs of establishing the system have been incurred, innovation and better targeting should allow more to be achieved with less.

Finally, a logical extension of welfare pluralism is, to the extent practicable, mainstream elder care across all providers in the community. For example, house builders, swimming pools, libraries, supermarkets and banks should all be well incentivised to provide goods and services in a way that makes it easier for older people to access, in the context of the challenges they face. A number of examples were found while preparing this report, and some opportunities for further efforts identified (discussed in part III).

Social impact bonds

Two significant problems with health funding (identified earlier) are:

- Funding cannot keep up with demand, that is, even projects with strong cost benefit ratios go unfunded because of higher priority projects; and
- Government agencies work in silos. In spite of exhortations over many decades, agencies find it difficult to co-ordinate action and policies for the greater good.

Social impact bonds are a possible circuit breaker to these problems. Social impact bonds involve third parties interrogating the government's social spending programmes for opportunities to introduce projects that will realise significant savings or benefits elsewhere. As alluded to above, in the current environment the government and its agencies are likely to be particularly receptive to proposals that save money.

There are a number of significant differences between social impact bonds and existing mechanisms:

- Social impact bonds are potentially an important catalyst for finding savings *across* multiple government agencies, for example, DHBs, the Ministry of Health, Social Welfare Department, and in this way breaking down the existing silo approach to budgeting.

- By putting up private capital to fund the social programmes, the existing funding constraint is loosened. In return for funding the programme, 'investors' are provided with bonds by the government that provide them with a return, the size of which depends on the success of the programme they fund. If the programme is unsuccessful, the investors lose their money. If successful, they receive a profit over the amount they invested, funded in proxy by the savings achieved.
- Social impact bonds provide for the financial risk associated with the programmes to be transferred from taxpayers to private investors. Also, the investors provide another level of monitoring and accountability, and "entrepreneurship" to drive better performance.

In the United Kingdom, social impact bonds are being used to deal with homelessness (including those with mental health needs), reoffending rates among former prisoners, and rates for troubled youth being taken into care.[26] In New Zealand, the Ministry of Health is trialling their use.

Social impact bonds will be more successful where the outcomes being sought can be accurately measured, including the impacts they will have across different agencies, and where win-win scenarios present themselves. Success also requires a high level of skill and good will to negotiate the apportionment of costs (to fund the bonds) across the impacted government agencies, and between government and the intending investors with respect to the level of reward provided for a given level of performance. Bonds will be more difficult to use where the costs are short term and the expected benefits are dispersed and long term.

The United Kingdom experience suggests social impact bonds are likely to entail higher administration costs, in particular as a consequence of the negotiations required to establish them. Clearly, social impact bonds won't be appropriate in all circumstances, but they could be best practice in some.

The evolution of competition and market structure

In commenting on the system for providing social services in New Zealand, the Productivity Commission found that "Focusing on service outcomes requires new approaches to commissioning and contracting, as well as supporting systems such as good performance monitoring." In rising to the Commission's challenge of identifying what these approaches might be, it is worth pausing to see how (and why) we got to where we are.

Up until the 1980s it was common for government entities to be both the provider of services (including regulatory) and the policy development agency. However, agency theory suggested this combination of functions in the one agency too easily allowed the agency to

[26] The Guardian, "Social Bond: Tackling homelessness through payment by results", Amelia Gentleman, 11 December 2012.

operate in favour of its provider arm, to the detriment of the sector and wider government interests. A more arm's length arrangement was to be preferred.

Subsequently, it was felt there would be gains from allowing private entities to compete to be the provider. This competition "for the market" was supposed to encourage innovation and reduce waste (cost) thereby allowing the government (as funder) to achieve more with less. The government also retained responsibility for overseeing the activity and taking action if significant failure was identified. This approach also, however, had drawbacks:

- Barriers to entry could be high (the incumbent had a strong advantage through "the devil you know" and it could take considerable investment by an entity to obtain the scale and capability needed to take over the whole market), thereby reducing competitive pressure and related benefits.
- There was a lack of benchmarking information by which to assess, reward and sanction performance.
- It did little to increase choice and empower consumers.

In response, government agencies increasingly moved to contracting with different providers for the same service, that is, "within the market". With direct competition benchmarking between providers became possible, and it was easier for new and innovative providers to enter the market. Where the contracting arrangement allowed, consumers were able to exercise an element of choice.

In Sweden, the resulting model not only was found to produce efficiency gains, but working conditions improved as public sector providers were forced to match conditions offered in the private sector. However, a number of private providers failed. In a number of cases this was attributed to a lack of public sector competence in the purchasing process.[27]

However, by contracting for a fixed supply (for example, number of clients) with each provider, the new markets continued to be relatively rigid and unresponsive, with innovation expected from multiple providers eroded by the need to comply with the government funder's purchasing model. Further, through their contracting arrangements the relevant government agencies were at least implicitly making decisions on what the most efficient market structure (concentration of providers and their configuration) for delivering services would be. Even in the most pedestrian markets making these decisions are fraught with many pitfalls – the formation of Fonterra illustrates this point well.

As commented above, the market for elder support services is dynamic with many constantly moving and interacting parts. It would be a significant challenge for DHBs to assess their contracting practices against a normative competition model at a given point in time. And it is clear to the author, it simply does not happen - there is not the capacity, capability or incentive on DHBs to do so. In fact, recent moves to greater concentration in the Wellington/Hutt regions relating to SIL, including the DHB taking the WCA mental health

[27] The Road to Welfare Pluralism, Old Age Care in Sweden, Germany and Britain, Mai-Brith Schartau, Sodertorn University, Stockholm, Paper presented at IPSA XXI World Congress of Political Science in Santiago, Chile, July 12 – 16, 2009.

contract in-house, suggests ease of administering contracts may have become a driver behind increasing market concentration.

The view expressed in this review is that this is only a temporary departure from the path leading to best practice, a departure brought about by a system struggling to save money in the face of constrained budgets, increasing demand and shifting priorities. Broadly the system will continue to evolve towards a best practice model comprising:

- The government (or its agent) certifying providers as fit to provide one or more services carefully defined by the certifying agency. This may be on a regional, semi regional (DHBs clubbing together to reduce costs and promote consistency) or a national basis. Certification will replace individualised time bound contracts. Ideally, depending on the capability of the government agency, licencing will be principle based rather than prescriptive.[28]

- Providers seeking certification for the markets they perceive they can best provide services to relative to competitors, having regard to the combination of their incentives, capability and capacity to service those markets.

- Regional NASC's being responsible for matching clients to providers as best they can and determining the amount of funding to be attached to each client, reassessing client need (and allocated funding), reallocating clients where a relationship has broken down (in particular where a client has sought an alternative provider) and assessing the performance and facilitating information exchange to encourage continual improvement in practice. Regional NASC's would have a role in managing the risk of counterproductive competitive practices.

- Barriers for providers to enter and exit will be lower as, outside gaining certification, providers can slowly enter each service market at a rate consistent with their appetite for risk and available resources. Similarly exit (apart from losing certification) will be easier to manage and in a way that reduces disruption, for example, to employees.

