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Komiti Whiriwhiri Take Hauora

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Inquiry into the aged care sector's current and future capacity to provide support services for people experiencing neurological cognitive disorders

Presented to the House of Representatives
by Sam Uffindell, Chairperson

Contents

Summary of recommendations	5
Introduction.....	7
Future need for aged care	8
Scope of the inquiry.....	8
Committee process	9
Structure of this report.....	11
1. Access to aged care services and support.....	12
1.1 Overview of access to aged care services	12
1.2 Submitters' views.....	12
Demand for services is increasing.....	12
Lack of information about neurological conditions and access to support	13
Barriers to access posed by the current model of care.....	14
Difficulties accessing diagnosis and needs assessment.....	14
Consequences of late assessments.....	15
1.3 Committee opinion.....	16
2. Aged residential care	18
2.1 Overview of ARC	18
Number of people in ARC facilities by ownership type	18
Levels of care in ARC	19
Eligibility.....	20
Contracting of aged residential care.....	20
2.2 Funding for ARC.....	21
How residents pay for care	21
Premium rooms.....	22
Lifetime cost for individuals accessing ARC	22
Research on fiscal cost forecasts.....	23
2.3 Submitters' views.....	24
Inadequate funding for ARC and concerns regarding transparency	24
Comments on asset thresholds and means testing	25
Calls for an independent pricing model	25
Adequacy of the funding model.....	26
Shortage of beds.....	26

Support for patients with mental health and behavioural needs.....	27
Supporting the rights of people with neurological cognitive conditions	27
2.4 Comments from The Retirement Commission Te Ara Ahunga Ora	28
Trends in the residential care subsidy	29
Comments on asset thresholds	29
2.5 Insights from our site visits in New Zealand and Australia	30
2.6 Wait-time findings from the review of aged care and service models	32
2.7 Committee opinion.....	32
Chemical restraint	33
Insights from the Australian model	34
Possible funding arrangements for ARC	34
3. Home and community support services	37
3.1 Overview of home and community support services	37
3.2 Eligibility and funding for HCSS	37
Fee-for-service contracts	38
Case-mix contracts	38
3.3 Submitters' views.....	38
Under-recognition of HCSS can increase pressure on ARC.....	38
Inadequate funding for HCSS providers.....	38
Inconsistency in services and contracts	39
Discussion with the New Zealand Health Group.....	40
Discussion with Ageing Australia	40
The CREST model in Canterbury.....	41
3.4 Committee opinion.....	42
4. Support from NGOs and other services	44
4.1 Overview of community NGOs.....	44
Mental health services for older people, public hospitals, and palliative care	44
4.2 Submitters' views.....	45
Ageing in place and the role of community NGOs	45
The need for an integrated continuum of care	45
4.3 Committee opinion.....	46
5. Carers and the aged care workforce.....	47
5.1 Overview	47
5.2 Submitters' views.....	47
Resourcing and recognition of the workforce	47

The role and experience of informal carers	48
Respite care.....	49
Potential barriers to the ability to hire international candidates	49
5.3 Committee opinion.....	49
Increasing respite and support for carers	50
Appendix A: Committee process and membership	52
Appendix B: Components of the Australian aged residential care funding model	53

Inquiry into the aged care sector's current and future capacity to provide support services for people experiencing neurological cognitive disorders

Summary of recommendations

The Health Committee has conducted an inquiry into the aged care sector's current and future capacity to provide support services for people experiencing neurological cognitive disorders, and makes the following recommendations:

Access to aged care services and support

1. We recommend that the Government permit rest homes to carry out Needs Assessment and Service Co-ordination (NASC) assessments, subject to NASC assessors performing quality assurances within a reasonable time frame.
2. We recommend that the Government explore ways to provide culturally appropriate care and continuity of care.

Aged residential care

3. We recommend that, to increase transparency, the Government establish a reporting model that separates aged care funding into three streams: accommodation costs, daily living costs, and clinical care costs.
4. We recommend that the Government consider a range of funding and financing tools to address the shortfall of aged residential care beds, including but not limited to capital grants, depreciation incentives, consent relief, anchor contracts, Infrastructure Funding and Financing Act 2020 (IFF), and National Infrastructure Funding and Financing Limited (NIFFCo) financing.
5. We recommend that the Government consider a range of funding and financing tools to enable the development of more dementia beds, which are currently not profitable for providers.
6. We recommend that the Government consider undertaking further work on pathways for end-of-life care, including hospice care.
7. We recommend that the Government consider enabling alternative aged care models similar to the CARE Village in Rotorua.

Home and community support services

8. We recommend that the Government encourage flexibility in home and community support services (HCSS) contracting so that contractors can perform a range of tasks with a holistic view to keep patients well and out of hospital.
9. We recommend that Health New Zealand enable retirement care village providers to deliver home and community care, and vice versa.

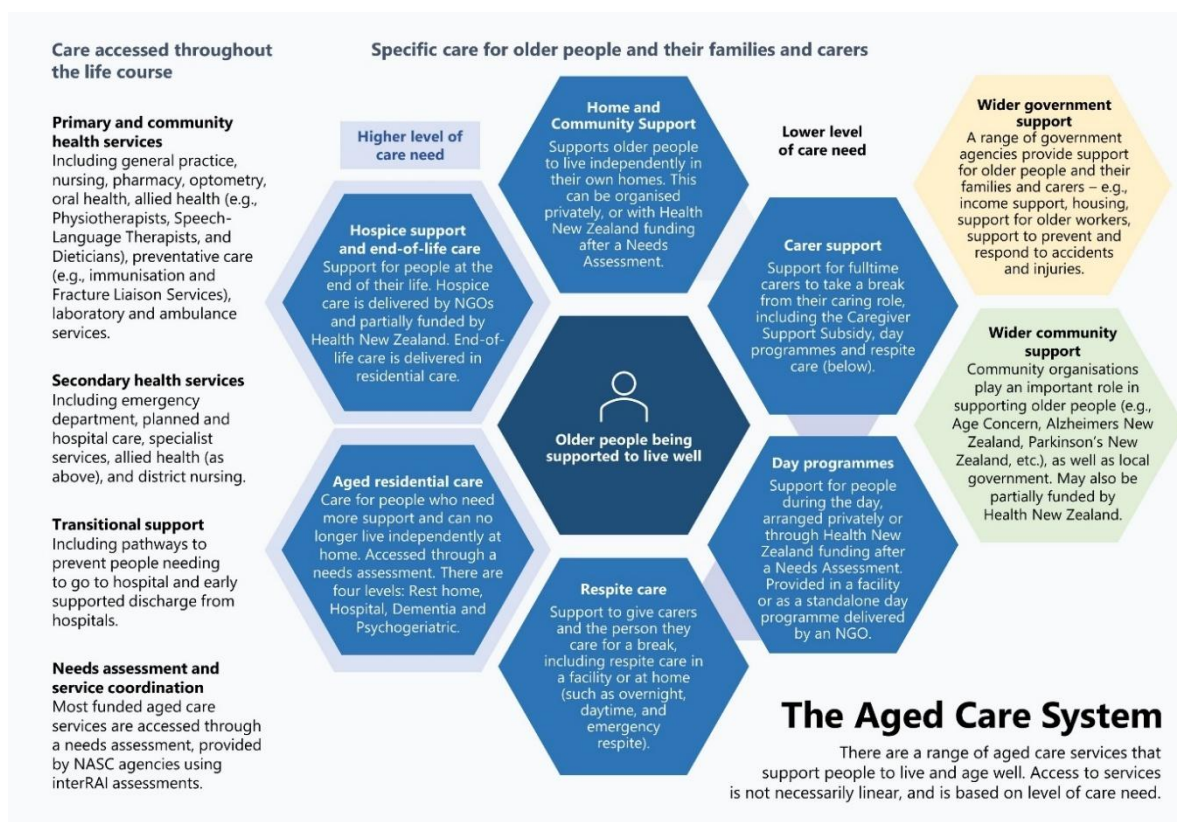
10. We recommend that the Government provide for longer-term contracts and national consistency of funding for HCSS providers.

Carers and the aged care workforce

11. We recommend that the Government consider setting up a regular respite care programme.
12. We recommend that the Government work with Health New Zealand and the sector to implement longer-term agreements and certainty of funding and conditions to enable a sustainable aged care workforce.
13. We recommend that any policy or funding changes intended to improve the financial sustainability of aged care providers be accompanied by measures that guarantee equal protection and benefit for the workforce.
14. We recommend that the Government continues to work to reduce gender-based pay discrimination in the aged care sector.

Introduction

According to Stats NZ, 17 percent of the New Zealand population is aged 65 or over. This figure is expected to grow to 20 percent by 2028, and to 25 percent by 2040, totalling 1.3 million people.¹ The aged care sector provides a continuum of support for older people. It encompasses aged residential care, home and community support services, and community non-governmental organisations. An overview of the aged care system is presented below:²



New Zealand's ageing population is adding stress to a sector already under considerable pressure. The prevalence of neurological cognitive disorders in New Zealand's ageing population is increasing, and so are the complex needs of individuals with neurological conditions and their families. Dementia and other disorders affecting memory, reasoning, and behaviour are now recognised as a major cause of ill health and disability, and demand for services is projected to continue to grow. As people live longer, they are more likely to develop a disability or more complex conditions that require specialised care and support.

¹ "One million people aged 65+ by 2028", Stats NZ.

² This diagram from the Ministry of Health, "Components of the Health Care System" is available on the [Parliament website](#).

Future need for aged care

In 2021, approximately 70,000 people in New Zealand were living with dementia. This is projected to increase to around 170,000 people by 2050, amounting to approximately 2.7 percent of the total population and 10.8 percent of the population aged over 65.³ We sought advice from the Parliamentary Library regarding the projected demand for aged residential care. We understand that demand for aged residential care is projected to increase significantly over the coming decade. Based on modelling in a 2024 report by Ansell Strategic, Health NZ projects that demand for aged residential care beds will rise by more than 13,000 within the next eight years.

The Parliamentary Library also cited an analysis by Ernst and Young (2019) which, using data from 2006 to 2017, projected that by 2031 demand for dementia care would reach approximately 2.0 million bed-days and 0.6 million bed-days for psychogeriatric care. A separate projection in the same report, based on data from 2013 to 2017, estimated around 2.1 million bed-days for dementia care and 0.2 million bed-days for psychogeriatric care by 2031.⁴

Successive governments have struggled to address the long-standing challenges faced by the aged residential care sector. We initiated this inquiry to examine the aged care sector's capacity to meet current and future needs for people with neurological conditions. We gathered feedback, visited residents in aged care facilities, and met with support workers and stakeholders in New Zealand and Australia. Our recommendations aim to ensure that the aged care sector is fit for purpose, supportive, and resilient.

Scope of the inquiry

For the purposes of this inquiry, we defined the aged care sector to include community non-governmental organisations (NGOs), home and community support services (HCSS), and aged residential care (ARC). We detail the differences between these forms of aged care providers below. The terms "neurological cognitive disorders" or "neurological conditions" include dementia, a collective term for a group of symptoms associated with cognitive decline. Dementia is a symptom of several underlying diseases, rather than one specific disease. Other conditions in the category "neurological cognitive disorders" include Parkinson's disease, stroke, traumatic brain injury, brain tumour, motor neuron disease, cerebral palsy, and others.

While some submitters and commentators referred to international literature on the prevention of dementia, we note that our terms of reference below do not extend to primary prevention. We have therefore confined our consideration to service access, diagnosis, and care pathways. We do, however, acknowledge the considerable literature available on the prevention of dementia, and that delayed or missed diagnoses can significantly increase downstream demand for residential and community services. We agree with submitters that

³ [Dementia Economic Impact Report 2020](#), University of Auckland for Alzheimers New Zealand, September 2021, p 14.

⁴ [The Alzheimers NZ website published infographics](#) in September 2025 that highlight the scale of dementia in New Zealand.

focusing on equitable screening and early diagnosis is worthwhile, and indeed critical, to improve quality of life and provide value for taxpayer money.

Terms of reference

We decided that our terms of reference would focus on examining the following matters relating to people with neurological cognitive disorders in the aged care sector:

- appropriate services for people with neurological cognitive disorders across the care continuum, including from home and community care to residential care, to palliative care
- the funding model, and amount of funding available, including best practice and international examples of funding models
- resources available and the ability for the health system to provide appropriate care, and what support enables “ageing in place”, including for priority populations
- the process of applying for funding and care resources
- appropriate and sustainable asset thresholds for people with neurological cognitive disorders
- process for diagnosing neurological cognitive disorders and the effects of diagnoses on funding and treatment
- projections of future needs for people with neurological cognitive disorders.

Committee process

We opened for submissions on this inquiry to receive feedback from stakeholders and the public. We invited submitters to meet with us. We also visited aged care providers across the country. A full list of the facilities we visited is available in appendix A of this report. We draw on our observations from these site visits in our report.

In addition, the Aged Care Association facilitated a visit by some of us to aged care homes, government agencies, advocacy groups, and private, public, and listed providers in Sydney and Canberra in April 2025. Our timeline for reporting this inquiry to the House was extended to incorporate insights from this trip. Where appropriate, we reference in our report these insights and subsequent hearings with stakeholders we met on the trip.

