Aged Care Association
NEW ZEALAND

FUTURE-FOCUSSED APPROACHES FOR REST-HOME-ONLY PROVIDERS



SNEHA PILLAI & RABIKAH BEGUM / September 2025



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Thank you to Kāpiti Retirement Trust, and its staff, residents and families who kindly allowed us into their home to take photographs for this report.



“The question is not if change will come, but how prepared we are to adapt to it.”

Hon. Tracey Martin

Foreword

The Aged Care Association (ACA) initiated this project in response to mixed signals from government and government agencies about the future of rest home level care. Te Whatu Ora | Health NZ has categorically stated that there is no formal policy to reduce or remove rest home provision.

However, the *Aged care service model and funding review, Phase 2: Modelling options for improved funding and service models* report projected ongoing declines in ARC admissions, particularly at rest home level, and our members are already experiencing this reality in practice. Referrals volumes are dropping sharply in parts of the South Island and there is a clear lift in acuity across the country. Together, these factors suggest that while the policy settings may not have shifted on paper, the trajectory of service delivery is already changing on the ground. It was in this context that ACA chose to act proactively, helping members explore how they might adapt and remain viable under these emerging conditions, rather than waiting for change to be formally declared. The question is not if change will come, but how prepared we are to adapt to it.

For our members, particularly those focused on rest home level care, the combination of declining referrals, higher acuity on admission, and the assumptions reflected in external modelling creates very real risks. Even without an official policy shift, the effect is the same: smaller, regional, and rural providers are finding it increasingly difficult to maintain viability, with flow-on consequences for local communities who depend on them for accessible and sustainable care.

This project was designed to help providers think ahead and prepare. Through case modelling we explored how facilities might transition into areas of high future demand, what changes in service mix, staffing, and facilities would be required, and where system-level support would be essential.

At the same time, ACA continues to press for a funding model that reflects the true costs of care and ensures equitable access, rather than relying on overly optimistic assumptions about substitution into home care or expecting providers to absorb ongoing losses.

This report reflects our proactive commitment to supporting providers to plan for the future while advocating for a sustainable, evidence-based funding model that keeps aged residential care strong, adaptive, and able to serve older New Zealanders in every community.



Hon. Tracey Martin
CHIEF EXECUTIVE
AGED CARE ASSOCIATION NEW ZEALAND

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Executive summary

This report outlines the findings of research undertaken to develop a sustainable transition framework for small, rest-home-only aged residential care (ARC) facilities in Aotearoa New Zealand. ARC is a significant component of the nation's healthcare system, providing essential clinical and daily care to approximately 36,000 residents. Rest-home-only facilities, particularly those in rural and remote areas, are critical health infrastructure for their communities and must be preserved.

The ARC sector, particularly rest-home level care, is struggling due to decades of systemic underfunding combined with a growing and aging population.

» **Financial pressures:** Funding has failed to keep pace with rising demand and operating costs. Most rest homes require 90–95 percent occupancy to break even, a target increasingly difficult to meet.

» **Acuity creep:** The government's 'ageing-in-place' strategy has led to a reduction in traditional admissions, meaning residents entering ARC now present with higher levels of frailty and acuity. This increases the need for clinical care, staff resources, and essential supplies (like incontinence products), costs which are often unfunded by the current daily rate.

» **Workforce:** The inadequacy of ARC sector funding means it cannot match public hospital pay rates, causing a constant migration of healthcare workers to better-funded sectors. Staff shortages are exacerbated in rural areas due to isolation and lack of housing.

» **Systemic barriers:** Providers face administrative complexity due to non-standardised contracts across regions. Needs Assessment Service Coordination (NASC) assessments are not nationally consistent and often prioritise clinical needs over critical factors like social isolation, mental health, and carer exhaustion.

The research found that diversified business models enhance financial viability, helping facilities remain sustainable.

» **Diversified care levels:** Offering higher levels of care (hospital and dementia) provides a more reliable revenue stream.

» **Dual-use beds (Flexi Beds):** Facilities operating with dual-use beds (rest home or hospital level) demonstrate significantly greater resilience by adapting to demand fluctuations and resident acuity shifts.

» **Integrated models:** Fully integrated health facilities combine ARC with services like GP/NP care, post-op/recovery care, respite, and primary care. By utilising infrastructure and staff for multiple services, they create cross-subsidisation, mitigating single service losses and proving sustainable, especially in rural regions.

SUMMARY OF RECOMMENDATIONS

The report provides both operational strategies for providers and policy reforms for government to strengthen the ARC sector.

EXPLORE FLEXIBLE CONTRACTS



Facilities should explore flexible HNZ contracts that allow beds to be used for multiple services (eg rest home, dementia, or a combination of two services) to increase occupancy and staffing flexibility.

CREATE FACILITY CLUSTERS



Small and medium facilities should collaborate to form clusters to negotiate bulk pricing deals for consumables and shared contracts. This collaboration could also extend to developing a shared staffing pool or jointly contracting specialist services like GPs/NPs.

PARTNER WITH EDUCATION PROVIDERS



Forge partnerships with universities and training institutes to gain access to cost-effective or pro-bono specialised services delivered by supervised students fulfilling clinical placement requirements.

PROVIDE PRIVATE CARE SERVICES



ARC facilities can diversify revenue by offering private home and community support services directly to the community, leveraging their existing clinical expertise.

STANDARDISE SYSTEMS AND CONTRACTS



Introduce a single contract for all services that can be offered in ARC (including end-of-life, respite, bariatric, and rehabilitation services) to standardise terminology, funding, and reporting, thereby reducing administrative burdens.

STANDARDISE NASC ASSESSMENTS



Transition assessments from snapshot evaluations to continuous monitoring of all dimensions of wellbeing (physical, mental, social, cultural, environmental). Funding decisions must not override holistic safety determinations, and deterioration in any dimension should qualify individuals for appropriate support.

ADDRESS WORKFORCE GAPS



Systematically embed nurse practitioners (NPs) specialising in aged care within ARC facilities to provide comprehensive clinical oversight, manage chronic conditions, and reduce reliance on stretched GP services and avoidable hospital transfers.

ENCOURAGE INTEGRATED MODELS IN RURAL AREAS



Provide the necessary contract and funding support for rural ARC facilities to transition into integrated health hubs, delivering primary care, recovery care, respite, allied and home support to the whole community.

Introduction

Aged residential care (ARC) is a significant component of Aotearoa New Zealand's healthcare system; part of the Ageing Well stream of the government's life course continuum of care strategy. Frail, elderly New Zealanders receive dedicated clinical and daily care in built for purpose facilities that its residents call home.

Aotearoa New Zealand has over 670 aged residential care facilities, more than 40,000 beds and around 36,000 residents. ARC providers are responsible for a variety of services, including rest-home, hospital, dementia, psychogeriatric, respite, and palliative care, and care for around 800 younger people with disabilities.

Sixty six percent of beds are run by religious institutions, charitable trusts, family-owned, not-for-profits, and privately owned facilities.

Aged residential care providers are contracted by Te Whatu Ora | Health NZ (HNZ) to provide care services at a rate that is set annually.

The underfunding of ARC over decades combined with a growing population of older adults, both in number and proportion, has resulted in a sector experiencing challenges that are not easily overcome.

