New Zealand Government
Te Kāwanatanga o Aotearoa

The Ministerial Advisory Group Report on
Aged Care in New Zealand

A place to grow old

Securing the future of aged care

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EXECUTIVE SUMMARY

New Zealand's aged care system is at a turning point. Rapid population ageing, increasing care complexity, and long standing system fragmentation are placing growing pressure on services that were designed for a different era. While many older people are supported well, current settings will not be able to meet future demand safely, equitably, or sustainably without major deliberate system change.

This report sets out a vision and a plan for supporting older people to live and age well through a new and better system of integrated aged care in this country – one where people can receive the right care, in the right place, at the right time.

New Zealand's aged care system[1] is already under strain. We are seeing bed shortages, some services closing their doors, and some carers unable to cope with demand. The gaps are already starting to show, and we cannot afford to watch them widen before we take action. We know the system is underfunded and we know we need better, more integrated services.

For older people who need formal aged care, access to high-quality, timely care is critical. It is not good enough for that support to depend on where you live, what you can afford and whether you can advocate for yourself.

For someone turning 80 this year, an eventual solution to these challenges is not good enough. For someone turning 21 this year, they need to know that aged care will still be there for them when they turn 80 if they need it.

Right now, the system is too fragmented, hard to access, and inequitable for many older people and whānau. There can be delays accessing assessments and services, and not enough trained carers available in the right places. Funding has not kept pace with the real cost of providing services.

Supporting our older people to live and age well, with dignity and choice, is both a social responsibility and a critical challenge, as demand is expected to drive up the cost of aged care services by almost 90% over the next 20 years.

Simply spending more on the system without changing how it works won't fix the problems, and will only buy limited time, leaving every underlying problem exactly where it was, at a steadily rising cost.

This is a genuinely hard challenge, and we don't claim to have all the answers or all the numbers. But our work has convinced us there is no alternative to fundamental reform. Every other option we tested leads to the same problem of a system that costs more every year while delivering less of what people actually need. Reform will have substantial costs up front but will be better in the long run, both for people and the country's books.

This report sets out how to build a better system that follows an older person through a connected journey of aged care, not trying to navigate alone through a maze of separate services or assessments. It means more help to support older people to stay at home for longer, better support for the carers and whānau who hold families together, and a simpler way for people to find and access the right care when it's needed.

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[1] Aged care covers a wide range of services for older people, including in-home care, residential care (different from retirement villages), respite, and other health and social services. Note that in this report, 'in-home care' relates to Home and Community Support Services (HCSS), and 'residential care' relates to Aged Residential Care (ARC) (although in some cases HCSS and ARC may be used when discussing the current state).

It also means being honest about cost. There is no avoiding the inevitable fact that population growth and the costs of aged care are escalating so fast that, unless changes are made, it may not be affordable in future. Those who can contribute to the costs of their own care should do so, fairly and transparently, so the system is still there for our children and grandchildren when their time comes.

All New Zealanders, including younger Kiwis, need to have confidence that in the future our aged care system will be there and able to give them the right care, in the right place and at the right time. The only real question is whether we have the will to act on change now, while it's still a choice, or wait until the harder choice is made by crisis.

Doing nothing is itself a choice. It is not one we recommend.

Why change is needed

The truth is uncomfortable, but we need to face it. There are not enough beds in residential care for the number of older people who are going to need them, and not enough workforce to care for people. That is not only a projection for the future – it is already starting to happen. Already we are seeing workforces overstretched and some facilities closing as providers walk away from a model that no longer pays for itself.

The whole of New Zealand's aged care system is under real pressure today, and those pressures will only grow as the population ages. More people are living longer, and many are arriving at the system with more complex needs than it was originally designed to handle. This will place even more pressure on our hospitals, emergency departments, GPs and residential care.

The aged care system has not kept pace with growing demands — it remains fragmented, difficult to access, and inconsistent in the support it offers, particularly for Māori and Pacific peoples, people in rural communities, people with dementia, and those with limited financial means.

Underneath all of this sits a more basic problem: funding has not kept pace with the real cost of providing care, leaving providers under strain and limiting their ability to invest in new capacity, capability, innovation and improvement. More residential care beds will soon be needed urgently. Meanwhile, current in-home care services are not consistently designed or funded to manage people with today's higher level of needs.

Most of the future cost demand is driven by the sheer volume of people that will need aged care. There is no way around this – most of these people are already over 60 years old – we either need to put the right system in place, or more and more older people will need to be cared for long-term in hospitals. We've seen this play out overseas.

To understand what reform across the aged care sector could achieve, we tested three possible paths. All three build on a baseline projection of demand and costs for aged care services, which assumes that costs grow slightly faster than the general rate of inflation.

In the first scenario ('Scenario A'), the number of available residential care beds fails to keep up with rising demand, as prices are too low to give incentives to providers to invest in new supply. This creates a growing waitlist of people who must either spend long periods waiting in hospital or waiting at home, where they will need more government-funded in-home care, more informal family and community care, and more frequent trips to hospital, translating to more human misery.

Besides the severe negative impacts on the health and wellbeing of older people, their families and carers, this situation also sees direct costs to the government and the health system balloon by about $59,000 per older person per year, as well as wider economic costs. By 2037/38, a shortage of more than 9,000 residential care beds would cost the government nearly $600 million more each year than our baseline projection, and the cost to the government would reach $4.4 billion (in 2025/26 dollars).

In the second scenario ('Scenario B'), the government pumps more funding into the existing aged care system to induce the necessary growth in supply of residential and in-home care services, without changing how the system itself works. By 2037/38, the cost to the government would grow by 80%, or around $2 billion, to reach $4.6 billion (in 2025/26 dollars).

The third scenario ('Scenario C') involves a full structural reform programme and redesigns the system itself. It focuses on creating a more integrated and responsive aged care system, while also reducing costs over time as it takes form. While more work needs to be done on the modelling, our initial work shows we can expect there to be substantial reduced costs over time compared to the 'business as usual' through reforming the system.

Substantial changes – including better targeting residential care funding, a new approach to how people contribute toward their care costs, and better care to help people live at home for longer – could reduce growth in costs to government by just over **$830 million per year** by 2037/38 (in 2025/26 dollars) compared to Scenario B.

Modelling these paths showed that if we do nothing there will be a mountain of unmet need, alongside a much higher demand for hospital beds. Spending more money within the current system provides short-term relief but does not resolve the underlying problems, and the costs grow substantially over time. Structural reform requires some upfront investment, but saves much more than the alternatives. At the same time, the analysis shows it produces a more resilient system: one capable of adapting to rising demand and acute needs while remaining more affordable for the country in the long run.

There are no easy solutions here, only increasingly difficult trade-offs. Reform will mean increased investment in the short term, with people having to pay more for the services they receive. However, we are confident that this will mean people receive better services, and that there will be both fiscal sustainability benefits and benefits across the health system over the long term.

With only six months to look at the issues, and with limited industry data available, our Advisory Group has only begun the task of laying the groundwork for change, and much further work needs to continue. But urgent change is needed now. It is vital that we have a more resilient system that can adapt to rising demand and acuity while remaining affordable for New Zealand.

This dilemma has been studied before, with more than a dozen reports to government outlining the challenges to aged care in this country. Our mandate was not to provide further diagnosis of well-known system shortcomings, but to propose practical and meaningful solutions – and we acknowledge the people and organisations who contributed to the problem-solving process through their submissions to our review. We know that without reform, the situation is going to get worse. Delaying action will simply see costs mount further with more complex and expensive reform needed later. Governments must act now to put in place foundations for a better future.

What does a better future look like?

To support our elders at home for longer, we need a better, more integrated aged care system built for the future as well as better services.

As well as a new funding model that sees new standard residential care beds become investable, our proposed reforms make use of some major levers to reduce avoidable future costs, such as an advanced in-home care model where people can receive better care at home until other care is most appropriate.

An advanced in-home care model would build on restorative care by adding a wider range of clinical, nursing, support worker, coordination, technology and data capabilities around the person in their own home. This would create a more clinically capable, integrated and responsive community-based service for people with higher and more complex needs who could otherwise present to emergency departments, be admitted to hospital, require repeated primary care, or enter residential care earlier than necessary.

Of course, this model should be complementary to District Nursing, primary care, hospital services and residential care. We also recognise there are a range of other factors that impact how people access care and age well at home, like transport, housing, and social support. This model targets improving care for a group of people with high needs who can be safely and effectively supported at home when the right clinical oversight, workforce capability and care coordination are in place.

An integrated system

For many older people, the experience of accessing care today is one of moving between disconnected services, each with its own rules, eligibility criteria and points of entry. Currently, in-home care and residential care operate largely in isolation from one another and from the wider health system, creating silos that don't reflect how people's needs evolve over time. This fragmentation is felt most acutely in rural and low-density communities, where smaller providers struggle to sustain siloed service models designed with urban areas in mind.

We recommend moving away from this patchwork to a single, integrated and culturally appropriate system, in which in-home care and residential care and wider health and social services work together. Central to making this work is a national casemix framework for aged care services: a common way of understanding and funding the need for care across the whole system, so that the level of support someone receives reflects their actual circumstances rather than which services they happen to have accessed first.

For an older person and their families and whānau, the practical effect of this change would be a system that feels like a single journey rather than a series of separate negotiations. Instead of having to re-explain their situation and reapply for support every time their needs shift, people would move through a connected pathway, with information, assessments and care plans following them rather than starting over at each new service door.

New Zealand can't afford to keep patching the current model. We need a better, more integrated system built for the future, and this work needs to start now.

Better services to support ageing well in place

For people to genuinely age well at home, the services available to support them must match how their needs change over time. That starts with better support to access the system, and a more flexible and culturally appropriate assessment model that reduces wait times and ensures getting help doesn't depend on navigating a slow or rigid process at the point of crisis.

It also means strengthening in-home care and the workforce that provides this care so it can handle higher levels of need and significantly more people, as well as making short-term care and respite options consistently available – not as an occasional extra, but as a core part of how the system supports people to recover and remain at home. Culturally grounded service models must also be embedded as core components of the aged care continuum to help reduce unmet demand among marginalised communities.

Carers and whānau play an enormous, often invisible role in keeping people safely at home, and this report recognises that the system currently does not support them adequately. Inadequate access to planned and emergency respite places real strain on informal carers, and that strain is itself a major driver of crisis-driven admissions into hospital or residential care that could otherwise have been avoided. Better support for carers, together with clearer ways for people to navigate the system and find the help available to them, addresses this directly.

There is also an important role for technology and new service models. A fully integrated aged care system cannot be achieved without leadership and investment in technology. We recommend health agencies review digital tools like monitoring and alarms, accelerate work on digital integration and information sharing, and establish a new telehealth service for aged care providers for when a person's usual primary care provider is unavailable. Together, these changes are intended to catch problems earlier and at lower intensity, before they escalate into the kind of crisis that forces an unwanted move into higher-cost care.

Strengthening in-home care will also better support people with dementia living at home, and their carers. We endorse the Dementia Mate Wareware Action Plan, which recommends a range of supports for people with dementia in the community. We urge the government to carefully consider the Action Plan.

Contracting and regulatory settings and workforce

Some of the rules currently governing aged care add cost and complexity without making care meaningfully safer. This report recommends rebalancing some settings while maintaining and strengthening care quality and safety. These include extending certification periods for aged care providers while keeping surveillance audits in place, regulating in-home care providers in line with residential care providers, regulating support workers and healthcare assistants, and taking a risk-based rather than a rules-based approach to some settings that do not contribute to care safety.

These changes are framed around a central balancing act: access, safety, flexibility and sustainability - all need to be weighed together, rather than safety being treated as something that can be protected only through more rules and red tape. The aim is to free providers to deliver care more efficiently and flexibly, without compromising the standards that genuinely protect people.

Of course, none of this is achievable without a sustainable capable workforce to deliver it. An effective aged care system depends on a stable, well-trained workforce able to work across home and residential settings. We recommend that the government work with unions, aged care providers, and consumer and community groups to develop a cross-sector workforce strategy for aged care that sets out what is needed for a well-trained, certified, and sustainable workforce.

We note that key workforce issues (including terms and conditions) were outside the scope of this report. We have taken an outcomes-based approach to considering workforce, recognising that workforce is central to delivering aged care services.

Changing the funding model

Aged care is expensive to deliver, and the costs are rising. In 2024/25, government spending on in-home and residential aged care totalled about $2.5 billion, with New Zealanders receiving residential care contributing roughly $1.26 billion themselves (not including additional premium charges in residential care). Despite this substantial combined spend, the system remains underfunded. Funding has not kept pace with the real cost of delivering care, and the consequences are already visible in residential care being at capacity and providers unable to scale up the services people need.

This report concludes that simply adding more money to the current funding model without systemic reform is not a viable solution. Doing so might help to meet demand, but at an unsustainable cost. What is needed instead is a redesigned funding model that limits cost increases while also tackling some of the underlying issues driving pressure on the system.

The funding model needs to reflect what care costs to deliver. An immediate funding uplift is needed to sustain services now, and to make sure no more capacity is lost.

Under a redesigned model, residential care costs should be unbundled into three categories of care, daily living, and accommodation, and pricing should be linked to these costs, so that funding matches costs over time. Accommodation funding should take a new 'differentiated' approach that creates clear incentives to build more residential care rooms, and providers should increase the number of rooms they provide without premium charges by at least one for every two new rooms they build in order to receive higher funding rates (with an appropriate transition path in place).

Alongside this, commissioning approaches for in-home care should evolve to support a diverse range of providers and increased competition, and travel costs must be made more efficient.

Funding needs to be reviewed regularly so it keeps pace over time, and directs investment to where it's genuinely needed, rather than spreading it thinly across an inefficient structure.

The proposed Aged Care Pricing Authority sits at the centre of this new approach, intended to keep pricing efficient and competitive rather than letting it drift out of step with real costs. The Authority would collect and analyse financial and other data and transparently advise government on pricing to ensure the aged care sector funding is sustainable and cost-effective. For providers, this should mean a more investable, sustainable basis for planning and growing services. For the people relying on those services, it should mean more standard residential care beds, greater capacity, and more transparency in the system. These are practical changes that are critical to making the aged care system investable and sustainable over time.

Contributing towards the cost

Clearly more government investment in the system is needed, but the sheer scale of increasing demand for aged care services means it will not be sustainable for the government to pick up all the additional costs. Those who receive and benefit from aged care services will also need to contribute more towards the cost of care, where they can afford to do so. Many people already contribute towards the cost of their aged care, whether through residential care fees or by privately funding services that help them remain at home.

Healthcare in New Zealand should remain primarily publicly funded and accessible to everyone, regardless of their ability to pay – that principle isn't up for negotiation here. We argue that the government should fund a portion of people's healthcare costs to reflect and maintain that principle. But accommodation and daily living costs are the responsibility of those who have the means to pay, and only part of the total cost of care relates to clinical services. People who can contribute to these costs must do so.

We recommend a new approach to contributions for in-home and residential care, where contributions toward costs would be based on both care needs and ability to pay, determined through income testing (for in-home care) and asset and income testing (for residential care), with a more graduated approach than currently exists. We recognise that means testing is never popular, but it is necessary, and we have sought to land on a fair approach here.

We also recommend specific protections for situations where charging wouldn't be appropriate, including no contributions required for short-term care up to a set limit, or for people entering residential settings specifically for end-of-life care, alongside a lifetime cap on care-related contributions to residential care, so people who need care for longer than most aren't unfairly penalised.

This report also recommends that the government explore a save-as-you-go social insurance scheme, as a way of spreading the cost of future care across a person's working life rather than concentrating the burden at the point they need support. This will not address pressures coming in the system over the next 10 – 15 years, but our research suggests that this may be the missing piece of the jigsaw. This would ensure that aged care is available in the future when the mismatch between the number of older New Zealanders and younger workers to support them is at its greatest.

Asking people to contribute more now will protect the system's ability to look after everyone, including those with the least, over time.

Implementation and delivery of reform

The case for major reform is clear; what happens next depends on how well it can be delivered. This cannot happen in a piecemeal way but requires an integrated and staged programme of reform. Actions should begin immediately, anchored around a clearly defined critical path that establishes the legislative, funding and system foundations needed before wider changes can follow.

We recommend that a dedicated sector steering group support this transition alongside sector working groups, operating through a time-bound programme rather than an open-ended process. This reflects a clear concern that there is more work to be done, and that transition risk has to be actively managed, with proper accountability arrangements in place, so that the shift to a new system doesn't come at the cost of continuity of care for the people relying on it right now.

The urgency here is partly about cost but largely about people. The longer implementation is delayed, the more difficult and expensive it becomes to fix the underlying pressures, and the longer that older New Zealanders currently navigating a strained system will have to wait for something better. Getting the sequencing right, starting now, is just as important as getting the policy design right.

Achieving successful reform will take sustained commitment and difficult decisions, including being upfront about contributions to rising costs. But continuing to defer decisions will leave both today's older people and tomorrow's taxpayers worse off.

Major systemic reform must start now.

Full list of recommendations

An integrated system

1. Reform the aged care system to be:
   a) a single, integrated system, encompassing in-home care, residential care, end-of-life care, and wider health and social services
   b) more responsive to the needs of New Zealanders, providing flexible, culturally appropriate, consistent and connected aged-care pathways and supports
   c) underpinned by a new single shared national casemix framework for identifying and responding to need across all care settings, including dementia needs.
2. To support this, Health New Zealand should adopt an approach to aged care commissioning which:
   a) establishes a nationally consistent contracting framework, integrated across in-home care, residential care and aligned services, with modular service specifications and schedules for different types of care
   b) allows aged care providers to deliver services across different settings, including in-home care, residential care, alongside and incorporating primary care and other health and social services
   c) expands the range of services delivered by and alongside aged care providers in the community, including Early Supported Discharge services, District Nursing and a range of allied health services.
3. The government should review agency responsibilities and funding rules across aged care services, ACC, and Disability Support Services, to better align the support that different groups receive and ensure that nobody is unfairly disadvantaged.

Better services to support ageing well in place

4. Streamline assessment in the aged care system by:
   a) enabling aged care providers to undertake most assessments for in-home care and residential care, including reassessments
   b) redefining the role of Needs Assessment and Service Co-ordination (NASC) agencies within the system, to focus responsibilities and resources on:
      i. undertaking high acuity assessments in a timely way – such as entry into secure care
      ii. operating as an independent oversight function to provide monitoring and assurance for provider assessments
   c) increasing the use of lower intensity screening tools including self-assessments
   d) supporting assessments with transparent national standards and regular reporting about the timeliness
   e) establishing a national interRAI governance group to provide ongoing oversight and ensure the assessment framework remains fit for purpose.
5. Modify current assessment tools, or develop and implement new accompanying tools, to:
   a) identify and take account of the holistic wellbeing and cultural needs of those being assessed
   b) identify and take account of non-clinical social factors that can increase the cost to provide effective services to the person and their whānau
   c) improve the identification and assessment of dementia needs.