As a part of our inquiry, we consulted previous reports published on the aged care sector in New Zealand. We summarise the key findings of these reports below, and draw on them across this report:

A review of aged care funding and service models: A strategic assessment of aged residential care and home and community support services

In July 2023 Health New Zealand | Te Whatu Ora began a review of aged care services. The review has two phases. Phase one produced the review of aged care funding and service models, commonly referred to as the Sapere Report.⁵ The report identified five significant issues:

- Both aged residential care and home care support services are under-funded.

⁵ Phase two also produced a report by the Sapere Research Group which detailed modelling options for improved funding and service models. This report is [available here](#).

- The funding models used to distribute funding to the sector are no longer fit for purpose.
- There are material ethnic inequities in accessing aged care services.
- The aged care sector continues to face significant workforce pressures.
- Issues with aged care are exacerbated in regional and rural New Zealand.

Future of Ageing Well service and funding model review: Sector and public engagement summary and themes

As a part of its review, Health NZ heard from over 2,000 people and received over 10,000 pieces of feedback. This summary of Health NZ's sector and public engagement indicated a "strong appetite for significant change".⁶ Feedback suggests that the model of care and system for aged care services needs to be:

- person and whānau centred
- financially sustainable
- effective at reducing avoidable hospital admissions and bed days
- supports people to live as independently as they can
- nationally consistent while meeting the needs of local communities
- delivered by a competent workforce that is valued and supported.

Recognising the Contribution of the Home and Community Support Sector to New Zealand

In November 2019, Ernst & Young (EY) examined the HCSS sector.⁷ It described how the sector was important in supporting people to age in place. EY's review found that most people continue to interact with the health system through a traditional, episodic model of care. It concluded that this approach will not be sufficient to meet the needs of a rapidly ageing population.

The review noted that age-related health conditions are placing increasing pressure on the system. It recommended a redesign of service delivery models to improve responsiveness and quality of care, reduce reliance on hospital services, and ensure the long-term financial sustainability of the health system.

Amplifying the voices of older people across Aotearoa New Zealand

The Aged Care Commissioner's report (March 2024) draws on the voices of older people, their family/whānau, carers, and service providers to highlight issues in health and disability services for older people. It emphasises the need for an integrated, preventative, and person-centred continuum of care that enables older people to navigate services easily and age well at home. The report emphasized the importance of:

- a national strategy dedicated to ageing and the health and disability needs of an older, more diverse population
- improving transitions of care from hospital to home and aged residential care through better discharge planning and specialist roles

⁶ Health New Zealand, *Future of Ageing Well service and Funding model review: Sector and public engagement summary themes*, p 10.

⁷ EY report, *Recognising the Contribution of the Home and Community Support Sector to New Zealand*, November 2019.

- supporting culturally safe, person-centred communication that involves family/whānau and carers
- recognising home and community support services (HCSS) and aged residential care as integral to the health system, and improving funding, access, and sustainability
- addressing clinical workforce shortages across aged care, including nurses, carers, and geriatric specialists
- urgently expanding access to psychogeriatric and kaupapa Māori aged-care services
- investing in innovative primary and community care models and preventative approaches
- enhancing data collection and monitoring of workforce, service demand, and consumer experience to support planning and equity.

Structure of this report

This report is structured around five main chapters:

1. Access to aged care services and support
2. Aged residential care
3. Home and community support services
4. Support from NGOs and other services
5. Carers and the aged care workforce.

Each chapter includes an overview (informed by advice from the Ministry of Health | Manatū Hauora), a summary of submitters' views, and our views and recommendations.

1. Access to aged care services and support

1.1 Overview of access to aged care services

A registered health professional provides the diagnosis of a neurological condition; the process differs depending on the condition. Once a diagnosis is made, people may be referred to a Needs Assessment Service Coordination (NASC) agency. NASC assessments, which are funded by Health New Zealand | Te Whatu Ora (Health NZ), assess both the person's support needs and the support available to them, including from family/whānau, friends, neighbours, workplaces, and community groups. The assessment determines the level of care required.

NASC agencies are responsible for identifying the services available to support older people and disabled people. Their aim is to maximise quality of life and independence. Some needs assessments are funded by the Ministry of Social Development or the Accident Compensation Corporation (ACC).

All Health of Older Persons NASC services use the International Resident Assessment Instrument (interRAI). This international tool is applied across New Zealand and includes several key assessments for older people.

A needs assessment determines whether the person's condition can be reversed, whether they can be safely supported in the community, what level of care is required, and—if long-term residential care is needed indefinitely—what level of care is appropriate. A person in an aged care facility must have a needs assessment before moving between care levels.⁸

1.2 Submitters' views

Demand for services is increasing

We heard from submitters that New Zealand's rapidly ageing population, coupled with a rising incidence of neurological conditions such as dementia, is increasing demand for services. We were told that this trend is compounded by growing complexities including social challenges, substance abuse, issues of consent, family conflict, and abuse and neglect. According to Alzheimers NZ, approximately 70,000 people in New Zealand were living with dementia in 2021. This number is projected to increase to around 170,000 people by 2050.

We heard that neurological conditions are now the leading cause of ill health and disability worldwide, and that around one in three New Zealanders will be affected at some point in their lifetime. While dementia was highlighted as a major concern, submitters also drew attention to the consequences of conditions such as brain injury, tumours, stroke, Parkinson's disease, multiple sclerosis, and motor neurone disease. The Neurological Alliance emphasised the significant scale of these conditions, their economic cost, and their

⁸ More details on needs assessment are [available on the Health NZ website](#).

growing prevalence among older people. It noted that multiple sclerosis is one of the most common causes of neurological disorders in young people and middle-aged adults.

Some groups are disproportionately affected. Māori and Pacific peoples were noted as having higher rates of dementia and experiencing strokes at a younger age. Women were reported as being more likely to develop dementia than men, largely due to longer life expectancy. People with intellectual disabilities, particularly those with Down syndrome, also face much higher rates of dementia, often with an earlier age of onset.

We heard that neurological conditions place a heavy burden on health and disability systems, especially for older people with long-term conditions such as stroke, Parkinson's, and dementia. Rising levels of dementia in particular are expected to drive significant increases in costs to the health system and the wider economy. Demand for dementia and psychogeriatric care beds is projected to grow substantially, and submitters noted that as the population ages, expectations from those with neurological conditions and their families and whānau for responsive, appropriate services will also increase.

Lack of information about neurological conditions and access to support

Despite this prevalence, we heard overwhelming concerns about the lack of information for people living with dementia and their families. Submitters told us that people often do not know where to go following a diagnosis, as information sources are inconsistent and clinicians do not always know what services are available. We also heard that information about costs was difficult to locate and understand.

Many submitters observed that there is inequity in access to information. They called for clear and accessible information for people living with dementia and their families, particularly whānau Māori. We heard that information should be in culturally appropriate formats and languages, that resources should be centralised, that phone or app-based support should be available, and that information should include the financial implications of care.

Submitters also commented that awareness of neurological conditions and their progression is generally poor among individuals, family/whānau, clinicians, and health services. Some submitters, including the New Zealand Nurses Organisation, said that memory loss and behavioural changes are not solely a normal part of ageing and may be symptoms of other conditions, although this is not widely understood. The shortness of primary care appointments was seen as a barrier to recognising symptoms and achieving timely diagnosis.

We heard that, at times, the lack of awareness about the progression of neurological conditions can cause tension between families and ARC providers. Submitters noted that some families were reluctant to accept that their loved ones required higher levels of care, which can delay access to services.

Equally, submitters pointed to a lack of understanding of the needs of those with neurological conditions within the health system. The Australian and New Zealand Society for Geriatric Medicine (ANZSGM) commented that this can lead to avoidable decline, higher morbidity and mortality, and increased rehabilitation needs.

Barriers to access posed by the current model of care

Submitters said that models of care and funding are inflexible and difficult to navigate. They said that people with neurological conditions are cared for across the continuum, but that the system makes it difficult to meet their specific, individual needs. Some people do not need secure dementia units but may require extra resources or staff input. Submitters said that additional funding to cover these needs is very difficult to obtain.

Submitters expressed concern that funding models do not account for changes in a person's condition. One example was that people with dementia often only receive the specialist care they require if they meet the high threshold for a secure dementia unit. We also heard that moving between levels of care can be difficult due to challenges in getting re-assessments.

Submitters further highlighted that the model of care cannot “scale up” temporarily when people have short periods of higher need, such as frailty or a temporary illness. This limitation was noted across all levels of care, but especially for people living at home.

We heard that this inflexible approach increases the number of people visiting emergency departments or being admitted to hospital rather than receiving short-term hospital-level care at home. In some cases, people may end up entering permanent secure care unnecessarily.

Concerns were raised about significant regional variation in resources and access to aged care services. Submitters told us about a lack of services in rural and regional areas—where a greater proportion of older people live—particularly for HCSS, dementia care, and psychogeriatric care. Access to specialists was also more limited in rural areas, which could delay or complicate assessment and management. Submitters pointed to reduced availability of diagnostic neuroimaging outside major centres, as well as regional differences in how assessment tools are applied. Concerns were also raised about inequitable costs—both for people with high medical complexity and across regions, where funding for equipment and care varied considerably.

Submitters said that funding does not adequately reflect the need for appropriate services for Māori and other ethnic groups. As a result, culturally appropriate support options are limited. Some submitters cautioned that this gap means Māori and Pacific peoples may, in some cases, miss out on care altogether.

We heard that the ability for people to age in place is shaped by a range of factors, including the availability of appropriate services, housing, access to primary care, and support for carers. Access to primary care was highlighted as critical across the continuum of care, helping to prevent health emergencies, reduce hospitalisations, and support older people to remain at home. However, we were told that access is often limited, particularly for older people in rural areas.

In addition, submitters were concerned about inadequate access to primary care within aged residential care facilities. We heard calls for better integration and funding of primary care in these settings, alongside more affordable access for older people.

Difficulties accessing diagnosis and needs assessment

Some submitters observed that dementia is under-recognised and under-diagnosed, despite being a common late-life neurodegenerative condition. It is estimated that only 20 to 50

percent of people with dementia receive a formal diagnosis. Submitters also pointed to inequities in accessing a diagnosis. For instance, we heard that neurological conditions are particularly underdiagnosed in Māori, who often present late for diagnosis. Late presentation reduces one's opportunities for treatment that could delay progression. Some submitters commented that culturally appropriate diagnosis of cognitive decline is vital. They recommended nationwide use of the MANA (Māori Assessment of Neuropsychological Abilities) suite of tools.⁹

The main causes of underdiagnosis, as identified by submitters, are a poor understanding of dementia, stigma, and barriers to accessing primary care. Other challenges include patient confidentiality when a person is unwilling or unable to seek diagnosis for themselves, difficulties navigating appointments and moving between primary and secondary care, and inequitable access to diagnostic tools such as neuroimaging. Many submitters said that access to diagnostic neuroimaging is not equitable between regions.

We heard serious concerns about delays and inaccuracies in needs assessments. Many reported waiting times of several months to a year for assessments, particularly for dementia care, psychogeriatric care, and the Mental Health Service for Older Persons. Delays were linked to high demand, limited NASC capacity, and staffing shortages for administering the interRAI tool. Since all assessments must be managed by NASC services, this creates a bottleneck.

Many submitters recommended enabling trained health professionals in HCSS and ARC to carry out assessments (audited by NASC) to increase capacity and flexibility. They argued that in-home nurses and ARC staff are often competent to do assessments and could respond more quickly than NASC staff to changes in needs.

Submitters also emphasised that COVID-19 service disruptions had increased diagnostic backlogs, with memory clinics overwhelmed and families left without post-diagnostic support for extended periods. In addition, submitters from rural regions noted inequities in neuroimaging and specialist access compared with major centres. Workforce shortages across geriatricians, neurologists, and NASC assessors were repeatedly identified as structural barriers, compounding regional inequities. Carers described the process as fragmented and confusing, with limited follow-through into community NGO supports, leading to isolation and crisis-driven hospital presentations.

Several submitters emphasised that diagnostic and assessment delays are compounded by shortages of specialist staff. They noted that there is a limited number of geriatricians, neurologists, psychiatrists, and trained memory clinic professionals across the country. Workforce pressures within NASC teams, already stretched by interRAI demands, were cited as a key driver of bottlenecks in needs assessment. Rural areas are particularly disadvantaged, with fewer specialists available and long travel times to clinics.

Consequences of late assessments

Several submitters drew attention to the broader consequences of delayed diagnosis and assessment. They noted that deterioration while waiting often results in avoidable hospital

⁹ MANA has been designed for the holistic assessment of *mate wareware* (dementia) in Māori. More information is [available on the Dementia NZ website](#).

admissions, increased pressure on acute wards, and higher long-term costs to the health system. Families described crisis-driven pathways into ARC, which were more stressful and expensive than earlier planned admissions. Providers said this cycle ultimately undermines equity, with disadvantaged groups more likely to experience poor outcomes and costly crisis interventions.

In addition, submitters observed that delays in assessment and subsequent changes in a person's needs mean a reassessment is often needed, compounding the demand on services. Wait times for reassessment can vary significantly across regions. Providers noted that delays in reassessments can lead to high-risk and dangerous situations for staff and residents at ARC facilities, as the needs of the residents are not reflected in the level of care they are allocated. Facilities also reported difficulties completing their own assessments on admission when official assessments had been delayed. Delayed access to essential services resulted in varying assessment outcomes and inadequate support overall.