- Optimal market concentration entity structure and relationships is found through the interaction of providers seeking to best meet the needs of clients (at a price deemed acceptable to the NASC/DHB). As technology, preferences, demand and standards change, so to market structure and market relationships will automatically change to better match the evolving environment.

- Consumers will receive bulk funding tied to the purchase of services from certified providers of their choice. For complex need, low capacity individuals, the NASC will work with them to help them make the best decision possible. This role will provide the NASC with useful insight into the performance of the system, which is in turn fed back to the respective DHB. This is consistent with and reinforcing of the client

[28] Consistent with the literature on principle vs prescriptive regulation, this will better promote innovation, choice and in turn social outcomes. Success depends, however, on the regulator being able to operate at a very competent level in a number of different areas, including building trust, openness and reasonableness with the industry, and technical competence. It is not uncommon for regulators to fail to meet the standards needed.

centric and empowering model of best practice described in the preceding sections. In theory, per capita funding could alter in line with the government's overall financial constraints. In reality it is more likely to alter only gradually (in the absence of a major financial shock), probably indexed to an appropriate price index linked to the sector.

There are a number of caveats to the above scenario. First, it has not been tested (or bought into) with the many stakeholders who have a keen interest and deep knowledge of the sector. Second, the health system is under some strain. In this environment the focus is firmly on getting more for less. The appetite for and ability to accommodate significant change is likely to be small, and the considerable one off investment in time and money needed to make it happen unavailable.

Looking at the evolving pressures on the health system over many decades, and the modest reforms (some of which have been counterproductive), one might be excused for comparing it to the unfortunate frog placed in a pot of water on a stove. Because the frog's environment deteriorates only slowly through its eyes, it never takes the violent corrective action needed to save itself, so is boiled to death. In contrast, were the frog dropped into boiling water, the shock would cause it to instantly jump out. Similarly, perhaps a violent shock is needed to jolt the health system in a measurable way along the path towards best practice? It can be argued this has been the case for Australia (where aged care has been made the responsibility of the Commonwealth), Czechoslovakia, the United Kingdom, Japan and the Netherlands, where shocks from the financial crisis have preceded significant reform in the elder care sector.

Competition isn't everything: introducing co-opetition

It would be wrong to give the impression that competition is the silver bullet needed to drive the system forward. Perhaps it would be more accurate to describe it as one of a number of tools needed to make the system work as well as it might. Another is obviously co-operation. The importance of co-operation between different agencies was noted earlier with respect to achieving an effective client centric approach. But there is another way to think about getting the most out of co-operation and competition, a way that reinforces them being thought of as complements, not substitutes. This is encapsulated in the term "co-opetition". This term captures the notion that there are circumstances where the client is best served:

- by entities competing to supply goods and services that better meet client needs with respect to quality and cost; and
- by those same entities co-operating to provide something better than could be achieved by acting alone.

To illustrate, the formation of databank is an example of co-opetition. While the banks compete to offer banking services to funders and borrowers that best meets customer price quality trade-offs, they were also able to come together to jointly develop a clearing house which paved the way for eftpos and other intra-banking services which has seen New Zealand's banking system operate seamlessly across many areas, to the customer's

considerable benefit. Even today many overseas banking sectors are many years behind that found in New Zealand.

As discussed in Part III, there may be similar co-opetition opportunities in the elder care sector.

PART III

FINDINGS AND RECOMMENDATIONS

The "health warning"

In the process of undertaking this review, a number of threats to current WCA performance and opportunities for improvement have been identified. These are outlined below. The net has been cast wide. The supporting analysis is brief, and the conclusions tentative. In some cases conclusions may appear naïve to people familiar with the sector.

An attempt has been made to introduce WCA to concepts and ways of thinking about issues that will be useful for developing other topics on the WCA agenda.

Taking time for big picture thinking: guided by a public interest touchstone objective

A common criticism of entities is that they spend too much time on detailed day-to-day decision making, at the expense of standing back and looking at the changing environment within which they operate and strategically positioning themselves to take best advantage of that environment.

One of the purposes of part II of the review document is to assist WCA develop a clear medium to long term view of the environment it will be operating in.. This is necessary if WCA is to take decisions now on how it is to best meet the future needs of its clients and potential clients. By looking at the factors underlying demand, supply and best practice, it is also hoped it will spark other strategic discussions leading to better decision making across other areas of WCA activity. This exercise should be a routine part of WCA's strategic planning.

WCA is strongly focused on contributing to the public interest. This was confirmed by its endorsement of the review framework which gave primacy to the contribution WCA can make to the community's well-being. It was also confirmed in discussion with staff about how they saw their role.

Given these observations and the WCA culture, there is merit in more explicitly incorporating a public interest touchstone objective into WCA's vision and mission to guide its decision-making. A public interest touchstone provides a common point of reference and focus for internal and external stakeholders as WCA works through any change. It helps provide a focus on the core issues of value to the community while weeding out the more extraneous arguments. The more ambitious and controversial WCA's reform programme is, the more important it will be to have a clear statement on, and buy in to, WCA's purpose. Further, a public interest touchstone objective is consistent with the framework used by government for making regulatory and spending/taxing decisions.

Finally, the environment described in Part II is one of increasing competition in the social services space. It is the researchers view that organisations with a lack of focus, or having practices based other than on promoting the public interest, will increasingly risk becoming irrelevant. Moreover opportunities for organisations better meeting the needs of the community may be missed.

Recommendation no. 1: WCA annually review and amend Part II of this review "thinking about care of older people in a changing environment", on demand, supply and best practice to sustain a common understanding of the environment within which WCA operates for strategic planning purposes.

Recommendation no. 2: WCA adopt as its decision making touchstone a public interest objective, its precise form to be determined through consultation internally and with key external stakeholders.

Recommendation no. 3: WCA establish a formal programme of engagement with leading and innovative thinkers to challenge and invigorate WCA and others as appropriate operating in the elder care sector.

WCA meeting the social challenge through setting and exceeding best practice

The current environment described in Part II is of a clunky system under pressure, offering limited client choice and mismatching and wasting resources. Eemerging best practice will be a system that works hard to make best use of existing resources and that automatically evolves to eliminate waste and deliver innovation and variety. It recognises heterogeneity between individuals and their circumstances, and the importance of tailoring solutions to the individual. It has the client at the centre of decision making. Further, incapacitation is recognised as a continuum, not a condition that can be neatly delineated into boxes of care options. Client care options will increasingly blur into each other, including across age groups. WCA should view itself as an agent for encouraging moves towards a holistic best practice elder care system.

WCA has a proud and respected tradition of care in the community. It also is a proven innovator. It works hard within the government system of elder support to achieve and set new standards of best practice. It has a strongly co-operative and collaborative culture. WCA operates both horizontally across all four sectors of care, and vertically across many of the types of client needs. It has financial resources in reserve, social capital from the community and good will with government to draw upon. WCA is ideally placed to pilot and lead best practice in elder care. To take it to the next level will take investment resources, and nerve. Innovation is replete with failure.