6. Invest in training and resources to increase the capability of providers to undertake assessments, and to ensure that all assessors can undertake culturally appropriate assessments.
7. Support people to age well in place by strengthening in-home care, including:
    a) allowing providers to take on additional functions and deliver higher intensity care with a restorative focus in the home, where it is clinically safe and economically feasible to do so
    b) strengthening collaboration with primary care and ensuring sufficient primary care capacity to support older people with increasingly complex needs in the community
    c) strengthening and scaling up short-term residential and in-home care options for rehabilitation and recovery, including providers delivering Early Supported Discharge services
    d) reviewing the way that the government currently funds medical alarms, and other monitoring technologies and digital support, to determine whether there are better ways to fund and commission these services and maximise their value to support people to remain at home
    e) ensuring that services are culturally appropriate, and support language, identity, culture, spirituality and wairua, and community participation, including innovative culturally based delivery models where appropriate.
8. Make support for carers accessible and consistently available by:
    a) standardising restorative respite across the system
    b) developing a package of support for carers, including options for contracted residential respite, in-home respite and day programmes, based on carers' needs identified through assessments and the casemix framework
    c) refocusing the Carer Support Subsidy as a flexible fund for equipment and items that carers need for respite, including paying for informal respite
    d) more government investment in training and education for informal carers so that they can support their family members more effectively.
9. Support people to better understand and navigate the system by:
    a) investing in navigator roles who can work with people and communities facing barriers to accessing information, and navigating the system
    b) ensuring navigation and care pathways are easier to travel, and are whānau centred and culturally responsive
    c) developing a national aged care pathway map, clear public information, and shared tools such as websites, decision aids, and decision-support technologies that can be used consistently across providers and settings.
10. Health New Zealand should prioritise developing fully interoperable digital architecture built on strong foundations for how information is managed, including consistent data standards (including metadata), cybersecurity, and privacy protections, and including a national database to record admissions, casemix level, NHI, and provider, linked to other critical databases including interRAI assessments and medication management systems.
11. Health New Zealand should establish a subsidised urgent telehealth medical service for in-home and residential care providers, enabling health professionals or designated staff members to obtain timely clinical advice when a client's usual GP or nurse is unavailable.

Contracting and regulatory settings

12. Extend and standardise certification periods for aged care providers, while retaining surveillance and issues-based audit processes to ensure that care standards are maintained, so that:
    a) all aged care providers can be certified for a maximum of five years, rather than the current four years for residential care
    b) high-performing residential care providers who open new facilities have certification timeframes aligned to those for their other facilities where appropriate.
13. Regulate all in-home care providers (including those publicly and privately funded) against the Ngā Paerewa Health and disability services standard, under the Health and Disability Services (Safety) Act 2001, in line with requirements on residential care providers, to improve safety and quality and confidence in the system.
14. Remove fixed dementia unit size restrictions from residential care agreements and replace with flexible requirements based on staffing, environments, and clinical oversight, alongside capability and quality of care.
15. Move routine medical reviews (by a GP or Nurse Practitioner) and medication reviews for residents in aged care facilities from fixed minimum frequencies to clinician-determined, needs-based intervals, to target more frequent reviews to those with higher and more complex needs. This should be supported by increased use of telehealth.
16. Allow aged care providers to access Health New Zealand's procurement catalogue to purchase items and equipment at a reduced rate and drive cost efficiency in the system.
17. Reconsider consenting processes to better enable residential care providers to build new capacity by reducing consenting burden, including by considering reclassifying residential care facilities as a permitted land activity under national environmental standards, and ensuring land is zoned appropriately to meet current and future need.
18. The government should work with unions, aged care providers, and consumer and community groups to develop a cross-sector workforce strategy for aged care, which seeks to:
    a) ensure that the aged care workforce has the right capacity and capability for the future
    b) reduce staff churn through fair remuneration and standardised employment conditions, leading to greater job satisfaction, and sustainable career pathways
    c) extend protections under Part 6A of the Employment Relations Act to support workers to ensure employment continuity
    d) review training requirements, including standardising training requirements across aged care settings and ensuring training supports the workforce to care for people with dementia
    e) better utilise the workforce by expanding support workers and healthcare assistants' scopes of practice, supported by greater delegation with clear clinical governance
    f) explore regulation of support workers and healthcare assistants through options such as a regulator, certification or qualification requirements, and a workforce register, so that there are stronger safeguards and increased trust and confidence in the system
    g) promote aged care as a career to attract people to the workforce and expand the pipeline, such as through workforce development pathways that support Māori and Pacific workers and examining immigration policy settings.

Changing the funding model

19. The government should commit to significant price uplifts within two years to ensure that the sector can deliver the quality and quantity of aged care services New Zealand needs to meet rapidly growing demand:
    a) For in-home care:
        i. In 2027/28, a 6% increase above adjustments for inflation, wage growth and demand growth, to address rising service costs and funding shortfalls that constrain providers' capacity to deliver sustainable quality services.
        ii. A further investment in 2028/29 that will grow the capability of the sector to deliver care to people with more complex needs, and which includes funding for a sector-wide technology platform, increased wages for more and higher-skilled workers, enhanced carer support systems, and other measures to underpin the capability lift required for higher acuity clients.
    b) For residential care:
        i. In 2027/28, an uplift in the prices paid per bed day (through government subsidies and resident contributions) which our modelling estimates should average 7.1% above inflation, to stabilise current provision and address current funding shortfalls. This should be differentiated by care level and region and provide larger percentage uplifts for rest home and dementia-level beds, and facilities in areas with higher land costs, where our analysis indicates that current funding shortfalls are greatest.
        ii. In 2028/29, implement differentiated funding rates based on the age and characteristics of rooms in each facility, which our modelling estimates should be:
            1) for new-built rooms, a price uplift of 13.8% above inflation, to ensure the construction of new residential care capacity at scale is commercially investable
            2) for existing modern rooms, a price uplift of 3.8% above inflation to more accurately reflect the relative capital value of older legacy and more modern stock
            3) for older and smaller 'legacy' rooms, a price uplift matching inflation to achieve the targeted level of price differentiation.
20. Explore targeted capital support for residential care providers on a case-by-case basis where there is clear evidence of an investment barrier (for example, for smaller rural or remote providers or culturally specific providers with otherwise viable business cases):
    a) Possible capital support could include loans, underwrites, or equity injections
    b) Any capital support should be offset against price uplifts to avoid duplication of public funding.
21. Fundamentally restructure the funding model for aged care services by:
    a) unbundling residential care funding into three cost categories: care costs (which include both clinical and personal care), daily living costs, and accommodation costs, while retaining an integrated funding approach for in-home care
    b) linking pricing and funding directly to costs for each of these categories with:
        i. pricing for all levels of care directly linked to costs set through a single casemix framework
        ii. pricing for daily living costs set at a standardised national price
        iii. pricing for accommodation based on a differentiated approach.
22. A common casemix model should provide a framework for identifying need across all aged care settings, where:
    a) costs are determined for each level of the framework based on case weights

b) non-clinical social factors are recognised where these increase the cost of delivering effective services to some people, such as economic deprivation, lack of access to services, level of carer support, and housing.

23. Develop a differentiated approach to accommodation funding in residential care, using objective measures of accommodation quality and capital investment to better reflect underlying accommodation costs, which could include:
    a) funding older and smaller rooms at lower 'legacy' rates
    b) funding rooms that meet a defined threshold at a new 'modern room' rate
    c) funding new rooms that are added to the system at the highest 'new room' rate.
24. Support the improved supply of affordable residential care options by requiring providers to increase the number of rooms they provide with no premium charges by at least 50% of the number of new-built rooms to receive the highest 'new room' rate.
25. Introduce a new admission and discharge payment to meet the additional costs of admission and discharge for people entering residential care for short-term care and respite care.
26. Modernise In-Between Travel (IBT) so that it is fit-for-purpose and cost effective, taking a phased approach that involves:
    a) fixing the biggest inefficiencies quickly through the introduction of clear rules, thresholds, and definitions
    b) shifting incentives through the incorporation of IBT into bulk funding and a workforce model redesign
    c) locking in the new system through legislative change
    d) ensuring that efficiency gains from IBT reform contribute to sustainable workforce conditions, provider viability, and investment in workforce capability and service delivery.
27. As a principle, public funding should prioritise essential needs-based care, and individuals should be expected to contribute towards the additional costs associated with personal preferences that increase the cost of providing care, such as:
    a) allowing travel costs to be funded within a defined limit where a person has chosen their carer (including Paid Family Carers), with travel costs for personal preferences beyond this limit to be self-funded
    b) capping public funding where the cost of supporting a person at home exceeds the cost of clinically appropriate residential care, with any additional costs met by the individual if they choose to remain at home.
28. Redesign the current discretionary rural loading framework used by Health New Zealand for residential care providers into a rules-based model aligned to key cost drivers.
29. Health New Zealand should investigate transitioning in-home care, in all regions, to a more dynamic version of the restorative bulk-funded approach being progressed to support opportunities for local service provision and competition, and provision of rural, remote, or culturally specific services through targeted arrangements. The following should be investigated and completed in consultation with the proposed Aged Care Pricing Authority once it is established, and be dependent on sustainability for the sector:
    a) Reducing the size of the geographic areas or cohorts used for restorative bulk funding.
    b) Updating populations within each cohort with increasing frequency so that funding dynamically adjusts to population movement.
    c) Adopting commissioning cycles of 3 – 5 years.
    d) Allowing residential care providers to deliver in-home care where this aligns with consumer preferences or supports integrated service delivery.

e) Allowing for locally and culturally specific models of service provision.

f) Grandparenting existing contracts through the transition.

30. Develop a clear, evidence-based approach to improving transparency, consistency and trust in pricing decisions by establishing an Aged Care Pricing Authority that provides confidence to consumers, providers and government that funding levels and consumer contributions are based on objective evidence of costs, and that:

    a) is independent of aged care funders and providers, and can therefore be trusted by both

    b) has authority to collect and analyse data from aged care providers on their costs, and has powers to make recommendations to government on appropriate pricing for aged care services to inform its funding decisions (but not to mandate prices for aged care services)

    c) develops a methodology to update prices over time, and a long-term pricing framework that considers rural loading for both in-home and residential care provision based on evidence on differences in the cost of delivering services in rural areas

    d) learns from the Australian model and is adapted to the New Zealand context, rather than being a direct transposition.

31. Alternative options to the Aged Care Pricing Authority could include:

    a) an independent body within the Ministry of Health (similar to Medsafe)

    b) a confidential and trusted mechanism managed by an outsourced information provider

    c) reviewing the current contracts for aged care providers to ensure there is an annual process for setting pricing that is based on clear and independent evidence of actual costs.

Contributing towards the cost

32. The government should take the following approach to balancing contributions to care:

    a) What individuals pay towards the cost of their care should be based on their casemix level with contributions increasing when care needs increase to reflect the higher costs of providing and funding care. This should be aligned across care settings.

    b) A portion of the care that every person receives through aged care should be funded by the government, recognising that clinical care needs should be primarily funded by the government.

    c) Those who have the means should contribute towards other care costs (personal care), as well as daily living costs and accommodation costs, while the government should support those who cannot afford to pay to ensure they receive the same level of care.

33. The government should institute arrangements that support fairness in the system by:

    For in-home care:

    a) continuing to provide fully-funded in-home care to people with incomes below the Community Services Card (CSC) threshold

    b) requiring people receiving in-home care who have incomes above the CSC threshold to contribute to the cost of their care – with those on income between the CSC threshold and twice the CSC threshold required to pay a low set amount based on their casemix level (up to 25% of care costs), and those with incomes more than twice the CSC threshold required to contribute up to 50% of care costs).

    For residential care:

    c) lowering the threshold at which people with assets need to contribute more towards the cost of their care to $100,000

d) introducing a new stepped approach based on asset bands above that level to determine the contribution people need to make, up to a maximum of $350,000 of assets above which people are required to make a maximum contribution (excluding a notional amount paid by government to recognise clinical care costs)

e) where people elect to exclude the family home from asset testing, limiting this exemption to exclude the value of the family home only up to a maximum level, the value above which would be included in the asset test

f) reviewing and tightening current rules and exemptions within asset and income testing settings to close any loopholes and make the system fairer.

34. People should not be required to contribute to the cost of short-term care up to a set time limit, or where they have entered residential care specifically to receive end-of-life care (where they are expected to pass away relatively quickly).
35. Introduce a lifetime cap set at the equivalent of five years of contributions to the care component for residential care, so that people needing care for longer than the norm are not unfairly disadvantaged.

Looking to the future

36. Explore a save-as-you-go social insurance scheme, with a recommended common pool, to provide a guarantee of access to aged care for future generations by forward funding the costs of aged care.

Implementation and delivery of reform

37. Reform should begin immediately, and implementation should prioritise the critical path: the legislative, funding and system changes required to reset the foundations of the aged care system. Sustained commitment and investment in these reforms is essential to deliver the structural and system change needed for long-term sustainability.
38. Establish a steering group and set of sector working groups to support implementation of reform:
    a) The steering group should oversee implementation of the recommendations in this report, and could include some members of the Ministerial Advisory Group.
    b) The working groups should provide cross-sector coordination, delivery expertise and stakeholder engagement on specific areas of work, and could include representatives from consumer groups, unions, clinicians, providers, and iwi and Māori.
39. Implement reform through a structured, time-bound transition programme that balances urgency with continuity of care. Delivery should occur across three horizons:
    a) Horizon 1 - legislative settings and system foundations (2026-28)
    b) Horizon 2 – structural reform (2028-2032)
    c) Horizon 3 – system change (2032 and beyond)
40. Establish clear transition management that provides certainty for providers, the workforce, and consumers, while maintaining strong accountability for delivery, performance and outcomes, and actively managing transition risks and system dependencies.

PART ONE:
Ageing well in place

Chapter 1 - Introduction

Every New Zealander deserves to grow old with dignity – receiving the right care, in the right place, at the right time.

For most older people that simply means continuing to live their lives at home: still independent, connected to family and community, contributing as leaders, mentors, parents and grandparents, employers and employees, volunteers and carers themselves.

But a significant number of older people will, at some point, need more help. For them, getting the right care quickly, safely and without having to battle through the system for it, can mean the difference between recovering well after an illness or incident, never quite getting back on their feet, or even having to go to hospital when that experience could have been avoided.

As life expectancy rises and our population ages, supporting older people to live and age well, with dignity and choice, is both a social responsibility and a critical challenge for the future of the health system.

While the current system works well for many people, it is clearly under strain, with only more pressure expected. Multiple reviews over recent years have highlighted persistent and pressing challenges in aged care, and we know these challenges will only increase with an ageing population with more complex needs.

Urgent action is needed now to fix the system for the future, so that successive generations can continue to receive the care they need to age well. We cannot let this report be just another lament about the problems – as a country we must now be willing to not only have this difficult conversation but to muster the will to act on it.

In October 2025, Cabinet agreed to progress a work programme on aged care, built around the goals that:

- Older people are supported to live well at home and in their communities.
- Older people receive care that is timely, integrated and meets their health needs.
- The aged care system is sustainable and responsive and meets demand.

The Aged Care Ministerial Advisory Group (the Advisory Group) was established as part of this work programme to provide independent advice on the changes needed to ensure New Zealand's aged care system is sustainable and effective into the future. This report sets out our recommendations for improving the system. It does not hold all the answers to this very complex problem, but it offers a possible pathway forward, with much more work still to be done.

The role and approach of the Advisory Group

The Advisory Group was established by Hon Casey Costello and Hon Simeon Brown in December 2025. Their direction was for the Advisory Group to provide independent, practical recommendations that would support any future government's policy and funding decisions to develop sustainable and quality aged care in New Zealand.

A glossary of key terms used in this report is provided at **Appendix 1**.

The issues facing aged care are complex, significant and long-term, and require sensitive political decisions. To support independent findings built on a shared commitment to change, Ministers took a deliberately bipartisan approach to establishing the Advisory Group. This included seeking input from across the political parties on the Terms of Reference (see more details in **Appendix 2**) and on the membership for the Group (see **Appendix 3**).

Our members have deep expertise and experience across the aged care system. They were appointed as knowledge holders and experts, rather than as representatives of specific organisations or sectors, to ensure the Group's advice focused on the overall performance of the system and the interests of older people.

We were asked to deliver our advice within a tightly constrained timeframe, with only six months to develop our recommendations for the system. To deliver a meaningful, well-informed and actionable report, we focused our efforts on developing possible solutions on the most critical system-level issues affecting aged care in this country.

The challenges facing the system are well-known and documented. Multiple reviews, inquiries, and stakeholder engagements have identified persistent problems relating to funding adequacy, service sustainability, system fragmentation and inequitable access. Rather than revisiting this ground, we drew on the existing body of work to focus on defining a future direction and practical, achievable solutions for the system.

We took a programmatic and structured, solutions-focused approach, starting by developing shared objectives and mapping issues that reflected the Terms of Reference, and the challenges consistently identified across previous reviews of the aged care system. This evidence-based and logically structured approach supported the Group to make all its decisions by consensus – no votes were needed and this report has the support of all members of the Group. More detail on our approach can be seen in **Appendix 3**.

The Group benefited from an able and dedicated Secretariat including key policy experts, modellers and managers from the Ministry of Health – Manatū Hauora (the Ministry of Health), working closely together with expertise from the private sector to support economic modelling, project management, communications and report writing. The Ministry of Health and Health New Zealand – Te Whatu Ora (Health New Zealand) provided data and analysis to support our deliberations, including updated population and demand projections and cost modelling.

The Group also sought detailed information and advice from a range of sector experts, industry representative bodies, and representatives of patients, providers and workforce.

We are grateful to everyone who gave us their time and valuable expertise. **Appendix 4** provides a list of our sources and an overview of the groups we met with and received input from.

Our Terms of Reference

Our Terms of Reference (**Appendix 2**) emphasise the need for changes to build a sustainable and effective aged care system that is easy for people to access and navigate, delivering the right care in the right place at the right time.

Within that, the Terms of Reference requested the Advisory Group provide independent advice on three specific areas, including:

- **funding model components and mechanisms** needed to support sustainable aged care services, particularly a sustainable supply of standard residential beds
- **how the costs of providing aged care could be reasonably shared** between individuals receiving care and the government, to support sustainability while ensuring timely access to aged care services for all who need them, including questions of means testing and asset thresholds
- **changes needed to contracting arrangements and regulatory settings** for aged care services, to remove red tape, support cost-effective and innovative service delivery, and increase cohesion and integration between aged care services, wider health services, and Disability Support Services.

Several significant and related questions were out of scope of our consideration, including giving direct Budget advice, and advice on workforce requirements, training and accreditation. This is not because they don't matter, but because they require separate processes of their own. However, we inevitably had to consider some limited aspects, since aged care clearly cannot be delivered without a sustainable and well supported workforce.

A very hard problem to solve

We want to be clear that this is a very hard problem to solve. Aged care is a particularly difficult area because of our rapidly ageing population. This is a generational problem that we all need to grapple with. Healthcare costs are already escalating fast enough that they are gobbling up the lion's share of new operating allowances, starving the country of much needed investment. Our scenarios make it clear that, if we do nothing, there will be an unacceptable amount of unmet need. This comes with its own costs, including to the wider health system and society. Meanwhile, if we continue to pump money into the same system, costs will continue to balloon.

Our Advisory Group has been rigorously examining the numbers and testing possible scenarios, and we have come to the conclusion that there is no alternative but fundamental reform, designing and implementing a more integrated system which can provide more flexible care so more people can age well in place. Our work has underlined that there are no easy solutions, only increasingly difficult trade-offs. The only real choice is between a hard set of changes made deliberately now, or a more painful set of changes forced on the country later.

This change will mean increased costs in the short term. We do not want to disguise that. But our work has shown that making changes now will reduce some of the considerable cost increases in the future by curbing demand on higher-cost care and building a more effective system. This means fewer people ending up in hospital emergency departments and residential care, as well as reduced pressure on general practice. Reforms will help to make the aged care system more resilient and fiscally sustainable into the future, so that today's young people and their families can benefit from an aged care system that will be there for them when they need it.