Concerns were also raised about inaccurate assessments resulting from delays or because they were conducted at a time of crisis or rushed hospital discharge. Some submitters believed that assessments were deliberately conservative to avoid costs or due to a lack of available places. ARC providers said inaccurate assessments often led to residents being admitted at an inappropriate care level. They said this creates risks for staff and residents.

1.3 Committee opinion

We acknowledge the concerns raised by submitters about the lack of clear and accessible information about neurocognitive disorders. Submitters told us that barriers to accessing information and support create delays in assessment, diagnosis, and treatment. We also note the concerns that under-recognition and under-diagnosis—particularly for Māori and Pacific peoples—contribute to delays in care and inequitable outcomes.

We sought information about the prevalence of neurocognitive disorders in New Zealand. While dementia prevalence has been documented, there are some gaps in national-level data for other disorders, such as Huntington's and Parkinson's. These limitations make it difficult to form a clear picture of how many New Zealanders are affected, and to plan appropriately for services across the care continuum. We note that a 2022 study estimated that the prevalence of diagnosed dementia is approximately 3.8–4 percent for patients aged over 60, and 13.7–14.4 percent for those aged over 80.¹⁰ However, real dementia prevalence rates are likely to be higher than these estimates because they do not count individuals early in their cognitive impairment pathway (those accessing primary care).

We note, too, that prevalence estimates may not fully capture the diversity of experiences across ethnic groups. In particular, Māori and Pacific peoples may be under-represented in existing data, despite evidence that they face inequities in both diagnosis and access to care. A number of submitters noted the higher prevalence of dementia among Māori and Pacific people than for European and Asian populations, as well as the higher prevalence for women.

¹⁰ Cheung, G, et al, Dementia prevalence estimation among the main ethnic groups in New Zealand: a population-based descriptive study of routinely collected health data, *BMJ Open*, 7 September 2022.

NASC assessments

As we noted earlier, aged care providers commented on issues associated with the NASC assessment and the time taken for this to be done. In some cases, the NASC assessor must travel some distance; in Southland the assessor travels from Christchurch. The time lag means that patients with dementia and psychogeriatric needs are often placed in inappropriate settings, without necessary security, and are a threat to themselves and others.

We heard some very troubling stories about such situations. We consider that aged care facilities, with the appropriate staff onsite, should be able to assess patients and place them into what they consider to be the appropriate level of care. We consider that NASC assessors could then perform a quality check later, within a set period. This would allow timely and appropriate placement of patients and reduce risks to staff and others.

We support greater flexibility in who can undertake NASC assessments to improve access and timeliness but note the importance of safeguards to prevent any incentives for providers to overstate levels of need in order to access higher subsidies.

1.4 Recommendations

1. We recommend that the Government permit rest homes to carry out NASC assessments, subject to NASC assessors performing quality assurances within a reasonable time frame.
2. We recommend that the Government explore ways to provide culturally appropriate care and continuity of care.

2. Aged residential care

2.1 Overview of ARC

Aged residential care (ARC) refers to the long-term care provided in rest homes and hospitals, including rest home care, dementia care, continuing care hospital services, and specialist psychogeriatric hospital care for people with ongoing health and personal care needs. Approximately 30,000 individuals with long-term health conditions and disabilities are residing in care.

There are 683 ARC facilities in New Zealand, providing about 42,800 beds. Facilities are owned under a range of structures. Most are run as for-profit businesses, with owners ranging from large multinational companies to smaller, private operators. Around 13 percent are owned by not-for-profit organisations, such as charities and local trusts. About 1.5 percent are owned by Health NZ, mostly in smaller communities.

Facilities vary in size. The median number of beds per facility is 56, and the average is 63. We note the increasing adoption of dual-use beds, which can be allocated for either rest home or hospital-level care. The proportion of dual-use beds has risen from 19 percent in 2013 to 47 percent in 2024. Providers offering dual-use beds must meet the regulatory, audit, and contractual requirements for both levels of care, and employ a workforce that can be flexibly deployed across levels.

Number of people in ARC facilities by ownership type

We asked the Parliamentary Library to provide information on how many individuals use for-profit residential care versus not-for-profit residential care facilities. We found that the Aged Care Association (ACA) publishes an annual sector profile containing information on the proportion of ARC facilities by ownership type, across five ownership categories.¹¹ The sector profile provides data on facility numbers and bed supply by ownership type but does not include information on the number or percentage of residents by ownership. The Library advised that, as at September 2023, the distribution of ARC facilities and bed supply by ownership type was as shown in the table below:

Percentage of ARC facilities in each ownership segment	
Ownership type	Percentage
Individual/minor group: private	35.5%
Major group: private	20.1%
Major group: publicly listed	24.3%
Total private and publicly listed	79.9%

¹¹ Data sourced from the Aged Care Association's *Aged residential care sector profile 2024*.

Major group: charitable	7.9%
Individual/minor: group charitable	12.1%
Total charitable	20.0%

Percentage of bed supply in each ownership segment	
Ownership type	Percentage
Individual/minor group: private	24.6%
Major group: private	22.0%
Major group: publicly listed	34.6%
Total private and publicly listed	81.2%
Major group: charitable	8.0%
Individual/minor: group charitable	10.8%
Total charitable	18.8%

Levels of care in ARC

Four levels of care are available in aged residential care. Care is allocated, depending on a person's assessed health needs, to rest home, hospital-level care, dementia-level care, or specialist dementia and psychogeriatric care.

Rest homes

Rest homes provide accommodation and support for older people who can manage some daily tasks but need help with personal care. Rest home residents are often able to remain partly independent but would find it difficult to live safely in their own homes without assistance. Rest homes employ a registered nurse for some hours a week, and at least one care staff member must be on duty at all times. Around 10,000 people receive rest home care.

Hospital-level care

Hospital-level care (also called continuing care) is for people with more complex health conditions who require 24-hour nursing care. Two staff (one registered nurse and one carer) are on duty at all times. Around 13,200 people receive hospital-level care in New Zealand.

Dementia-level care

Dementia units (also known as D3 or D4 units) provide specialist care and a secure environment for people with dementia. Residents have some independence. A registered

nurse works for some hours a week. At least one staff member is always on duty, with another readily available on site. About 5,500 people receive dementia-level care.

Specialist dementia and psychogeriatric care

Specialist dementia and psychogeriatric care units are also known as D6 units. They are designed for people with advanced brain disease or psychiatric conditions, and with behavioural and psychological symptoms of cognitive impairment. These facilities have at least two members of staff always on duty: one registered nurse and one carer. Around 950 people receive this level of care.

Distribution of population groups in services

Most older people entering residential care, including at a rest home care level, have some form of cognitive limitation or multiple co-morbidities. This has led to increasing demand for higher-intensity services such as continuing hospital care and dementia care, while demand for rest home-level care is declining. This trend is expected to continue as people enter residential care later in life and with more complex needs.

Older Māori and Pacific individuals use ARC at lower rates than other groups. In 2021/22, 25.1 percent of Māori and 22.6 percent of Pacific people with high needs entered aged residential care, compared with 36.6 percent of Asian and 49 percent of NZ European/Other populations. This difference has been attributed to both cultural preferences and the greater reliance of Māori and Pacific communities on HCSS. Asian populations are under-represented in both ARC and HCSS activity, which could indicate cultural preferences, barriers, or unmet needs in these population groups.

Eligibility

To enter Health NZ-contracted aged residential care, a person must first undergo a needs assessment confirming they have high or very high care needs that are indefinite and cannot be safely supported in the community. In addition, the person must be aged 65 or over, or aged 50–64 and unmarried with no dependent children. They must also be eligible for publicly funded health and disability services.

Contracting of aged residential care

To be eligible for public funding, an ARC provider must be a signatory to at least one of two national funding agreements: the Age-Related Residential Care (ARRC) Agreement (covering rest home, hospital, and dementia care) or the Aged Residential Hospital Specialised Services Agreement (covering psychogeriatric care). The agreements are reviewed annually by funders and providers and set out providers' obligations and seek to ensure that national standards of services are maintained in long-term residential care.

In addition to being under contract, ARC providers must also be certified under the Health and Disability Services (Safety) Act 2001 by the Ministry of Health's HealthCERT team. They are required to meet Ngā Paerewa Health and Disability Services Standard NZS 8134:2021, which covers consumer rights, organisational management, care delivery, environment, use of restraint, and infection control. Providers are audited against the standards to ensure that their services are safe, and of high quality. Providers are certified for up to five years.

2.2 Funding for ARC

ARC facilities are funded through a combination of means-tested contributions from residents, government subsidies, and any premium accommodation charges that residents pay. The funding covers both accommodation and care. In 2023/24, Health NZ funding for ARC services was approximately \$1.591 billion, and resident payments totalled approximately \$1.238 billion.¹²

Each of the four ARC categories has a separate bed-day rate, negotiated annually between Health NZ and ARC providers. Rates are adjusted slightly for a facility's geographic location. The average bed-day rates (exclusive of GST) in 2024/25 were \$183 for rest homes, \$247 for dementia-level care, \$296 for hospital-level care, and \$327 for psychogeriatric-level care.¹³

Although prices vary by level of care, residents' fees are capped at the maximum contribution price, which is set at the rest home rate. Health NZ pays the difference for higher-level care categories. The maximum contribution varies regionally.¹⁴

How residents pay for care

An individual's fees for aged residential care can be met in two ways: either through government financial assistance (if they are eligible) or privately with their own funds, which can include superannuation. Should a person wish to apply for financial assistance, the Ministry of Social Development carries out a financial means assessment. The assessment has two components: an asset test and, if the person's assets are below the threshold, an income test. The assessment also takes account of any gifting of assets. A person aged between 50 and 65 who is single and without dependent children is assessed on income only and not assets.

If a person owns assets above the asset threshold, they must pay the maximum contribution, and may be eligible to receive an interest-free residential care loan. If their assets are at or below the applicable asset threshold, they qualify for the Residential Care Subsidy (RCS) to cover most of the cost of their care. The current asset threshold is \$291,825 for a single person.

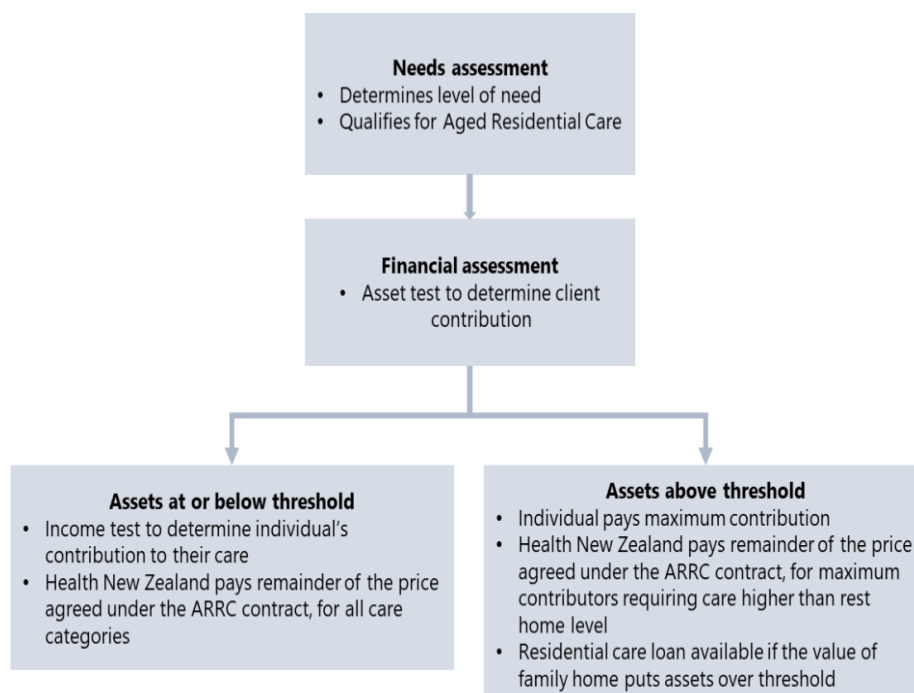
An income test is then applied to determine what portion of the remaining costs they must contribute. Where a person receives New Zealand Superannuation, a Veteran's Pension, or another form of benefit, most of it goes towards their care.

The Ministry of Health provided the following diagram to illustrate the assessment process:

¹² Ministry of Health, *Summary of Submissions to the Health Committee*, p 16.

¹³ Ibid p 16.

¹⁴ Maximum contribution rates per region are available on the [Ministry of Health website](#).



Premium rooms

Under the ARRC agreement, providers must supply certain services to all residents. Some services are covered under the maximum contribution rate, while others, such as premium rooms, are not included. A premium room is one that offers features not required by the ARRC, such as an ensuite bathroom, more space, or garden access. Residents occupying these rooms are charged additional fees on top of the standard ARC price.

The ARRC agreement specifies that residents cannot be charged for premium rooms if no standard rooms—only premium rooms—are available at their preferred rest home.

Exceptions apply when the provider can demonstrate that:

- no standard rooms suitable for the service category required are available to the resident at the facility, or
- another facility located 10km or less from the resident's preferred facility has a suitable standard room, and the resident has decided not to move into that room.