Worst affected are ARC facilities that only offer rest-home level care. A policy-driven push for support for elders being delivered in the community, residents entering ARC with high levels of frailty and acuity, and no capital return to invest in higher levels of care, mean that these facilities are at high risk of failing.

Rest-home level facilities, particularly those based in rural and remote areas, are critical health infrastructure for the communities they serve. It is vital they are preserved. Their loss would be sorely felt in an economy where the cost of building new beds is significant.

Acknowledging these challenges, the Association undertook research to explore what diversified business models might work to assist rest-home-only facilities become sustainable businesses.

This report is the outcome of that research. It captures the challenges faced by three case study rest-home-only facilities, and the experiences of six other facilities, which have been looked at as learning models. The authors also spoke to key stakeholders, including two Needs Assessment Service Coordination (NASC) assessors and a senior HNZ official to understand the government agency's perspective on the challenges facing ARC.



The aged residential care system in Aotearoa New Zealand

Aged care in Aotearoa New Zealand is provided as part of a continuum of care to those with ageing-related health concerns, primarily for those over 65. This continuum of care includes home and community support services (HCSS), primary health care, hospitals, allied care and ARC. Apart from public hospitals, all other types of care are delivered through a public-private partnership model, with individuals contributing to the cost of their care and the government subsidising the rest.

Aged residential care in Aotearoa New Zealand is made up of privately operated facilities that provide accommodation, daily living and health care services to older people whose needs can no longer be met in their own homes. Facilities generally offer four levels of care: rest home care for people who need some personal care and assistance but remain mostly mobile; hospital-level care for those with significant medical needs requiring 24-hour nursing support; secure dementia care for residents with moderate to severe cognitive impairment; and psychogeriatric care for people with severe dementia or complex psychiatric conditions who need specialised support. There are also some other care contracts which are contracted separately, including respite, palliative, primary, and day support.

Facilities are owned and run by private providers, including corporate groups, charitable organisations, and independent operators. All services must be certified under the Health and Disability Services (Safety) Act 2001 and meet the Ngā Paerewa Health and Disability Services Standard. Registered nurses provide clinical leadership and are supported by care and support workers and allied health professionals.

Entry into aged residential care is determined by a NASC assessment of a person's health and care needs. The results of the assessment determine which of the four levels of care the person receives.

The ARC sector plays a key role in providing healthcare to the elderly which otherwise would need to be provided by the public hospital system. Around 36,000 residents live in aged residential care homes across the country. With a significantly smaller capacity of 10,748 public hospital beds, Te Whatu Ora | Health NZ relies on the ARC sector to control the demand for public hospital beds. Moreover, the cost of hospital-level care in ARC facilities is less than a quarter of bed-day cost in a public hospital medical ward bed (New Zealand Aged Care Association, 2023).

The long-term viability of the sector depends on government funding keeping pace with rising operating costs, workforce challenges, and the growing complexity of residents' health needs.

FUNDING AND THE COST OF CARE

Age residential care is partially funded by HNZ; funding for younger people with disabilities by Disability Support Services (DSS); and funding for people requiring residential care after an accident or injury by the Accident Compensation Corporation (ACC). Funding is paid as a daily rate for each eligible resident, with rates varying according to the level of care being provided.

Funding for aged residential care is a combination of capped, means-tested resident contributions, and government subsidies.

To determine the subsidy, the Ministry of Social Development (MSD) undertakes a Residential Care Subsidy asset and income means test. People whose income and assets are above the threshold set by MSD pay for the cost of their care, up to a maximum contribution set by the Director General of Health. People whose assets and income fall below the threshold contribute a portion of their income (often New Zealand superannuation) decided by MSD. The government, via HNZ, pays the cost of care above the maximum rate, and subsidises most of the cost of care for those whose assets fall below the threshold.

Providers of aged residential care may also charge for non-essential services, premium rooms and items that are not covered in the ARRC agreement.

Although most residents receive subsidised care, a considerable number pay privately.

CHALLENGES TO THE PROVISION OF AGED RESIDENTIAL CARE

The ageing population

In New Zealand in 2023 around 875,000 people (17 percent of the population) were over 65 years. That number is expected to grow over 50 percent over the next decade (Stats NZ, 2023). Significantly for the ARC sector, the number of people over 75 years will increase by 75 percent; from 384,000 in 2023 to 675,000 in 2038. According to Stats NZ (2023) projections, there are over 100,000 people aged 85 and older as of 2025, and this number is expected to double to around 200,000 by 2040.

By 2050, the incidence of dementia will more than double to 167,500 people; over 10 percent of the population aged over 65 years. Longer life expectancies mean older adults increasingly live with functional limitations with about 1 in 4 people experiencing multiple physical/mental conditions, driving hospitalisations for diabetes, hypertension, falls, and dementia (Sarfati, 2023).

This demographic transition presents both opportunities and challenges for policymakers, aged care providers, and the broader health system – with a smaller tax base supporting an increasing number of elders.

New Zealand's aged care facilities, particularly those providing only rest-home level care, are caught between intensifying demographic pressures and systemic underfunding. As the population rapidly ages, demand for aged residential care escalates. Yet facilities providing rest home care confront a paradox: the government's ageing-in-place strategy has reduced traditional admissions, while those entering now present with 'acuity creep' including incontinence, cognitive decline, and mobility issues. Further pressures are becoming evident, with smaller families and geographic dispersion eroding informal care networks, transferring a greater burden to under-resourced facilities.

The need for a fit-for-purpose funding model

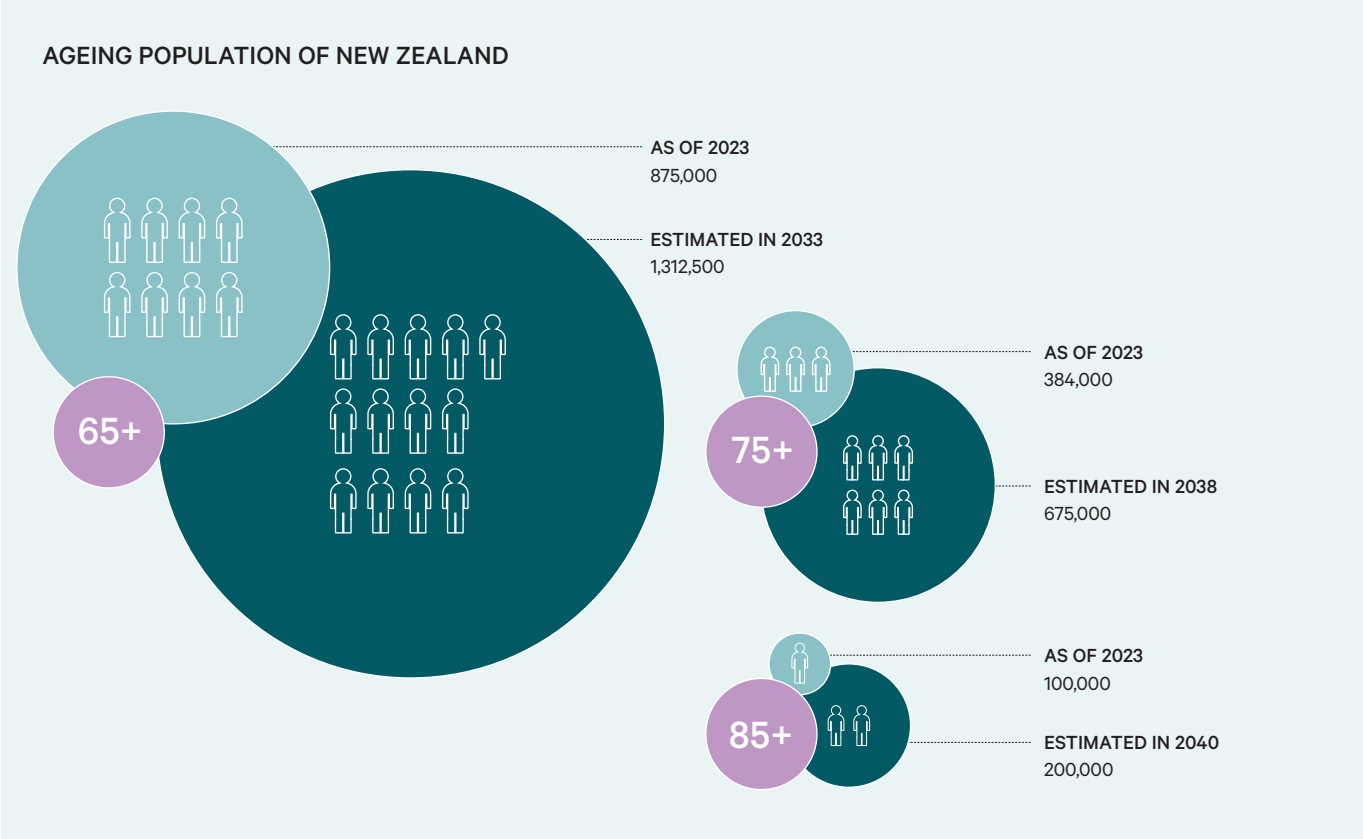
The share of health services used by people over 65 years has increased from 42 percent in 2015-16 to 50 percent in 2025-26 (HNZ, 2024). Funding has failed to keep pace with increasing demand. Rest home daily rates, unchanged in real terms for years, do not cover the costs of complex care, specialised staff, or essential supplies.