We acknowledge that the aged care workforce is central and critical to the delivery of aged care services. Our task was focused on high-level system design, and we considered workforce questions where they directly related to the design and sustainability of the aged care system. We need a better trained, well-supported workforce to deliver better care in the home. Supporting the workforce with a dedicated strategy will need to be a central consideration to any implementation pathway following our recommendations.

Equally, we also recognise that older people are diverse and some face barriers to accessing aged care services. Services can be difficult to navigate and not responsive to some needs – particularly for Māori, Pacific peoples, people with dementia, people living in rural areas, and those with limited financial resources. It is important that older people are engaged in reform so that any changes work for older people and their whānau.

Every New Zealander deserves to age well. That means living happier, healthier and more connected lives for longer. But without reform that is not the track our country is on. We need a better path for our older people and whānau of today, and for future generations. For aged care to be effective, compassionate and sustainable, fundamental system reform is needed.

This report sets out our best understanding of how to change the trajectory. This is not a complete blueprint, and not the final word, but presents a credible and tested path forward, built on the work already done by those before us, for the benefit of older New Zealanders today and the generations who will need the aged care system after them. We acknowledge limitations in available data, and the truncated time for this review, but consider this plan to be the best available within these constraints. We are confident in the proposed direction and recommendations.

Overarching objectives

While a wide range of supports and services help people to live and age well, our work programme deliberately focused on the sustainability of core aged care services as an immediate priority – including in-home and residential care, and the points at which they interact with other services in the health and disability systems.

As we have said, addressing the challenges facing the system requires some hard choices. A clear set of objectives is therefore needed to guide reform and support decision-making.

In forming our recommendations, we considered that the aged care system should be:

- **Integrated and focused on ageing well at home** – people should be supported to live safely and with dignity at home or in a preferred setting for as long as possible, with access to the right care, in the right place, at the right time. This requires an integrated system organised around people's needs and preferences as they change over time, enabling continuity of care and flexible responses across the continuum of care.
- **Equitable and accessible** – people who need care should be able to access it in a timely, fair and culturally responsive way, regardless of their location, income or background. The system should reduce barriers to access, support navigation, and deliver equitable outcomes across populations and communities.
- **Efficient and well coordinate**d – resources should be used effectively to maximise outcomes and minimise avoidable cost. The system should support care in lower-intensity settings where appropriate, align funding with need, and reduce fragmentation, duplication and administrative complexity.
- **Responsive and sustainable supply** – the system should ensure sufficient capacity to meet current and future demand, including an adequate supply of standard residential care beds and a sustainable, appropriately skilled workforce across in-home and residential care, supporting timely access to care. Providers should be able to compete and innovate in ways that drive quality, efficiency and responsiveness of care over time.
- **Fiscally sustainable** – the system must remain financially sustainable over the long term, ensuring that today's generation can access affordable care without compromising fairness for future generations. This requires a balanced approach, where those able to contribute to their care do so, while others are supported to access the care they need.
- **Deliverable and durable** – reform should be clear, coherent and capable of being implemented within the New Zealand context. Changes should be carefully sequenced to mitigate disruption, reflect delivery capacity and system constraints, and align with the expectations and values of older people, whānau and the wider community.

Recognising the scale of future demand and cost pressures, long-term fiscal sustainability has been a central lens through which all recommendations have been considered. At the same time, we have maintained a strong commitment to equitable access to care and improving outcomes for older people across different backgrounds, communities and cultures.

We recognise the government's obligations under te Tiriti o Waitangi – the Treaty of Waitangi, including to ensure that Māori have equitable health and wellbeing outcomes and access to appropriate services, including Māori models of care. Several submissions received as part of our review highlighted this as an important ongoing obligation that must be recognised.

This report sets out a roadmap for how to reform the system so that it is strong, stable, sustainable and fair. This future is possible, but it will require bold and significant changes. Not minor tweaks but an integrated package of changes, designed to help New Zealanders age well for longer in their own place, while still being able to move quickly into more intensive care when they need it.

Getting this right will mean better health outcomes for older people and their families and whānau, fewer avoidable hospital visits, and less pressure to move people into residential care too early. Over time, it should help keep the system affordable and working well for everyone.

Chapter 2 – Why change is needed

New Zealand's aged care system is **under real pressure** which will only increase as more people are ageing, living longer and needing more complex care than before.

Right now, the system is **fragmented, hard to access, and inequitable** for many older people and whānau.

There can be **delays accessing assessments and services**, alongside long-standing workforce challenges.

Funding has not kept pace with the real cost of providing services.

We modelled different scenarios to see what level of reform is needed.

Without urgent change, surging demand will outstrip supply – with a mountain of unmet need, pushing more older people into hospital and driving up costs across the health system.

Adding funding to the current system without wider system reform simply buys limited time with costs still rising and an inadequate system **quickly becoming unaffordable**.

Major reform is needed to put in place an integrated system of aged care which **supports more people to stay at home for longer**. This costs more up front but is less costly, and better for our people and our economy over the longer term.

New Zealand's aged care system is under pressure

Our aged care system is already feeling the pressure and it's going to get worse. People are living longer, meaning a large increase in the number of older people in New Zealand. Over the next 20 years, the level of demand from population ageing alone will climb sharply and is expected to push aged care service costs up by almost 90%, with a lot more strain on the system.[2]

In the meantime, the current system is fragmented and hard to navigate. Support isn't shared fairly across the country, and the people doing the caring, both paid and unpaid, are stretched thin. The truth of it is that funding hasn't kept up with what care costs to deliver.

When older New Zealanders can't access residential care, the health system suffers, which has impacts on everyone else needing hospital care. An adequate supply of in-home care, as well as more access to standard residential care capacity across the country, are essential to avoid unnecessary load on the hospital system and ballooning fiscal cost. Without these fundamentals, pressure on the health system will rise even faster, due to:

- **longer hospital stays for older patients** and delayed discharges and capacity pressures
- **more pressure on emergency departments** and more hospital admissions for older people needing residential care, compounded by a loss of respite care options
- **more demand for in-home care and primary care** for people who need residential care.

[2] Based on the percentage growth in baseline cost projections (accounting for inflation) from 2026/27 to 2046/47, in 2025/26 dollars.

This compounding pressure on the health system will restrict access to healthcare for all New Zealanders: reducing hospitals' capacity for elective procedures, increasing wait times for care, and adding further pressure to our emergency departments, many of which are already overstretched. It also costs too much. For people aged 75 or older, the average hospital stay costs just over $12,800 for 7.3 days of care, at $1,750 per day. Care can cost more if a person needs more treatment. This exceeds the average cost of a year of in-home care (at $10,800 for 3.1 hours per week).

We need to take systemic action now to avoid this story playing out.

An ageing population

New Zealand's aged care system was built for a different era. In 1996, about one in 10 people in New Zealand were aged over 65.[3] By 2028, this will be one in five, and by the 2050s, this will be one in four.[4] The aged care system was built in a time of lower demand, lower acuity for those in residential care, shorter life expectancy and a lower 'dependency ratio' of older people to working-aged people.

New Zealand's population is ageing rapidly, as larger cohorts of people enter older age and as life expectancy continues to increase. There are currently about 418,000 people aged 75 and over in New Zealand (about 8% of the population), and about 105,000 people aged 85 and over (about 2% of the population).

This population is going to continue to grow significantly. From 2025 to 2047, the number of people aged 75 and over is projected to increase to more than three-quarters of a million people (about 12% of the population).

The number of people aged 85 and over is projected to increase to almost 265,000 (about 4% of the population) – a growth rate seven times faster than the New Zealand population as a whole. There are currently three New Zealanders aged 85 or older for every hundred people aged 15 to 65. By 2060, this will rise to eight people over 85 for every hundred aged 15 to 65.[5]

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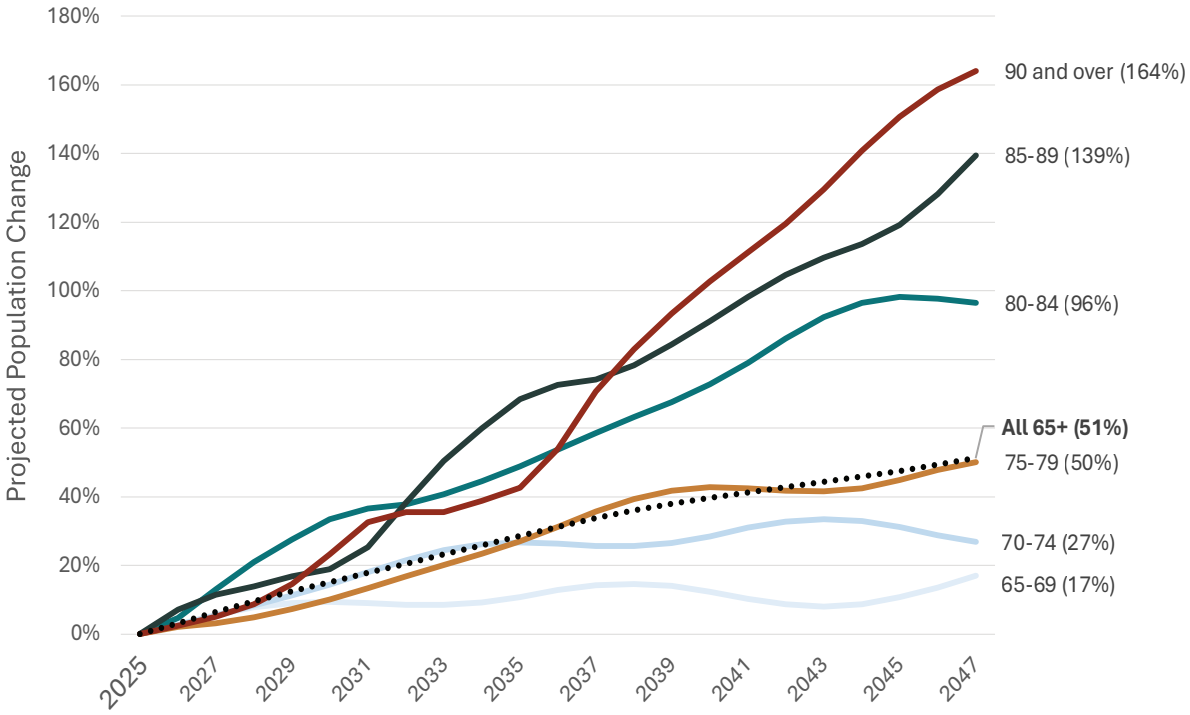
[3] Contextual population figures use Statistics New Zealand's national projections (2024 base). The demand and cost modelling for this report uses projections prepared for Health New Zealand (2023 Census base), which are somewhat lower for the oldest age groups. The choice of series does not change any conclusion.
Contextual population figures: Statistics New Zealand. (2025b). *National population projections: 2024(base)–2078*. https://www.stats.govt.nz/information-releases/national-population-projections-2024base2078/

[4] Statistics New Zealand. (2022). *One million people aged 65+ by 2028*. https://www.stats.govt.nz/news/one-million-people-aged-65-by-2028

[5] Statistics New Zealand, 2025b.

Figure 1 below highlights the projected growth of the population aged over 65 between 2025 and 2047.

Figure 1: Projected growth of the New Zealand population aged 65+ from 2025 to 2047[6]



At the same time, with slower population growth in younger age groups, the older age 'dependency ratio' will increase, as there are fewer working age adults to support each older person.[7] Expressed another way, there were 4.2 working aged people for every person aged 65 and over in 2020,[8] which will decrease to 3.1 by 2038, and 2.0 by 2073.[9]

Older people are also living longer with multiple long term conditions, disabilities, and cognitive impairment. These trends are driving sustained growth in both demand for aged care services and increased care complexity.

Our modelling shows that rising rates of multimorbidity, disability, and health needs – particularly among the fastest growing age group of those aged over 85 – will mean that demand for aged care services will continue to rise sharply in both scale and complexity.

This is not only a matter of more people needing care, but of more people needing more intensive, coordinated and responsive care. This means sustained and growing demand not only on aged care, but across the wider health and social support ecosystem, including primary care, hospitals, and community-based services.

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6 Statistics New Zealand 2025 population projections for Health New Zealand (2023 Census base).

7 Statistics New Zealand. (2025c). *Births and deaths: Year ended March 2025*. https://www.stats.govt.nz/information-releases/births-and-deaths-year-ended-march-2025/

8 Statistics New Zealand. (2020). *National population projections: 2020(base)–2073*. https://www.stats.govt.nz/information-releases/national-population-projections-2020base2073/

9 Statistics New Zealand, 2025b.

The current care system is fragmented

The aged care system has been developed iteratively over time in response to changing pressures on services. As a result, the current system is complex and fragmented, and does not support a coordinated, person-centred system that responds effectively to people's needs. See more detail on the current system in **Appendix 5**.

There are a range of funding models and approaches, where people's needs are defined by separate and disjointed service categories.

In-home care, for example, is delivered on either a fee-for-service model, or a restorative bulk funded casemix model, depending on the district where providers deliver services. Casemix is a classification system that groups individuals based on their assessed level and type of need, using consistent criteria. Individuals with the same case mix category are assumed to require a similar level of resources. Funding can either be attached to the individual or aggregated at provider level.

Residential care is different again, and bases care and support on four service categories (rest home, hospital, dementia, and psychogeriatric care).

Surrounding these services is a range of complex and bespoke regional arrangements for short-term care, respite care and dementia day services, including between home, hospital and residential care settings. These funding arrangements add complexity, make services more difficult for providers to deliver, and limit integration with wider health and social services.

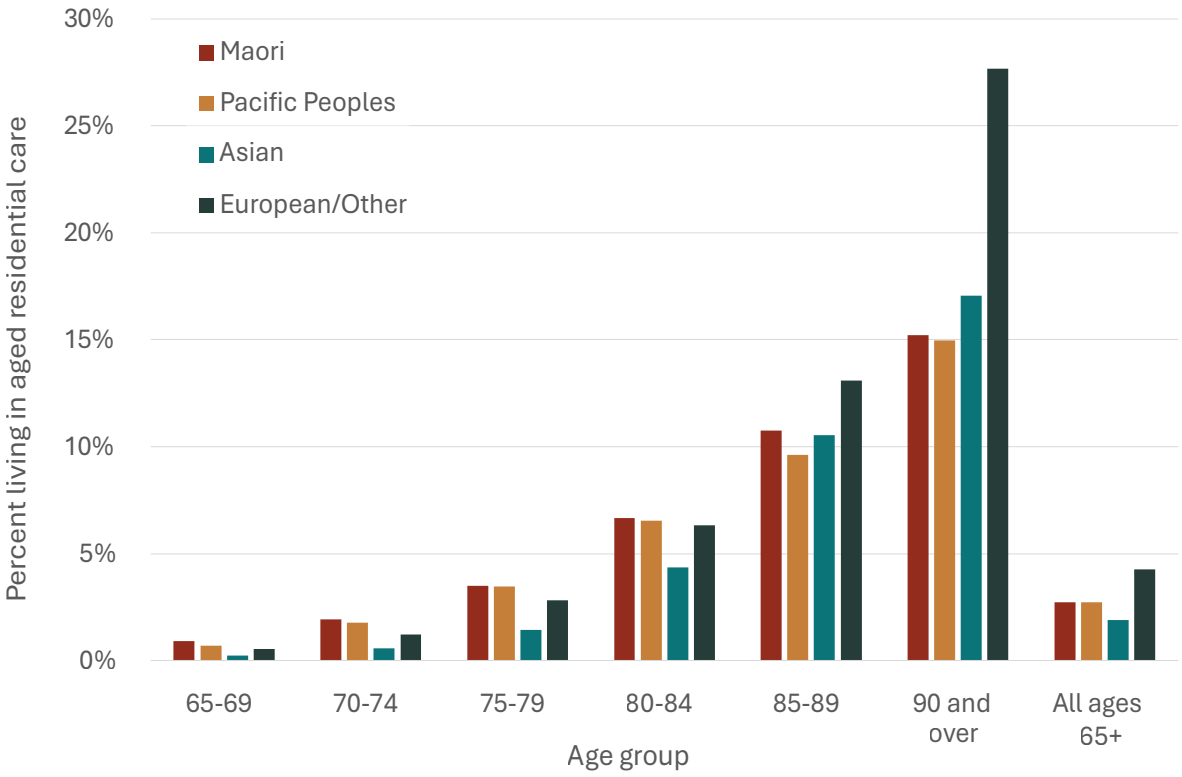
This fragmentation has serious impacts for older people, their families and whānau, and their carers. People's needs evolve over time, and many move between in-home care, residential care, and different levels of support within each setting. Many people (including health practitioners) can struggle to understand how to enter the system, what services are available, or what people may be able to receive. As a result, support is often accessed late, through emergency departments or hospital admission, rather than earlier through community-based services.

> "Fragmentation between primary care, hospitals, community services, and aged residential care is a key driver of avoidable harm."
>
> *- The Royal New Zealand College of General Practitioners.*

Inequities are getting worse

There are well recognised inequities in aged care that are structural and compounding. The proportion of people living in residential care increases with age for all ethnic groups, but Māori, Pacific and Asian people are much less likely to be living in residential care in advanced old age (see Figure 2).

Figure 2: Residential care utilisation rates by prioritised ethnicity and age, 2024/25



There are a number of reasons for lower utilisation of residential care for Māori, Pacific, and Asian populations. Historical inequities in health outcomes for Māori and Pacific peoples have contributed to poorer health, higher rates of disability and much lower life expectancy for these populations.[10] This is reflected in higher residential care utilisation rates for Māori and Pacific peoples at younger ages (65-79).

Asian people in all age groups, and Māori and Pacific peoples in the oldest age groups (85+) are less likely to live in residential care than people of other ethnicities. In part this likely reflects different preferences for care in later life, including a preference for being cared for at home by family and whānau. Research indicates that Māori and Pacific peoples and people of Asian ethnicity have a high degree of unpaid caregiving from families, compared to people from other ethnic groups with similar health status.[11],[12]

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[10] Ministry of Health. (2024). *Health and Independence Report 2024 – Te Pūrongo mō te Hauora me te Tū Motuhake 2024.* https://www.health.govt.nz/publications/health-and-independence-report-2024

[11] Hikaka, J., August, T., Duque, M., Kerse, N. (2026). *Planning for Māori Futures: A Scoping Review of Experiences, Priorities and Opportunities for Culturally Informed and Appropriate Aged Care Design.* Australasian Journal on Ageing, 45(2). https://onlinelibrary.wiley.com/doi/10.1111/ajag.70147

[12] Walker, X., Abey-Nesbit, R., Kayes, J., Bergler, H., Cheung, G., Waters D., Grey C., Stuart, M., Jamieson, H. (2026). *The Epidemiological Profile of Older Adults of Pacific Peoples Ethnicity in New Zealand Assessed for Home Support and Aged Residential Care.* Australasian Journal on Ageing, 45(2). https://onlinelibrary.wiley.com/doi/10.1111/ajag.70143

Research further indicates that access to services is also likely driven by an absence of culturally safe and responsive care and trust that acts as a deterrent to entry.[13,14] Culturally specific models of care tend to be under-developed and under-funded. Recent research also indicates that language barriers are significant for Pacific peoples.[15]

Over the next 20 years, more Māori and Pacific peoples are likely to need residential care.[16] When older Māori and Pacific peoples enter residential care, they are more likely to have higher and more complex needs, reflecting cumulative unmet need arising from long-standing structural inequities in access to health and disability services, earlier onset of long-term conditions, and persistent barriers to timely assessment and access to care.[17,18]

This highlights the ongoing importance of giving effect to te Tiriti o Waitangi – the Treaty of Waitangi by ensuring equitable access to culturally safe, appropriate and responsive healthcare, including aged care, and achieving equitable health outcomes.