Lifetime cost for individuals accessing ARC

We sought further advice about the lifetime cost for people accessing ARC. We were advised that the amount people pay for ARC over their lifetime depends on:

- their income and assets (which determines whether they are required to pay the maximum contribution towards the cost of their care, or are eligible to receive the Residential Care Subsidy to cover some of the cost of their care), and
- the length of time that they spend in ARC, which varies widely.

We were given the following estimates of the average lifetime cost to a person for ARC services:

- \$110,745 for those paying the maximum contribution toward their care (38 percent of residents)
- \$28,355 for those whose assets are equal to or below the asset threshold, and who receive the Residential Care Subsidy to cover some of the cost of their care (62 percent of residents)
- \$51,360 averaged across all categories of contribution that people make to the cost of their care.

These costs are based on the assumption that the average length of stay is 18 months (calculated based on days between a person's first entry into ARC and death for those who died between June 2024 and June 2025). The average cost per day was derived from Health NZ's payment system and is based on the average bed day data following the uplift in the bed day price from 1 September 2024. Costs do not factor in additional charges for premium rooms.

Research on fiscal cost forecasts

We considered research commissioned by Health New Zealand and undertaken by the Sapere Research Group on the projected fiscal costs of aged residential care. Section four of the *Aged Care Service Model and Funding Review (2024)* sets out modelling of expected costs for aged residential care under a range of assumptions about demand, pricing, and funding. We cite this research below as we consider that it offers insight into the cost of ARC to the State over time.

Overview of modelling approach

Fiscal cost forecasts were prepared using projected bed-day rates and bed-day demand over a 15-year period (2024/25 to 2039/40). The modelling tested two price paths (low and high bed-day rate assumptions), two demand projections, and two funding allocations (private and public).

The first demand projection—the five-year trend scenario—reflects the base demand projection for ARC. It is derived from the observed rate of entry into ARC over a recent five-year period (2017/18 to 2021/22) and assumes that this trend will continue through the forecast period.

The second demand projection includes the five-year trend and a substitution scenario. The substitution scenario assumes that some lower-needs residents who would otherwise enter aged residential care will instead receive home-based support, reducing the projected demand for residential beds.

Public and private funding composition and definition of “option 1”

Individuals in dementia, hospital, or psychogeriatric care with assets over the asset threshold must pay the regional rest-home rate. Any costs exceeding this sum are covered by the top-up subsidy. This ensures that residents do not pay more than the maximum contribution set in each region. Option 1 is a scenario in which this maximum contribution is removed. Those who have assets above the limit would pay the full cost of their care in dementia, hospital, or psychogeriatric services, and not receive the top-up subsidy.

When comparing the percentage of public contribution in 2024/25 across the current scenario and option 1, results suggest that the public contribution towards rest-home care would be the same under both scenarios. However, option 1 would lead to a lower public contribution for dementia, hospital, and psychogeriatric care because of the removal of the top-up subsidy and maximum contribution requirement.

Forecast scenarios and modelling results

Sapere modelled eight fiscal scenarios combining the demand, price, and funding settings:

Scenario	Demand assumption	Bed-price assumption	Funding allocation	2024/25 Fiscal cost (\$billion)*	2024/25 Total cost (\$billion)	2039/40 Fiscal cost (\$billion)*	2039/40 Total cost (\$billion)
1	Five-year trend	Low price	Status quo	1.60 (55%)	2.89	2.82 (46%)	6.10
2	Five-year trend	Low price	Option 1	1.31 (45%)	2.89	1.92 (32%)	6.10
3	Five-year trend	High price	Status quo	1.79 (55%)	3.26	3.61 (46%)	7.86
4	Five-year trend	High price	Option 1	1.47 (45%)	3.26	2.47 (31%)	7.86
5	Trend + substitution	Low price	Status quo	1.60 (55%)	2.89	2.72 (48%)	5.72
6	Trend + substitution	Low price	Option 1	1.31 (45%)	2.89	1.82 (32%)	5.72
7	Trend + substitution	High price	Status quo	1.79 (55%)	3.26	3.46 (47%)	7.35
8	Trend + substitution	High price	Option 1	1.48 (45%)	3.26	2.33 (32%)	7.35

* (percentage of total cost funded by public contribution)

2.3 Submitters' views

Submitters' concerns about ARC included comments about its funding and whether support for residents is adequate.

Inadequate funding for ARC and concerns regarding transparency

Many submitters said that funding levels for aged residential care are insufficient to cover the real costs of services. Providers argued that the gap between government funding and the

actual cost of care has widened. They said that facilities are facing significant financial pressure.

We heard that the process for setting ARC funding is not transparent and does not reflect the real cost of care. Providers pointed to recent reviews of the ARRC agreement, which resulted in funding increases of 3 to 5 percent, while actual cost increases averaged 7 to 11 percent.

Submitters such as the Aged Care Association called for Health NZ to be required to provide evidence for how it sets subsidised and maximum contribution rates. Some also recommended that ARC funding be adjusted to reflect the costs of mandatory reporting and interRAI requirements, which are currently not recognised in the funding model.

Comments on asset thresholds and means testing

When asked by the committee, several submitters chose not to comment on appropriate asset thresholds. Those who did said that any initiative to reconsider asset thresholds must be evidence-based, and ensure that quality services remain accessible to those who cannot afford to contribute. Some submitters said that cost is a barrier for many families, and that the asset threshold is not high enough.

Some submitters commented that there should be reasonable consumer contributions to their care, based on their means. Summerset, for instance, proposed that consumers should remain responsible for their daily living and accommodation costs, as they are currently within the community, and that there should be strategies for those who cannot afford these costs.

Summerset also indicated support for the Australian system of categorising residents based on their means. In this system, based on a means test, residents may be asked to contribute towards their care and accommodation costs, or may receive financial assistance for accommodation costs. Providers receive an accommodation supplement based on the proportion of residents receiving financial assistance, and the age of the facility.

Submitters canvassed broader solutions, such as the creation of dedicated capital funding streams (targeted grants, Crown finance, or availability-payment models), the establishment of independent pricing or transparent annual methodologies, and commissioning approaches tailored to Māori and Pacific peoples. Several submitters also recommended ring-fenced funding for NGOs distinct from home and community support services, ensuring that community support and capital planning proceed in tandem.

Calls for an independent pricing model

Submitters like the New Zealand Aged Care Association and Alzheimers NZ told us of the importance of an independent pricing structure as exists in Australia. The Aged Care Association referred to the Australian independent body (the Independent Hospital and Aged Care Pricing Authority, or IHACPA) which undertakes costing studies to recommend to the government the price of care. This, along with the Australian funding structure's separation of care, daily living, and accommodation costs, was seen by submitters as a way to enhance transparency of asset and means testing settings. Submitters posited that this would clarify the allocation of costs. They noted that care-related expenses are the responsibility of Health NZ. Other expenses could be met by the individual themselves, or, once means testing has

been completed, could be supported by the Ministry of Social Development if need be. We respond to these suggestions below.

Adequacy of the funding model

Submitters told us that the ARC funding model is outdated and unsustainable. Some, like E Tū, suggested that it disadvantages smaller and rural providers. They said that, because the funding model relies on a broad-based average pricing model with a focus on bed numbers, it penalises smaller providers in rural areas. Facilities with fewer residents can struggle to cover costs and employ staff.

Providers also raised concerns about contractual constraints under the ARRC agreement. For example, facilities are required to employ separate registered nurses for hospital and psychogeriatric units, even though increasing use of swing beds—rooms that can cater to multiple levels of care—means the staffing rules often do not match residents' needs. Such requirements make it difficult to establish small psychogeriatric homes in regional areas.

Shortage of beds

Some submitters expressed concern about a growing reliance on premium charges in ARC, which they said is distorting access. They argued that new developments have little incentive to provide standard rooms. We heard that this makes such rooms increasingly scarce and, in some areas, forces older people to move away from their communities.

Submitters also cautioned that premium charges risk deepening inequities, as people with limited finances may struggle to secure a place while wealthier people have more choice. In mixed retirement villages, some people live in an aged care facility and others live in independent housing. We heard that spaces in the rest home or hospital facility are often prioritised for residents of the village itself. This reduces access by external applicants wanting to move into ARC. Submitters said that smaller and rural providers, which cannot rely on premium income or village cross-subsidies, are particularly disadvantaged by these trends.

Submitters told us that the funding and profit settings in aged residential care leave many providers unable to invest in new facilities or upgrade older ones. As a result, some facilities are closing and fewer new ones are being built. In some cases, providers explained that they must calculate the minimum number of beds needed to remain financially viable, rather than planning facilities that meet long-term needs.

Submitters highlighted that the total number of beds is shrinking, particularly in dementia and psychogeriatric care. Submitters said that the shortfall in ARC beds not only causes a longer wait time for those who need care, but also increases pressure on hospitals, as people remain in hospital beds while waiting for aged residential care placements.

We were told that long wait times are a major issue. Summerset noted that people requiring dementia and psychogeriatric care may wait, on average, 169 and 176 days respectively to be admitted to a facility, even after being assessed as high priority for transfer into aged residential care. Those entering at these more complex levels of care face the longest waits.

Submitters also told us that shortages mean people are sometimes transferred away from their families and communities to facilities in other areas where beds are available. In some cases, this can result in another transfer when a place closer to home later becomes free.

Support for patients with mental health and behavioural needs

We were told that a growing challenge in aged residential care is the increasing number of older people entering dementia units who have complex needs such as substance dependencies, head injuries, or aggressive behaviour. These residents often require security and intensive attention from staff, and cannot be adequately supported in acute inpatient settings.

Submitters were also concerned about residents with both dementia and mental health conditions, who some submitters described as atypical for ARC facilities. They were seen as posing risks to frail residents and to staff, especially because staff are not trained to manage aggressive behaviour. They were considered to pose a high risk of harm.

Some submissions focused on the use of medical restraint. Many advocated reducing or minimising the use of restraint to improve the quality of care and safety for people with neurological conditions. Others said that restraint is sometimes unavoidable in under-resourced settings. They submitted that eliminating restraint would be unrealistic without adequate funding, staffing, and specialised support. Submitters also emphasised that facilities require more specialised services and workforce capability to meet the complex behavioural and mental health needs of some ARC residents.

Supporting the rights of people with neurological cognitive conditions

We heard of the importance of upholding the rights of older people and those with neurological cognitive conditions in the delivery of aged residential care. Residents, including those with dementia who may not be free to leave at will, are particularly vulnerable and rely on others to safeguard their basic rights and needs. We heard that those providing care in these situations have specific obligations to ensure residents are supported to participate in society on an equal basis with others.

Submitters said that people with neurological cognitive conditions should be presumed to have decision-making capacity, and that residents should be the primary decision-makers in processes relating to their care to the “fullest extent possible”. We were told that supported decision-making models should be embedded for those who require them, with approaches that reflect the needs of tangata whenua and their family/whānau.

We also heard concerns about the implications of shifting from a “best interests” approach to one based on the “rights, will, and preferences” of residents. This could result in people with dementia remaining at home despite needing higher levels of care. We were told that in cases where following an individual’s expressed wishes could result in significant risk of harm to themselves or others, the “best interests” approach should prevail.

Some submitters commented on the need to address elder abuse within the aged care sector. They recommended reviewing existing policies, incorporating elder abuse considerations into the design of services, and establishing review mechanisms to strengthen protections.

Complex legal requirements for admitting a person into residential care when they no longer have capacity

Should an individual no longer have the capacity to make decisions about their care and welfare, legal authority is required for the person to be placed in secure care. Under the Protection of Personal and Property Rights Act 1988 (PPPRA), legal authority can be provided by:

- the person's attorney under an activated enduring power of attorney (EPOA) for a person's personal care and welfare
- the person's court-appointed welfare guardian
- a personal order made by the court providing that a person shall reside at a specified institution (like a dementia care unit).

A temporary measure is also available in the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996. If there is no substitute decision-maker for a person assessed as lacking the capacity to make these decisions, the Code of Rights provides legal justification for offering health and disability services without consent. The Rights permit healthcare providers to act in what they consider to be the person's best interests.

A few submitters expressed concerns about the legal requirements for admission to residential care. The Chief Ombudsman told us that there are various records of the legal authority for placement in aged residential care, including assessments of decision-making capacity, the "consent" of an authorised representative, or a court order. The Ombudsman recommended that we consider what safeguards may be needed to ensure that facilities have appropriate legal authority when placing people in secure aged residential care.

We were also told by other submitters, largely providers, that securing an EPOA can be lengthy, costly, and complicated. In cases where a person has no family or loved ones available, it is unclear who should meet the cost. The New Zealand Aged Care Association and The Care Village explained that, if an EPOA is not in place, the process of establishing a court-appointed guardian is expensive and can face resistance from families.

Submitters noted that, given these barriers, some people do not have an EPOA at the time they need to be admitted into residential care. We heard that facilities are then faced with either admitting the resident on the basis of a guarantee from family members that they will secure a court order, which can take several months, or denying admission, which can be distressing for families.

The Chief Ombudsman, the Australian and New Zealand Society for Geriatric Medicine, Ryman, and others stressed that simplification of EPOA processes is crucial to supporting access to care.

2.4 Comments from The Retirement Commission | Te Ara Ahunga Ora

We sought information from the Retirement Commission on the ability of people to pay for aged care services. We include comments pertinent to aged residential care below.