Most rest homes require 90–95 percent occupancy to break even, a target that is becoming increasingly unattainable due to both funding and policy settings. Rural facilities face compounded disadvantages, including severe General Practitioner (GP) shortages and isolation-driven costs.

Despite over 40 percent of ARC residents receiving rest home level care, it is this part of the ARC system that is most affected by the challenges facing the sector. The number of dedicated rest home beds has fallen from 9,300 in March of 2020 to 7,500 in March 2025, but the number of older adults assessed for rest home level care has increased in the same period[1]. This disparity may explain increased hospital admissions and longer discharge waiting periods.

Without a deliberate and sustainable funding strategy, aged care services, particularly rest home level, may not be able to meet growing demand or maintain quality. A long-term plan is essential to strengthen the ARC sector's financial sustainability, support workforce development, and enable flexible, responsive care models. Addressing these challenges requires a comprehensive review of how aged care is valued, prioritised, and sustainably funded, with a focus on practical, long-term solutions.

[1] Analysis by ACA Data Insights and Specialist based on source data from HNZ ARC Quarterly Reporting Survey



It is also important to recognise that the ageing population is not homogenous. This cohort ranges from relatively independent seniors requiring minor support to age in place, to those requiring 24/7 assisted living support but with low clinical needs, to those needing intensive 24/7 nursing and dementia care. The aged care system must support all these people so that other parts of the health system are not overwhelmed. That will require funding that covers the cost of providing all four levels of care, and an increase in ARC beds to provide respite and step down/recovery care.

The funding model also needs to address chronic workforce shortages. The inadequacy of ARC sector funding means it is unable to match public hospital pay rates, resulting in a constant migration of healthcare workers from ARC to other parts of the health system. The projected surge in demand for aged care will exacerbate these shortages.

In addition, recruiting and retaining sufficient nurses, caregivers, and allied health professionals presents a critical operational challenge, particularly in rural and regional facilities. The burden of this is often felt the most by rest home level only facilities, which are under-resourced to retain or access well-trained staff.

Redesigning policy to deliver on government health targets and stabilise the ARC sector as a secondary health support system

Current government policies emphasise 'ageing in place', with programmes aimed at enhancing home-based care and community support services. However, to effectively meet health targets and stabilise the aged residential care sector as a vital secondary health support system, policy redesign is needed. This includes scaling up and better integrating home-based care with ARC services to ensure continuity and quality of care. Achieving this will require significant investment in expanding capacity, including new infrastructure and upgrades to existing home support networks and ARC facilities, to address current fragmentation and meet growing demand.



Scope of the research

This study aims to develop a sustainable transition framework for small, rest-home-only ARC facilities in New Zealand. It targets facilities grappling with declining occupancy, workforce shortages, funding inadequacies, and the shift to ageing-in-place policies. This transition is essential, not only to keep rest-home-only facilities viable, but to support broader health system goals such as enabling seven-day hospital discharge targets and reducing the 200,000 annual hospital bed nights occupied by patients awaiting ARC placement.

By shifting towards models of care that include the provision in ARC of greater recovery and return-home services, as well as respite care to support family and whānau carers, these facilities can help people remain at home for longer while maintaining timely access to care when it is needed. While most older people prefer to remain in their own homes, ageing in place should not be used as a policy justification to limit or reduce access to appropriate aged care services in all communities. A balanced approach is needed to ensure that care options remain available, affordable, and responsive to the diverse needs of older New Zealanders.

The scope of this research encompasses service model innovation, rural and equity considerations, considerations for workforce optimisation, and policy and funding reform pathways.

LIMITATIONS

1. Data accessibility and standardisation: Financial and occupancy data from our case studies are self-reported and lack of standardised cost reporting, which limits comparative analysis.
2. Case study generalisability: Some of the challenges facing rest-home-only facilities and some of the successes of diversified facilities are unique. While we have tried to contextualise findings for the broader sector, some of the learnings may not be transferable, and may require further contextualisation to be effective.
3. Policy volatility: Contract flexibilities vary across regions and are often dependent on the discretion of the HNZ Ageing Well regional manager, making them subject to inconsistent and unpredictable funding approvals.
4. Stakeholder representation bias: Insights for this project rely heavily on provider perspective, though we have included NASC and HNZ regional manager insights.
5. Rural-specific barriers: Solutions for GP and ambulance access, and infrastructure may not be feasible for rural facilities without systemic intervention.

METHODOLOGY

The authors of this report interviewed a mix of rest-home-only facilities, small to medium sized providers offering multiple levels of care, government authorities and key stakeholders in the aged care system.

Three rest-home-only facilities from different regions were selected to be case studies. Six small to medium sized providers were interviewed to capture learnings that may be applicable for rest-home-only facilities, and three government officials were interviewed – one from HNZ and two NASC managers.

PROFILE OF THE PARTICIPATING ARC PROVIDERS

1. CASE STUDY ONE

29
REST HOME BED

MAJOR URBAN AREA
GEOGRAPHICAL LOCATION

CONTRACTS HELD
YOUNGER PERSONS WITH DISABILITY (YPD), LONG-TERM SUPPORTS – CHRONIC HEALTH CONDITION (LTS-CHC), RESPITE.

100%
OCCUPANCY RATE

FACILITY
HOUSED IN A RENTED HERITAGE BUILDING, WHICH RESTRICTS RENOVATION OR BUILDING UPGRADE.