More older people will be living in rural areas in the future.[19] Aged care services and other health supports can be limited in rural areas – there may be limited access to residential care, and access to in-home care can also depend heavily on geographic location and workers.[20] This means that people may need to move away from their families and communities to access care.[21] The Health Committee inquiry into aged care noted that access to primary care and specialists is becoming increasingly difficult, with fewer specialists available and long travel times to clinics, which can delay or complicate assessment and management of care for older people living in rural areas.[22]

> "Equity does not mean treating rural communities the same as urban ones; it means designing the system to work effectively in different contexts."
>
> *- Hauora Taiwhenua Rural Health Network*

[13] Hikaka, J. & Kerse, N. (2021). *Older Māori and Aged Residential Care in Aotearoa*. Health Quality & Safety Commission New Zealand. https://www.hqsc.govt.nz/assets/Our-work/Improved-service-delivery/Aged-residential-care/Publications-resources/Older_Maori_and_ARC_report_Dec2021_final.pdf

[14] Walker et al., 2026.

[15] Walker et al., 2026.

[16] Hikaka J., Abey-Nesbit R., Wu Z., Jamieson, H., Parsons, M., Kerse, N., Gibson, R. (2024). *Changes in indicators of well-being on moving from home to long-term care for Māori in Aotearoa New Zealand: A retrospective cohort study. Australasian Journ*al on Ageing, 43(4). https://onlinelibrary.wiley.com/doi/full/10.1111/ajag.13361?msockid=2bf15ea1c48a656524724839c5a064fa

[17] Hikaka et al., 2024.

[18] Walker et al., 2026.

[19] Ministry of Health. (2025). *Inquiry into the aged care sector's current and future capacity to provide support services for people experiencing neurological cognitive disorders – Summary of Submissions*. https://www3.parliament.nz/resource/en-NZ/54S-CHEA_ADV_68ded697-e85e-4888-de1a-08dc7a1062a5_HEA14995/42b7c497f34d8b7332cedd1c132060daae2faab2

[20] Health New Zealand – Te Whatu Ora. (2024). *Future of Ageing Well service and funding model review: Sector and public engagement summary and themes*. https://static.info.content.health.nz/docs/publications/Future-of-Ageing-Well-service-and-funding-model-review.pdf

[21] Aged Care Commissioner. (2024). *Amplifying the Voices of Older People Across Aotearoa New Zealand*. https://www.hdc.org.nz/media/o3tb5dfa/amplifying-the-voices-of-older-people-across-aotearoa-new-zealand-march_2024.pdf

[22] Ministry of Health, 2025.

Socioeconomic disadvantage, low health literacy, intergenerational trauma, historical mistrust in health services and systemic bias can drive inequitable access to care services. A growing number of the general population are reaching retirement with lower rates of home ownership and limited or no assets, constraining their ability to self-fund care, adapt their housing, or bridge gaps in publicly funded support once they engage with the aged care system.[23] Māori and Pacific peoples and low-income adults in particular face challenges including lower rates of home ownership, with a high proportion of income or pension paid on rent and increased risk of living in poor quality and unsuitable housing.[24,25]

Inequity in access has clear downstream consequences. Delayed or fragmented access to care contributes to avoidable emergency department use, preventable hospital admissions, prolonged hospital stays, and premature entry into residential care. In addition to poorer outcomes for older people, these patterns drive higher overall system costs and reduce opportunities for timely, lower intensity support through in-home care.

Assessments and timeliness are under strain

Multiple reports and providers highlight that there can be long delays accessing assessments for services, and services themselves. Submitters to the Health Committee's inquiry into aged care, for example, raised that wait times can vary significantly across regions, long wait times can result in the need for reassessment, and people with short-term conditions are generally unable to get an assessment for support.[26]

While people receiving in-home care should receive annual reassessments, we heard that in practice this occurs only on average about every three years due to resourcing constraints. The Home and Community Health Association highlighted there can also be significant delays between having an assessment and starting a service, which can contribute to unnecessary hospitalisation.

These pressures result in uneven access to assessment and variable responsiveness across regions, with people experiencing postcode-driven entry points and inconsistent care pathways. Underfunding of assessments and delays in the system force prioritisation of assessments that can effectively function as a rationing mechanism within the health system.

Delays have serious impacts and consequences for older people and their families and whānau. When assessments are delayed, decisions about the care a person receives and funding can also be delayed, and people's health may deteriorate while they wait. As a result, some older people may be admitted to hospital before they receive the care they need.

We make some recommendations regarding improving the assessment system in Chapter 5.

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[23] Ministry of Social Development. (2025). *Long-Term Insights Briefing – Meeting the future needs of older New Zealanders: Trends, risks and opportunities*. https://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/long-term-insights-briefings/draft-long-term-insights-briefing.pdf

[24] Ministry of Social Development, 2025.

[25] Ministry of Social Development, 2025.

[26] Ministry of Health, 2025.

Long-standing workforce challenges constrain service delivery

A well trained and supported workforce is essential to delivering safe and high-quality care in all settings.

In-home care relies heavily on a mobile, community-based workforce operating across diverse settings with access to consistent clinical support. The in-home care workforce consists of about 17,000 support workers, as well as coordinators, nurses, physiotherapists, training and quality staff, administrative and finance staff, and managers.[27]

Rising demand, increasing care complexity, and changing expectations are placing sustained pressure on this workforce. Engagement undertaken by Health New Zealand highlighted high turnover rates due to the challenging nature of the work,[28] and the Aged Care Commissioner has pointed to a need to focus on recruitment and retention of the workforce, in particular skilled support workers.[29]

About 35,000 people are employed in residential care facilities, including mostly healthcare assistants or kaiāwhina, nurses, non-care staff (including office administration and chefs), and activity coordinators. The Aged Care Association estimates that about 45% of residential care workers are on visas, including 59% of Registered Nurses and 51% of healthcare assistants.[30]

Support workers and healthcare assistants are an unregulated workforce, meaning they are not subject to professional registration requirements or oversight by a regulatory authority in the same way as regulated health professionals such as nurses and doctors. This places greater reliance on employers and service providers to make sure that workers have the necessary training, competence, supervision, and ongoing professional development to deliver safe, high-quality care.

Pressures on workforce reflect historically low pay, significant funding variation across funders, regions, contracts and provider types, limited career pathways, fragmented employment arrangements, and competition across the healthcare ecosystem.

Workforce capability and capacity have not kept pace with the growing demands placed on in-home and residential providers. This constrains the system's ability to scale capacity, deliver timely support, and respond flexibly as care needs change, directly affecting access, continuity and responsiveness of care. For example, constraints increase the likelihood of transfers to public hospitals during periods of instability, particularly where staffing shortages limit the ability to manage higher acuity needs safely.

Demands on workforce, both in home and residential settings, are expected to grow significantly.[31] The challenges will become more acute in the future, including difficulties attracting and retaining skilled workers, high turnover, and capability gaps. Constraints will be worse in rural areas, particularly as the trend for younger workforce to move to urban areas continues.[32,33]

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[27] Ernst & Young. (2019a). *Recognising the Contribution of the Home and Community Support Sector to New Zealand*. https://www.hcha.org.nz/publications/ey-report

[28] Health New Zealand – Te Whatu Ora, 2024.

[29] Aged Care Commissioner, 2024.

[30] New Zealand Aged Care Association. (2026). *Aged Residential Care Sector Profile 2026*. https://aca.org.nz/Public/Our-Work/Publications-list/Aged-residential-care-sector-profile-2026.aspx

[31] Employment New Zealand. (2024). *Employment Relations Sector Report: Aged Residential Care Sector*. https://www.employment.govt.nz/assets/uploads/documents/employment-new-zealand/enz-ers-report-aged-residential-care-feb-2024.pdf. See also: New Zealand Aged Care Association, 2026.

[32] Health Committee. 2025. *Inquiry into the Aged Care Sector's Current and Future Capacity to Provide Support Services for People Experiencing Neurological Cognitive Disorders*. New Zealand Parliament. https://selectcommittees.parliament.nz/view/SelectCommitteeReport/a9f6b53e-5bd3-4fb6-09f7-08de27ba32ec

[33] Sapere. (2024a). *A Review of Aged Care Funding and Service Models*. https://www.healthnz.govt.nz/publications/a-review-of-aged-care-funding-and-service-models

Alongside the formal workforce, family and whānau carers are relied upon to deliver care, often providing substantial levels of unpaid care in the home. There are about 655,000 informal carers in New Zealand (across a range of population groups, including carers of older people and disabled people).[34] Many play a vital role in caring for their older family and whānau at home. Caring responsibilities can often mean reduced opportunities to take part in education, paid work, and community life, affecting carers' health, wellbeing, finances, and social connections.

While carers are critical to enabling people to remain at home for longer, support is unevenly available and frequently assumed rather than planned for within funding, assessment and service models. Reviews of the aged care system have consistently identified that carers need more support, but carer support options like respite vary widely across the country.[35] Growing reliance on family care shifts risk and burden onto whānau, particularly women, Māori, and those with fewer financial resources, masking underlying system constraints.

We consider workforce issues further in Chapters 6 and 9. We note that workforce remuneration and regulatory issues were out of scope for this report, and have taken a strategic, outcomes-based approach to considering workforce.

Funding has not kept pace with the real cost of services

The aged care system is under sustained financial pressure, with funding no longer keeping pace with the rising costs of delivering care. This has been highlighted in a multitude of reports on aged care over the last decade.

Across both in-home and residential care, funding arrangements make it difficult for some providers to stay financially viable, while others have struggled with minimal margins. These constraints reduce the ability of providers to invest in new services, expand their capacity, or plan for future growth. As a result, the aged care system struggles to keep up with increasing demand and the growing complexity of older people's needs.

For residential care, growth in demand is outpacing increases in supply. Average occupancy has increased over the past five years, and residential care facilities are at or near capacity in some areas.[36]

From 2025/26 to 2037/38, we project demand for residential care to grow by 16,100 'bed years'[37] or 45%. By 2047/48, demand will grow by 31,000 beds or 87% (see Figure 3 and Figure 4 below).

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[34] Infometrics. (2022). *The economic contribution and sacrifices of unpaid family, whānau, and aiga carers in New Zealand*. https://cdn.alzheimers.org.nz/wp-content/uploads/2023/04/Infometrics-Economic-Value-of-Caregiving-November-2022-FINAL90.pdf

[35] Sapere, 2024a.

[36] Average occupancy has risen from around 87% to over 92%. The upper limit on occupancy rates is below 100% as beds will be un-occupied during renovations and transitions between residents, to provide choice to prospective residents and to ensure capacity for urgent and short stay care.

[37] Occupied residential care beds are funded on a per-day basis. One 'bed year' is 365 funded days.

Figure 3: Projected demand for residential care by care level (in bed years)

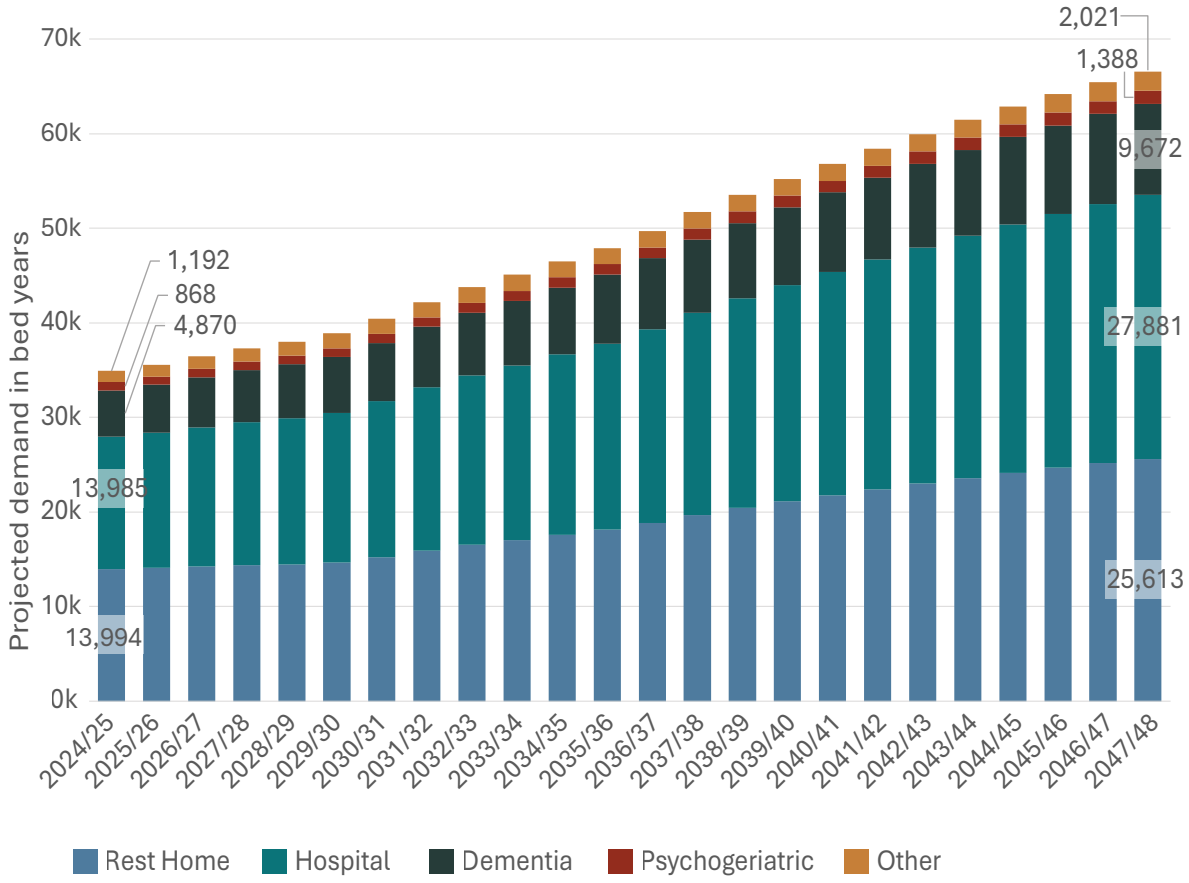
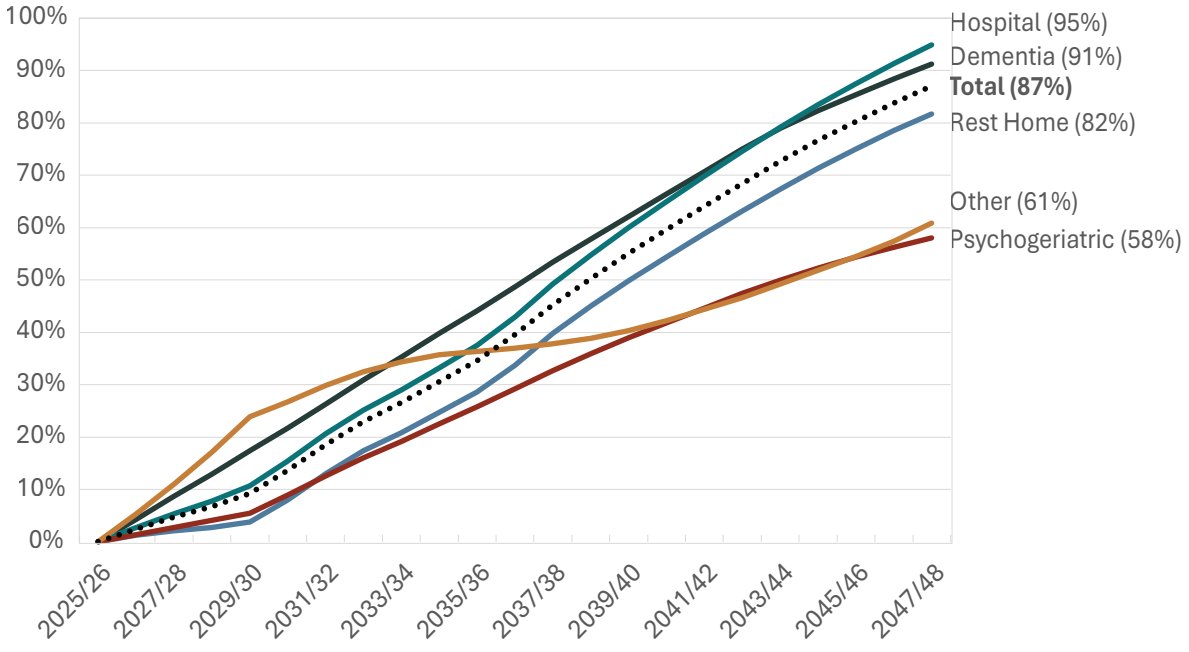


Figure 4: Projected growth in residential care demand by care level (as a percentage increase from 2024/25 levels)



Note: 'Other' includes respite, short stays, and some ACC clients.

Underfunding has meant that 'standard' residential care beds (for which providers do not charge additional 'premiums' or fees) are funded **below the cost of provision**. Most new supply is of 'premium rooms' and 'care suites' rather than these rooms without additional charges.[38] The proportion of beds available throughout the country without additional charges has dropped from 70% in 2010 to 47% currently.

This creates a two-tier system of support and encourages providers to increase capacity in higher socioeconomic areas where residents can more afford additional charges, leading to barriers for those with reduced means to access care.[39] Without change, the shortage of beds without additional charges will get increasingly acute.

Likewise, in-home care has typically become more intensive and complex over time, but baseline funding, assessment capacity, service settings, and workforce capabilities have not kept pace with changing patterns of need and preferences to be cared for at home. This constrains providers' ability to scale services, adjust intensity over time, or maintain continuity of care, particularly for people with higher or evolving needs. The Aged Care Commissioner reported a high level of vacancies and turnover in all roles across in-home care, reflecting underlying funding and pay pressures.[40] Over the decade from 2025/26 to 2035/36, we project the volume of in-home services to grow by about 1.7 million hours or around 18%.

Where the right services are not available to support people in their home, they risk entering residential care or hospital. A lack of safe options for care in the community can also lead to delayed discharges from hospital.[41] As a result, the system's capacity to stabilise people earlier and at lower intensity has been diminished, increasing the likelihood of escalation into higher cost care settings elsewhere in the system.

> "The current Aged Care settings no longer match the reality of care provision, especially noted by providers for older people who cannot afford to pay for additional services or Premium fees. These providers report that while the emphasis on ageing well outside of residential care, the funding, frameworks and system supports have not met pace with the change in service expectations."
>
> *– New Zealand Council of Christian Social Services*

[38] 'Premium rooms' and 'premium charges' are those where residents pay above the standard price for extra services or accommodation options. Premium fees can be charged for things such as an ensuite, more space, or garden access. Residents may also enter into Licence to Occupy agreements, making large up-front payments to secure a bed. 'Care suites' or 'Occupational Rights Agreements', for example, are apartments with care component options governed by the residential care contracts, where residents make upfront payments to secure a care suite. The up-front payment is partially refunded on their death or transfer.

[39] Ernst & Young. 2019b. *Aged Residential Care Funding Model Review*. https://natlib.govt.nz/records/44822161

[40] Aged Care Commissioner, 2024.

[41] Ministry of Health analysis.

Scenarios to test the level of change needed

So, what kind of change is needed? We tested what happens under three scenarios to see what the future might look like. These included changing nothing, simply spending more within today's system, and genuinely redesigning how care is delivered.