As a starting point, WCA should review its vision and related strategic documents to ensure they are consistent with and reinforcing of it leading best practice. This process, driven collectively within WCA, should quickly determine whether the interests of the community, WCA and its funders (MoH and DHBs in particular) are best served by it adopting a more overt role in leadership and pushing the boundaries of best practice. If WCA decides the role outlined above is right for it and the community, the next step is information gathering and relationship building (as prerequisites to sound decision making).

There are a number of innovative and talented individuals and organisations that are pushing the boundaries, within and outside the age care sector. Sam Johnson of student army fame, for example, is rapidly building for himself a reputation as the Steve Jobs of the philanthropic sector. Also, ANZ Bank is working closely with government on making social impact bonds a success (refer "Social impact bonds" above). WCA will be aware of other innovative thinkers and organisations. They should not be limited to the philanthropic or elder care sectors. A formal programme of tapping into the expertise and perspectives of these people should be put in place, both in collaboration with other stakeholders in the sector (for sector wide issues), and individually for WCA specific issues.

Recommendation no. 4: WCA review its vision and related strategic planning documents to ensure they are consistent with WCA leading best practice in the elder care field.

Recommendation no. 5: WCA advocate with government and other stakeholders as appropriate to move the elder care system towards best practice.

WCA meeting client need through growing and competing

Size matters. The small size of WCA's SIL operations is, or could become, a barrier to offering the best services possible at a given price point (cost). By realising the economies of scale and scope that come with increasing size and diversity, WCA will be better able to meet the needs of existing and potential clients in new areas of need. Some *economies* include the sharing of ideas, experiences and the use of specialist resources. For example, where WCA's client group has a range of complex needs, it is useful for WCA to have, or have access to, a range of specialist skills to help in meeting those needs. (However, the client base - over which to spread the cost of these specialist services/expertise – has to be large enough to justify this; a specialist resource to help manage elders with severe pain management issues is only practical if sufficient clients require this.)

Currently, WCA provides SIL services to clients funded by the two local DHBs. In the past it has also, on occasion, provided these services to clients for free. WCA has not provided services to clients (or their families) willing to fund those services themselves (private

clients). For its current client group, older people with high and complex needs, this is of less consequence as there is little overlap between those with high needs and those meeting these costs privately. However, if WCA is to expand the range of services it offers, and it is a recommendation (no. 6) of this review that it should, it should commence with private fee paying clients in preference to either:

- Winning existing contracts from other entities providing services under contract to the DHB; or
- Identifying new areas of need and commencing a process with the DHB's to fund that need.

The reviewer asked stakeholders whether there were significant needs of older people going unmet in the community to which WCA could make a case for DHB funding. None was identified. Considerable effort may be required to find them which may ultimately prove fruitless.

Further, as part of the review, different stakeholders did identify the changing "nature" of current demand, for example living with disabilities, drug and alcohol addiction, end of life planning, and budgeting/money management services. However, for the most part these conditions and services relate to the clients funded under the existing DHB contracts, that is, they can be managed and provided under current arrangements with the DHBs.

However there are a number of benefits to targeting fee paying clients (in preference to existing DHB contracts):

- The expansion is more gradual and easier to fund, and therefore lower risk to WCA;
- WCA would not have the encumbrance of DHB reporting and accountability to build into its overheads and restrict innovation; and
- It is consistent with the environment WCA will increasingly be operating in in the future.

Also, fee paying clients may give WCA the capacity to independently target areas of greatest need. As noted in Part I, in the current environment government is giving priority to projects that save it money, in particular across the Health portfolio. This leaves at risk proposals with high benefit cost ratios, but no savings to government. Social impact bonds may in time go some way to filling this gap. Fees from paying clients may also give WCA greater capacity (from any surplus - which needs to be applied to charitable purposes, and spare capacity) to target greatest need, need that the DHBs may be unwilling to fund. Further, by experimenting and building an evidence base in support of any new programmes, it may in the future lead to the evidence needed to persuade the government to support these programmes.

The review did not extend to identifying what areas of private demand might be targeted first (a decision must first be made on whether fee paying clients are "out of scope" for

WCA). However, in making these decisions, regard needs to be had to the nature and size of that demand, and the ability of WCA to access the resources needed to better meet client need than other providers.

It may be that WCA has made a deliberate choice to target only those who cannot afford to pay for the services WCA provides. If that is the case, it is suggested this be revisited in the context of the environment WCA will increasingly find itself operating in, and the added benefit to WCA's clients. This includes the potential that fee paying clients could offset costs to non-fee paying clients, and support WCA to continue its role in innovation.

Finally, there are a number of caveats to WCA growing its client base and expanding the range of services it offers. Many entities have failed because they have taken on too much too quickly, or tried to deliver too many services. They have lost focus or failed to develop the capability to deliver, monitor and integrate the activities of the entity. For this reason, any plans for expansion should be incremental, and built around (reinforcing) the existing SIL services.

Recommendation no. 6: WCA commence an environmental scan to identify fee paying clients to whom it might offer services, in the first instance leveraging off the strong base provided by its SIL activities.

Meeting the need for short term residential care

In its report into elder care in the Capital Coast, Hutt and Wairarapa regions, the Sapere[29] review found that clinicians would like more options to reduce the length of stays in hospital for older patients. The barrier is that these patients either still require low level medical monitoring or they are incapable of looking after themselves at home.

Similarly, the strain on family caring for high needs older people can become too much, in particular when other commitments such as a work trips, illness in the family or relationship breakdowns make care more difficult. In the absence of respite care to allow carers to better cope with their own life challenges, the risk is that older people may find themselves permanently in residential care. This is not just an issue for low income older people, but also for those who could afford high end accommodation (especially if it is only temporary).

[29] Needs assessment service co-ordination and home and community support services review: Review of older people, Jo Esplin, Christine Howard-Brown, Sapere Research Group, 2 February 2015. While the momentum behind this report has dissipated with the three DHBs choosing to go their own ways, the issues identified in the report should not be allowed to float unresolved.

Finally, the Sapere report also found that some primary care stakeholders felt there needs to be better access to short term care, in preference to either hospital or long term residential care.

Both rest homes and retirement villages do offer some short term stay options, with varying degrees of support. However, the Sapere report suggests there are gains to be had by extending the range of circumstances covered.

WCA operates a rest home, Wesleyhaven. It is operating short of capacity. It is staffed by skilled staff experienced in medical and social work. Next door are WCA social workers who support high needs older people to live in the community as an alternative to residential and even hospital care.

There will be other rest homes in a similar position throughout New Zealand. Similarly, retirement villages do not operate at full capacity. Increasingly these villages are able to accommodate high needs clients who may have high medical needs for example.

At face value it would appear the residential care sector (retirement villages and rest homes) could offer at least an in part solution to the demand for short term care facilities by offering up a portion of their unused capacity. This would:

- reduce the burden on hospitals (avoiding admission in the first place and achieving earlier discharge, thereby freeing up hospital beds);
- reduce the burden on rest homes (who would take clients short term rather than long term);
- save money through greater availability and use of low cost options; and
- improve outcomes by offering clients more choice, and strengthening client centric care.