Nil
PER DAY PREMIUM CHARGES
LOW INCOME POPULATION MAKING PREMIUM CHARGES UNVIABLE.

2. CASE STUDY TWO

27
REST HOME BED

PROVINCIAL URBAN AREA
GEOGRAPHICAL LOCATION

CONTRACTS HELD
RESPITE, DAY PROGRAMME, YPD.

88%
OCCUPANCY RATE

FACILITY
THE ROOMS IN THE FACILITY ARE SMALL. CAPITAL INVESTMENT WOULD BE NEEDED FOR REFURBISHMENTS.

$15
PER DAY PREMIUM CHARGES
IN FIVE ROOMS.

3. CASE STUDY THREE

34
REST HOME BED

RURAL AREA
GEOGRAPHICAL LOCATION

CONTRACTS HELD
RESPITE, YPD.

85%
OCCUPANCY RATE

FACILITY
HAS CAPACITY FOR DUAL BEDS, BUT NO CONTRACT.

$5-25
PER DAY PREMIUM CHARGES
IN THE THREE ROOMS WITH ENSUITES, HOWEVER CHARGES ARE OFTEN NOT APPLIED DUE TO RESIDENTS' INABILITY TO PAY.

1. LEARNING MODEL ONE

33
REST HOME BED
INCLUDING 10 DUAL-USE

25
HOSPITAL LEVEL BED
INCLUDING 1x COUPLE ROOM

24
DEMENTIA BED

MEDIUM URBAN AREA
GEOGRAPHICAL LOCATION

CONTRACTS HELD
RESPITE, DAY PROGRAMME (VIA CARER SUPPORT FUNDING).

100%
OCCUPANCY RATE

FACILITY
RETIREMENT VILLAGE WITH 266 DWELLINGS AND 330 RESIDENTS. ACCESS TO ARC IS PRIORITISED FOR VILLAGE RESIDENTS. FIFTY PERCENT OF RESIDENTS ENTERED THE ARC FACILITY FROM THE VILLAGE.

66.7%
PROFIT DECLINE
FINANCIAL PERFORMANCE
2019–2024

$18-35
PER DAY PREMIUM CHARGES

2. LEARNING MODEL TWO

33
REST HOME BED
INCLUDING 10 DUAL-USE

31
HOSPITAL LEVEL BED
INCLUDING 1x COUPLE ROOM

17
DEMENTIA BED

27
PSYCHOGERIATRIC BED

MAJOR URBAN AREA
GEOGRAPHICAL LOCATION

CONTRACTS HELD
DAY PROGRAMME, RESPITE.

76%
OCCUPANCY RATE
REST HOME BEDS
100% FOR ALL OTHER LEVELS

FACILITY
REST HOME CURRENTLY OPERATES IN AN OLD BUILDING. THERE ARE PLANS DRAWN UP FOR RENOVATIONS BUT NO INTENTION TO INVEST DUE TO INADEQUATE FUNDING.

$15-30
PER DAY CHARGES
NO PREMIUM ROOMS AT REST-HOME LEVEL.

3. LEARNING MODEL THREE

21
DUAL BEDS
OF WHICH 5 ARE REST-HOME

31
HOSPITAL LEVEL BED

MAJOR URBAN AREA
GEOGRAPHICAL LOCATION

CONTRACTS HELD
RESPITE, YPD, DAY PROGRAMME.

96-98%
OCCUPANCY RATE

FACILITY
LOCATED QUITE CENTRALLY IN A MAJOR CITY.

$20-40
PER DAY PREMIUM CHARGES

4. LEARNING MODEL FOUR

20
REST HOME BED

MEDIUM URBAN AREA
GEOGRAPHICAL LOCATION

CONTRACTS HELD
RESPITE, DAY PROGRAMME, END OF LIFE CARE.

95-100%
OCCUPANCY RATE

FACILITY
OWING TO FINANCIAL CHALLENGES, AND DESPITE HIGH OCCUPANCY RATES, THE FACILITY WAS **RECENTLY SOLD.**

Nil
PREMIUM CHARGES

5. LEARNING MODEL FIVE

8
REST HOME BED
UNDER A FLEXIBLE CONTRACT

RURAL AREA
GEOGRAPHICAL LOCATION

CONTRACTS HELD
RESPITE, PALLIATIVE.

98%
OCCUPANCY RATE

FACILITY
AN INTEGRATED HEALTH FACILITY, THAT OFFERS ARC, GP SERVICES, 'FLEXI-BED' FOR RESPITE, PALLIATIVE, POST-OP, AND ACUTE CARE.

Nil
PREMIUM CHARGES

6. LEARNING MODEL SIX

5
REST HOME BED

20
HOSPITAL LEVEL BED

SMALL URBAN AREA
GEOGRAPHICAL LOCATION

CONTRACTS HELD
RESPITE, PALLIATIVE, END OF LIFE.

91%
OCCUPANCY RATE

FACILITY
A PRIVATE CHARITABLE TRUST HOSPITAL WITH HNZ CONTRACTS FOR MATERNITY, PRIMARY CARE, ARC, TRANSITIONAL, PALLIATIVE AND END OF LIFE, RESPITE AND CARER SUPPORT.

Nil
PREMIUM CHARGES



Challenges faced by rest-home-only facilities

WORRY ABOUT THE FUTURE OF REST-HOME LEVEL CARE

All the three case study facilities shared concerns about the future of rest home care. It was the belief of all three owners that the government's ageing in place policy would result in people entering ARC only when they required hospital level care.

Case study two shared that admissions at rest-home level care had noticeably dropped in their facility after December 2023. The facility had an empty bed for nearly seven months. Case study one shared that they had noticed a decline in older persons entering rest home level care, and that their length of stay was shorter before they needed to be transferred to higher levels of care.

An HNZ senior manager acknowledged that in the last 10 years the number of people entering ARC at rest home level has reduced. But she added that she expects admissions to plateau and does not believe that rest home level care will become redundant because home and community support is not able to provide 24/7 care.

FINANCIAL INSTABILITY

All the providers we spoke to, including the learning model facilities, attested that rest home funding was inadequate, even more so than funding for other levels of care. On average, facilities require between 90-95 percent occupancy to avoid operating at a loss, yet rural providers such as case study three operate well below this threshold at 83 percent occupancy.

All three of the case study facilities expressed an interest in providing hospital level care but were unable to make the changes required to due inadequate funding. Case study two, for instance, operates in an older building where the rooms are too small to cater to hospital level care without significant refurbishment work. Inadequate funding not only restricts their ability to carry out these upgrades but also undermines their capacity to borrow, as lenders view the sector's financial position as too high-risk.

Case study three also noted that construction costs have increased significantly post-COVID. The owner-operators noted that their initial plan was to expand to 50 beds and have a secure dementia wing, for which the quoted budget was approximately $1.4million. Post-COVID, the proposed budget increased to $2.4 million. They were subsequently declined a bank loan, and the owner-operators believed that the facility's tight operating margins and the sector's overall financial pressures made it difficult to demonstrate the ability to meet repayment obligations. Without access to capital for improvements, the project was abandoned.

The learning model facilities also attested that funding for rest home level care is insufficient to sustain operations without additional revenue sources. Learning model one identified that rest home level is the hardest level of care to make money from. Learning model two, which has an independent rest home only facility, noted that they have been unable to invest in improving their rest home infrastructure because of funding levels. The rest home facility was also making a loss, with occupancy of only 76 percent. Learning model three shared that having dual beds worked best for them.