Scenario A – Do nothing: Demonstrates what happens if we continue current system settings with only modest funding increases that are insufficient to induce significant new supply, resulting in unmet need and a growing 'waitlist' for residential care.

Scenario B – More funding pumped into the system: Demonstrates what happens if we add more funding within the existing system to increase the supply of services (including residential care beds and workforce capacity) to meet growing demand, without any changes to how the aged care system is set up.

Scenario C – Structural reform: Represents the set of reforms recommended in this report, including the financial implications and improvements in health outcomes. (See more detail on this scenario in Chapter 3).

Appendix 6 provides an overview of the assumptions underpinning our projections.

What happens if we continue without change?

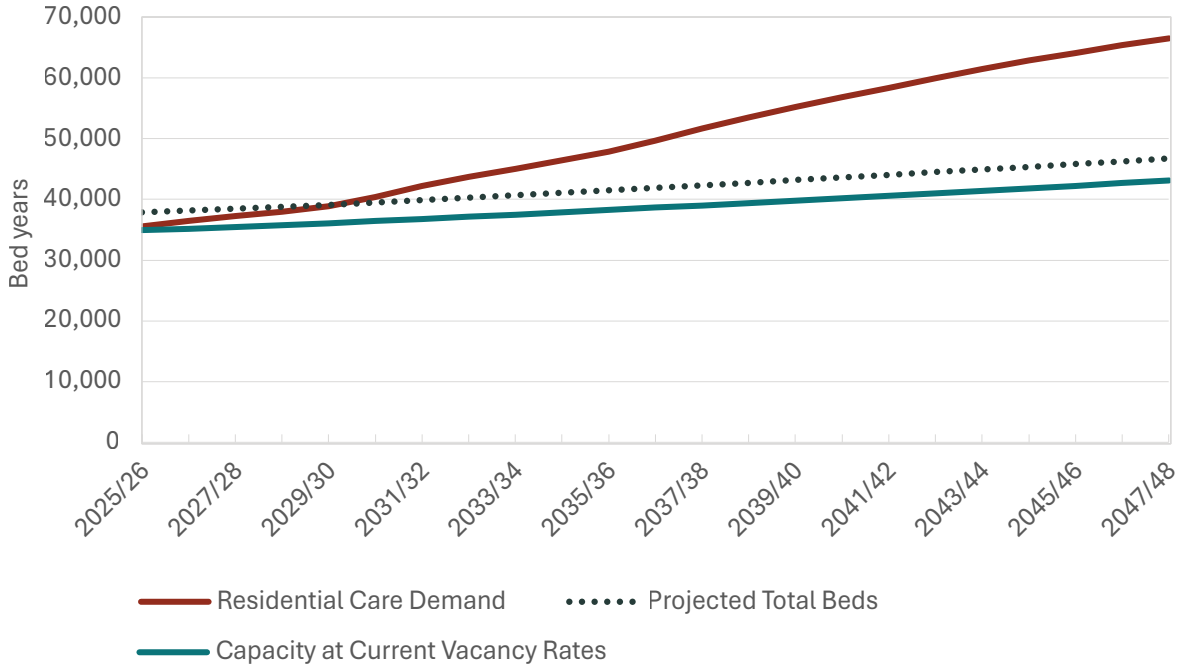
Scenario A – Do nothing

Under this scenario, the current system keeps going without significant reform, and with only modest annual increases in funding. The supply of aged care services fails to keep up with rising demand. This situation translates into more human misery and earlier deaths, as well as rising costs.

Our modelling looks at the costs of allowing the need for aged care services to outstrip supply. If funding rises only in line with price and wage inflation, building new residential care capacity will not be a financially viable investment. A growing 'waitlist' for residential care will see more people waiting for longer in hospital, more people staying at home beyond the point where it is safe for them, and more care delivered in the highest-cost settings.

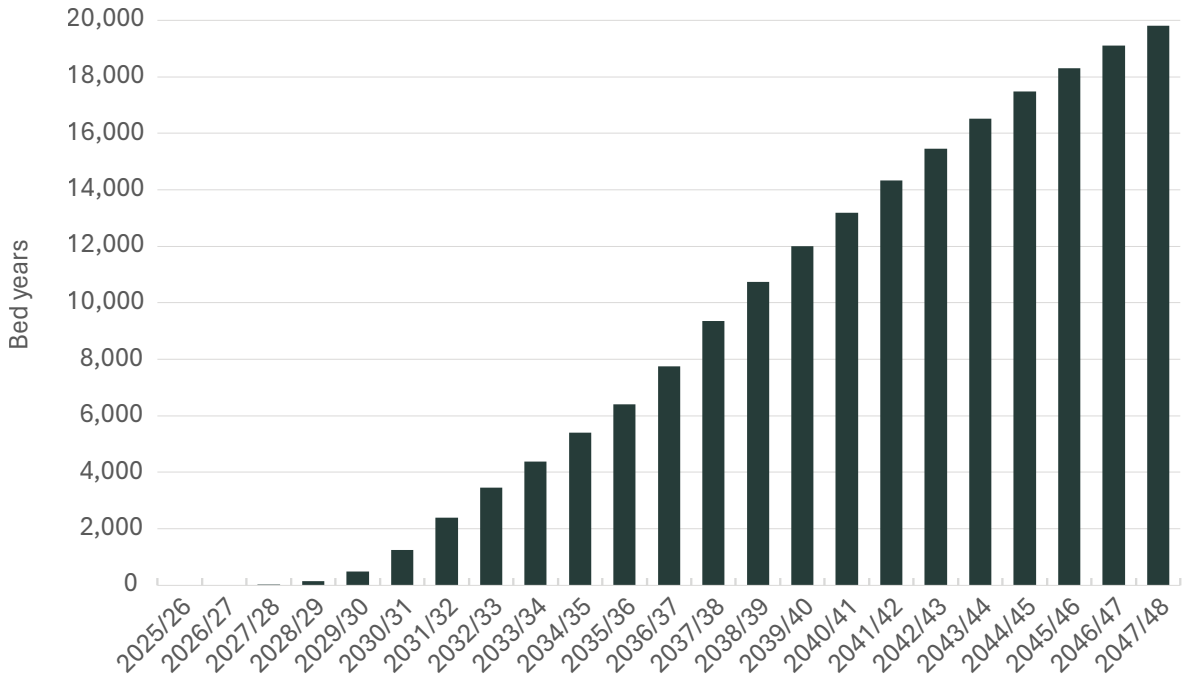
Figure 5 below shows how our model's projected demand for residential care will outstrip supply if total capacity in regions with capacity constraints grows at a rate of 1% per year (a provisional estimate).

Figure 5: Projected demand and supply of residential care (in bed years)



The resulting level of unmet demand is shown in Figure 6 below. This shows the projected national level of unmet demand in this scenario, across all levels of residential care.

Figure 6: Projected unmet demand for residential care (in bed years)



In this scenario, the national shortfall in residential care capacity would reach 2,385 bed years in 2031/32, and 9,360 bed years by 2037/38. If growth in supply is lower, at 0.5% per year, excess demand by 2037/38 would rise to 11,630 bed years.

Without sufficient residential care capacity, the system would not just leave older people without care but would shift the cost into the hospital system, which is significantly more expensive than residential care. As the public hospital system's capacity is taken up with older people waiting for a residential care place, the government will face a choice to either commit additional spending into hospitals or to pass this cost to the public in the form of reduced access to hospital care due to hospital overcrowding.

The costs of this scenario are of course not primarily economic. They are measured in terms of human suffering – both of older New Zealanders and their families and whānau, and of those other New Zealanders displaced from hospital beds or kept longer on waiting lists because of overcrowding caused by unmet need for aged care elsewhere. This scenario is a tragic picture of lives shortened and disabled by a health system that cannot keep up.

Our modelling estimates that, on average, each person unable to find a residential care place would cost the government over $59,000 more each year than they would in rest home level care. This is the amount by which the costs to government of people waiting in hospital, and of in-home care and avoidable hospitalisations for people waiting at home exceed what government saves in unpaid Residential Care Subsidies.

By 2037/38, this **additional cost to government would exceed $589 million per year** (in 2025/26 dollars). If 10% of the time people spend waiting for a residential care place were spent in hospital, this would consume 5% of total hospital system capacity.[42] This avoidable increased pressure on hospitals will be in addition to the broader demand pressures from a growing population of people aged 85 and over, who are more likely to be hospitalised.

As well as these costs to government and the health system, family members (mostly women) providing care for older relatives would bear economic costs through reduced employment opportunities. There would also be broader adverse impacts from older people needing to stay in hospital longer, including reduced health and wellbeing for both older people and their families and significant unaddressed carer stress.

What happens if we add funding without wider system reform?

Scenario B – More funding pumped into the current system

Spending more without significant system reform will alleviate short-term supply pressures for a while, but rapidly becomes unaffordable. Adding funding into the system to meet demand without wider change will come at a significant and growing fiscal cost, while still leaving many of the system's underlying problems unresolved.

Scenario B considers the impact of increasing funding to meet rising demand, making sure that providers can continue to deliver aged care services, without any changes to how the system is set up.

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[42] See **Appendix 6** for modelling assumptions. This scenario assumes that:
- all displaced residential care demand is from rest home-level care costing the government on average $80 per day or $30,000 per year, and excess demand for higher levels of care is accommodated at no additional cost over the usual prices
- 10% of total wait time is spent by people waiting in hospital (as 'stabilised' patients at $1540 per bed day, reflecting the average cost per day of geriatric hospital admissions)
- people waiting at home receive 5 hours of in-home care per week and experience 6 days of avoidable hospitalisation per year (the average length of one hospital stay for this age group, at a higher cost of $2150 per bed day for acute patients).

To meet growing demand for residential care, more investment in new facilities will be needed. For example, the projected capital cost to build an additional 10,000 beds (costing approximately $260,000 per bed) would be $2.6 billion, plus other costs such as construction and price inflation.

This will require the price for each 'bed year' to increase (through a combination of government subsidies and resident contributions), so that investors can earn a return that covers their costs.[43]

Based on our modelling, we estimate the average price per bed-day across all levels of residential care would need to increase by approximately 21% above inflation, averaging $55 per day, to induce the level of capital investment in new residential care capacity that we need in order for supply to keep up with rising demand.[44]

For in-home care, we estimate that a price uplift of approximately 6% above inflation would be needed to address existing funding shortfalls, including workforce-related costs that are not currently fully reflected in funding.[45]

These price uplifts are aimed to ensure that the capacity of providers grows to meet rising demand (without any change to current service models). However, they do not include provision to meet any significant growth in workforce costs, or provision for investment beyond business-as-usual in new technologies, new models of care, or any expanded scope of services.

In this scenario, total aged care costs (including government funding and private contributions) would rise from about $3.9 billion in 2025/26, to $5.1 billion in 2028/29 and to over $9.3 billion by 2047/48 (in 2025/26 dollars). Within this total:

- costs to government would rise from $2.5 billion in 2025/26 to $3.3 billion in 2028/29 (an increase of 30%), and to over $6 billion in 2047/48 (an increase of 125%)
- total private contributions from people in residential care would increase by 17% from $1.4 billion in 2025/26 (averaging $39,625 per year for people in residential care) to $1.8 billion in 2028/29 (averaging $46,550 per resident), and by 135% to $3.3 billion in 2047/48 (averaging $49,700 per resident).

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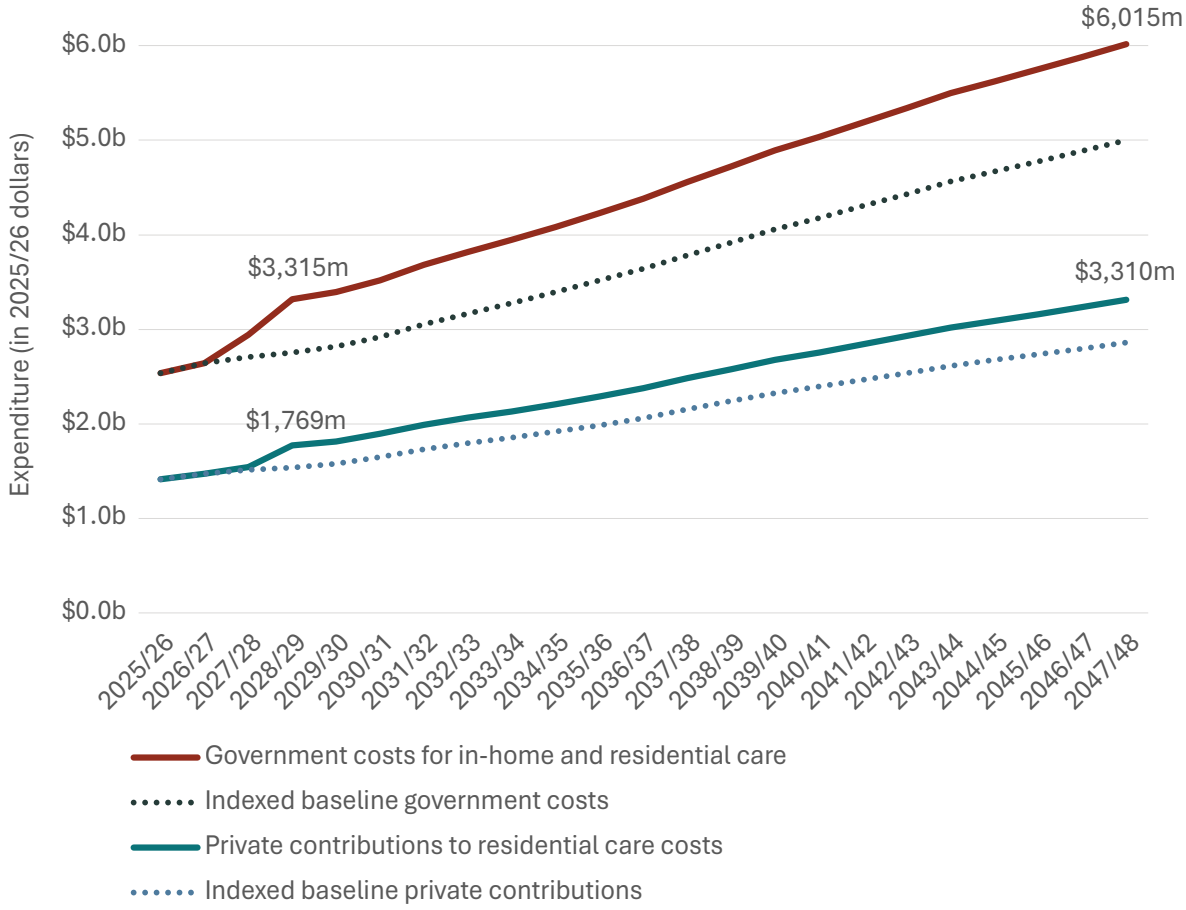
[43] Under the current funding system, the price per bed day is the same for new-built residential care beds and for existing stock in more depreciated facilities. Although they are less capital-intensive, prices for in-home care services will also likely need to increase to provide operating margins that can induce the growth needed to meet demand.

[44] The average price uplift in this scenario reflects the modelled prices required for new-built facilities to be 'investable'. We modelled discounted cashflows for a range of residential care facilities, to estimate the prices per bed per day at which facilities cover their cost of construction, ongoing operating costs, land lease, depreciation and asset replacement, and can deliver a return on investment equal to their cost of capital.

[45] This was informed by the Settlement Parties Action Group (SPAG), which was established in 2015 following the Director-General of Health's Reference Group review of the in-home care sector. See https://www.hcha.org.nz/assets/Uploads/dg-reference-group-report-final-august-2015-1-v2.pdf.

Figure 7 below illustrates the rising annual cost of meeting growing demand, with price uplifts totalling 21% above CPI inflation for residential care and 6% above CPI inflation for in-home care services applied over 2027/28 and 2028/29.[46]

Figure 7: Projected cost of meeting growing demand for aged care services under current system settings



Our projections do not include other social and economic trends that may impact people's ability to pay for aged care services, such as declining home ownership rates. As a result, this scenario represents a conservative view, with actual demand pressures and capacity shortfalls likely to emerge earlier and be more pronounced than projected.

Scenario A is clearly not feasible: it would create significant unmet need, increase hospitalisations, and add growing cost pressures. Failure would be measured in human suffering as well as a broken system.

Scenario B shows us that simply adding more funding to stabilise the system (let alone improve the system) without changing system settings will lead to unsustainable rising costs, both for people and the government.

So what happens if we reform the system in a way that stabilises and improves the system while reducing long-term costs, with a new sustainable funding model?

Let's take a closer look at Scenario C.

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[46] See **Appendix 6** for modelling assumptions.

PART TWO:
Recommended Reform

Chapter 3: What does a better future look like?

Change is needed now. New Zealand can't afford to keep patching the current model.

Scenario C considers what happens if we move towards **supporting more people at home through an integrated system** with **better services**.

We looked at some ways to reform the system by using **major levers to reduce future costs**, including supporting more people at home, better targeting residential care funding through differentiated pricing, rebalancing how we share the costs of care, and finding more efficiencies in the system.

Scenario C estimates the effect of an integrated package of changes for full-scale reform. It is based on a future where more older people can stay living safely and independently in their own homes for longer, supported by an integrated aged care system that meets people's needs and builds care capacity, including more care at home and a new funding model.

The main principles involve:

1. **Better integrating the system to provide a clear and coordinated care pathway for people**. This requires a single aged care system, with a joined-up pathway so that people can access the right care at the right time, supported by digital integration and shared information for smoother care experiences.
2. **Providing the right level of care for each person's needs** through a central casemix framework that consistently matches people with the right level of care, supported by earlier and more timely assessments, and better short-term care to respond flexibly when people's needs change. Assessments, planning and service delivery must be culturally safe and responsive.
3. **Delivering more care at home** by strengthening in-home care, short-term care, and carer support and respite. This will enable people to age well in their homes for longer, reduce the amount of time people spend in hospitals, and prevent avoidable hospitalisations or unnecessary long-term residential care.
4. **Developing a system that meets people's needs and builds care capacity**. This means a new, transparent model for aged care services that better targets public funding and provides stronger investment signals, making sure that beds and services are there when people need them. This includes better use of technology, a well-supported workforce, and contracting and regulatory settings that balance safety, efficiency and access will drive efficiency and reduce costs over time.
5. **A new funding model balancing cost-sharing for a sustainable system over time**. Immediate changes to funding levels to support more services (including more in-home services and residential care beds) and enable investment in a new system designed to improve productivity, efficiency and long-term sustainability. A sustainable system means that more people should contribute when they can and are protected when they cannot, and that the system is affordable for the government to provide.

In this chapter, we outline how reforms can achieve a system that delivers better care for people while reducing costs compared to just adding money to the existing system.

A better future where more people can age well in place

As New Zealand's population ages, more people will need support to live well with increasing levels of frailty, disability and complex health needs. For many older people, remaining in their own home and community for as long as possible is both their preference and the setting most likely to support their independence, wellbeing and quality of life.

However, there will be times when home is no longer the most appropriate place and people will need timely access to other forms of support and care. In this sense, ageing well in place is not simply about staying at home; it is about making sure people receive the right care, in the right place, at the right time. This must be a deliberate design strategy, not something left to chance.

> "Most older people want to remain living in their own homes for as long as possible, and the system should be designed to support this by strengthening community-based care and enabling people to maintain independence and quality of life."
>
> *- The Australian and New Zealand Society for Geriatric Medicine*

Supporting more people at home will **require in-home care to be delivered differently**. In-home care services will need to support people with higher levels of need than is typical today, including people with complex clinical conditions, dementia, mobility challenges and increasing care requirements that would otherwise lead to earlier entry into residential care. There will need to be a broader range of services and capabilities delivered by in-home care providers than currently exists.