The Retirement Commission told us that the cost of aged residential care in New Zealand ranges from about \$1,460 to \$1,536 per week, with premium accommodation costing up to \$2,240 a week, or around \$116,480 a year. It said there has been a notable shift in the sector toward premium beds, which has reduced the availability of standard beds and made them harder to access in some regions.

We were told that the median stay in aged residential care is around 18 months, although stays can range from only a few days to as long as 10 years, and that people with dementia tend to have longer average stays. The demand for dementia care is increasing rapidly, with around 83,000 New Zealanders currently living with dementia—a number projected to double by 2050.

By the Retirement Commission's estimate, privately funding aged care would require between \$72,000 and \$116,480 per year. Because of a shortage of standard beds, people may need to plan to pay for premium accommodation. The median stay could cost around \$180,000.

The Retirement Commission referred to data from the Household Economic Survey (HES) to illustrate the financial capacity of older people to meet these costs. Although the data is limited to individual rather than household asset levels, it shows that New Zealanders aged 65 and over have a median individual asset level of \$555,000. This suggests that nearly half of people aged 65 and over would not have sufficient assets to privately cover aged care costs, particularly dementia care, over a five-year period. As most wealth is held in housing, many people would need to sell their home or draw down on housing equity to fund their care. For couples, this can be further complicated when only one partner requires care. With home-ownership rates projected to decline in the future, this source of funding might no longer be available to people. Consequently, more people may need to access residential care subsidies to help meet these costs.

Trends in the residential care subsidy

The Retirement Commission reported that, in 2023, around 32,000 older people were living in aged residential care across New Zealand. Most were in rest homes or hospital-level care, with about 5,500 in dementia or psychogeriatric units. Approximately 60 percent of the cost of this care is met through residential care subsidies, with the remainder privately funded.

The Commission told us that NZ European/Pākehā made up 73 percent of those receiving the residential care subsidy in 2023, while Māori accounted for 7 percent. The overall number of people receiving the residential care subsidy each year increased by 7 percent between 2019 and 2023.

Comments on asset thresholds

The Retirement Commission said that it was not able to provide insights into household assets for people over 65, or a breakdown of assets by quintile for various age groups, as this would require access to customised HES data that was not available within the timeframe for its response. The Commission suggested that further analysis of HES data would be useful to determine whether the current thresholds remain fit for purpose.

The Commission said that “other assets” thresholds for the residential care loan scheme appear to be very low, and that many older people are likely to hold assets at about that

level to cover emergencies. While the asset thresholds for the residential care subsidy are adjusted annually for inflation, the Commission said that this is not the case for the “other assets” threshold under the residential care loan scheme. That threshold was set in 2005, when the scheme was first introduced. The Commission commented that good practice would be to adjust thresholds to reflect the impact of inflation and suggested that the low threshold may contribute to the low uptake of residential care loans.

A similar issue was identified with the accommodation supplement (AS), where the limit on “cash assets” that can be held—such as savings, shares, stocks, bonds, and loans to others—is \$8,100 per person. From the age of 65, this also includes KiwiSaver investments, as these become fully accessible. The Commission pointed out that this limit has remained unchanged since the AS was introduced in 1993 and continues to reflect the level set for the previous accommodation benefit in 1988. It has never been adjusted for inflation. The Commission reiterated an earlier recommendation, made in the 2022 Review of Retirement Income Policies, that this limit be increased to at least \$42,700 per person, with provision for annual inflation adjustments.

2.5 Insights from our site visits in New Zealand and Australia

In addition to hearing from submitters in Wellington and visiting providers in New Zealand, some of us travelled to Sydney and Canberra in April 2025, visiting several aged care homes, government agencies, advocacy groups, and private, public, and listed providers. We note below some of the insights gained from discussions we held on the Australia trip and our site visits in New Zealand.

The benefits of a mixed, village-style model

As submitters have observed, there is an international transition away from large institutional care environments. One of the facilities we visited is the CARE village in Rotorua. It is a mixed-services model ARC provider which cares for residents across the continuum in their homes.

The CARE Village offers a very interesting case in how aged care can be delivered, including for those with dementia. Residents in the village go about their day with all the usual household routines and in-home hobbies. Each home has its own rhythm and distinct design reflecting different ways of life. There are gardens, pets, and plenty of visitors. We note that the CARE Village is the second facility in the world, after De Hogeweyk Dementia Village in the Netherlands, to pioneer a new approach to aged care that challenges the traditional models of rest home, hospital, and secure care levels. We consider that, among the important benefits of the CARE village, it is a non-institutional setting, which can improve the experiences of residents and family.

The Ministry of Health has made compliance possible with a three-year pilot programme. We encourage the ministry to continue supporting rest homes such as the CARE Village. We note that, at present, there is no business model for CARE villages that is sustainably funded.

Cost of dementia and psychogeriatric beds (D3 and D6 beds)

Submitters commented that the funding model does not adequately support psychogeriatric care. It was observed that the ARRC agreement caps the number of dementia beds in a facility at 20, whereas a minimum of around 68 beds is required for such units to be financially sustainable. This misalignment, submitters observed, means that facilities providing specialised dementia and psychogeriatric care may be structurally disadvantaged under the current model.

Listed healthcare providers commented on how challenging it can be to provide dementia and psychogeriatric level care beds. The cost of these beds, due to the significantly higher level of support required, is more than the support they get from the government. As listed entities, the directors have a fiduciary duty to shareholders to deliver value. To achieve best value, a rational director would advocate closing their D3 and D6 beds.

These beds are already closing, as evident in the centres we visited. We are concerned about the cost burden of D3 and D6 beds on listed and private aged care providers. It may lead to a hollowing out of services unless further support or incentives are provided to encourage the maintenance and further development of appropriate dementia and psychogeriatric services.

Our discussion with the Australian Independent Hospital and Aged Care Pricing Authority

We invited Professor Michael Pervan, CEO of the Australian Independent Hospital and Aged Care Pricing Authority (IHACPA) to tell us about the Authority's work. The IHACPA was originally established to implement a national programme of activity-based funding for the hospital sector. We heard that it was created to address a lack of trust between the states and the federal government over hospital pricing. The Authority's role has since expanded to include the provision of pricing advice to the Minister for Health on aged residential care and home services.

We heard that the IHACPA's pricing process is data-driven and highly transparent. Pricing advice is based on cost and activity data. The initial assessment relied on financial reports from the residential care sector and wage decisions from Australia's Fair Work Commission. Prices have increased but remain within the Treasury's budget parameters, and confidence in the process remains high from stakeholders in the sector and across governments.

The IHACPA explained that its pricing methodology is guided by a published framework that is open to consultation and feedback. Cost and activity data collected by contractors is validated by the IHACPA to ensure completeness and accuracy, with anomalies closely examined. The IHACPA then issues a public price determination that sets out how prices were calculated and the data sources used. Weightings are allocated for rural and remote services and specialised care for Indigenous and homeless Australians. We heard that transparency and public consultation have been vital to maintaining confidence in the system.

Noting that the IHACPA's development is partly due to Australia's federalism, we asked if a government agency in New Zealand could carry out the IHACPA's functions. We heard that independence when setting prices has been critical to maintaining confidence and trust with the sector. The IHACPA still operates as a statutory body and in a manner similar to a

government department, and reports frequently to the Minister. It was acknowledged that, while some might consider it a conflict of interest for a government department to set its own prices, others might see it as an important alignment.

We asked how the IHACPA has confidence that it is setting prices correctly. It told us that it has a wide-ranging network that consults across the sector, and expects that providers would offer feedback if prices were not sustainable. It also noted that the base pricing appeared to be sufficient to ensure that rural and remote services remained viable and open.

The IHACPA told us that nurses would like more flexibility and choice in their work, including the option to move between hospitals and other settings. He encouraged the government and Health NZ to engage directly with the sector, rather than relying on consultants, when considering workforce planning and reform.

2.6 Wait-time findings from the review of aged care and service models

We are particularly concerned by the findings in the Sapere report (*A review of aged care funding and service models*), which suggest that there will be a shortfall of 12,000 beds by 2032. The review also found that high-needs dementia and psychogeriatric care residents are waiting nearly six months, on average, before being admitted into an ARC facility.

There are also significant regional variations in wait times, and a decrease in the proportion of high-acuity individuals being admitted to ARC within 12 months of being assessed. There are significant decreases in the proportion of high-acuity individuals being admitted to ARC South Canterbury (from 47.7 percent to 34 percent), Hutt Valley (from 51 percent to 41.1 percent) and Auckland (from 50.5 percent to 42 percent), but significant increases in MidCentral (from 49.7 percent to 74.9 percent) and Wairarapa (from 41.9 percent to 50.3 percent).¹⁵ There is significant regional variation in access to ARC, as high-acuity individuals in MidCentral experience an average admission time of 82 days, while those on the West Coast wait for an average of 219 days.¹⁶

2.7 Committee opinion

We recognise the concerns raised about the adequacy of funding for aged residential care. We note that ARC facilities often provide palliative care. Research in 2019 found that 24.3 percent of patients are admitted for the first time to ARC facilities in the last three months of life.¹⁷ We understand that current funding settings leave many providers struggling to cover core costs, which in turn affects their ability to sustain services, retain staff, and plan for the future. In addition, as providers have highlighted, some limits in the ARRC agreement, such as the 20-bed cap in facilities, can mean that it is difficult to break even.

¹⁵ David Moore, Jeff Loan, Mehrnaz Rohani, Rohan Trill, Nick Manning, Douglas Yee, *A Review of Aged Care Funding and Service Models: A Strategic Assessment of Aged Residential Care and Home and Community Support Services*, p 25. The review notes that this discrepancy between regions may be a result of substitution of ARC with HCSS, and increasing preferences to stay at home longer.

¹⁶ Ibid p 26.

¹⁷ McKinlay, E, et al, *What does palliative care look like in a New Zealand aged residential care facility when patients are admitted to die?*, *NZMJ*, 8 November 2019.

Adverse effects of funding shortfalls also include a lack of facilities, meaning that spouses and families have to travel far to see their partners and loved ones in care.¹⁸ We acknowledge that responsibilities for means testing and other assessments are spread across different ministries, and are not centred on the individual, as in the Australian model.

We also note the possibility of bed closures and the risk of further reductions in capacity if funding is not addressed. We are concerned about how the system will meet projected demand, especially for dementia and psychogeriatric care. We note that submitters have highlighted that there is an additional cost on hospitals due to the lack of ARC beds. We note that comments from submitters and research undertaken in the production of both Sapere reports (produced as a part of Health NZ's review of Aged Care Funding and Service Models) give us a picture of projected demand and costs for ARC. However, the ministry advised that it does not hold data on projected costs for ARC specifically. We are concerned that this lack of information makes it harder to understand cost pressures and plan for the long-term sustainability of aged residential care.

Chemical restraint

We were concerned by submitters' comments about the use of chemical restraint due to staff and bed shortages, and sought advice from the Ministry of Health about the use of chemical restraint. The ministry noted that there are standards for the use of chemical restraint; they are set out in section 6 of the Ngā paerewa Health and disability services standard.¹⁹

We were advised that this section establishes several criteria designed to achieve certain outcomes for service providers. They include demonstrating the rationale for the use of restraint within a framework that aims for its elimination; ensuring that least-restrictive practices and de-escalation techniques are considered and that restraint is used only as a last resort; and maintaining or working towards a restraint-free environment through the collection, monitoring, and review of data and other improvements.

Under subsection 6.1, governance bodies must demonstrate a commitment to eliminating restraint. Service providers must implement policies and procedures, underpinned by best practice, that include restraint elimination and the use of alternative interventions.

Under criterion 6.2.1, any decision to approve restraint for a person receiving services must be made only as a last resort:

- after all other interventions or de-escalation strategies have been attempted
- after adequate time has been given for cultural assessment
- following appropriate assessment, planning, and preparation, including consideration of available resources
- by the most appropriate health professional
- and in an environment that is suitable and safe.

¹⁸ The Social Services and Community Committee considered the petition of Sue Brown ("Retirement villages must have capacity when residents move to next level care") in June 2022. A copy of the report is [available here, on the Parliament website](#).

¹⁹ The Ngā paerewa Health and disability services standard is available [on the Standards New Zealand website](#).

We were further advised that all medicines must be prescribed and used for valid therapeutic purposes. The use of medication solely to restrict a person's freedom of movement or to render them incapable of resistance is considered chemical restraint, and providers must be able to demonstrate their compliance with the relevant requirements. We consider that some providers are finding it difficult to meet these standards.

Insights from the Australian model

Australia's aged care reforms demonstrate the value of a transparent and independent approach to costing and pricing. The creation of the IHACPA has depoliticised funding by grounding decisions in robust, sector-wide cost data. This has built confidence across the sector and reduced the "funder versus provider" disputes that characterise New Zealand's current environment.

As we note above, the Australian model separates aged care funding into three distinct streams: clinical care, daily services (costs such as meals and laundry), and accommodation (capital and infrastructure). This disaggregation of costs clarifies where government subsidies are applied, highlights gaps, and makes it easier to assess equity and efficiency. It also enables differentiated treatment of capital investment, an area where New Zealand providers face persistent underfunding. However, we note that the disaggregation of costs in Australia coincided with an increase in the contribution users of aged residential care made towards non-health costs. The Australian model may be seen as a market-access, user-pays model which offers more choice to consumers.