Just because retirement villages are commercial entities, it should not be assumed they would be unwilling participants in providing short term respite and transitional accommodation for older people as an alternative to hospital accommodation. Provided fees more than covered their variable costs, and it is seen as consistent with their brand image, they may welcome the opportunity to explore the option. Also, short term clients occupying rest homes may help to break down negative stereotypes relating to this care option, especially with many of these clients transferring *back* to independent living. Ryman Healthcare appears to have already taken steps in this direction.

WCA, partnering with the DHBs, is ideally placed to explore the greater use of Wesleyhaven's spare capacity for short term care of high needs older clients. For example, WCA social workers are able to expertly transition short term clients at Wesleyhaven back to their private accommodation, and ensure they have appropriate home support while they recover.

Through careful monitoring, it should be possible to estimate the savings available to the DHB for possible roll out of a more ambitious respite programme to other areas of the country. If successful, the arrangement might be extended to people under the age of 65 in some circumstances.

Recommendation no. 7: WCA (Wesleyhaven and SIL) co-ordinate a meeting with representatives of the relevant DHBs, MoH, and rest home representatives with a view to exploring the nature and magnitude of the need for short term residential care, and the practicality of rest homes better meeting this need.

Social bonds: can WCA catch the wave?

Social impact bonds were discussed above "Social impact bonds". By definition, if they can be made to work they offer, in select areas, the potential for tremendous gains in the social services sector. WCA, due to its culture and capability (refer "
WCA meeting the social challenge through setting and exceeding best practice") is well placed to trial social impact bonds, and further the interests of clients and potential clients in doing so.

Further, there are early mover advantages available to WCA in embracing social impact bonds, including valuable learnings, credibility, and becoming more competitive (better able to meet client needs). One possible area to explore is their use in transitioning older people from hospital back to home via residential care facilities.

Recommendation no. 8: WCA follow closely the Ministry of Health trials with respect to social impact bonds, and commence informal discussions with potential funding partners, for example, ANZ.

Taking advantage of being a charitable organisation: Leveraging volunteer effort

WCA staff are highly specialised professionals. Their time is limited relative to the demands on it. Some of those demands, while important (in some cases critical) for the wellbeing of the client, need not be met by staff.

WCA has in the past relied heavily on volunteers to support their work with older people in the community, for example, to take clients to and from doctor appointments and even shopping. That is not the case today. There are very few WCA volunteers working with staff. Volunteers take effort to mobilise and keep motivated. This in itself can be a distraction for staff.

WCA recognise the importance of leveraging the work of its staff with volunteer effort where it is practical to do so. It is one of the comparative advantages of the non-commercial sector. Working well, a system of utilising volunteer effort promotes social capital, provides direct benefits to the volunteers in terms of personal satisfaction and experience, provides new services to those in need, allows the paid professionals to focus their skills and expertise on the tasks for which those skills are most needed, and allows services to be provided at lower cost than would otherwise be the case.

It is emphasised that volunteers will have a number of motivations for contributing their time. However, it is expected that one of the key motivations is to contribute value to the cause in question, and the more value they contribute, the greater will be the satisfaction for the volunteer.

WCA has begun working with 'Volunteer Wellington' to secure the volunteer resources needed. This is sensible. Volunteer Wellington acts as a brokerage service to link disparate volunteer resources with the right non-commercial entity (interestingly, they do not provide this service to commercial entities – yet). They also provide advice and support for the management of volunteer resources.

A brokerage service offers economies of scale and scope which can make them a sensible option for sourcing volunteers. It will be interesting to see how well the arrangement works, that is, whether it successfully links to a sufficient number of the volunteers most needed by WCA.

In the event the brokerage service does not prove successful, it is noted WCA has alternative options to consider. WCA could, for example, club together with other service providers working on the elder care sector to set up the specialised infrastructure needed to best target the type of volunteer resource needed. Otago fruit growers did exactly this. Because the Department of Labour and other recruitment brokers did not achieve the quality/price trade-off needed by fruit growers, consistent with the co-opetition model outlined in "Competition isn't everything: introducing co-opetition" above, they successfully formed their own recruitment agency specialising at meeting their labour needs.

But it is clear WCA is already moving strongly in the right direction with respect to volunteers, so a recommendation is not offered on this point. However, in the course of the review a few minor opportunities for WCA were identified.

First, to progress the recommendations from this review will require specialised, professional advice. Some of that advice will be available from within WCA. Some will not. External advice will be expensive, putting at risk other WCA initiatives and objectives.

Other charities face similar challenges. One charity that has been particularly successful in overcoming this challenge is the SPCA. A step improvement in legal cases taken and won

against people committing animal cruelty was achieved when the SPCA secured, on an ongoing basis, the pro bono support of a number of senior lawyers.

There is no reason why WCA, alone or in concert with other charities, cannot achieve significant benefit from accessing the services of professionals on a pro bono basis. One option is for charities to encourage Volunteer Wellington to move more aggressively into this space. Another is for charities to set up their own organisations to target this part of the market, where projects are described, skills needed outlined along with the likely commitment needed. A third approach is for WCA to approach a number of professional bodies with a list of projects they would welcome input from professionals on. The Chartered Accountants Australia and New Zealand, for example, has a not for profit special interest group which will likely be sympathetic to an approach from WCA.

At the other end of the spectrum, a large part of volunteer effort used by WCA is likely to be applied to socialising with clients (while taking clients on trips, to appointments shopping etc). Volunteers and clients are unique people. It is inevitable that these social 'matches' will not always work. For all concerned, it is important that they work as well as they can. The reviewer spoke to one client who, while very happy with the WCA worker, quickly offered that things were not working well with one of the volunteers. The volunteer was not from WCA.[30]

Volunteers by definition are unpaid. It may seem ungrateful and awkward to decline or rescind a free offer of help, but there are times when it will be necessary, in particular when it is not working for the client. Otherwise it is a waste of both parties' time.

As commented above, most volunteers will want to contribute value, and the more value they contribute, the more rewarding will be the project for them. To this end, when WCA again takes on volunteers it is important that the value of their role is carefully explained to them, including getting the correct match between client and volunteer, and that it may take a number of attempts to achieve that correct match for both parties.

Volunteers working with clients will not be as trained and skilled as WCA staff. As commented above, the majority will want to feel they are being put into positions where they are contributing significant value. In the course of this review, the use of a checklist being used by WCA to determine client financial vulnerability was observed. In this instance a significant risk was identified and managed.

There will be other opportunities across WCA's activities to add value in this way. To aid this process it is perhaps worth bringing out more formally what was being observed – being "technocratic" versus "bureaucratic" decision making.

[30] The volunteer was from an organisation that actively manages poor fits between volunteers and clients, illustrating the importance of remaining vigilant to the problem.

A bureaucratic process involves applying a standard process to the collection, processing and decision making required for an activity. A tax call centre is a good example. People in the call centre will typically be operating with a flow diagram or similar as they work through an enquiry, for example, to determine someone's marginal tax rate or tax code. After getting responses to a number of standard questions, the operator will be able to give the correct answer – perhaps 98% of the time. The workers typically require little training to perform to a high level and are inexpensive.