There is an opportunity to shift from a model of in-home care that primarily provides personal care and household support to one that acts as an integrated community care platform. Within this model, a wide range of care would be provided in the home organised around a shared care plan, delivered by support workers, Registered Nurses, Nurse Prescribers, Nurse Practitioners, allied health professionals, primary care and hospital services. A capable and well supported workforce is essential for this – see more detail in Chapter 6.

This advanced in-home care model would be integrated and responsive, and able to provide care for people with higher and more complex needs – including people with dementia. While it is not a replacement for hospital services or residential care, it would work to organise a wide range of care and support around a person in their own home, so that they can live safely at home for longer. As a result, it would prevent admissions to hospital, presentations to emergency departments, repeated GP input, or entry to residential care earlier than necessary.

It will also require more than building up in-home care. People must be able to access support when they need it, receive timely assessment, and have confidence that services can respond as their needs change. People should be able to move smoothly between in-home care, primary care, hospital services, respite, rehabilitation, short-term care and residential care.

As more people receive care at home, timely access to respite, short-term care, rehabilitation and transitional care will become increasingly important. These services help prevent avoidable deterioration, support recovery following illness or injury, provide relief for carers and whānau, and reduce unnecessary hospital admissions or premature entry into long-term residential care.

Residential care will remain a critical part of the care journey. A successful ageing well in place strategy does not reduce the importance of residential care. Rather, it ensures people enter residential care at the right time, for the right reasons, and can access facilities that provide a suitable standard of residential care close to their communities when living at home is no longer the best option.

Major reform levers to reduce future costs

Under Scenario B, we estimated the additional funding needed to meet growing demand under current settings. Combined with the upfront investment required to deliver the future system, and recognising that many of the benefits of reform will be realised progressively over time, this places significant pressure on the system in the near term.

To help manage these pressures, Scenario C includes a set of major reforms designed to moderate future cost growth and place the system on a more fiscally sustainable footing.

There are four major levers:

- supporting more people at home and reducing avoidable hospital stays
- better targeting residential care funding through differentiated pricing
- rebalancing how we share the costs of care
- initiatives to improve in-home care and improve efficiency across the system.

Across the first three levers, in 2037/38, Scenario C reduces direct costs to government and health system pressures by $830 million per year (in 2025/26 dollars) compared to Scenario B. Achieving this will require investment in the programme of initiatives in the fourth lever, with an estimated net cost to government rising to $168 million in 2037/38.

Reduced hospitalisations and shorter hospital stays are a large source of reduced cost pressure, freeing up hospital capacity valued in the order of $75 million to $100 million a year.

Supporting more people at home

Supporting people to age well in place is both a better outcome for older people and their whānau and an important way to manage costs. By ensuring people receive the right care, in the right place, at the right time, more people can remain at home and connected to their whānau and community for longer, reducing the need for long-term residential care and preventing avoidable hospitalisations. Because in-home care is generally lower cost, this helps slow growth in residential care spending and reduces hospital costs.

To estimate the impact of this shift, we modelled the proportion of people receiving residential care who could instead be supported by stabilising the current model of in-home care. For modelling purposes, we assumed 85% of these people would otherwise be in rest-home level care, while 15% would be receiving hospital-level residential care.

With sustained investment, planning and implementation, a materially larger proportion of older people could be supported to remain living at home for longer, delaying or avoiding a move into residential care. Over time, we estimate that 20% to 33% of people who would otherwise receive rest home level care could instead be cared for well at home. This would reduce projected demand for residential care by approximately 3,800 to 6,000 people in 2037/38. Were this to be achievable with no change to the current model of care, we estimate this shift would **reduce government expenditure by $80 million to $120 million a year** (in 2025/26 dollars) by 2037/38, while improving health and wellbeing outcomes in a lower-cost setting.

Caring for 6,000 more people in the community will require more than simply stabilising the current model of in-home care. The people contributing to this demand shift are likely to have higher levels of frailty, complexity and clinical need than are typically supported at home currently. We also need to improve support for the partners, family members and others caring for people at home, including through better access to respite care. Without this additional care and support, avoidable deterioration, hospital admissions and emergency department presentations will increase, quickly eroding the benefits associated with delaying or avoiding entry into residential care.

A new model of advanced in-home care is needed (as described earlier in this chapter and detailed in Chapter 5), delivered by well supported and trained workforce (detailed in Chapter 6). Preliminary modelling indicates that:

- around **5,000 higher-acuity people** could be supported to live at home with advanced in-home care, at an estimated cost of around **$110 million per year** – this would deliver around 1.4 million hours of complex care[47] provided by a highly skilled workforce and supported by technology
- another **1,000 people per year** could continue living at home for longer with better carer support, including improved access to respite care, at an estimated **cost of $15 million per year**.

Improved in-home care and carer support would also help to reduce avoidable hospitalisations (which cost on average just over $12,800 per event for people aged 75 or older). These initial cost and impact estimates are indicative and will need to be refined through further analysis.[48]

Better targeting residential care funding through differentiated pricing

Under the current system, funding rates are largely averaged across providers despite significant differences in facility age, quality and investment requirements. This means funding increases are either insufficient to encourage new investment in the sector, or excessively high for operators of older facilities.

Differentiated pricing introduces a more transparent and cost-reflective funding approach for residential care, helping to direct public funding towards the areas where investment is needed most. This strengthens incentives to build new facilities, refurbish existing facilities, and invest in the capacity required to meet future demand. Better investment signals will help ensure older people can continue to access high-quality residential care when living at home is no longer the best option.

Based on assumptions outlined in **Appendix 6**, we expect a differentiated approach that targets higher levels of investment to new and refurbished stock to reduce the cost to government by about **$285 million in the first year** of implementation (in 2025/26 dollars) compared to the current un-differentiated approach modelled in Scenario B in which all existing rooms get the same price uplift as new rooms. This cost reduction relative to Scenario B will decrease over time, as older stock is upgraded or replaced with new beds attracting the higher price. Figure 8 below shows the total projected total cost to government of residential and in-home aged care, comparing price uplifts in Scenario B and Scenario C, assuming that 3% of 'legacy' rooms are replaced with new rooms each year.

[47] Excluding associated travel.

[48] See **Appendix 6** for detail of our approach to modelling these estimates.

Figure 8: Projected increase in the cost of Residential Care Subsidies following price uplifts in Scenario B and scenario C (2025/26 dollars)

Rebalancing how we share the costs of care

Scenarios A and B show us that there is no realistic way for the government alone to fund the full cost of future demand growth. Changes to private contributions are needed to make sure that services remain available for future generations.

We considered a range of approaches and acknowledge that no option will be welcomed by everyone. Our recommended approach seeks to balance public and private contributions in a way that is fair, transparent and sustainable, with costs aligned to both care need and ability to pay. In practice, this means people with the means to do so will contribute more towards the cost of their care in future, while maintaining protections for those with limited financial resources.

Based on the settings outlined in Chapter 8, we estimate that changes to settings for the amount that people contribute to their care would result in reduced costs for taxpayers of **$145 million in the first year** of implementation (assumed to be 2028/29), rising to $408 million after a 3-year phase in of changes to residential care contributions, and to **$531 million** by 2037/38.

Initiatives to improve in-home care and improve efficiency

Scenario C includes a range of reforms designed to improve how the system functions and how resources are allocated to where they are needed most — delivering care and supporting people, families and whānau.

This lever primarily operates by finding efficiencies through:

- reducing fragmentation and duplication throughout the system, including through improved digital infrastructure and more coordinated care planning
- making the system easier to access and navigate
- allocating resources more efficiently, including through a shared casemix framework and greater transparency of funding
- enabling timely care throughout the system that is more responsive to changing needs, including through improved respite and end-of-life care.

We believe that our recommendations will enable aged care providers to use funding more efficiently and will result in fewer hospitalisations and relieve pressure on the hospital system. The package of recommendations we have made would have a direct cost to government of about **$270 million per year** in 2037/38 (expressed in 2025/26 dollars) but would contribute to benefits of around **$390 million per year** by 2037/38.[49]

The bulk of the reduced costs accrue from reducing hospitalisations and how long people stay in hospitals, as well as enabling providers to use funding more efficiently – for example, achieving efficiency gains through better use of workforce capacity, better digital infrastructure and information sharing, and faster access to care.

These benefits are spread across many parts of the system and are therefore more difficult to allocate to our recommendations individually, due to complex interaction effects. However, they play an important role in improving how the system operates more effectively over time. The Advisory Group has combined expert judgement with international evidence to estimate a range of potential long-term benefits. Further work will be required to refine these estimates and the assumptions underpinning them.

Delivering the future system

Scenario C is built on the premise that better human outcomes and long-term fiscal sustainability are not competing objectives. Benefits will be realised in different ways. For people, this means more beds available for more people when they need them, less unmet need for care, and better health outcomes. For the system, this means avoided costs, and productivity and efficiency gains over time.

Together, the reforms outlined in Scenario C seek to create a **more integrated and sustainable system** that can better meet the needs of New Zealand's growing older population. This includes a more transparent funding model, stronger incentives to invest in future capacity, more care delivered at home where appropriate, and sufficient residential care capacity for those who need it. The objective is not simply to contain costs, but to improve outcomes while moderating long-term growth in system expenditure.

The growth in demand that is coming cannot be avoided. The question is whether New Zealand invests now to prepare for that demand, or faces higher costs, growing capacity constraints and poorer outcomes in the future. Scenario C offers the programme of reform required to meet the needs of New Zealand's growing and increasingly complex older population.

[49] These are midpoint estimates of direct costs to government for service delivery and technology investment, and of related benefits that include direct cost savings to government, avoided health system pressures (hospital stays, ED presentations and ambulance calls), and cost net savings from reduced residential care demand, and efficiency benefits across the aged care system.

Delivering this future will require a sequenced programme of reform that addresses both the foundations of the system and the way care is delivered. Reform first stabilises supply, then resets the funding framework to a more sustainable footing. Many of these changes are interdependent. Changes to legislation, system design and funding settings form the critical path, creating the conditions needed to support a more integrated system, better care outcomes, and more sustainable investment decisions (see Chapter 10).

New Zealand cannot achieve this in half measures. Partial implementation is unlikely to deliver the outcomes described in Scenario C or avoid the pressures outlined in Scenario A. The reduced costs associated with shifting demand and improving system efficiency cannot be realised without first stabilising capacity. Many elements of the reform require upfront or early investment, while the reduced costs, particularly those associated with reduced use of high-cost care, accrue over time. But, in our view, this scenario leads to the best outcomes.

We want to be clear that much more comprehensive modelling and other work will need to be done to give the full detail on exact costings and all implications. The Advisory Group has been constrained by both the availability of industry data and the six-month timeframe available to complete this review. Detailed cost analysis and investment modelling are beyond the scope of this report. Further and more detailed work will be required through a dedicated steering group supported by sector working groups, as we recommend in Chapter 10.

We acknowledge that other factors outside the scope of this review play a role in shaping whether people can realistically age well in place, such as access to primary and community health care, adequate housing (especially given lower rates of home ownership and growing homelessness), prevention, disability and social support settings, transport, and the strength of whānau and community networks. Reform of aged care must therefore proceed with an explicit understanding of these wider dependencies, or there is a risk that pressure will simply be shifted onto families and whānau rather than resolved.

The rest of this report outlines specific reforms we recommend:

- a single, integrated system, encompassing in-home care, residential care, end-of-life care, and wider health and social services (Chapter 4)
- better services, such as a better assessment model, more help for people to navigate the system, and strengthening in-home care and short-term care options (Chapter 5)
- improving regulatory settings to balance access and safety and the need for a comprehensive workforce strategy (Chapter 6)
- changing the funding model (Chapter 7)
- sharing care costs fairly and consistently, depending on ability to pay (Chapter 8)
- bringing the reform package together (Chapter 9)
- the next steps in the critical path forward (Chapter 10).

Chapter 4 – An integrated system

The aged care system should be reformed to become **a single, integrated system**, supported by **an integrated and nationally consistent contracting framework**, allowing aged care providers to deliver in-home and residential care.

We need **a nationally consistent pathway** across aged care and wider health services.

The system should be **more responsive** to the needs of New Zealanders, providing **flexible, consistent, connected and culturally appropriate** aged care pathways and supports.

We recommend an aged care service model that is organised around **a national, shared casemix framework** that spans the full continuum of care.

People should be able to access **more integrated health services** delivered by aged care providers, including Early Supported Discharge services, District Nursing and allied health.

There must be a review of **how agencies respond to needs** across disability, injury, and aged care supports.

The aged care system should move from a patchwork of separate services to a single, integrated continuum of in-home care, residential care, end-of-life care, and wider health and social services.

There is currently no single, clear description of how the aged care system fits together or what services are available. A person's care can be put at risk when they move between in-home care, hospital, and residential care because each part of the system has its own rules, assessments, and gaps.

An integrated system is critical for supporting people to age well in place. Older people, their families and whānau need to experience aged care and health services as a single, culturally grounded and coherent journey over time, regardless of service setting or providers.

At the same time, the journey will not be the same for everyone. Integration in this context is about good continuity of care wherever someone is on their care journey.

In this chapter, we set out what is needed for an integrated system of aged care, so that people get the right care, in the right place and at the right time.

A consistent pathway

A nationally consistent pathway is required across aged care services and wider health services. The pathway should set out typical care journeys and transition points and should include long-term aged care services (including both in-home and residential care), as well as short-term care options (such as respite and stepping down from hospital).

The continuum should also include services provided by community organisations. These services support people to age well in place by facilitating access to the system, connection to community and culture, and providing a range of services and supports to respond to community needs. These include, for example, day programmes and Cognitive Stimulation Therapy[50] for people with dementia, support for informal carers, programmes to reduce social isolation, falls prevention, and other services that help people live safely and resiliently at home. Community led services often respond to social, practical and relational needs that fall outside the scope of formal in-home care.

[50] See: https://alzheimers.org.nz/explore/dementia-learning-centre/about-cst/

A nationally agreed aged care pathway should act as a shared reference point for the system as a whole. This does not mean that everyone follows one single journey, or that identical services are needed in every region. Rather, there needs to be a common understanding of how services connect and how people move through the system over time, including the diversity of journeys. The same pathway should be understood and used by GPs, hospital clinicians, Needs Assessment Service Coordinators, non-governmental organisations (NGOs), and providers as a shared basis for referrals, supported by clear governance arrangements and regular updates.

This pathway should be well communicated, logical and easy to understand, and easy to find for older people and their families and whānau, health professionals, referrers and service providers. It should enable people and their families and whānau to understand what services are available, to access appropriate support based on assessed need, and transition smoothly between settings as their needs change.

Submissions received during our review generally supported the development of a single aged care pathway. However, some cautioned that this should be inclusive of rural and other diverse communities, and to ensure visibility of aged care resources in these communities.

A more responsive, culturally appropriate, flexible system

We need an aged care system which is more responsive to the needs of New Zealanders, providing flexible, consistent, connected and culturally appropriate pathways and supports.

It is important that culturally appropriate aged care is available to all who need it. Without deliberate system design that embeds cultural safety and responsiveness and promotes whānau-centred approaches, existing inequities will persist or worsen within the aged care system. This is also consistent with the Crown's responsibilities under te Tiriti o Waitangi – the Treaty of Waitangi to achieve equitable outcomes, actively protect Māori health and wellbeing, and design and deliver services that reflect Māori needs, preferences, and aspirations.

Cultural responsiveness and safety should be an explicit expectation across navigation, assessment, care planning, and service delivery. This requires more than awareness of cultural difference. It requires reflective practice, attention to trust and power, and care that is experienced as safe by the person and whānau receiving it. This should be recognised as a core dimension of quality in the aged care system.

> "A sustainable aged care system must be capable of meeting the needs of diverse communities and groups, rather than relying on one size fits all models with limited flexibility."
>
> *- E tū*

A national casemix framework

The system must be underpinned by a single shared national casemix framework.

Casemix is a classification system that groups individuals based on their assessed level and type of need. A national casemix framework provides a common language for understanding need across the system. It underpins both service delivery and funding, ensuring that care is consistently matched to need regardless of setting.

A casemix system uses consistent criteria, such as functional status, clinical complexity, and care intensity. Individuals with the same casemix category are assumed to require a similar level of resources. The interRAI assessment determines what casemix category a person is in.

As we have highlighted, aged care services are currently fragmented across care settings. While the use of interRAI assessments is common across aged care services, the way that services respond to the assessment is not consistent or joined up. This means that access to care can vary by region, assessor, and local service availability, and there is limited system-wide visibility of how acuity and complexity are distributed across in-home and residential care.

A national, integrated casemix framework using interRAI assessments as a basis for understanding need would be a fundamental shift from system driven by care settings to one driven by needs. The framework should span in-home and residential care, and build on the casemix model already being developed and prototyped by Health New Zealand and the aged care sector.

This new casemix framework would group people with similar levels and patterns of need and indicate the right level of care to respond to those needs. It would enable consistent comparison across individuals, more easily identify where people could be safely cared for at home, and signal when reassessment or transition is required as needs increase or risks change. Casemix is key to achieving equitable health outcomes, enabling a more responsive system that adapts to people's needs over time.

This integrated framework would include categories of care that are delivered across in-home and residential care settings, as well as a new end-of-life care category (where a person enters residential care specifically for end-of-life care and is expected to pass away within a set timeframe).

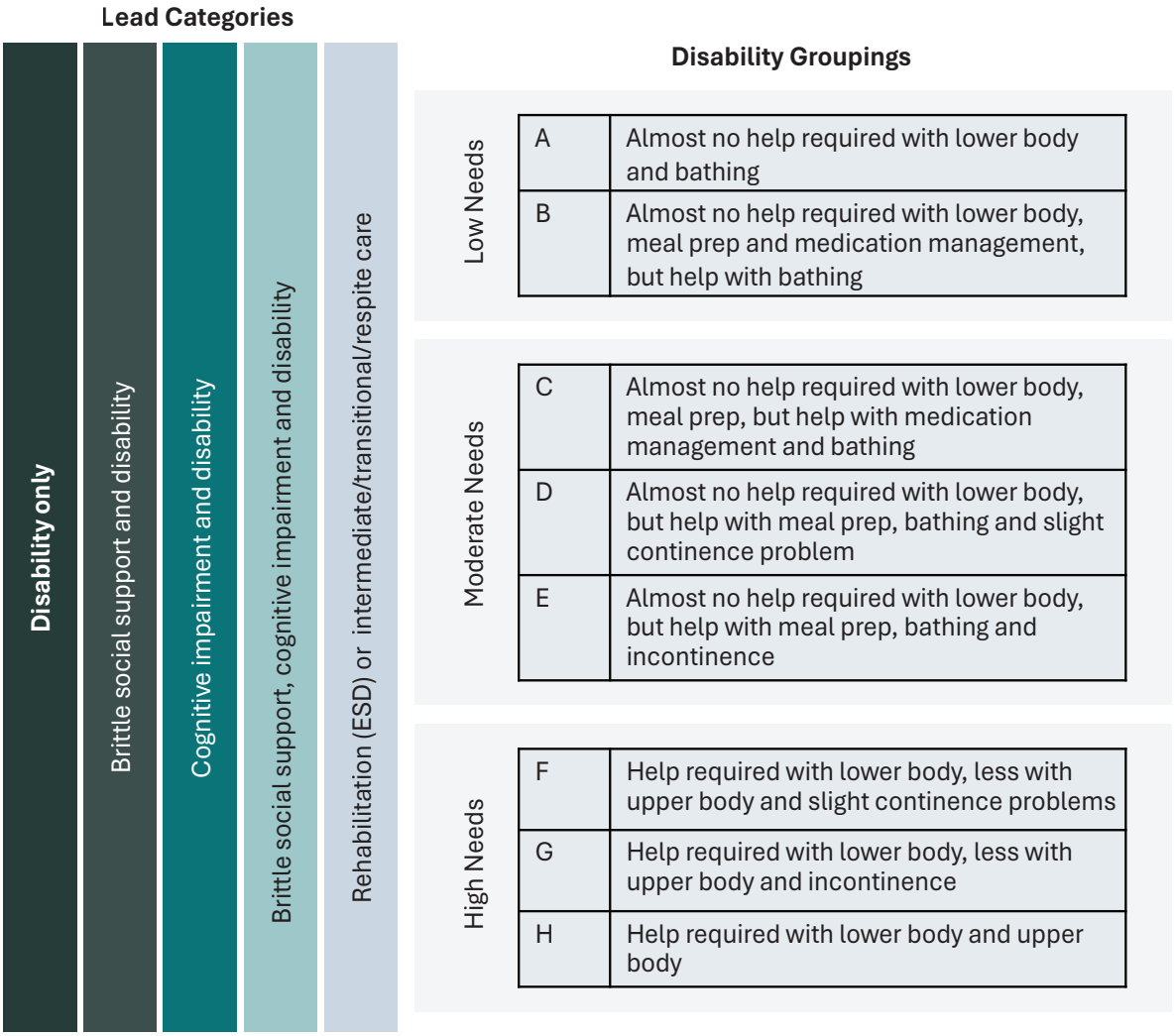
The casemix framework should also integrate with carer support, so that people receive a total package of support that includes their needs and their carers' needs.