Learning model three, which had one of the highest occupancy rates among the respondent facilities, noted that even a 100 percent occupancy rate did not return sufficient funding for essential maintenance and upgrading outdated equipment. The same applied to learning model one which with similar average occupancy rates, multiple levels of care and a retirement village, their profit had fallen by over 66 percent between 2019 and 2024.

RISING RESIDENT ACUITY AND RELATED COSTS

Almost all facilities noted an increase in the acuity of residents assessed at rest home level. Case study one shared that they have been seeing an increase in rest home residents with hospital level care needs including incontinence and aggression, necessitating more clinical care and more staff on shifts.

All facilities found that their cost of buying incontinence products had gone up substantially in the last few years, as more residents were presenting with incontinence issues. The cost of incontinence products is one of major expenses head for most facilities. Learning model two shared that they were spending nearly $80,000 a year on incontinence products.

Facilities also shared that ambulance transfers, admission and discharge coordination, and audit compliance fees had increased over the last couple of years, without a proportionate increase in the daily rate to account for it.

WORKFORCE CRISIS

Although rest home level care does not require a registered nurse to be on duty 24/7, there must always be caregivers on shift. Recruitment can be difficult as funding does not allow ARC facilities to match better funded and better paid sectors, including government funded public hospitals.

The NASC team in Dunedin identified significant skill gaps in rural areas.

Most facilities also shared that wage costs, their largest operational expense, had increased significantly in recent years. Learning model three shared that wage costs account for nearly 80 percent of their total expenses. Learning model one shared that they paid penal rates to attract skilled workers and provide pay parity with public hospital-employed workers.

Learning model five shared that they had ARC nurses who were handling multiple roles, including after-hours emergency care in the community, as recruitment is hampered by rural isolation, lack of housing and low pay compared to urban areas. They also noted that within the region there was a shortage of mental health assessors, which meant that older persons' health assessments for dementia and other mental health issues were taking months to be completed.

RURAL CHALLENGES

Rural facilities shared challenges that were unique to their location. Case study three shared that they have been struggling with reliable access to GPs as coverage has been poor in the region. Technological advancements like telehealth services have also been slow to penetrate in rural areas, where it's needed the most, due to poor internet bandwidth and services.

Rural facilities often pay more for specialised care for their residents, as specialists charge more to travel to their facilities. They also noted higher wait times, compared to their urban counterparts. Even ambulance transfers cost more in rural areas, as the nearest hospital is often several towns away.

Learning model five, a rural facility, and learning model six, a facility in a small urban area, acknowledged similar challenges and shared the benefits of having an integrated model of care, for maintaining an adequate economy of scope.

Facilities that provide an integrated model of care are known as community health hubs, or integrated health hubs.

"Theres's no ability to pick up the phone and say, send us someone...

There's just no one."

Learning model five

REGULATORY AND POLICY PRESSURES

NASC assessments

Several facilities shared issues with NASC assessments.

Inconsistencies between regions

Dunedin-based case study one had a resident, who had moved from a rest-home level facility in Auckland to case study one's facility to be closer to family. However, NASC assessors for the Dunedin region rejected her application for rest home level care. The facility had to get involved and after multiple back and forth, the NASC team agreed that the resident qualified for rest home level care. The NASC assessors that the authors spoke to admitted that such inconsistencies between regions, while few, were not unheard of.

NASC criteria prioritising clinical needs over social isolation/mental health

Case study one and case study three both shared instances where respite resident's mental health benefitted greatly during a short stay in ARC. Their families, recognising the improvement, requested a NASC assessment but both residents were denied rest home admission. The NASC assessors that the authors spoke to noted that the assessment was largely clinical. One of the assessors commented:

"Sometimes the person requests to stay at home even though the assessor might have assessed them as needing ARC support. However, on the contrary if a person requests to go into ARC but they do not have any clinical need for it, they are required to stay at home."

Time to complete assessments

In Canterbury, there have been reports of long wait times for dementia assessments, that stalls admissions and revenue for the facility.

Misalignment between assessment criteria and the level of care required

Facilities shared that NASC assessment criteria did not adequately consider the needs of the resident beyond their clinical conditions, resulting in an assessment for an inaccurate level of care. Learning model three shared that several of their rest home residents had advanced dementia or behavioural issues, requiring hospital level resources. However, because they were physically mobile, they were assessed at rest home level. One resident, for instance, was prone to wandering and would walk around the facility every 15 minutes, requiring constant monitoring and redirection to maintain safety. The facility believed that, despite the considerable staff time and resources needed to manage his care, NASC was unlikely to approve a reassessment because he remained mobile.

One of the NASC assessors the authors spoke to shared that most people who came for assessment are at the cusp between rest home and hospital level care. In assessing such individuals, she noted that the assessors often relied on their own judgement and opted for the "least restrictive option".

'Ageing in place' strategy

The providers in this study and the authors believe that the 'ageing in place' strategy is driven by the government's desire to save money and does not centre the needs of the person or population.

While the government has stated its intention to expand the provision of 'recover and return home' and respite care to support older New Zealanders to stay in their homes, there are challenges to overcome before the model works as intended.

Some of the facilities that we spoke to shared that people who were receiving home and community support at the time of being admitted into ARC showed signs of neglect. Learning model two shared their experience with an individual who had been attending their day programmes while receiving support at home. After she had missed two of the day programmes, the facility sent staff to check in on her and found that Meals on Wheels had left two meal boxes at her doorstep. Neither her home and community support carer nor Meals on Wheels had raised an alarm about this. The staff found her very ill. Case study three shared that people entering aged residential care from home appeared dishevelled, with signs of poor personal hygiene and inadequate nutrition.

While home and community support allows many people to age safely at home, there is evidence that some are being made to stay at home even when they need clinical care and support beyond what home and community support services can provide.

As people are staying at home longer, there is an increase in acuity of residents entering aged care that is not reflected in funding levels. The NASC assessors that the authors spoke to also noted that the average age of those being assessed is 84 years. They agreed that the acuity levels of people being assessed have increased.

While the government intends to expand the provision of respite care in ARC, facilities shared that respite would have to be funded at a higher rate to ensure that the strategy works. Given the high costs of admission, a short stay such as respite, would mean more financial pressure for ARC. NASC assessors commented that there should be base funding for facilities to hold beds for respite care, to ensure availability.

Contract limitations

Small and medium-sized providers face systemic exclusion from home and community support contracts because bulk-funding models prioritise larger home and community support providers.

A senior official in the HNZ Ageing Well Commissioning team stated that only "three to five providers across the South Island" will secure contracts, despite the fact that smaller providers, especially those in rural communities, have established community relationships and can quickly mitigate workforce gaps. This barrier disproportionately impacts and neglects a critical opportunity for established providers who are uniquely positioned to address the home and community support sector's workforce crisis (HCHA BIM Report, 2023). This approach contrasts sharply with the Australian model, where providers are certified, individuals are assessed and assigned a care package, and the person chooses their preferred provider. The health service then pays the provider's invoice for the agreed services, ensuring funding follows the client rather than being locked into bulk contracts.

Gaps exist in provider knowledge of specialised and flexible contracts including respite, Long-Term Support Chronic Health Conditions (LTSCHC), palliative and flexi-bed agreements that limits revenue diversification. Owner/operators of small facilities, especially those who are taking on multiple roles within their facilities to lower day-to-day costs, lack centralised guidance on availability, eligibility or application processes to secure contracts.