However, there will be enquiries that can't simply be answered through a process of box ticking as the operator works through flow charts. To make these decisions correctly will require varying levels of judgement based on a thorough understanding of tax law, underlying principles and a thorough understanding of the specific circumstances. These people will have considerable experience, training, judgement and responsibility. They will be technocrats. Besides dealing with the "two per cent" of cases not appropriately dealt with by established bureaucratic processes, they will also oversee the system and make changes where needed. Comparatively, they are in high demand and expensive relative to bureaucrats.

All organisations of any size will have both technocratic and bureaucratic roles. Most evolve on an ad hoc basis over time. It is the position of this paper that a more deliberate and strategic approach to the proportion of bureaucratic and technocratic skills on staff will realise greater gains from fewer resources.

In particular, as WCA moves to make greater use of volunteers, it needs to look carefully at opportunities to extract as much value from them as possible. Like in the tax call centre, aids such as check lists and flow diagrams can quickly add to the value of their efforts (and hopefully 'job' satisfaction), freeing up WCA staff (essentially technocrats) to apply themselves where their skills are needed the most, and thereby contributing greater value to client outcomes.

Recommendation no. 9: WCA write to the Institute of Directors, Law Society and the Chartered Accountants Australia and New Zealand as a first step to gauging these organisations' willingness to:

- A formal arrangement with Volunteer Wellington or a grouping of charities to bring together professionals with projects in the charities sector requiring professional help; and/or
- Trialling such an arrangement in the first instance with WCA.

Recommendation no. 10: WCA review its activities to identify what roles might be undertaken by volunteers, and how best to add value to the contribution they make.

Reducing client and carer risk: Sensible shopping

Dealing with client money is high risk. Age Concern prevention of elder abuse and neglect report a high proportion of financial abuse of older people, even when financial EPOAs exist. There have been a number of occasions recently where carers have taken financial advantage of clients. Not only is this taking money from those for whom it is most needed, it can also mean trust is lost between clients and the system, resulting in clients entering residential care earlier that would otherwise be the case. But it also promotes distrust in the home support system more widely, making potential clients less likely to accept carers into the home in the first place, leaving them at higher risk in an environment they struggle to navigate.

WCA is the only home care organisation supporting financial transactions with clients. They are currently exploring the possibilities of public, NGO partnership and corporate social responsibility partnerships to support the establishment of financial Power of Attorneys (rather than the Public Trust Office) for clients as a free or lower cost service than the public trust provides. This will reduce costs and introduce a number of protections for both parties.

In support of these objectives, there is also scope to improve the way grocery shopping on behalf of clients is done. Currently, there are two significant problems related to shopping:

- Transport - The time it takes for Wesley staff to provide transport – which means WCA staff have less time available for tasks requiring their specific skills; and
- The risks to staff and the financially vulnerable client in handling client money as commented on above.

This is not a problem particular to WCA. Other organisations providing home help, commercial and non-commercial alike, in old age care as well as for other age groups, are facing the same problems. With the trend to more home care, and with an aging population, the problem will compound over coming decades.

Supermarkets cannot afford to ignore this market. It is in their interests to take steps to meet reasonable needs. At this stage they may have little awareness of the issues, or the size of this market. This should be tested by WCA. In particular, WCA should test with the head offices of the two supermarket chains their willingness to:

- provide home delivery services;
- organise a stream-lined process for arranging direct debit facilities for home care clients; and
- fund the development of a home shopping “app” specifically designed for use by home carers and clients.

The shopping app would, among other things, provide for a unique standard weekly shopping list to be created for each client. This would mean the carer could, a couple of minutes each week, work through the list with the client to see what if anything needed changing from the standard list to generate the current week's shopping list. The app would also provide for the direct debit, and instructions for the supermarket relating to delivery time and special instructions, for example, "leave around the back".

Ideally, once the supermarkets understand the nature and size of the market, both chains will wish to participate in developing a "competition in the market" home shopping model. However, in the event this is not the case, WCA might like to increase the incentive on the supermarkets by co-ordinating its demand for these services with other home care providers. This could mean, for example, putting in place a "competition for the market" approach, with the relevant, minimal infrastructure (mainly the software app) owned by the home help providers. A third best option would be to enter into the arrangement with one supermarket chain only, that chain owning the related infrastructure, which in turn would give it some ongoing protection from competition.

At face value, from the outside, the establishment of such a mechanism appears straight forward. It won't be. There will be problems to work though, certainly technical issues, perhaps legal and financial as well. Specialists from the supermarkets and elsewhere will be needed. Members of the Law Society and Chartered Accountants of Australia and New Zealand and Bankers Association may be willing to help.

In the event there is success with the supermarkets, improving the client/pharmacy interface could also be looked at, although there may be greater legal obstacles to overcome.

Finally, one stakeholder commented that for some clients, going shopping with a carer could be providing benefits for the client beyond the groceries alone. In response, this is likely to be correct. But WCA staff together with the client are probably best placed to make the decision on the respective trade-offs in each situation.

Recommendation no. 11: WCA take preliminary steps to test, with the head offices of the two supermarket chains, their willingness to provide home delivery services that reduces client financial risk and the need for social workers to spend time shopping.

Making bulk funding work better

WCA SIL contracts are bulk funded. Unlike fee for service contracts, this means WCA has considerable discretion to apply those funds as it sees fits to best promote the interests of clients. It also means that even if WCA does not have a full complement of clients (75 across

the two regions) WCA gets to keep the funding provided for the full 75. It also means that if the original WCA assessment of client need is inaccurate or changes over time, WCA is able to quickly alter services provided without first having to refer back to the NASCA.

In the course of the review, there was a view detected from within WCA that if WCA did not maintain client numbers at or close to the full complement of 75, future funding and capacity to meet future demand would be placed at risk. This is a common asymmetric perception within government, that is, funding is easily lost where demand falls, but hard to reinstate when demand picks up. Further, even if funding is reinstated, the service is compromised because of the time it takes to get people up to standard again in the delivery of services.

On the other side, it was heard from external stakeholders that WCA may not always be operating as intended under the bulk funding arrangement. In particular there was a concern that WCA was working too hard to keep client numbers up (while acknowledging the number of clients receiving support is an important consideration) and should be taking the opportunity provided by low client numbers to invest in innovation and positioning itself for future developments.

However, it is not always easy to reprioritise resources dedicated to one purpose (in this case providing welfare services) to another purpose (planning and executing improvements to the way WCA operates). One option is for WCA to explore greater use of contract resources. This would give WCA greater flexibility to devote surplus resources (when client numbers are down) to defining and achieving best practice over time. In any event, the current disconnect between WCA and some stakeholders with respect to the best way to approach bulk funding is a risk and should be addressed.

WCA management are aware of the importance of getting the balance right between devoting resources to supporting clients and investing for innovation. They are also aware that views can differ over where that balance should be. It was further explained that WCA was in the process of investing to provide additional services, including budgeting and advanced care planning as part of its SIL services.