For New Zealand, adopting a similar independent pricing authority as Australia, with transparent methodologies and clear cost breakdowns, could strengthen fiscal accountability, improve equity of access, and encourage sustainable investment in facilities. By embedding independence in the pricing process, New Zealand could move from short-term, contested uplifts to a stable, evidence-based funding platform.

In keeping with the recommendations of the Aged Care Association, we consider that changing funding into discrete categories would allow Health NZ to better target clinical care costs. We include a breakdown of what is included in each funding category in the Australian model in appendix B.

Possible funding arrangements for ARC

We sought advice from the Ministry of Health about alternative funding arrangements for ARC, which we include in our recommendations below. The ministry advised that current funding arrangements in New Zealand focus on funding the services providers deliver to residents—contributing to their operating costs—rather than funding the up-front cost of building or expanding facilities.

The ministry noted that the models identified by us during our consideration (detailed below) all relate to ways of subsidising the up-front capital cost of development. Any such subsidy, it said, would need careful consideration to ensure that it represents the best use of Crown funds.

Capital grants

Capital grants involve the provision of government funding—either as a non-recoverable grant or a loan—to meet up-front project costs. The ministry noted that grants of this type have not been used for aged residential care facilities since the early 1990s. It commented on the importance of ensuring that any public value derived from such investment is preserved, for example by imposing restrictions on the future sale or use of facilities funded in this way.

The ministry cautioned that capital grants carry several risks. Difficulty attracting private investment in an area may signal issues such as insufficient demand or scale to sustain a viable service. This can lead to the creation of stranded assets or an ongoing obligation on the Crown to provide more financial support to maintain viability. Conversely, capital grants could “crowd out” private investment in areas where private interest already exists.

Depreciation incentives

Depreciation incentives allow organisations to claim depreciation of their infrastructure against taxable income at an accelerated rate. The ministry noted that the Government’s “Investment Boost” initiative is an example of this approach and is expected to benefit businesses investing in aged residential care facilities from 22 May 2025 onwards.

Consent relief

Consent relief refers to the relaxation of consent rules or the provision of exemptions for certain developments, reducing the cost and timeframe of construction. The ministry cited the Government’s “fast-track approvals” process as an example, which may be relevant to organisations developing major aged care infrastructure projects.

Anchor contracts

Anchor contracts involve the Government guaranteeing a certain level of ongoing funding for a provider through long-term service contracts, which the provider can then use to leverage borrowing for capital costs. We were told that this approach has been used in social housing, where providers receive long-term guarantees of Income-Related Rent Subsidy funding for houses they build.

The ministry advised that this model may carry risks when demand for a particular service is uncertain, as it may commit the Government to funding services when they are no longer needed or are being delivered at lower levels.

Infrastructure Funding and Financing Act (IFF)

The ministry advised that the Infrastructure Funding and Financing Act 2020 (IFF) provides mechanisms for local government to fund and finance infrastructure projects that support housing and urban development. It allows for the creation of special-purpose vehicles which borrow to fund infrastructure projects, with repayment made through levies on beneficiaries. The Ministry of Housing and Urban Development administers the Act.

The mechanisms available under the Act can be used to fund:

- three-waters infrastructure (water supply, sewerage or sewage treatment, or stormwater drainage)

- transport infrastructure (including roads, cycleways, rapid transit, rail, walkways, and ferries)
- community facilities such as reserves
- environmental infrastructure to manage natural hazard risks or support environmental restoration.

The ministry noted that these mechanisms do not appear to extend to funding capital costs associated with aged residential care facilities.

National Infrastructure Funding and Financing Limited (NIFFCo)

National Infrastructure Funding and Financing Limited (NIFFCo) was established in 2024. Its functions include:

- administering existing infrastructure funds
- partnering with government agencies to deliver projects involving private finance
- connecting investors with relevant funds and ensuring transparent and efficient private investment processes for Crown projects.

Government agencies are required to partner with NIFFCo on infrastructure projects that may involve private financing, including those using alternative procurement models such as public–private partnerships.

2.8 Recommendations

3. We recommend that, to increase transparency, the Government establish a reporting model that separates aged care funding into three streams: accommodation costs, daily living costs, and clinical care costs.
4. We recommend that the Government consider a range of funding and financing tools to address the shortfall of ARC beds, including but not limited to capital grants, depreciation incentives, consent relief, anchor contracts, IFF, and NIFFCo financing.
5. We recommend that the Government consider a range of funding and financing tools to enable the development of more dementia beds, which are currently not profitable for providers.
6. We recommend that the Government consider undertaking further work on pathways to end-of-life care, including hospice care.
7. We recommend that the Government consider enabling alternative aged care models similar to the CARE Village in Rotorua.

3. Home and community support services

3.1 Overview of home and community support services

Home and community support services (HCSS) are services that support people to live safely and independently in their homes and communities. The purpose of HCSS is to provide client-centred, culturally appropriate, and responsive support that maintains or enhances functional ability, health, and social connection, and to provide end-of-life support. Its objectives include maximising and maintaining independence, enabling clients to set goals and plan their care, providing flexible services that respond to changing needs, and pursuing continuous quality improvement within a “best for person, best for system” framework.

Around 45,000 people receive HCSS each month, including older people, people with complex medical issues, and medically fragile children; 93 percent of them are older than 65.²⁰ Some groups access HCSS at higher rates than others. In 2022/23, Māori and Pasifika received an average of 5.7 and 6 hours per week of home care respectively, compared with 5.1 hours for Asian individuals and 3.5 hours for NZ European/Other.²¹ We heard that the higher use of services by Māori and Pacific individuals reflects greater health needs, cultural preferences to remain at home longer, and perhaps, barriers in accessing ARC.

It is important to distinguish between HCSS and community NGO supports, as submitters highlighted that they provide different but complementary services. HCSS deliver contracted in-home care (personal care, household support), whereas NGOs such as Dementia NZ and Alzheimers NZ provide post-diagnostic services, navigator roles, support groups, and cognitive stimulation therapy pilots. Submitters emphasised that funding lines, eligibility rules, and workforce challenges differ, and conflating the two risks under-recognising the role of NGOs. NGO support is discussed in the next chapter of this report.

3.2 Eligibility and funding for HCSS

Health NZ funds HCSS if the recipient is eligible for publicly funded health and disability services and has a disability need, based on an interRAI assessment, that is not met by natural supports such as family or whānau. However, people receiving Health NZ-funded care may also choose to have a family or whānau member provide the service. In this case, the carer can be employed by an HCSS provider to deliver the agreed services. This allows family members to be compensated for their time and to access respite care.

HCSS is funded by several different entities. Health NZ funds HCSS for older people, Disability Support Services (part of the Ministry of Social Development) funds it for disabled people, and ACC funds it for people with injuries. Disabled people under the age of 65

²⁰ Ministry of Health, *Summary of Submissions to the Health Committee*, p 11.

²¹ *A Review of Aged Care Funding and Service Models: A Strategic Assessment of Aged Residential Care and Home and Community Support Services*, p 29; quoted in *Summary of Submissions*, p 11.

receive support through Disability Support Services, and transition to Health NZ–funded HCSS when their needs become age-related.

In 2023/24, Health NZ spent \$685.6 million on HCSS, including travel costs.²² This amount is about three-quarters of HCSS expenditure, with the remaining quarter funded by ACC. The service funding model for HCSS providers is based on the former District Health Board (DHB) contracting model. Districts use either fee-for-service contracts or case-mix contracts.

Fee-for-service contracts

In fee-for-service contracts, the district allocates hours of specific tasks for each client (such as dressing or showering) based on the number of hours that the needs assessment specifies. Providers are paid in blocks of time for services delivered at an hourly rate. Additional needs assessment must be carried out for the hours to change. Seven districts use fee-for-service contracts.

Case-mix contracts

The case-mix model, also known as bulk funding, offers HCSS providers a fixed amount of funding based on an estimate of the volume and complexity of their clients. Providers are responsible for non-complex clinical assessment and restorative goal-setting supported by registered health professionals, and providers determine how to allocate their resources across clients. Delivery of support can shift according to a client's needs without any additional needs assessment. Currently, 14 districts operate on this model. We discuss versions of case-mixing (drawing on international models of ARC) later in this report.

3.3 Submitters' views

Under-recognition of HCSS can increase pressure on ARC

We heard that community-based services and HCSS are under-recognised in the aged care system, even though they provide care to more older people than the aged residential care sector. Some submitters were concerned that there are reducing numbers of beds for residential care, but that HCSS services are not being expanded to fill the gap. Many submitters stated that when HCSS are delayed or rationed, people progress more rapidly towards needing ARC or acute services, adding pressure on residential care at earlier stages of neurocognitive disorders.

Inadequate funding for HCSS providers

Concerns were raised about the resourcing of dementia services. Alzheimers NZ commented that from 2018 to 2022, the operating costs for community-based dementia services rose by 16 percent, while revenue increased by only 8 percent. Alzheimers NZ and Dementia NZ estimated that less than 20 percent of people with dementia are receiving adequate support services, meaning that around 30,000 people do not get the level of care they require.

²² Ministry of Health, *Summary of Submissions to the Health Committee*, p 12.

These organisations stressed that they have limited ability to absorb further cost pressures. This affects their ability to attract and retain workforce. They reported that providers are working above contracted service levels simply to meet current demand. They said this leaves little capacity to prepare for future demand or to provide tailored, individualised care. They are worried that this situation risks defaulting to a one-size-fits-all approach that does not meet people's needs. They also drew attention to their business case *Fair funding for community-based dementia services*. Alzheimers NZ estimates that \$127 million is needed over three years to support the service delivery outlined in the business case.

Alzheimers NZ highlighted that in 2020, more than a million hours of unpaid care were provided every week to people with dementia, mostly by family members. As stated in the *Dementia Economic Impact Report 2020*, this unpaid care equates to 52.7 million hours per year. It would cost an estimated \$1.19 billion if provided by paid carers.²³ Of the costs that fall on families, Alzheimers NZ observed that Māori, Pacific, and Asian communities bear a disproportionate and inequitable share.

Inconsistency in services and contracts

Submitters expressed concern that HCSS is diminishing in quality and reliability. Alongside concerns about underfunding, they described reductions in the hours of care provided, inconsistencies between the carers and the level of care delivered, a lack of training and qualified staff, and insufficient travel time between jobs. Some submitters noted that in-home care was unreliable, with carers frequently unavailable or different carers arriving each week.

Some submitters described the system as a “lottery” in which services depend heavily on where a person lives and whether they have the funds to enter a retirement village or supplement their care privately. This variability means that some families can access timely and sufficient care while others face significant barriers. They submitted that availability of HCSS varies by region, with rural areas particularly disadvantaged. We heard that, because of inadequate travel subsidies, staff often cannot afford to drive to more distant clients, preferring to work for people who live nearby. This leaves rural residents with worse access to services.

Submitters commented on the two HCSS contracting models. Some argued that the fee-for-service model is inequitable across regions. The Home and Community Health Association estimated that funding rates can differ by 15 percent under this model, depending on the location of the service. Many submitters said that a nationally consistent case-mix model would be more flexible, equitable, and cost-effective. The New Zealand Health Group estimated that moving all providers to a case-mix model could save \$200 million a year.

Submitters also suggested that a nationally consistent case-mix system should be accompanied by independent pricing and assessment mechanisms, to ensure credibility and transparency. Alzheimers NZ and Dementia NZ emphasised that under-resourced NGOs risk being overlooked if case-mixing is applied without parallel investment in community services. Submitters argued that commissioning under a case-mix model must explicitly address Māori and Pacific inequities, and be tailored to culturally grounded models of care, not just clinical categories.

²³ University of Auckland (for Alzheimers NZ), *The Dementia Economic Impact Report 2020*, p 25.

Discussion with the New Zealand Health Group

We invited Mike Peters, CEO of New Zealand Health Group (NZHG), to share with us his perspectives on New Zealand's aged care sector and the lessons that might be drawn from Australia's experience. The NZHG employs around 11,000 workers around the country and is the largest HCSS provider.

The NZHG told us that Australia has faced challenges from an overly regulated environment, such as the introduction of mandated care minutes for nurses. The NZHG emphasised that cross-party support is vital for major reforms to succeed, suggesting that a taskforce approach would be valuable in New Zealand, and identified the establishment of an independent pricing authority as one of the most significant changes in Australia. It also pointed to the wider range of tasks undertaken by support workers in the home in Australia, which has enabled people to remain out of aged residential care for longer. On staffing, we heard that there is greater flexibility in Australia, with public sector organisations able to use private sector staff across hospitals and aged care facilities.

We asked whether there is value in costing and pricing even if the process is not carried out independently but instead by a government department. The NZHG told us that pricing should be independent, as in the past both funders and providers have drawn different conclusions from the same data, leading to disagreements. We also asked about differences between rural and urban models in Australia. We heard that rural environments present particular challenges. Partnerships are being developed with Australian universities to attract overseas workers to help meet workforce needs in rural areas.