Operational challenges such as protracted contract approval timelines and variable communication channels can delay service delivery and expansion. Case study two's experience in seeking rehabilitation contracts illustrates how streamlined coordination could accelerate solutions, reducing pressure on hospitals and primary care sector, while meeting community needs.

Inconsistent terminology and non-standardised care contracts create confusion and administrative burdens; for example, palliative care contracts in Canterbury are labelled 'end-of-life' contracts in Otago, and 'respite' services have different compliance requirements regionally, fragmenting service delivery.





What the learning model facilities showed

1. Diversified care levels enhance financial viability

Where feasible, facilities could look into offering higher levels of care, including hospital and dementia. This requires investment in both infrastructure and workforce but generally provides a more reliable revenue stream. It also supports the government's ageing in place strategy by ensuring that residents entering aged residential care have access to the appropriate level of care and that facilities can provide step-down, respite, and recovery services to help people return home safely.

2. Dual-use beds or swing beds fare better

Facilities that operate using dual-use beds (rest home or hospital level) demonstrate significantly greater resilience by adapting to resident acuity shifts and demand fluctuations. Hospital level beds provide critical revenue stability, offsetting the challenge expressed by learning model one, that "rest home is the hardest level of care to make money from".

3. Integrated models of care can offer better business model in the long term

Community health hubs such as learning model five and learning model six's combination of GP services, provision of other levels of care, including flexi-beds for acute, palliative or recovery-and return-home prove sustainable. By utilising the infrastructure and human resources to provide as many services as possible, ensures multiple revenue streams with cross-subsidisation mitigating single service losses. For instance, learning model five noted that there are no profits in ARC and it is the GP services they provide which subsidise their ARC provision. GP services can be made more profitable by opening enrolment among the wider community.

4. Flexible contracting framework

Learning model five reported having a contract that allowed them to have 'flexi-beds' for respite, palliative, post-op, and acute care, depending on the demand. They noted that this contract has been highly beneficial for them, allowing them to operate as an integrated facility. This model was necessary after standalone GP and ARC services stopped after the Canterbury earthquake. Procuring a flexible contract, based on their unique needs, have helped the business report better financial outcomes and viability for long-term sustainability.

5. Ageing-in-place strategies

Strategies encouraging elders to stay at home longer are collapsing demand for rest home care. NASC assessors stated that older adults now, "skip rest home to go straight to hospital level". This aligns with the observations of rising acuity of both learning models one and two.

6. Local partnerships enable viability in rural regions

Learning model five opened in 2019 with strong community support after fundraising nearly $3 million for the integrated health facility. Due to the small population that it serves, the facility relies on community volunteers for fundraising and staffing levels, and council support to offset isolation penalties. While this is not a desired pathway to build Aotearoa's rural health provision on, the authors note the important role played by volunteers in helping sustain ARC, especially in smaller and rural communities.

Case studies

1. CASE STUDY ONE

29
REST HOME BED

Case study one operates a 29-bed urban rest-home-only facility serving a low-socioeconomic community.

At the time of interview, the facility was full. The facility holds contracts for Whaikaha (disability support), ARRC, LTSCHC, and respite care. To maintain viability, the business runs a privately operated day program, funded by carer support funding. They reported that they are able to break even at an occupancy rate of 92-95.

The facility operates with 11 personnel daily: morning shifts include 2 registered nurses, 1 diversional therapist, and 4 caregivers, while afternoon shifts deploy 3 caregivers with staggered hours and a single night shift caregiver who looks after all 29 residents. While a single night shift coordinator for such a large number is not desirable, it is the best that small facilities such as case study one have been able to provide under the current funding model.

CHALLENGES

Some of the challenges specific to this facility are:

- Due to the low socio-economic status of the community it serves, the facility does not have premium room charges so it can maintain accessibility and sustain occupancy. They noted that premium charges for rooms with ensuites might mean a longer wait time to fill a room, and that's a possibility that they can't afford.
- The facility operates out of a building which is rented and heritage listed. This prohibits structural renovations, including room upgrades or adaptations for higher-acuity care.
- Prior to winning a prestigious recognition last year, the facility was experiencing declining admissions for rest home level care. Their occupancy rates have since improved, although the length of stay has decreased as resident needs escalate, meaning they need higher levels of care.
- To sustain occupancy, the facility had to make several operational exceptions. This includes accepting admissions outside of regular hours, sometimes later than 6 pm, and accommodating higher-acuity residents such as those experiencing incontinence or exhibiting challenging behaviours. A few years ago, such residents would not have been accepted for a rest home level care due to their structural and staffing constraints. The shift in resident profile often dubbed 'acuity creep places increasing pressure on already stretched staff and leads to additional, unfunded costs, including the purchase of incontinence supplies, ambulance callouts, and additional staffing hours to safely meet resident needs.

Despite growing care demands and limitations of a lean cross-functional staffing model, the facility continues to prioritise keeping residents in their facility for as long as safely possible. The facility has routinely absorbed operational costs without transferring the financial burden to residents or their families.

RECOMMENDATIONS[2]

a. Exploring alternative rental premises to expand or diversify care services

Given the heritage listing of the current facility, structural upgrades are not possible, limiting the ability to support higher-acuity residents or adapt spaces for changing care needs. Seeking an alternative site, either as an additional or future base, could provide the flexibility to offer other types of care (eg hospital-level care, secure dementia care, or reablement services). This would also reduce long-term dependence on a building that restricts service growth and infrastructure improvements.

b. Strengthening and potentially expanding day support services

The existing day programme, supported by carer support funding, is a valuable community resource and a revenue stream that does not rely on permanent bed occupancy. Expanding this service, whether through extended hours, weekend availability, or targeted support for specific groups (eg people with dementia), could increase utilisation and help offset operational costs. The existence of the carer support funding also empowers individuals to choose such programmes. It also positions the facility as a proactive community care provider, not just a residential service. Other facilities have also mentioned that a notable share of day care programme attendees eventually end up choosing the facility when they need long-term care.

c. Introducing private home care services as an additional revenue stream

Offering private home care services to older adults in the surrounding community could diversify the facility's income and be aligned with government's objective to support residents to remain in their own homes longer. This could include personal care, medication support, or respite services. These services could be delivered by existing staff outside of rostered hours (where feasible), or through a dedicated small home care team. It would also enhance continuity of care for those who may later transition into residential care.

d. Provide primary care services by hiring or contracting a general practitioner or nurse practitioner (NP)

Recruiting a GP or NP to provide their services from the facility could mean better on-site services for residents. The contractual agreement between the facility and the GP/NP could also be made cheaper by enabling the GP/NP to enrol residents from the local community, reducing pressure on local health services and improving resident outcomes. In-house GP/NP care would support early intervention, reduce hospital transfers, and strengthen multidisciplinary care planning. By making the services available to members of the community, it could create an opportunity for income while meeting a local health need, especially in the low-socioeconomic area that case study one operates.

[2] Note: The recommendations under the case studies are based on the authors' understanding of the care facilities' challenges and the appetite to explore different opportunities, as reflected in the conversations with the facility. The recommendations have also been tested against the learnings from the learning facilities. However, it's important for the facility to consider a cost-benefit analysis and a market testing to contextualise the recommended solutions to meet their needs.