Recommendation no. 12: WCA review its practices to ensure an appropriate balance is being struck between providing appropriate support to a high number of clients and investing in innovation.

General Practitioners: helping an essential group under pressure

The elder care sector and GPs, whilst improving, could likely be improved further. The Sapere report, for example, noted that primary healthcare was not well integrated with

NASC/HCSS, meaning clients may be going to hospital when HCSS would be more appropriate. It was further suggested that HCSS don't have the skills needed to deliver necessary health services at the level needed, denying other people access to hospital beds.

Also, although information was currently lacking on the effectiveness of different approaches to improving elder care outcomes, there is a widespread view amongst the stakeholders spoken to that further efforts to improve the GP interface with the sector would create good returns. WCA and other elder care stakeholders are, separately, working to improve this interface.

GPs are the key access point to specialist health services. They are under considerable pressure to improve their capability and the interface between their many stakeholder groups and related secondary health care providers. As a consequence, their overheads are under mounting pressure, at the expense of chargeable hours. This trend is not sustainable.

Ideally, the Ministry of Health should take the lead to take a stocktake and review of the demands on GPs to find a process for better managing, coordinating and processing those demands (at least cost to GPs).

Failing this, there may be value in elder care stakeholders in the WCA region coming together to co-ordinate their efforts, perhaps involving PHO's, the DHBs, and others as appropriate.

Recommendation no. 13: That WCA consider whether there would be value in co-ordinating the efforts of elder care stakeholders to improve the interface between GP practices and the elder care sector, and if so, how this might best be done having regard to the tremendous competing demands made on GPs time.

Targeting greatest need with the best tools

WCA prides itself on applying a cutting edge, client-centric, strengths based and goal focussed approach to client rehabilitation and care. A number of external stakeholders echo this view of WCA. However, in this service there is always a risk that client autonomy may dominate prudent client health and safety risk management, potentially leading to client risk not always being appropriately identified and managed.

Across this sector there is also anecdotal evidence of providers, on occasion seeking to retain clients who are easy to provide care for but are not highest need, and facilitating clients into retirement villages who are still capable of living in the community; or offering services that are easier and cheaper to provide, even though more expensive and complex services are expected to be better for the client.

WCA management advise that these issues are well understood within WCA and that efforts are made to ensure they are appropriately managed. It was also observed that any issues were probably more significant in the past than today. In fact, WCA advise that they have the capability and desire to manage more complex and higher need clients than they are being allocated; and WCA further acknowledged they perhaps have not been as effective as they could have been in conveying to stakeholders how the strength based approach to SIL is being applied by WCA.

The author notes that as markets across the elder care system become more competitive in response to insufficient funding, providers may seek competitive advantage by taking on easier and less expensive clients, and discouraging higher needs more complicated clients. Also, at an individual worker level, taking the easy course of action is human nature.

It is important WCA also be vigilant in respect of these risks, understand the causes, and apply appropriate solutions should the need arise. Support to individual workers, whether this takes the form of skills support, time or financial resource allocation, should mitigate against any problem manifesting.

It is important to note that it is unclear as to the extent that these problems might exist, if at all, across the sector as a whole, in individual providers, within WCA as an entity, or at individual staff level. However this is a constant threat to the culture of every organisation and the people who work within them.

Agency theory is dedicated to managing these problems, between entities, and for individuals within entities. It is the view of the reviewer that the issues noted above should be on the agenda for senior level discussion with staff.

Recommendation no. 14: WCA senior management consider whether the perception that clients could be placed at risk by privileging client autonomy over obvious threats to clients health and safety could apply to WCA and, if appropriate develop an external communication strategy with regard to this perception with key stakeholders.

Recommendation no. 15: WCA continue to develop staff competency in best practice clinical decision making and risk mitigation in determining client autonomy versus living at risk with respect to elder care in the community.

Political risk, is it being managed?

As commented above, there will at some point be incidents and the risk of fatalities of SIL clients, which could put at risk public support for SIL and result in counterproductive political pressure on DHBs and WCA. This is a common occurrence in the mental health sector where suicides and homicides involving people who would otherwise be in

institutional care generate political pressure against the system of mental health in general, and against community based care specifically.

While there is every reason to think WCA is appropriately managing safety risks to clients and staff, no safety system is foolproof. It is unclear whether sufficient preparation has been made for bad publicity and its fallout for when things go wrong.

Recommendation no. 16: WCA, together with other stakeholders as appropriate, ask the question as to whether they are appropriately prepared for managing the risks and controversy that comes with a strategy of caring for older people in the community.

Protecting and building effective relationships with accurate, timely and appropriate information

This review found some evidence of a mismatch between stakeholder expectations and what they believed WCA is providing. Also, there could be merit in reviewing whether WCA is appropriately prepared for inevitable bad news stories. Finally, the possibility of staff having different understandings of their key responsibilities was identified. An effective communications strategy is a useful tool to manage these issues.

A good communications strategy will identify key internal and external stakeholders and regularly assess their interests and information needs. It will identify risks and opportunities to WCA's objectives from incomplete or inaccurate stakeholder information. A communications strategy needs to be fully integrated into WCA's strategic planning if it is to be properly coordinated with WCA's other activities and supportive of WCA's objectives. Implemented well, it will be a useful tool to helping WCA win and retain additional contracts, and positively influencing the environment within which it operates. A senior staff member should be responsible for the strategy.

It was unclear to the author whether WCA has a formal communications strategy. If it does not, one should be developed urgently. If it does, its effectiveness and appropriateness against the environment discussed in Part II above should be reviewed.

Recommendation no. 17: WCA review its external communications strategy and give a senior member of staff oversight responsibility for that strategy.

Appendix one: An overview of New Zealand's elder care system

The outline of New Zealand's elder support system provided below draws heavily from the New Zealand Productivity Commission report "More Effective Social Services: Final Report", 15 September 2015.

The principal source of government-funded support for older people at home is the health system. The MoH funds home-based support for older people as part of a broad programme of support services for older people and people under 65 who have disabilities.

The government's Health of Older People Strategy sets overarching objectives for all government health policies and services for older people. The MoH is leading work to update the Strategy, which is expected to be available for public consultation mid-2016. The Strategy's current vision is:

> Older people participate to their fullest ability in decisions about their health and wellbeing and in family, whānau and community life. They are supported in this by co-ordinated and responsive health and disability support programmes (MoH, 2002).

The aim of support services is to assist people and their families to increase independence and participation in social life (MoH, 2003a). Services include support with household tasks and personal care, provision of equipment to enable people to manage everyday activities, and support for carers.

Depending on a client's needs and circumstances, ACC may fund other rehabilitation services, such as aids and appliances and housing modifications. ACC can also fund injury prevention assistance, for example to prevent people injured by falls from experiencing further falls when they return home.

The Government funds other services to assist older people at home, including services to help prevent elder abuse and neglect, as well as advisory services for people living in retirement villages or rented accommodation. The Government provides financial assistance in the form of rates rebates for low-income homeowners (delivered through councils), subsidised taxis for people with limited mobility and the SuperGold Card.