Casemix categories should be explicitly linked to expectations for regular reassessment and change over time, to reflect the dynamic and changing nature of older people's needs. This flexibility is key to preventing unnecessary hospitalisation or long-term residential care. The casemix framework will provide more clarity on when people's needs could potentially be met at home or in a residential setting by identifying the point at which residential care is necessary. We consider this should be where it is clinically necessary, where it would be more cost effective overall for a person to be in residential care (unless the person can self-fund care at home), or where family and whānau are unable to continue caring for the person at home.

A successful casemix framework works alongside other parts of the care continuum, including funding, workforce capability and digital infrastructure. Framing services through a casemix lens is not new for in-home care, where all providers across the country are transitioning to a restorative, bulk funded casemix model.

Figure 9 provides an illustration of the current casemix framework for in-home care as an example. There is a set of 'lead categories' that reflect a specific set of needs and what care is needed to respond to those. The lead categories are further defined by sub-groupings (sometimes called 'disability groupings') that more precisely categorise the level of acuity a person has.

Figure 9: Illustration of current in-home care casemix framework



However, it is a fundamental change for residential care and will mean that current care levels (such as rest home, hospital, dementia, and psychogeriatric levels of care) will be replaced with casemix groups. This has implications for how services are funded, which is explored later in Part 3.

Using casemix as an input into funding calculations will reduce systematic over-funding for some groups, and under-funding for others. Over time, casemix will support more coherent monitoring, funding, and planning across settings. Better visibility of acuity patterns and needs could help policymakers to assess whether current service models remain fit for purpose as the population ages and becomes more clinically complex.

Submissions received during our review were supportive of introducing a casemix system that adjusts for acuity and complexity, noting it will provide more transparent information about volumes and delivery cost, and recognise the full continuum of care.

An integrated, nationally consistent contracting framework

Aged care providers should be able to operate across home and residential settings, to respond flexibly as people's needs change. In-home care providers should be able to deliver residential care, and residential care providers should be able to deliver in-home services, where this enables continuity and responsiveness of care.

There should be an integrated and nationally consistent contracting framework across in-home care, residential care and aligned services, with service specifications for different types of care. This is needed to allow aged care providers to deliver different services, including in-home and residential care.

Under this approach, contracts would be structured so that defined services – such as in-home care, short-term care, rehabilitation and long-term residential care – can be added, varied or redeployed across settings without requiring wholesale contract redesign. This would allow for more tailored or innovative service scopes, multi-service contracts, and shared delivery models between providers.

The contracting framework should set clear national expectations for quality, accountability, and safety (including requirements under Ngā Paerewa). The same nationally consistent standards for safety, workforce, cultural appropriateness, and accountability for each service should apply to all providers delivering those services, with clear roles, responsibilities and governance.

However, there should be flexibility for rural and community providers (like kaupapa Māori providers) to support different ways of working, or innovative models of care, where that would better meet the needs of local communities. Alongside system reform, current contracts will need to be assessed and modernised to reflect the changing operating environment and compliance requirements.

Enabling providers to deliver both in-home and residential aged care services across the system is a key shift. This would support system stewardship by allowing funders to more easily adapt the service mix over time while maintaining clear standards, accountability, and pricing. In rural contexts, this could support service continuity and access by allowing providers to operate across a wider range of functions and settings. An integrated approach would also help to position residential care as a flexible part of the aged care continuum, rather than a fixed endpoint. Removing home and residential siloes is also likely to improve competition and efficiency across the system.

This integrated approach recognises the shared workforce capabilities, clinical expertise and infrastructure across in-home and residential care providers. Support workers, nurses and other health professionals should be able to work across the current boundaries between residential and in-home care, supporting continuity of care. Integrated models allow trusted care relationships to continue as needs change. This is particularly important for Māori and Pacific peoples, older people with dementia, and people with more complex needs, where trusted relationships are key to good care.

We also acknowledge that demands on aged care services are affected by how people are supported across a range of other domains, including community supports, primary care, housing, transport, and social services. Allowing aged care providers and primary care to deliver both in-home and residential care would open the door to further integration across other services, particularly where smaller communities may require arrangements of services to be viable. This could include community hubs that combine aged care, primary care, kaupapa Māori services, social services, and other specialist supports that wrap around people, families and whānau.

> "Streamlined contracting would free up scarce rural capacity to focus on care delivery rather than contract management, while improving coherence across the system."
>
> *- Hauora Taiwhenua Rural Health Network*

Expanded and integrated services

People should be able to access integrated health services delivered by aged care providers, including Early Supported Discharge (ESD), District Nursing and allied health (such as physiotherapy, diet and nutrition, and speech-language therapy).

Older people access a range of services over time as their needs change, including primary care, aged care, allied health, nursing, geriatricians, and more. Some health services support older people to recover outside of hospitals and achieve better health outcomes at considerably lower cost through reduced hospital stays.

For example, ESD teams provide short-term, intensive, community-based rehabilitation service for medically stable people that enables them to leave hospital earlier or avoid hospital entirely. The teams incorporate oversight from an interdisciplinary clinical team, including nurses, allied health and geriatricians as required. Some examples include the Supported Transfer and Accelerated Rehabilitation Team (START) in Waikato and the Community Rehabilitation Enablement & Support Team (CREST) in Canterbury.

District Nursing services also support people in the community who have complex health needs, to prevent hospitalisation or support people after hospitalisation, and allied health professionals work with people across in-home and residential care settings.

We consider that these critical supports could be more accessible and work better together as people move between in-home care, residential care, and other settings. Some services, like allied health, are critical for aged care but are currently prioritised for work in hospitals. As a result, meeting needs in the community is deprioritised.

Better aged care is dependent on the availability of allied health and nursing. We recommend aged care providers work more closely with District Nursing, allied health, and other health professionals through direct provision of allied health, District Nursing and other services by in-home and residential care providers, and considering local, multidisciplinary teams funded by Health New Zealand that work across aged care services in their local communities (a hub model).

We also recommend that both in-home and residential aged care providers deliver ESD services. The CREST model is an example where this has worked well, delivered by in-home care providers.

More effective integration would enable better person and whānau-centred care, as providers are able to more easily wrap services around the person. This can also support better health outcomes. Early and ongoing access to allied health services, for example, can slow functional decline, support recovery, and delay or prevent entry into higher-cost care, enabling older people with dementia to live at home longer.

Sione is 72 and lives in Whanganui. He was admitted to hospital due to a respiratory infection and has mobility needs. He wants to return home, but he needs in-home care and a medication review. His daughter spends weeks trying to work out who to call. She tells his story multiple times to different services.

In the new integrated system, Sione has one assessment and one shared care plan. He is connected with a provider who supports him to leave hospital by providing an ESD package of care with ongoing in-home care if required. All the people supporting him know what support he needs and what support he is getting. When he needs more help, his support package changes quickly and he recovers faster. Sione and his family experience one connected system rather than several disconnected ones.

Our modelling estimates that it would cost around $30 million per year to run ESD teams in every region, but there would be significant reduced costs from avoided hospitalisations and reduced length of stay in hospitals of about $50 million per year.[51]

Submissions to us supported embedding multidisciplinary allied health teams in aged care (for example, recreational therapy, massage therapy, speech-language therapy, dietetics, social work, podiatry, psychology, etc), with virtual or onsite models for rural areas.

> "Both providers and older people still find the system to be fragmented, prescriptive, and insufficiently responsive to holistic need, especially for those with few resources to pay for them independently. Older people and their care partners experience multiple difficulties as a result, while providers struggle to deliver the right care at the right time for the right funding, and hospitals bear the pressure of this shortfall."
>
> *- New Zealand Council of Christian Social Services*

Clearer responsibilities and funding rules

The government should undertake work to align responsibilities and funding rules across agencies, with a view to ensuring that nobody is unfairly disadvantaged.

As well as silos separating different aged care services, there are also silos separating the supports funded by different agencies. Different eligibility, funding and assessment frameworks used by ACC, Disability Support Services and Health New Zealand can mean older people's access to care, equipment and other resources depends on their age, diagnosis, or entry pathway rather than their level of need. This creates uncertainty, distress, and inequity for people whose needs evolve across these boundaries.

There should be equitable access to care for people who need it, which was highlighted by the Aged Care Commissioner when we met with them as part of our work. Transitions between Disability Support Services funding and Health New Zealand-funded aged care are a key pressure point.[52] If a disabled person's needs are determined to have become age-related, they may move from disability-funded to health-funded support, losing access to specialist disability services, and shifting to services for older people that are not designed for their needs. This can disproportionately impact Māori and Pacific peoples, who have on average lower life expectancy and higher morbidity rates at younger ages.[53]

Similarly, people can receive very different support for age-related and injury-related needs through health and ACC funding, when the underlying needs and the responses required may be the same. It is not always clear where needs are 'age related'. Aged care providers report that navigating eligibility boundaries can be complex and time-consuming.

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[51] About 77,000 bed days a year are occupied by older people who no longer need hospital care but cannot be discharged. We estimate that ESD could reduce these bed days by about 30%, and that some people may need less support at home as a result of timely, intensive care and rehabilitation.

[52] This was highlighted in the previous Aged Care Commissioner's report (Aged Care Commissioner, 2024).

[53] Hikaka et al., 2026.

Older people should not be unfairly disadvantaged by how their needs are assessed, categorised and which providers are delivering support to them. We recommend that the government aligns responsibilities and funding rules better across agencies, to ensure that nobody is unfairly disadvantaged and to reduce administrative burden. There must be clear responsibilities, aligned assessment expectations, and transparent funding and care settings across system boundaries, based on need.

While beyond the scope of this review, we also recognise that some younger disabled people and individuals with complex needs may be better supported in alternative settings outside residential care for older people. We consider that the government should review future care and funding pathways for people entering aged residential care funded by Disability Support Services, including investment in alternative community-based options and clarification of transition points into Health New Zealand-funded aged care services.

Submissions received during the review generally agreed that funding and care provision for people should be aligned, and funders should take the same approach to care. However, some noted that older people (and older people with disabilities) have specific needs that should be recognised.

Recommendations

1. Reform the aged care system to be:
    a) a single, integrated system, encompassing in-home care, residential care, end-of-life care, and wider health and social services
    b) more responsive to the needs of New Zealanders, providing flexible, culturally appropriate, consistent and connected aged-care pathways and supports
    c) underpinned by a new single shared national casemix framework for identifying and responding to need across all care settings, including dementia needs.
2. To support this, Health New Zealand should adopt an approach to aged care commissioning which:
    a) establishes a nationally consistent contracting framework, integrated across in-home care, residential care and aligned services, with modular service specifications and schedules for different types of care
    b) allows aged care providers to deliver services across different settings, including in-home care, residential care, alongside and incorporating primary care and other health and social services
    c) expands the range of services delivered by and alongside aged care providers in the community, including Early Supported Discharge services, District Nursing and a range of allied health services.
3. The government should review agency responsibilities and funding rules across aged care services, ACC, and Disability Support Services, to better align the support that different groups receive and ensure that nobody is unfairly disadvantaged.

Chapter 5: Better services and strengthening in-home care

People need the right services to age well wherever they are.

Access needs to be improved with a **more flexible assessment model** delegated to aged care providers that better accounts for holistic needs.

In-home care needs to be strengthened and scaled to manage higher needs and support more people to remain safely at home for longer. The advanced in-home care model would feature **expanded services, better coordination and oversight, and a multidisciplinary workforce**.

Short-term care options must be **consistently available** as core services to support people to recover from illness or injury and return home.

Carers need better support, including options for residential respite, in-home respite and day programmes, so that support networks can keep looking after loved ones in their homes and communities.

People need more **support to understand and navigate the system**.

Technology and tools like **monitoring and alarms** should be reviewed.

Better **digital infrastructure** is needed so that providers have the right information about what a person needs, faster.

A new **telehealth medical service** should be established for all aged care providers to access when a person's usual clinician is unavailable.

Most people want to stay in their own home for as long as possible and, with the right support, many more could. That means there needs to be a faster, simpler way to get assessed, for in-home care to handle higher needs, reliable short-term and respite care so carers don't reach breaking point, and better support to help people, family and whānau understand what's available and how to access it.

Some key changes are needed to services. In this chapter, we set out changes that would improve access to care with a more flexible assessment model, more in-home services and better short-term and respite options, strengthened support for carers, help to navigate the system, and new technology and digital systems.

Better access to care through a more flexible assessment model

How people access and are assessed for aged care is critical. It shapes whether people receive timely support, experience smooth transitions as their needs change, and can remain living well at home for as long as possible.

The current system of assessments for aged care is not responsive enough. Needs Assessment Service Coordination (NASC) agencies are the gateway for access to most funded aged care services and reassessments of need, which creates a bottleneck in the system.[54] Reports and submissions have highlighted that delays in assessment and reassessment are common, sometimes extending to many months.[55] At the same time, assessments can sometimes be duplicated.

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[54] Submissions to the Group.

[55] The Health Committee's inquiry into aged care highlighted that in some cases, NASC assessors must travel some distance, and the time lag can mean that people with dementia and psychogeriatric needs are often placed in inappropriate settings, without necessary security.

The system was also largely built around an individualised model of care that does not adequately reflect the needs, values, and lived realities of Māori, Pacific peoples, and other diverse communities.

All of this has very real impacts for people's health and costs to the system.

The system needs to change so that people can access care faster and earlier, wherever need is first identified. We recommend implementing a more flexible and delegated assessment model where providers undertake most assessments. This approach includes the following elements:

- Low-intensity assessments or screening tools, including self-assessments and comprehensive geriatric assessments, should be used more widely to identify risks and determine when an older person needs more support.
- To be effective, funded supports must be linked to these early assessment pathways, including primary care, specialist services, District Nursing, allied health, iwi and kaupapa Māori organisations, and wider social services.
- Aged care providers should undertake most assessments for access to in-home care and residential care, including managing referrals, and assessments for short-term care where appropriate. This would improve access to care, reduce duplication in the system and increase system efficiency and responsiveness while maintaining safety and oversight.[56] Pathways for permanent entry into residential care should ensure that in-home care options have been fully explored and clinical needs appropriately addressed before admission.
- In-home and residential care providers should undertake all regular reassessments.
- As part of this shift, the role of NASC agencies in the system must evolve. NASC agencies would move away from delivering high-volume, routine assessments and instead focus on two core functions:
    - Strong oversight of provider-led assessments, including auditing, monitoring, benchmarking and reporting, to ensure the consistency and quality of provider assessments and in so doing, reduce the risk of gaming.
    - Undertaking high acuity assessments that involve significant complexity, including assessments for entry into secure care (such as current dementia and psychogeriatric care), and assessments for people in hospitals (where this is more efficient).[57]
- Assessment tools and practices should be applied consistently and within a defined timeframe. It is essential that interRAI assessments are used consistently throughout the new system to guide allocation of services and support. This is key to safety and fairness, as interRAI data can be used to analyse whether there are inappropriate care placements and packages of care being provided.
- Assessment frameworks must also accommodate specialised pathways where required. Assessments for end-of-life care, for example, must be flexible and not overly intensive, and could make better use of the interRAI Palliative Care Assessment. It is also critical that mental health needs are factored into assessment and care planning.
- National minimum expectations are needed to guide how assessments are conducted and how outputs are applied. Provider-led assessments must be supported by clear national training, accreditation, and competency standards.

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[56] The Needs Assessment Service Co-ordination Association (NASCA), in a submission to our review, indicated that in-home care providers undertaking all regular reassessments and reviews for people known to them would free up about 48% of current assessment workload, releasing an estimated 45–270 minutes of skilled assessor time per event.

[57] Assessment into secure care is highly sensitive and carries significant ethical and legal implications. Secure care is often effectively permanent, with many people remaining in that care for the rest of their lives. The assessment process must reflect an increased duty of care for vulnerable older people who require secure care, many of whom may lack decision-making capacity.

- Assessments should be timely and not overburdensome for people being assessed for services. We recommend clear and transparent reporting on the timeliness performance and quality of assessments, alongside key performance indicators.
- Data sharing between health services and aged care providers, particularly interRAI assessment data, is key to reducing delays, limiting repeated information-gathering and improving coordination across care settings. This includes pre-populating data from one assessment to the next, and connecting interRAI directly to provider systems through APIs.[58] These settings must be underpinned by robust privacy and data security safeguards.
- A well-resourced national interRAI governance group should be re-established with permanent frontline representation from residential care providers, in-home care providers, NASC agencies, geriatricians and primary care clinicians. The governance group should provide ongoing oversight and ensure the assessment framework remains clinically useful, proportionate, culturally appropriate and suitable for people living with dementia, and fit for purpose.
- Assessments should be culturally grounded, accounting for cultural needs and safety, and how services will respond to those identified needs. There is also a need to build culturally appropriate capacity in providers doing assessments, and NASC agencies.

Mary is 85 and lives alone. She is finding it difficult to move around the house and struggles with showering and dressing. Under the current system, she does not know what support is available to her and has a fall before booking an appointment with her GP. Her GP refers her to a NASC agency for an assessment. Mary then waits two months to be assessed for in-home care and while she is waiting her needs deteriorate further.

In the new system, Mary can find information easily on where to go for support and does a self-assessment to understand her needs and what support can be provided. She can go directly to an aged care provider in her community or go to her GP to be referred. Mary goes direct to a provider that is known to her. The provider undertakes the assessment for in-home care within a few days, and a support plan is developed and care provided. Mary is glad she can access the support she needs quickly.

We recognise that having more provider-led assessments introduces more risk into the system. Strong information-sharing and data collection requirements through interRAI and clear audit and regulation mechanisms through NASC agencies will be needed to support safety and consistency, including detecting any potential gaming by providers. We believe we can achieve a safe, efficient and person-centred assessment framework with these safeguarding mechanisms in place.