2. CASE STUDY TWO

27
REST HOME BED

Case study two is an owner operated, small town, 27 bed rest home facility, currently occupied by 24 residents. Apart from rest home contract under ARRC, they provide respite care, and care for four residents under an LTSCHC contract. Currently, they do not have anyone attending day programmes.

Case study two reports that it breaks even 74 percent occupancy, excluding owner's earnings and profit. This is substantially lower than the break even point for other facilities that the authors spoke to. The disparity is at least partially because the owners subsidise operations through unpaid labour and taking on multiple roles, including handyman jobs. Following a period of low occupancy where a bed remained empty for nearly seven months, they have recently seen a slight improvement, with three new residents admitted since July.

The facility maintains a roster of about 25 staff members. This includes four staff for 'tea shifts,' two cooks working seven hours a day, two part-time cleaners (five and a half hours/day), and a team of caregivers. An enrolled nurse contributes by covering half a shift as a caregiver, and there is one RN.

Case study two's primary costs include staff wages, interest on loans (from purchase), electricity, GP services, incontinence products, food, and maintenance. Wages alone have surged by $130,000 in the past couple of years, the owner noted. They also bear the full cost of incontinence products. The facility is currently absorbing penal rates, which were set at 72 cents by previous owners.

CHALLENGES

Some of the challenges specific to this facility are as follows:

- A critical concern is the sustainability of their business model, as staff costs are increasing at a rate that is not matched by funding increases, and standard operational costs are also rising disproportionately. Finding appropriately qualified and trained staff has also been a challenge.
- As an older facility, providing higher-acuity care would require physical refurbishments, which has been financially unviable for case study two. While they have considered offering hospital-level care, they foresee substantial added costs, estimating around an additional $250,000 would be necessary. They also expressed doubts about the sustainability of a 'half and half' model (combining rest home and hospital care). Their key concerns about shifting to a new model is the length of the transition period to fill beds, increased staffing costs, and the need for a higher staff-to-resident ratio. As a result, they are not exploring 'dual beds' as a solution for flexibility.
- Case study two operates in a community with several other aged care facilities, and only one of these does not offer hospital-level care. This may indicate a shift to higher acuity services. Many smaller facilities have closed in the last three years.

Case study two's owner is concerned, having noticed rest-home admissions declining over the last few years. He also mentioned his concerns about the sustainability of his rest-home only facility following recent statements by HNZ about people staying in their homes longer. However, he's also worried about the financial viability of expanding the service provisions offered by the facility.

RECOMMENDATIONS

a. Explore flexible contracting and agency partnerships to support higher-acuity or transitional care needs

To respond to the increasing complexity of resident needs without committing to a full hospital level model, case study two could consider entering into a flexible contract arrangement with HNZ, similar to learning model five, as noted in point 4 of the section 'What the learning model facilities showed'. This would give the facility the ability to care for residents who need more support, such as those requiring 24/7 RN cover, without the long-term staffing and financial obligations that come with a permanent change. Partnering with a nursing agency could help meet these care requirements on an as-needed basis.

At the same time, case study two could approach the local NASC team or the rehabilitation manager to discuss providing short-term rehabilitation care for people transitioning from hospital to home. These types of placements are often funded and time-limited, making them a practical option for expanding services within the current facility setup. Together, these approaches could help improve occupancy, diversify services, and strengthen links with the wider health system.

b. Convert a limited number of rooms to trial higher-acuity or dementia-level care

Case study two could explore converting a limited number of rooms to cater to residents with more complex needs. This could include either higher-acuity rest home level residents who require additional support, or individuals needing a secure environment due to cognitive impairment.

A small dementia care unit could be a practical and financially safer alternative to hospital level care, especially given the ongoing demand for dementia services across the sector. It would also allow case study two to build a niche offering in a market that is increasingly shifting toward higher care needs. For example, repurposing four to six rooms could allow the facility to pilot a specialised service without major structural renovations or immediate increases in staffing ratios across the board.

This kind of gradual diversification would give the facility time to test demand, train staff, and adjust operations before scaling up further. It may also open the door to new referral pathways and funding opportunities, particularly if case study two demonstrates success in managing more complex resident profiles within its current rest home framework.

3. CASE STUDY THREE



34
REST HOME BED

Case study three is a rural 34 bed rest home only facility, with an occupancy rate of 83 percent at the time of their interview. Apart from rest home level care, they also offer respite and YPD services. The facility has three premium rooms with ensuites and sea views, but sometimes residents are not charged the premium. It also has one double room, though there haven't been requests for a couple in the last several years.

The facility requires a minimum of 85 percent occupancy to break even and feels comfortable at 90 percent. Since October, their bed occupancy has been around 87 percent, but was lower for the month during which the interview took place.

Case study three has observed an increase in residents admitted with cognitive decline, though they are able to manage these residents well as they are not wanderers. The facility maintains a lean staffing model, including one care manager who handles all interRAI assessments and paperwork, two caregivers providing 24/7 coverage, one RN on the morning shift, one short-shift caregiver in morning and afternoon, two activity staff with overlapping shifts, two cleaners who also assist with breakfast in the morning, one full-time maintenance staff, and three cooks.

The main costs for case study three are staff wages, meals, and activities. Other significant expenses include audits (such as electrical tagging, staff training, menu, dietician services), property maintenance, laundry (they recently leased a dryer), and tax.

CHALLENGES

Case study three is acutely aware that the current business model is not sustainable. They previously faced significant financial difficulties, including a $200,000 GST debt after hiring an office manager and administrator. They eventually had to make staff redundant, and one of the owners now handles all the work. The IRD eventually wrote off the debt.

Pre-COVID, they had plans to expand to 50 beds and include a secure dementia wing, with an initial quote of $1.4 million. Post-COVID, this quote escalated to $2.4 million, leading to bank rejection and the scrapping of the expansion idea.

Being rural, they do not have good GP coverage for their residents.

Despite having the physical capacity for dual beds, they currently lack a contract for them. They have expressed to HNZ that they are keen to explore dual service contracts. Their application for a rehabilitation, pre/post-op contract was rejected.

Despite the financial challenges the facility has stayed afloat, mostly because the owners are doing more. One of the owners is working as the office manager and administrator. The other owner drives residents to appointments without payment.

RECOMMENDATIONS

a. Optimising occupancy and revenue stream

Implement a clear, consistent policy for charging premiums. Waiving premiums should be a rare exception based on genuine financial hardship, but not a standard practice. Have conversations with the HNZ regional manager, NASC team, GPs and Whaikaha | Ministry of Disabled People to try and increase referrals for these higher-funded services. Re-engage with HNZ regarding the rejected rehabilitation pre/post-op contracts, emphasising that the provision of this care within an ARC facility frees up beds in the public hospital system.

b. Enhancing clinical and operational efficiencies

Given that GP access has been an issue for this facility, they could explore the possibility of establishing an onsite GP/NP access by recruiting a GP/NP service to operate from the facility. While priority could be given to residents, a cheaper contractual agreement could be drawn by enabling the GP/NP service to enrol members of the local community as well. GP/NP costs could thus be partially supported by the capitation rates from residents and local community members. Facilities that are located in areas with good internet connectivity could also explore telehealth opportunities for additional resourcing support.