Support services for people aged 65 and over are commissioned differently to services for those aged under 65. The MoH purchases support services for under 65s directly from non-government service providers. By contrast, funding for over 65s is devolved to New Zealand's 20 District Health Boards (DHBs), which in turn purchase services from non-government service providers.

As part of the devolution of funding, central government retains the right to tell DHBs which kinds of support services they should purchase. There is in effect a chain of influence in support services that extends from the Government to the DHBs, and from there on to providers and their staff.

In addition to making decisions about health priorities and funding levels, the Government regulates the way support services are provided. Providers are also required to respect the rights of older people and ensure safe conditions for older people and their workers, in line with laws such as the Health and Disability Services (Safety) Act 2001, the Health and Safety in Employment Act 1992, the Human Rights Act 1993 and the Privacy Act 1993.

Contracting arrangements

Most DHBs purchase home help from providers using a "fee-for-service" model of contracting. Under this model, a DHB will refer an older person to a home-support provider following a needs assessment, and the DHB will pay the provider for the number of hours of support it provides.

The other DHBs purchase home help from providers using bulk funding, where the DHB and the provider agree on a package of care to be provided to a specified client population, and the DHB pays the provider in lump sums for home-help services. This allows the provider more flexibility to target need.

Needs assessment

DHBs use the International Residential Assessment Instrument (InterRAI) to assess needs for home and community support services. It provides rules and criteria for assessing whether an older person needs various types of support, including medical care, rehabilitation and support at home. Using InterRAI and a "case-mix" system, DHBs generally sort people into categories based on the type of support required.

DHBs subsidise home and community support services for older people with low incomes. The Ministry of Social Development (MSD) provides Community Services Cards (CSCs) to people with low-to-middle incomes (less than $27 637 a year before tax for single people living alone). If a person over 65 has a CSC and they are assessed as needing some care, they will get all home management and personal care services paid for. If they do not have a CSC they are only entitled to personal care support. People without a CSC must contribute some or all of the costs of support for households tasks, depending on their income. Older people may also be entitled to a MoH carer support subsidy to assist unpaid, full-time carers to take a break from their caregiving role, and a MSD disability allowance for costs such as gardening.

Workforce

The consulting firm BERL Economics described the health and disability workforce in a report commissioned by Careerforce, New Zealand's Industry Training Organisation for the health and community support sectors. Of the 41,232 people that BERL identified as carers based on the 2013 Census, only 5,772 were carers of aged or disabled people. In addition, 29,859 of the 41,232 carers were personal care assistants and some of these workers may be also providing home-based care to older people. Nearly half of the carers (49%) were aged 50 or over, and nearly nine in ten carers (89%) were female. Of the carers identified in the Census, 68% identified as European, 14% as Māori, 14% as Asian, 9% as Pacific peoples and 1% as other ethnicities (BERL Economics, 2013).

Appendix two: Wesley Community Action (WCA)

Overview

WCA was established by the Methodist Church in 1952 to promote "social justice and quietly helping create just and caring communities" in the Wellington region, including Otaki, Kapiti, Porirua, Hutt Valley and Wellington. WCA provides services to:

- Older people living in the community
- Providing residential care for older people through independent units, supported units and hospital care
- Supporting community pantry and gardens
- Working with youth
- Providing training on parenting skills and financial management
- Supporting families to reach their potential

WCA has a full time staff equivalent of over 117 and draws on approximately 95 volunteers. WCA has gross income of approximately $7.5 million, of which approximately $7 million comes from government fees and subsidies, $0.2 million from community partners (grants and philanthropic trusts) and $10k from simple donations.

Supported Independent Living (SIL) services

The Capital and Coast District Health Board (CCDHB) and the Hutt District Health Board (HDHB) purchase from WCA community support services for older people with complex needs including age related disability support needs to support them living independently in the community. WCA clients typically have complex needs and a low ability to manage the system themselves – they often need help in making choices. The productivity commission has identified this group as the most vulnerable in the community, and where the greatest improvements might be made. This view is shared by WCA.

Among other things, the SIL programme is intended to reduce the risk of inappropriate or premature placement into residential care because of support needs, needs which cannot be met solely by existing services.

The respective DHB contracts are (for Capital Coast Health) 2.6 full time equivalent community workers/social workers, having approximately 50 complex needs clients directed from the Needs Assessment and Service Coordination (NASC) agency. The HDHB is for 1.4 full time equivalents and 25 complex needs clients. The NASC agency must have deemed the client as needing support to live independently in the community and the assessment will determine the client's support needs, motivational and recreational requirements. The NASC is responsible for any transfer of a client to an alternative provider. Some funding is also received from the Lotteries Research Grant.

Population in the Capital Coast region is approximately 303,000. 33 % will be over the age of 65 by 2031, a 12 % increase on the current population. In the Hutt DHB region the population is approx. 146,000. 40% of the Hutt population will be over 65 by 2031 (a 15% increase).

The service contracts between WCA and the two DHBs are almost identical. Further, the contracts provide for bulk funding under a restorative and goal setting approach to care.

To qualify for support, a client must be:

- Living independently in the CCDHB area.
- A person with a disability, ie, assessed as having a physical, intellectual, sensory or age related disability (or a combination of these) likely to continue for a minimum of six months and result in a reduction of independent function to the extent that ongoing support is required.
- Over the age of 65, or assessed as having the potential to benefit from a high level of support (or over the age of 55 for Pacifica and Maori persons).

Exclusions include persons:

- In a residential setting.
- With overriding primary need related solely to personal health and or mental health funded services.
- Assessed at risk of causing immediate harm to self or others.
- Eligible for services under the Injury Prevention, Rehabilitation and Compensation Act 2001.

The community/social workers seek positive outcomes for their clients by providing services to maximise their independence through working with the client to develop a 6 monthly goal centred support plan, which will typically cover:

- Goals and how they are to be achieved and when by
- Community participation;
- Education for the client;
- Promoting social networks;

The plan will reflect the client's social, cultural, economic, spiritual and physical context and where practicable reflects the client's preferences, capabilities and support needs. It will also be formed with input from whanau and other service providers and the resources they make available.

Every client is assigned a responsible support worker. Care is taken to ensure a good match between client and support worker. It is expected the client will remain in the programme

for a maximum of 30 weeks, although longer periods are possible with the agreement of the NASC agency. The average period for support per client is 2.14 years. Average age of clients is approximately 75.

WCA is required to demonstrate links with:

- Primary and secondary medical services
- Service providers – including coordination, ie, ensuring duplication is minimised, services are complimentary and targeted to greatest need.
- Government departments
- Ethnic and cultural groups etc

Six monthly and annual performance reporting to the respective DHB is provided for, including client satisfaction, and input from other stakeholders and service providers. Also, progress towards goals, any issues and achievements are reported.

Clients are grouped into three levels depending on complexity of needs, level three being the most complex. As at 31/12/15, 50 % were at level three. Clients with dementia are trending up – now present for approximately 50% of clients. Case complexity (and cost per client) is also trending upwards.