We asked about the balance in New Zealand between residential care and HCSS, and sought comments on ageing in place in New Zealand and Australia. Residential care remains the default in New Zealand, whereas Australians have greater ability to remain at home, supported by better-funded initiatives. The NZHG said that people using home and community support services in New Zealand are not generally aware of the range of supports available to them.

We asked the NZHG what the most important steps are to strengthen the sector. It replied that recognising and rewarding support workers was critical, particularly through a funding uplift. In Australia, support worker wages increased by 25 percent to \$29.81 per hour, compared with a minimum wage of just over \$24. In New Zealand, the NZHG said, the entry-level rate is \$23.50, which is the minimum wage. It said that lifting wages had helped Australia attract and retain staff. It also identified the establishment of an independent pricing authority as another essential reform.

Discussion with Ageing Australia

Some of us met with Tom Symondson, CEO of Ageing Australia, during our visit to Canberra. The association has 11,000 members across all states and territories, reflecting a diverse range of providers. We subsequently invited him for a hearing.

We heard that Australia's aged care system is shaped by governance structures that are either shared between federal and state governments or entirely separate. The sector is nearing the conclusion of reforms stemming from the Royal Commission into Aged Care Quality and Safety (2018). The final major recommendation of the Royal Commission—the

introduction of a new Aged Care Act—took effect on 1 November 2025. Ageing Australia told us that this Act explicitly incorporates the human rights of older people, which represents a central reason for the reform.

We heard that the occupancy rate of residential care in Australia is around 98 percent in most regions and that the new Act should help to open up further funding. Ageing Australia told us that the move to independently set prices has been significant in ensuring sustainability as it means that the true costs of delivering care are always visible. Contracts are formed between the individual and the provider, rather than the provider and the government. Although this means a reliance on markets (which may be very small in some areas, leading to fewer providers), confidence in the sector has grown. Ageing Australia also commented that most older people want to access services in their own homes.

We heard that Australia's three-pronged funding model makes it clear what individuals are paying for, whereas a single pricing model lacks transparency and can lead to hidden fees. It also provides more data for the government, showing exactly how spending is distributed across these categories.

The CREST model in Canterbury

Health NZ told us that different early supported discharge (ESD) models of care are used across New Zealand, including the Community Rehabilitation Enablement Support Team (CREST). We were particularly interested in the CREST model in Canterbury and sought to understand that better. We were told that CREST, which was based on the Waikato START model, was launched in April 2011 to relieve pressure on stretched hospitals following the Christchurch earthquakes. It is a community-based team designed to facilitate earlier discharge from hospital, or to prevent hospital admission.

CREST provides up to four visits a day, seven days a week, for up to six weeks. Multidisciplinary teams—comprising nurses, occupational therapists, physiotherapists, and support workers—work with clients to achieve specific goals and return them to independence after injury or illness. The service is integrated with hospital, community, and primary care services.

We were told that ESD models of care improve outcomes for older people who require support on leaving hospital. Evidence shows that hospitals are not always the best place to provide rehabilitation for older people, and effective community-based alternatives are essential. ESD services typically focus on those with functional decline following illness or injury, such as fractures, joint replacements, and some neurological conditions. Achieving a safe discharge as soon as possible benefits both patients and hospital services. ESD models significantly reduce the length of stay in hospital, both at the time of admission and in the following six months.

Cost analysis of the START model and evaluations of CREST

We are given to understand that cost analyses support this approach. Evaluation of the START model showed cost savings. A randomised control trial showed that, in the six months after participating in START, health care costs were calculated at a mean of \$10,836. In comparison, the mean cost for patients who had usual care models was \$16,943.

Participants in CREST reported improvements across five key health dimensions: mobility, self-care, usual activities, pain and discomfort, and anxiety and depression. Evaluations of CREST suggest that the length of stay in hospital is reduced without an increase in subsequent readmission rates. While demand for community dementia services increased by 6.6 percent, demand for rest home care fell by 6.7 percent. Health NZ submitted that the effect of CREST and START shows the potential for savings of up to 16,190 bed-days, and \$16.8 million per annum from the START model.

3.4 Committee opinion

We recognise the concerns raised by submitters about the adequacy of funding and the inconsistencies in contracting models. We heard that the coexistence of fee-for-service and bulk-funded arrangements has created inequities between regions and uncertainty for providers, carers, and families. We agree that these issues need to be addressed to ensure fairness and sustainability in aged care services. We note that the Sapere report found that a regionally based funding model heightens the risk of a “postcode lottery” for HCSS provision, and that fee-for-service funding is not appropriately linked to patient outcomes. The report also identifies that the current HCSS model lacks transparency.²⁴

We were interested in the evidence on case-mix models as the primary approach and inquired further. We learnt that the principle of case-mix can apply to a range of health services, such as hospital planning, clinical reviews, monitoring, benchmarking, and management. International examples show that case-mix funding offers greater flexibility and a better alignment of resources with need. The international examples we draw on here are also applicable to ARC. We include them here as they formed part of our consideration of case-mixing models for HCSS.

In Australia, the Australian National Aged Care Classification (AN-ACC) was introduced in October 2022. It includes three components: a fixed tariff, variable funding that depends on a person’s resident classification, and a one-off adjustment when a new resident enters care. Assessments are carried out independently by contracted assessment organisations. Independent analysis and pricing advice are provided through a dedicated advisory body, which informs AN-ACC funding.

Canadian provinces such as Ontario and Alberta have used the Resource Utilisation Group (RUG-III or RUG-Plus) system. This approach allocates residents into one of 30 to 44 categories—depending on the system—based on their diagnoses, treatments, and care needs. Each facility is then assigned a case-mix index, which adjusts the care component of funding according to the relative intensity of resident needs.

We consider that these models provide useful points of comparison for New Zealand. They suggest that moving towards a nationally consistent case-mix approach could improve equity, provide stronger incentives for quality, and ensure that funding better reflects the complexity of residents’ conditions.

²⁴ A Review of Aged Care Funding and Service Models: A Strategic Assessment of Aged Residential Care and Home and Community Support Services, pp 70-72.

Residential carers should be able to provide health care at home

We learnt from our discussion with Mr Symondson (Ageing Australia) that in New Zealand, Health NZ currently prevents providers from delivering both residential and home care services—a restriction that has no legislative basis and serves no clear policy purpose. In Australia, providers are not contracted by the Government. Instead, funding follows the person, and the contractual arrangement is between the individual and their chosen certified provider. This model enables many residential providers to also deliver homecare, giving people greater choice, ensuring accountability through certification, and making better use of the workforce.

Lack of flexibility for HCSS contractors

We heard from the New Zealand Health Group that there are limits on what home care workers are able to do. It said that there is potential for expansion in their work and that under a nurse's delegation, they may be able to do such things as provide vaccinations at home. He noted that in Australia support workers already deliver a wider range of services, including vaccinations.

We consider that the current system is too siloed. This leads to contractors visiting someone's home and only doing what they have been contracted to do before leaving, when they could have done other required tasks while there. This frustrates residents seeking to age in place and increases travel time and cost in the system.

We heard that the inability of contractors and carers to do tasks can lead people to be forced from home into more expensive aged care facilities. We consider that this is a bad outcome for them and a bigger financial cost to New Zealand.

3.5 Recommendations

8. We recommend that the Government encourage flexibility in HCSS contracting so that contractors can perform a range of tasks with a holistic view to keep patients well and out of hospital.
9. We recommend that Health NZ enable retirement care village providers to deliver home and community care, and vice versa.
10. We recommend that the Government provide for longer-term contracts and national consistency of funding for HCSS providers.

4. Support from NGOs and other services

4.1 Overview of community NGOs

Community non-governmental organisations (NGOs) play an important role in supporting older people and people with neurological conditions. They often provide education, advocacy, and direct services in the community. Dementia NZ and Alzheimers NZ provide supports such as information about dementia, guidance for families and whānau, post-diagnostic services, support groups, and day programmes.

Some NGOs also deliver cognitive stimulation therapy (CST), a non-medicine intervention that uses group activities and discussion to improve memory and quality of life. CST and related programmes, such as “Active Brain Day Programmes”, are funded through a small number of pilot contracts.

In 2023/24, Health NZ allocated \$13.1 million to NGOs for dementia-specific community services (excluding ARC costs). In addition, Budget 2022 provided \$12 million over four years for the Dementia Mate Wareware Initiative, which supports the *Dementia Mate Wareware Action Plan 2020–2025*. The action plan was jointly developed by Dementia NZ, Alzheimers NZ, the NZ Dementia Foundation, and Mate Wareware Rōpū.²⁵ The 2022 funding has established seven new services, including four post-diagnostic trials and 12 navigator roles, with a focus on improving access for Māori, Pacific peoples, rural populations, and people with younger-onset dementia.

Mental health services for older people, public hospitals, and palliative care

Beyond community NGOs, older people rely on a range of other services. The service Mental Health Services for Older People (MHSOP) supports older people with mental health needs. MHSOP teams consist of inter-disciplinary staff including psychogeriatricians, psychologists, mental health nurses, occupational therapists, social workers, and support workers.

Public hospitals also provide care to older people. Compared with younger groups, older people spend much longer in hospital. Also, discharges can be delayed if safe options for care in community settings are not available. In 2020, the cost of hospital admissions was estimated at \$237.1 million for all people living with dementia.

Palliative and end-of-life care are part of the continuum of services for older people and those with neurological conditions. These services provide holistic support to people with life-limiting illnesses, addressing their physical, psychosocial, spiritual, and cultural needs. They also support family/whānau, and carers during bereavement. Palliative care may be provided in aged residential care facilities, hospices, or at home. Some people are admitted to ARC facilities specifically to receive end-of-life care, for example, being transferred from public hospitals. Health NZ currently provides or funds palliative care services across a

²⁵ The Dementia Mate Wareware Action Plan, updated in 2021, is [available online](#).

range of settings. Most of these services are bulk funded, with the cost of palliative care included in the funding.

4.2 Submitters' views

Ageing in place and the role of community NGOs

Most submitters agreed with the idea that people with neurological conditions should be able to age “in place” (at home). They noted that many live at home independently or with support from family/whānau or carers, and want to remain independent for as long as possible.

Submitters emphasised that services and programmes delivered in the home and community are essential to make this possible. Dementia NZ observed that about 80 percent of a person's dementia journey is usually managed in the community.

Community services were described as a “critical lifeline” between people with dementia and the wider health system. Community services are also particularly important for family/whānau providing care at home in keeping with cultural preferences.

Submitters also pointed to wider system benefits of comprehensive community-based services. They include reducing demand for long-term residential care, easing pressure on hospitals, lowering overall costs by shifting away from high-cost settings, and providing support for rural and dispersed communities where residential options are limited.

Equally, some submitters expressed concern about limitations in home- and community-based care. Some submitters proposed that “ageing in place” is being used as an economic model rather than a care model. They contended that it has been interpreted by the government as “ageing at home at all costs”. Other submitters warned that keeping people at home without the right supports could place significant personal, financial, and emotional pressures on carers. It could also present safety risks for people with dementia.

Many submitters referenced the Dementia Mate Wareware Action Plan, saying that the plan should be refreshed and funded. Kaitiaki of the Action Plan considered it to already represent the “last word” from the dementia sector on current priorities for action.²⁶ Kaitiaki of the Action Plan emphasised the urgent need for both a commitment to implementation and a clear funding pathway.

Submitters also called for cognitive stimulation therapy to be fully funded and incorporated into care, as evidence shows that it improves cognition for people with mild to moderate dementia. We were pleased to hear that work is underway to make CST accessible in te reo Māori and other languages.

The need for an integrated continuum of care

Submitters commenting on the continuum of care said it should be innovative, well-resourced, and responsive to people's choices. They saw the continuum as spanning the full pathway from pre-assessment through to end-of-life care, including community NGOs, HCSS, aged residential care, respite services, and palliative care. Submitters also

²⁶ The kaitiaki consists of Alzheimers NZ, Dementia NZ, NZ Dementia Foundation and te Mate Wareware Advisory Rōpū.

highlighted the importance of preventative programmes, primary care, and specialist interventions that support and wrap around these services.

Many submitters, particularly providers and sector representatives, called for an integrated continuum of care that can adapt to people's changing needs. They also suggested that the continuum should not be limited to dementia alone, but should include other neurological conditions.

A number of submitters also emphasised the importance of a multidisciplinary approach to care. One submitter suggested learning from paediatric services by expanding the mix of disciplines across inpatient, outpatient, and community teams working with older adults. The New Zealand Association of Gerontology and Geriatric Medicine similarly recommended creating a dedicated care stream for older adults and people with chronic multimorbidity.

4.3 Committee opinion

We acknowledge the immense contribution of community NGOs and other health services. They play a critical role in supporting people to age in place. We also note the importance of holistic, culturally appropriate services that respond to individual and family/whānau needs. The continued advocacy and work, including on the Dementia Mate Wareware Action Plan, has been important in efforts to improve diagnoses, facilities, and access.

We sought to find out if the dementia day programme helped carers remain in employment. The ministry told us that although it does not hold this information, research from the University of Auckland found that dementia day programmes provide important benefits to caregivers.²⁷ The study reported that carers valued the respite these programmes offer and identified the ability to keep working as one of the main benefits, alongside reduced stress and greater freedom to engage in personal or social activities. The research indicated that participation in dementia day programmes enabled many carers to continue working, either full-time or part-time.