The facility could also optimise staffing by training cleaners to provide support during meal times. Variations of this are already happening in some facilities, particularly smaller ones where staffing flexibility is essential. It is important that clear boundaries are maintained so clinical care remains with trained staff.

The owners could also claim mileage or explore volunteer driver programmes.

Partnering with other facilities to create a regional buying group could also help case study three achieve enough scale for buying food and other supply provisions at discounted rates.

Recommendations

OPERATIONAL RECOMMENDATIONS

a. Explore flexible HNZ contracts

If facilities have business ideas for flexible contracts that may work for their situation, they could approach their HNZ regional manager with a proposal. A contract that allows flexi beds, (beds that can be used for rest home, dementia care, or a combination of any two services) could give facilities more flexibility with staffing and a better chance at increasing the occupancy, compared to moving to dedicated hospital or dementia beds.

Requirements:

- Access to additional staff, when needed, preferably through staffing agencies
- Rooms, beds and equipment that can accommodate hospital or dementia patients

b. Creating facility clusters for increased bargaining power

Small and medium facilities in the same community could collaborate to purchase commonly used provisions. By forming clusters, facilities could negotiate bulk pricing deals, for consumables such as incontinence products, toilet rolls, cleaning supplies, and food. This model could extend beyond consumables, to include collective shared contracts, such as negotiating a better rate for waste removal or laundry service or even develop a 'shared staffing pool' or 'reliever pool' among clustered facilities. This would eliminate agency fees and build a more stable regional workforce.

Crucially, clusters could also improve access to services. For example, a cluster could jointly contract GP/NP service for scheduled visits, share the cost of recruiting a physiotherapist, mental health professional or even a dentist. This collaborative approach would enhances efficiency, reduce individual financial burdens, and improves access to services and expertise.

c. Partnering with educational institutes for specialised services for residents

Aged care facilities can forge valuable partnerships with universities, polytechnics, and training institutes offering health professional programmes (eg dentistry, physiotherapy, occupational therapy, podiatry, nursing, social work). These partnerships could be mutually beneficial: facilities could gain access to cost-effective or pro-bono specialised services for their residents, delivered by supervised students fulfilling clinical placement requirements. This would remove the difficulty and expense many facilities face in sourcing allied and specialist health care. The benefit for the education provider would be access for clinical placements for their students, enhancing their practical skills and understanding of gerontology. Successful implementation would require clear agreements covering scope of practice, supervision, scheduling to minimise disruption, liability, and confidentiality. Facilities should proactively approach local educational providers to establish structured programmes, turning a service gap into an opportunity for enhanced resident care and student learning.

d. Providing private care services

Many ARC facilities provide services directly to the community using a private funding model. Day programmes are common, with most facilities reporting a positive response. Day programmes may not be a significant source of revenue, but they do allow people to experience the services the facilities provide. Many choose that facility when the time comes for them to move into aged residential care.

During the fact-finding process for this report some facilities such as case study one, shared the desire to offer home and community support services to elderly in the community. However, they were advised by their regional manager that this would not be possible due to the contracting model in place for home and community support. However, there is no reason why a facility cannot offer home and community support to a person who wishes to pay for it privately. Indeed, ARC facilities may also be better equipped to provide these services given their clinical expertise, and their ability to utilise their existing staff. Home and community support services offered by an ARC facility could also provide a continuum of care for a person who may wish to become a resident in future.

POLICY RECOMMENDATIONS

a. Standardising systems and contracts

While the ARRC agreement is for rest home, hospital, dementia, and psychogeriatric care, other contracts such as end-of-life care (also called palliative care in some regions), bariatric, rehabilitation and respite services are governed by regional frameworks. This variability creates administrative complexity and disadvantages smaller providers seeking to diversify their service provision.

NASC assessments are also not nationally consistent.

To ensure standard access to care across the country, we strongly recommend:

» **A single contract for all services that can be offered in ARC**
This should encompass all services that are deliverable within an ARC facility, including end-of-life, bariatric, rehabilitation/step-down, respite, and transition services. This framework must standardise terminology, eligibility criteria, funding models, and reporting requirements to reduce administrative burdens, creating a level playing field for providers of all sizes and enable seamless service provision and expansion.

» **Standardised and consistent NASC assessments**
Assessments should transition from snapshot evaluations to continuous monitoring of all dimensions of wellbeing. Assessments must explicitly weigh carer exhaustion, social isolation, untreated depression, and safety risks with equal rigor as clinical needs. While supporting ageing in place remains a priority, the 'least restrictive option' principle should be applied when all dimensions of wellbeing (physical, mental, social, cultural and environmental) are sustainably secured, not just when clinical metrics meet minimum thresholds. Assessments must identify masked vulnerabilities, particularly for those with cognitive decline whose coping mechanisms may falsely signal independence while concealing malnutrition, self-neglect or hazardous living conditions. Funding decisions must never override holistic safety determinations: deterioration in any wellbeing dimension must qualify individuals for appropriate support, including residential care when holistic safety cannot be maintained at home.

b. Workforce infrastructure gaps

Nurse practitioners specialising in aged care should be systematically embedded with ARC facilities, either as salaried employees or through contracted service models to provide accessible, holistic primary care. NPs would deliver comprehensive clinical oversight, manage chronic conditions, reduce reliance on stretched GP services, and minimise avoidable hospital transfers.

Aged care facilities are providers of end-of-life care, as hospices operate at capacity under capped funding. This means ARC providers must manage complex palliative needs without commensurate specialist support, clinical resources, or funded training. Frontline staff would greatly benefit from funded training in essential high-acuity skills like pain management, terminal symptom control, dementia-related behaviour de-escalation, and family communication protocols.

c. Encourage rural ARC facilities to build integrated models of care

ARC facilities that are rurally located can serve as a critical health infrastructure for the whole community. Learnings from Australia, and interviews with integrated models of care in New Zealand such as learning model five and learning model six show the potential for such integrated health hubs. With the right contract and funding support these hubs could deliver primary care, hospital level care, step-down/recovery care, respite, home and community support, mental health support, and other allied health and care services which are usually lacking and hard to fund separately in rural and remote regions. With the rising costs of building new hospital infrastructure, it is vital to look to ARC facilities to become integrated health hubs.

It is also important to consider how services such as telehealth may be given a further boost in these areas, to provide specialist services in a timely manner.

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Appendix 1: Glossary

ACC	Accident Compensation Corporation
ARC	aged residential care
ARC facilities	Aged residential care facilities
ARC sector	Aged residential care sector
CM	Care manager
CS	Case study (referred to as case study one, case study two, and case study three to refer to the three case study facilities)
DSS	Disability Support Services
DT	Diversional therapist
EN	Enrolled nurse
GP	General practitioner
GST	Goods and Services Tax
HCSS	Home and community support services
HNZ	Te Whatu Ora | Health NZ
IRD	Inland Revenue Department
LM	Learning model, referred to as learning model one, learning model two, learning model three, learning model four, learning model five, and learning model six to refer to the six learning model facilities
LTS-CHC	Long-term supports – chronic health condition
MSD	Ministry of Social Development
NASC	Needs Assessment and Service Coordination
NP	Nurse practitioner
RN:	Registered nurse
YPD	Younger person with disability

CONTACT ACA

P 04 473 3159
E office@nzaca.org.nz
W nzaca.org.nz

Level 13, 342 Lambton Quay, Wellington

@nzagedcareassociation
nzagedcareassociation
Aged Care Association NZ