There is growing demand for 'transitional' social work (clients moving from SIL to residential care), including; EPOA, wills, asset divestment, communication, and working with complex 'family' situations.

<u>WCA culture: driving innovation in care</u>

WCA Have a culture of innovation and problem solving within a framework of evidence based decision making. Achieving and then setting best practice comes through strongly. For example, they have:

- led the way in working with clients in the difficult area of client monies;
- spearheaded and co-ordinated management of client hoarding; and
- pioneered the client centric approach now regarded as best practice.

Going forward, initiatives being pursued include:

- developing the trustee guardianship approach in Wellington to address the problem of not having the authority to manage client finances;
- introducing money management training for clients;
- working with specialist agencies to best access and leverage available volunteer resources;
- working with other agencies to mainstream old age across the community;

- end of life planning; and
- commissioning an independent review to challenge existing thinking and encourage further gains in providing SIL services.

While WCA regard their current practices as close to best practice, they also believe there is plenty of scope for further gains.

WCA's main stakeholders

Clients and their whanau
Needs Assessment and Service Coordination Services
Home help services
Kenepuru, Hutt and Wellington hospital inpatient services
City Council Housing staff
Housing New Zealand
Older person's community team at Hutt Hospital
Older Person's mental Health team – social workers, occupational therapists, doctors, nurses
PHOs – Compass, WellHealth, Medical practice staff, Doctors, Practice Nurses, admin staff
Ministry of Social Development
Ministry of Health
Work and Income NZ
PG/Psychogeriatric team – Porirua
ORA Wellington and Kenepuru Hospitals
Mission for Seniors
St Vincent de Pauls
Wellington Night Shelter
Presbyterian support Central
Well Elder
Freedom Medical Alarms
Bupa health
Health and Disability Advocacy Service
Age Concern
Life unlimited hearing
Wellington city council
CCDHB
HVDHB

Appendix Three: Shared lives

In Shared Lives, an adult (and sometimes a 16/17 year old) who needs support and/or accommodation moves in with or regularly visits an approved Shared Lives carer, after they have been matched for compatibility. Together, they share family and community life. Half of the 12,000 people using Shared Lives are living with their Shared Lives carer as part of a supportive household; half visit their Shared Lives carer for day support or overnight breaks. Shared Lives is also used as a stepping stone for someone to get their own place. The outcomes can be startling, with people reporting feeling settled, valued and like they belong for the first time in their lives. They make friends (a third make five or more friends through Shared Lives) and get involved in clubs, activities and volunteering, often for the first time. Half of people using Shared Lives went on their first ever holiday, as a result of the support and companionship of their Shared Lives carer.

Shared Lives is used by people with learning disabilities, people with mental health problems, older people, care leavers, young disabled adults, parents with learning disabilities and their children, people who misuse substances and offenders. It is being developed as a home from hospital service, an acute mental health service and a form of short breaks for family carers. There are over 8,000 Shared Lives carers in the UK, recruited, trained and approved by 153 local schemes, which are regulated by each home nation's care inspectors. Shared Lives is growing by 14% p.a: an extra 1,300 people each year.

Shared Lives has rigorous training, approval and matching processes, yet also costs less than other forms of care; on average £26,000 a year cheaper for people with learning disabilities. If all areas caught up with those using Shared Lives most, 33,000 people would use it, immediately saving £120m (not including further savings associated with better outcomes). Even areas making good use of Shared Lives are often not reaching certain groups: in the Yorkshire and Humberside region 30% of Shared Lives arrangements are for over 65s, but in the North East, this is only 2.1%.

Shared Lives schemes are regulated under:

- the Health and Social Care Act 2008 in England;
- the Adult Placement Scheme (Wales) Regulations 2004;
- the Regulation of Care (Scotland) Act 2001, superseded April 2011 by the Public Services Reform (Scotland) Act 2010 (Schedule 12);
- the Adult Placement Agencies Regulations (Northern Ireland) 2007.

Official Definition

The official Shared Lives Plus definition of Shared Lives is as follows:

Shared Lives is a service provided by individuals and families (SL Carers) in local communities and is distinguished by the following features:

- Arrangements are part of organised Shared Lives Schemes that approve and train the Shared Lives Carers, receive referrals, match the needs of service users with Shared Lives Carers, and monitor the arrangements.
- People using Shared Lives services have the opportunity to be part of the Shared Lives Carer's family and social networks.
- Shared Lives Carers use their family home as a resource.
- Arrangements provide committed and consistent relationships.
- The relationship between the Shared Lives Carer and the person placed with them is of mutual benefit.
- Shared Lives Carers can support up to three people at any one time (up to two people in Wales).
- Shared Lives Carers do not employ staff to provide care to the people placed with them.

Joint Statement

The joint statement from Shared Lives Plus and regulators CQC 2010, gives this description: "Shared Lives care offers people an alternative and highly flexible form of accommodation and/or care or support inside or outside the Shared lives carer's home. Shared Lives arrangements are set up and supported by Shared Lives schemes and the care and accommodation people receive is provided by ordinary individuals, couples or families in the local community. This alternative enables individuals taking up a Shared Lives opportunity and the Shared Lives carer/s to enjoy shared activities and life experiences.

Shared Lives enables a wide range of vulnerable people to live independent lives, have their health and well-being promoted and can reduce the need for admission to hospital or residential care (for example through 'Home from Hospital ' services). Shared Lives schemes can also support disabled or ill parents to continue to look after their children and also young people (ie 16+) in transition to adulthood. The opportunities that Shared Lives has to offer are greatly valued by both people using the service and by family carers and commissioners."

Shared lives care may include:

- Long term accommodation and support
- Short breaks
- Daytime support
- Rehabilitative or intermediate support
- Kinship support where the carer acts as 'extended family' to someone living in their own home and where both the homes of the people using the service and the Shared Lives carers are available for contact.

Where Shared Lives carers are providing personal care in people's own homes, there is a distinction between this and domiciliary or supported living care. Domiciliary carers follow a rota to visit and support a number of people with specific care tasks to be performed. Similarly, supported living carers may provide varying degrees of support but only in or from the person's own accommodation. The relationship with the person using the domiciliary or supported living care service will be entirely 'professional' and will not involve any of the carer's family or their home. A Shared Lives carer supporting a person in the community will do this in the context of a matched relationship as part of a Shared Lives agreement. They will carry out their support in much the same way that a natural family member may provide that support.

Where care is being provided but there is no link back to the Shared Lives carer's home and family, the Scheme should consider whether the personal care is provided by a domiciliary care service or a supported living arrangement, rather than Shared Lives. In these instances, when monitoring their compliance with the Essential standards, services should check the additional prompts in the Guidance about compliance: Essential standards of quality and safety for DCC (domiciliary care) or SLS (supported living). It should be noted that the regulatory requirements for Shared Lives, Domiciliary Care and Supported Living are very similar and all fall within the regulated activity of Personal Care and in the service type 'Community Social Care'. Where schemes are providing more than one type of service this should not therefore add significantly to their regulatory burden.