We also note the sector's call for a continuum of care that is integrated, adaptable to changing needs, and inclusive of all neurological conditions. We heard strong support for multidisciplinary approaches, better access to therapies such as CST, and greater resourcing for community engagement and post-diagnostic support. We consider it important that these initiatives are resourced appropriately.

²⁷ Evaluation of Dementia Day Care Programmes by Caregivers: A New Zealand Case Study, Gerontology & Geriatric Studies, March 13, 2018.

5. Carers and the aged care workforce

5.1 Overview

Carers are individuals and family/whānau who provide day-to-day support for someone close to them with a disability, health condition, illness, or injury. They play a crucial role in enabling people to live in their communities and maintain independence.

The 2018 Census recorded more than 430,000 New Zealanders providing informal or unpaid care. This is thought to be undercounted, with the real figure considered to be closer to 655,000.²⁸ Most carers are women, many are over 65, and the majority are European or Māori. Māori women are more likely to be carers than other women, and they are typically younger than other carers.

Caring responsibilities often mean reduced opportunities to take part in education, paid work, and community life, affecting carers' health, wellbeing, finances, and social connections. Despite these pressures, carers are estimated to contribute \$17.6 billion annually in economic value, alongside wider social benefits.²⁹

To recognise their role, the New Zealand Carers' Strategy was launched in 2008. It is supported by rolling, five-year action plans that aim to improve support for unpaid carers and address key priorities identified by carers, NGOs, and the government.

Roughly 35,000 people are employed in ARC, mostly registered nurses, caregivers or kaiāwhina, enrolled nurses, and activity coordinators. In 2019, approximately 40 percent of the registered nurses and carers were in New Zealand on work visas.

Similarly, most of the HCSS workforce consists of 22,000 care and support workers. They include coordinators, nurses, physiotherapists, training and quality staff, administrative and finance staff, and managers. As with ARC staff, the workforce has a high turnover, averaging 21 to 30 percent a year between 2005 and 2019.

5.2 Submitters' views

Submitters raised concerns about the well-being and training of both unpaid carers and the paid aged care workforce.

Resourcing and recognition of the workforce

Submitters expressed concern about underfunding that has resulted in barriers to recruitment and retainment in the aged care workforce. Other significant issues are pay

²⁸ The economic contribution and sacrifices of unpaid family, whānau, and aiga carers in New Zealand for Alzheimers NZ, Carers NZ, the Carers Alliance, IHC and the Ministry of Social Development, p 5.

²⁹ Ibid, infometrics, p 6; quoted in *Summary of Submissions*, p 26. This estimate accounts for carers who care for friends, family, whānau, and aiga members with a disability, health condition, or illness who need help with everyday living.

disparity and inequity and the relatively low salaries in the sector. Overall, submitters suggested that the skills required for aged care were not recognised.

Standardising wages and incentivising graduates to enter the workforce are seen as vital to growing the aged care workforce. Other proposals included developing pathways for nurse practitioners training in aged care, formalising specialist nurse roles, and increasing the perceived value and status of aged care work through media campaigns and leadership initiatives.

Submitters commented that ensuring all staff are adequately trained is essential. They noted that there are a limited number of providers offering specialised training, and that, while many staff members have theoretical knowledge, they do not have practical skills.

Submitters recommended ensuring workers have attained the Certificate for Dementia Care.

Pay disparity, pay inequity, and relatively low salaries in the aged care sector were raised as key issues by many submitters. They told us that much of the workforce, particularly nurses, can earn higher pay either with Health NZ or by moving overseas. Several submitters highlighted, for example, that community nurses are not remunerated at the same level as nurses providing equivalent care in hospitals. At the same time, NZNO considered that the residents that nurses care for in aged residential care often have more complex needs than those managed in acute hospital settings. We also heard that these issues are worse in rural areas and kaupapa Māori services.

E Tū told us that while the pay equity claim within public hospitals has increased wages for nursing staff in both in-home support and residential care, the wages of care and support workers remain very low given the responsibilities of their role. Some submitters also noted that this disproportionately affects women.

The role and experience of informal carers

Many submitters highlighted the important role carers play in supporting people to age in place. They told us this role is generally not recognised.

One submitter noted that, although supporting people to remain at home is the most cost-effective approach for the health system, the fact that this transfers costs to families and communities must also be acknowledged. This effect is exacerbated when caring for people with neurological cognitive disorders. Alzheimers NZ estimates that around one million hours of unpaid care are provided each week across New Zealand to people living with dementia. This equates to 52.7 million unpaid hours annually, with a value of \$1.19 billion.

Several submitters told us that support for families and carers is an essential part of the continuum of care. They noted that family members caring at home need help with daily activities such as showering, managing medication, preparing meals, and housework. We heard that this support is provided by community organisations, home and community support services, and aged residential care providers, including through respite services.

Submitters also described the challenges faced by carers when supporting people at home. They raised concerns about the effect on carers' mental health, pointing to fatigue and burnout. We were told that families and carers directly affected by dementia may themselves

live with a health condition, disability, or mental health issue, and that addressing their own health needs is often delayed because of their caring responsibilities.

Submitters also spoke about the physical strain of lifting and moving those they care for, and the risks of physical harm that can arise from behavioural and psychological symptoms of dementia. One submitter observed that a sense of duty to a partner may prevent people from asking for help or lead them to delay seeking support until a crisis occurs. We also heard that because of behavioural symptoms, some submitters felt that could no longer have visitors to their home and could not leave the house often, resulting in isolation.

Submitters told us that caring responsibilities can have financial consequences. They noted the increased costs of health and social care, combined with a reduction or loss of income. They said that working carers often reduce their hours or give up employment altogether, creating financial pressures and limiting their ability to prepare for their own retirement and future care.

Respite care

Some submitters called for greater support for carers to prevent burnout and isolation. We heard that respite, including day programmes and periods of short-term care, is key to supporting carers. However, the New Zealand Nurses Organisation (NZNO) said that the respite system is inequitable because programmes are not available in rural areas.

Many submitters recommended funding for a continuum of flexible respite options. These would include day programmes and kaumātua programmes, regular home-based carer respite, and an increase in the number of overnight respite beds in residential care facilities.

Potential barriers to the ability to hire international candidates

We heard that immigration plays an important role in sustaining the aged care workforce and that policy settings need to support a steady flow of health workers into the sector. Concerns were raised about recent changes to the Accredited Employer Work Visa, which may limit the ability to employ internationally qualified workers. We were also told that the introduction of Objective Structured Clinical Examinations for nurses has reduced the time nurses are trained in a New Zealand setting, raising questions about whether they will be fully work-ready for aged residential care.

We heard that employing staff from overseas involves significant administrative time and cost, and that providers are not funded for these processes. Frequent changes to immigration requirements create additional challenges, with the risk that applicants may no longer meet visa criteria by the time their applications are processed.

5.3 Committee opinion

In forming our views, we have drawn on Health NZ's Future of Ageing Well service and funding model review, including its sector and public engagement summary and themes. This review identified challenges for carers in the aged care system which are echoed in the submissions we received as a part of our inquiry.

We note that carers face considerable administrative complexity in accessing support. Many struggle to understand what is available, what they qualify for, or how to request it. The

processes of filling out forms and submitting invoices for subsidies can act as a deterrent. In addition, inconsistencies in the application and interpretation of policies across regions make access more difficult.

The review also set out problems with access to respite services. Availability was found to vary significantly across regions, and even where respite is allocated, carers may have difficulty finding places. We are concerned to observe a lack of restorative respite models, which would actively support carers' well-being.

The review found insufficient mental health support for carers. Carers often experience high levels of stress and burnout, but there are few accessible mental health resources specifically designed for their needs. Systems of support for carers' emotional and psychological well-being remain inadequate.

We further note the review's finding that cultural and regional needs are not being met. The current system does not sufficiently address the requirements of Māori and Pacific peoples, and options in rural areas are very limited or absent altogether.³⁰

We consider that these findings provide important additional context for our inquiry and support our view that carers need more flexible, consistent, and culturally responsive support across the aged care system.³¹

Increasing respite and support for carers

We understand that current projections indicate that, by 2031, an additional 380 full-time-equivalent (FTE) registered nurses will be needed in aged care, and an additional 2,910 FTE caregivers and enrolled nurses will be needed. We were unable to obtain data on the number of respite beds available.

We also recognise that unpaid carers provide the most support for people with neurocognitive disorders, yet they face financial hardship, limited respite, and negative effects on their own health and wellbeing. While the Carers' Strategy has established a framework for action, submissions indicate that carers continue to experience insufficient recognition and support. We note that the Sapere report concluded that offering "more support for informal carers is widely acknowledged as an important aspect of aged care". It acknowledges that, at present, respite options available vary across the country.³² We consider that, to address this inequity more widespread provision of respite care in rural areas must be encouraged.

We understand that financial support for carers can vary. The Carer Support subsidy is available to those providing more than four hours of unpaid care per day to individuals who

³⁰ For further information on how rural areas are affected by workforce shortages, see [A Review of Aged Care Funding and Service Models: A Strategic Assessment of Aged Residential Care and Home and Community Support Services](#), p 97. For information on how the current system does not sufficiently address the requirements of Māori and Pacific peoples, see p 45.

³¹ Health New Zealand, [Future of Ageing Well service and Funding model review: Sector and public engagement summary themes](#), pp 34–35.

³² [A Review of Aged Care Funding and Service Models: A Strategic Assessment of Aged Residential Care and Home and Community Support Services](#), p 40.

have an age-related disability that is expected to last for more than six months.³³ Some carers receive the supported living payment or employment by Health NZ as a family member caring for an individual who has high or very high support needs.

Based on the significant feedback on how much care is done by unpaid carers, usually family members, for people who are ageing in place (at home), we suggest that the Government should consider setting up a regular respite care programme. We consider that carers require respite care options to ensure they can continue caring sustainably. Without this, many will find caring duties arduous and stressful. They will move their family member into an aged care facility, significantly increasing the cost burden on the state. The cost of funding a respite care programme should be lower than funding those additional people in aged care facilities because their carers did not get the respite they needed.

We set out below a recommendation for a sustainable pay and conditions framework for the aged care workforce. This framework should ensure parity between aged care and equivalent roles in the public health system, inclusive of nurses, caregivers, and support workers. It should provide clear pathways for training, qualifications, and advancement and include targeted funding to address workforce shortages in regional and kaupapa Māori services. We consider that fair pay and stable employment conditions are essential to attract and retain skilled staff, maintain continuity of care, and uphold quality and safety in aged care settings.

In addition, we consider that increases in provider revenue or capital support should be contingent on demonstrable reinvestment into staff pay and conditions. These protections should be embedded in aged care contracts and monitored by Health NZ to ensure that efficiency measures do not compromise workforce conditions or the quality of care for residents.

5.4 Recommendations

11. We recommend that the Government consider setting up a regular respite care programme.
12. We recommend that the Government work with Health NZ and the sector to implement longer-term agreements and certainty of funding and conditions to enable a sustainable aged care workforce.
13. We recommend that any policy or funding changes intended to improve the financial sustainability of aged care providers be accompanied by measures that guarantee equal protection and benefit for the workforce.
14. We recommend that the Government continues to work to reduce gender-based pay discrimination in the aged care sector.

³³ Further information on the Carer Support subsidy, and how this is allocated, is [available on the Health NZ website](#).

Appendix A: Committee process and membership

Committee procedure

We met between 22 May 2024 and 19 November 2025 to consider the inquiry. We called for public submissions with a closing date of 19 August 2024. We received submissions from 107 organisations and individuals and heard oral evidence from 44 submitters. We visited the following aged care facilities and service providers:

- Bupa Windsor Park Care Home, Gore
- Wyndham and Districts Community Rest Home, Wyndham
- Peacehaven Village, Invercargill
- HealthCare NZ, Invercargill
- Althorp Village, Tauranga
- Arvida Copper Crest, Tauranga
- The CARE Village, Rotorua
- Rauawaawa Kaumātua Charitable Trust, Hamilton
- Auckland City Hospital, Auckland
- Dominion Home, Auckland
- Access Community Health, Lower Hutt

We received advice from the Ministry of Health and the Parliamentary Library.

Committee members

Sam Uffindell (Chairperson)

Dr Hamish Campbell

Dr Carlos Cheung

Ingrid Leary

Cameron Luxton

Hūhana Lyndon

Jenny Marcroft

Debbie Ngarewa-Packer

Hon Dr Ayesha Verrall

Related resources

The documents we received as advice and evidence for this inquiry are available on the [Parliament website](#), along with the recordings of our meetings on:

- [23 October 2024](#)
- [20 November 2024](#)
- [11 December 2024](#)
- [18 June 2025](#).

Appendix B: Components of the Australian aged residential care funding model

Residential clinical care

- Care and services plan oversight
- Allied health, rehabilitation, and therapeutic exercise programmes
- Medication management
- Nursing
- Dementia and cognition management
- General access to medical and allied health services

Residential non-clinical care

- Care and services administration
- Personal care assistance
- Communication and emotional support
- Mobility and movement needs
- Continence management
- Recreational and social activities

Residential everyday living

- Operational administration and emergency assistance
- Utilities, cleaning, and waste disposal
- Communal, bedroom and bathroom furnishings
- Toiletry goods and personal laundry
- Meals and refreshments.