These changes, alongside robust quality and safety requirements, will reduce bottlenecks in the system and support people to be assessed faster and by workers that they know and trust. NASC agencies and providers must be appropriately resourced for the roles recommended above.

[58] APIs refer to a set of rules and protocols that let different software applications communicate with each other.

Strengthening in-home care

As people live longer with higher health needs, including cognitive impairment, in-home care must be able to support more intensive care safely.

We recommend strengthening and scaling in-home care so that providers can safely support higher and more variable levels of need in the community over time, where clinically appropriate. This includes expanding higher-intensity and restorative in-home care that can stabilise people during periods of increased risk or health decline, support recovery following hospitalisation, and maintain continuity of care across changing circumstances. This should be supported by the proposed casemix and assessment frameworks, and take account of other factors such as carer stress, sufficiency of housing, and personal preference.

While there has been a gradual shift toward a restorative approach over the last decade, the current system lacks sufficient intensity, flexibility and clinical integration to prevent avoidable hospitalisations, prolonged hospital stays, or early entry into residential care.

Traditionally, in-home care has focused on personal care and household support. Where additional support beyond the scope of current in-home care is needed, providers must coordinate with District Nursing services and other services, such as allied health. However, in-home care providers have observed District Nursing services are under strain and not always available at the right time, which can result in unnecessary hospital admission. Research also indicates that people receiving in-home care are more likely to enter hospital than those in residential care, and there are opportunities to strengthen in-home care.[59]

Strengthening in-home care to manage higher acuity is central to enabling ageing well in place. Under this new approach, people receiving in-home care would be able to access a broader range of services that can be safely provided in the community. The expanded service scope would include:

- **Clinical support and treatment** – including nursing support, medication management, wound care, continence assessment and management, delegated clinical activities, and other services that help people manage ongoing health conditions. This may include delegated or nurse-led activities that are traditionally delivered through hospital, District Nursing or specialist services where this can be done safely and appropriately.

Marg is 75 with slight cognitive impairment and lives alone in Whitianga away from family. Marg has type 1 diabetes and is still able to adjust her own insulin as needed. After a procedure on her arm and a stay in hospital, Marg's family is worried that she is still under stress and won't be able to go back home, because she can't manage her insulin on her own and change her own dressings. Regular in-home care support workers can't manage the insulin for her. While she could get District Nursing help every few days, this isn't enough for her to live alone at home safely. As a result, she stays in hospital until she can manage her own insulin again.

Under advanced home care with increased clinical supervision, a Registered Nurse from the in-home care provider trains and supervises an advanced support worker. The support worker visits Marg three times a day to monitor her blood glucose levels and administer insulin as needed. The support worker helps with simple wound dressing and monitors her condition. The insulin provision is monitored by the Registered Nurse through online logs. The support worker notes any changes in Marg's condition and alerts the Registered Nurse for additional clinical support where required.

[59] Boyd, M., Broad, J., Zhang, T., Kerse, N., Gott, M., Connolly, M. (2016). *Hospitalization of Older People Before and After Long-term Care Entry in Auckland, New Zealand*. Age and Ageing, 45(4). https://academic.oup.com/ageing/article/45/4/558/1679966

- **Monitoring and early intervention** – including direct or technology-enabled monitoring of vital signs, nutrition and hydration, functional decline, falls risk, infection risk and other indicators of deterioration, supported by appropriate escalation pathways and timely clinical intervention.
- **Recovery, rehabilitation and restoration** – including post-hospital support, rehabilitation, reablement, allied health services, equipment and home modifications, and other interventions that help people recover from illness or injury, regain function and maintain independence.
- **Dementia and complex-needs support** – including care for people living with cognitive impairment, behavioural symptoms, frailty, multiple long-term conditions and other complex needs that require a more coordinated response.
- **Preventative and wellbeing services** – including falls prevention, vaccinations, medicines optimisation, proactive care planning and other interventions that help people maintain health, independence and quality of life for longer.

The advanced in-home care model would provide more clinically coordinated and responsive support than is typically available through current home-care services. Care would be guided by comprehensive care planning and stronger coordination between support workers, nurses, allied health professionals, GPs and other clinicians to ensure services are delivered in a timely and connected way. Some people may need more clinical oversight and involvement than others, which would be informed by their casemix. Digital tools (including shared care plans and remote monitoring) would be an important enabler of coordination and oversight, and would help to identify changing needs earlier.

Within this new model, more clinical and specialist input would be available through the in-home care provider. Registered Nurses would play a larger role in assessment, care planning, clinical monitoring and oversight, and the delegation of clinical activities. Allied health professionals would support rehabilitation, recovery, prevention and maintaining independence. Support workers would have stronger training and competencies to enable them to undertake a broader range of delegated activities and provide more intensive support than is common today, operating under appropriate clinical oversight. Some activities could also be undertaken by family members, whānau, carers, or individuals themselves with the right education, support and oversight.

With greater intensity of care comes greater responsibility. The success of this model will depend on effective implementation, including a suitably skilled and regulated workforce, and appropriate safeguards to maintain safety and quality of care. We discuss workforce considerations in Chapter 6 and broader implementation considerations in Chapter 10.

The model would require a workforce with stronger clinical capability and a higher level of specialist input than traditional in-home care services. This means a higher cost than standard in-home care, reflecting not only the additional clinical expertise required, but also increased care hours. We estimate that around 5,000 people who would otherwise require residential care could be supported safely and effectively at home through an advanced in-home care model.

Our preliminary modelling indicates that this could require investment of around $110 million per year.[60] This level of investment would deliver around 1.4 million hours of complex care delivered in the community, excluding travel, provided by a highly skilled workforce comprising advanced support workers, Registered Nurses, and allied health professionals. This also includes increased use of technology to support safe, effective, and coordinated care in community settings.

[60] These figures are indicative only and should be refined through further analysis to confirm the precise level of investment required and the associated impacts on residential care demand.

More work is needed to determine the precise level of investment required and, importantly, to test and validate the effectiveness of the proposed model. The benefits described in this report depend on achieving safe and effective care in community settings. If investment is insufficient, workforce capability is inadequate, or technology does not perform as intended, the expected reductions in residential care demand and hospital utilisation may not be realised.

For many people with higher needs, this level of support is still likely to be a lower-cost and more appropriate alternative to residential care or hospitalisation. Our modelling estimates that advanced in-home care could reduce demand for residential care by about 5,000 beds, and reduce costs to government by around $28,000 per person per year.[61] Cost reductions also result from avoiding unnecessary hospitalisations (which cost on average just over $12,800 per event for people aged 75 or older), and avoiding or delaying progression into higher levels of residential care (for example, hospital-level residential care costs the government an average of $52,000 per person per year).

We recognise that not all people can be safely or efficiently supported at home. There will be clinical, safety and cost thresholds where residential care is more appropriate and cost-effective where:

- residential care is more clinically appropriate (based on casemix and clinical assessment)
- residential care is more cost-effective
- carers can no longer look after a person at home due to carer stress.

These factors should be clearly understood through the casemix framework, which would incorporate clear triggers and protocols to transition to residential care.

The expanded role for in-home care providers and better integration of services will significantly improve the level of care that people are able to access in their homes. This means better support for more people living at home – including people with dementia and their families and whānau – and more options where family and whānau are looking after an older person at home for cultural reasons. This approach will simplify discharge planning, result in general improved efficiency, better use of resources across the health system, and more timely healthcare.

Submissions to inform our report were supportive of more comprehensive in-home care and highlighted that in-home care providers could deliver more services that prevent escalation of health need. Many submissions, for example, raised that continence is a significant (and treatable) issue that can worsen health outcomes and lead to premature entry into residential care. There is a significant opportunity to better care for people at home.

> "Grey Power would urge that pathways for eligible patients to secure appropriate domestic and in-home care to allow older people to age well in their own homes be streamlined and communicated well to both health professionals and those seeking assistance."
>
> *- Grey Power New Zealand Federation Inc*

[61] In the avoided cost of Residential Care Subsidies.

Consistently accessible short-term care options

We recommend short-term care options be standardised as core services across the system, rather than treating them as exceptions or discretionary add-ons. These services must be available and accessible in a nationally consistent and clearly understandable way.

Short-term care options help people to move between home, hospital and residential care when their needs change for a short time. These can include:

- where a person transitions through a residential care facility between hospital and home – this includes where rehabilitation is needed (utilising ESD services)[62] or where no rehabilitation is needed but the person needs time to recover in a facility or is waiting for equipment in their home (sometimes called 'interim care' or 'transition to home')
- where a person living at home has a planned or urgent short stay in a residential care facility when their needs have increased for a short period (for example, where they need rehabilitation, or have a planned post-operative stay).

While residential respite is also considered a short-term care option, we have considered this in a separate section below.

Short-term care has developed in an ad hoc and regionally variable way, resulting in a complex and fragmented arrangement of services that varies across regions. There is an absence of standardised approaches for managing short-term care placements in residential care, a range of contracts, funding pools, and service models, inconsistent admission and discharge criteria, and unclear accountability between hospitals, primary care, and residential care providers.[63,64] There is also low short-term care capacity.[65] Residential care providers have little incentive to offer short-term care in the current system, as caring for short-term residents incurs higher average daily costs than long-term residents.[66]

People should be able to consistently access short-term care options, wherever they are. Clear and reliable pathways for transitioning between home, hospital, and residential settings can act as a pressure valve across the aged care continuum, stabilising people during periods of change, and preventing the need for long hospital stays and long-term residential care.[67] A coherent set of short-term and transitional service will also reduce the clinical and social risks to older people associated with prolonged hospital stays.

As part of a new standardised system of short-term care, we recommend that rehabilitative support in residential care must be strengthened and scaled. This should be supported by enabling aged care providers to deliver ESD so that people do not need to stay in hospital longer than needed, and can get comprehensive support during short stays in residential care. Rehabilitation should be commissioned as a multidisciplinary service (including allied health and nursing) with defined transitions to and from care (where this is delivered by separate providers). Regular assessment and clear outcomes will be key to ensuring rehabilitation is responsive to need, underpinned by the casemix framework.

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[62] An example of this is the Non-Acute Rehabilitation Pathway service (NARP).

[63] Health Committee, 2025.

[64] Engagement from the Aged Care Funding and Service Models review highlighted a desire for short-term residential care to be seamlessly integrated into the healthcare continuum.

[65] Sapere, 2024a; engagement from the Aged Care Funding and Service Models review.

[66] Sapere, 2024a; Ernst & Young, 2019b.

[67] Research by Health New Zealand provided for this review showed that residential care can act as an effective intervention for some people assessed as 'low acuity', particularly where social support and symptom management are fragile. A study showed improvements in health outcomes after admission to residential care, including loneliness, pain, depressive symptoms, and health instability. Likely reasons for improvement in some of these include medication optimisation, regular nutrition and improvements in symptom control and pain management following entry.

Rehabilitative support will help people to recover faster after a hospital stay or to prevent a hospital stay, shorten length of stay in hospital, and return home safely rather than entering long-term care.[68] Models such as ACC's non-acute rehabilitation pathway (NARP) demonstrate how structured, time-limited rehabilitation can keep the focus on return to independence.[69]

Effective handovers are needed to support transitions. There must be clear expectations for how responsibility is shared when care spans multiple providers, including requirements for minimum datasets for transitions between care levels and settings, and information sharing. As we recommend below, there should be improved shared care planning where multiple providers and health professionals support a person's care. Digital integration is a key enabler for more effective transitions and shared care plans.

Noah is 77 and lives at home. He has been an in-patient in hospital for three weeks following a stroke. He was previously fit and healthy. He doesn't need to be in hospital anymore, but it isn't safe for him to return home yet and he still needs lots of rehabilitation.

In the new system, there are easily accessible options for Noah to enter a residential care facility for rehabilitation for a short time, and he doesn't need to stay in hospital. He stays in the residential care facility for three weeks, makes good progress, and then returns home.

Support should be designed to distinguish temporary needs from long-term needs, support timely movement across care settings, and prevent avoidable hospitalisation or long-term residential care driven by system delays rather than clinical necessity.

In this new system, while the main function of residential care facilities would be for long-term care, providers should take on a more flexible role in offering short-term and transitional care, including respite and rehabilitation. This is already happening in some areas of New Zealand, and as part of our work we heard this has created positive results for people accessing the system and for hospital capacity, particularly in rural areas where residential facilities are often the most viable local option for short-term support. This would fundamentally reframe residential care as providers of short-term and transitional care alongside long-term care, supporting a range of assessed needs rather than just at points of crisis.

To deliver this role effectively, residential care providers must be properly resourced and supported by fit-for-purpose pricing for short-term and transitional versus long-term care. This is explored further in Part 3. Availability of short-term care capacity also depends on investment to increase the supply of residential care beds quickly enough to meet both the rising demand for long-term care and the need for short-term and transitional care.

Our initial modelling estimates that it could cost an additional $2 million per year to support short stays in residential care,[70] but there will be significant reduced costs from avoided hospitalisations and length of hospital stays.

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[68] Heppenstall, C., Hanger, H., Wilkinson, T. (2019). *The Canterbury Community Rehabilitation, Enablement and Support Team (CREST) Service: A Novel Service to Support Wellbeing and Independence in the Community*. Age and Ageing, 48(2). https://academic.oup.com/ageing/article/48/Supplement_2/ii24/5530429

[69] See: https://www.acc.co.nz/for-providers/provider-contracts-and-services/non-acute-rehabilitation-pathway-service

[70] This assumes providers would be funded $250 per short stay, and that there would be 8,000 short stays per year across the system.

"Ageing in place is not primarily a question of where care is delivered, but whether care can be delivered consistently, safely, and with sufficient time."

- E tū

Strengthened respite care options

We recommend expanding and standardising respite across the country. Planned and emergency respite (and short stays, as above) should be accessible through clearly defined and funded pathways, and should link to ESD. Access to respite must be standardised and simplified so that carers are consistently able to access the care that they need, regardless of where they are.

Carer stress is a significant driver for entry into residential care, particularly for people living with dementia. Without reliable short-term supports, carer strain can lead to avoidable hospital admissions or permanent residential placement. The Kaitiaki of the Dementia Mate Wareware Action Plan stressed this point to us when we met them. This underlines the importance of support for carers at home. We were impressed by the Action Plan,[71] which we generally endorse.

Support for carers, including respite, is critical to enabling ageing well in place by supporting carers to continue in their caring role, and recognising the support they provide their loved ones. Currently, respite can include:

- **residential respite**, where a person may enter a residential care facility for either emergency or planned short-term stays, or in exceptional circumstances (for example, where a person without a carer can take a break from managing their own day-to-day care activities)
- **in-home respite**, which is temporary support in the home while the primary carer has a break (including paying a family member to provide support)
- **day programmes**, which provide an important opportunity for informal carers to take a break and for older people to socialise and take part in meaningful activities, reducing social isolation and carer stress. Some day programmes cater to specific needs, such as dementia support and kaumātua services
- **equipment** that supports giving the carer a break.

Despite its importance, respite and other short-term support is delivered inconsistently across the country, with access and entitlements varying widely across regions (including access to day programmes). Capacity constraints within residential care facilities can also limit access to residential respite.

These inequities are reinforced by two separate systems that are used to allocate resources for respite, depending on the region the older person is in:

- In some regions, Health New Zealand contracts with residential care providers for a set number of respite days, which are allocated to a person by NASC following an assessment of the older person and their carers' needs. NASC allocations are currently capped at 28 days a year. While this element of respite is similar to short-term care, it is not currently aligned in its funding or operating model.

[71] See: https://www.nzdementia.org/Articles/dementia-action-plan-for-nz.

- Other regions offer respite through the Carer Support Subsidy, which gives carers an individualised budget to purchase respite services of their choice (up to 25 days at $80 per day).[72] While it offers more choice, it can be difficult for carers to manage.[73] It is also not enough to cover the cost of respite in a residential facility, requiring carers to combine multiple subsidy days to pay for a single day of care.

Respite models are also not adequately resourced to be restorative, increasing the risk of functional decline during respite stays.

To address these issues, we recommend that carers receive a package of respite that is linked to their needs through the proposed casemix framework. This package should include:

- an allowance of days of respite in a residential care facility that is fully funded to the level of an appropriate room, in the same manner as short-term care
- an allocation of funding for respite in the home (where a family member or support worker stays and assumes care for a period) and/or day programmes.

The Carer Support Subsidy should be retained, but repurposed as a flexible fund for non-contracted support and equipment, and other respite-related items that carers need (that is, it should not include residential or formal in-home respite).

Day programmes must also be consistently available across the country – not just for respite, but also to support people with dementia and address loneliness and social isolation, which have significant impacts on older people's health and wellbeing. Day programmes play an important role in reducing social isolation, supporting carers, maintaining function, and delaying entry into higher-cost residential care, particularly for older people with dementia.

The government must work on building a sustainable range of offerings for day programmes. This should include expanding access to Cognitive Stimulation Therapy, which has been shown to improve mood, memory, and quality of life for people with dementia. Barriers to accessing day programmes and respite – including transport, inconsistent funding, referral pathways, regional availability, and limited awareness among clinicians and assessors – should be identified and addressed.

Thomas is 70 and lives in Wellington with his wife Angela. Angela looks after Thomas most of the time, and she is feeling burnt out and needs a break. Angela is given an allocation of the Carer Support Subsidy through NASC, but is struggling to figure out what respite is available. She organises respite in a residential facility, and pays the residential care provider the full cost up front. Angela later needs to claim back some of the cost through the Subsidy, and isn't sure what she's entitled to claim per stay.

In the new system, Angela is able to find clear and easily understandable information online about where she can get respite and how to access it. She gets an assessment for respite through her local in-home care provider and is given an allowance of days that she can use at a residential care provider. She can organise respite quickly and doesn't need to pay anything.

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[72] This can include a contribution to respite in a residential care facility, paying a family member or other person to take over care for a period, or to purchase equipment that can make care easier (for example, monitoring equipment).

[73] Health New Zealand engagement highlighted that carers face difficulties navigating and accessing support services, and that funding and support mechanisms are too rigid and do not accommodate the needs of carers and their families. Because the Carer Support Subsidy is primarily claims-based, it can be difficult for older people and their carers to use who do not have resources to pay for services upfront.

More consistent, integrated and restorative respite will reduce pressure on carers, and downstream pressure on hospitals and residential care by sustaining care at home through periods of instability and recovery. For Māori, Pacific, and other diverse communities where caregiving is collective and shared, flexible respite and short-term care services are particularly important and must support whānau involvement, continuity, and culturally safe transitions across the care journey.

Carers should also have access to better training, education, information and wider support, to help them care safely while looking after their own health.

Our initial modelling estimates that these changes would require additional investment of around $15 million per year, but would result in significant longer-term cost reductions in avoided residential care costs.

> "Respite care for clients being cared for by family members needs urgent attention due to poor availability and frustratingly challenging pathways to secure respite care. Often the carer is a partner of similar age and in poor health carrying a huge burden often affecting their mental health and ability to continue providing care in the home."
>
> *– Grey Power New Zealand Federation Inc*

Culturally grounded and holistic care

Many reports and reviews have identified that mainstream aged care services are often not culturally responsive and lack sufficient Māori and Pacific representation in the workforce and governance.[74,75] These factors undermine trust and can act as deterrents to accessing the right care needed to live and age well.

We know that kaumatua Māori need to be connected to their whānau, and that whānau relationships need to be supported and enshrined in the system. While culturally grounded models exist, they are not well supported by funding and regulatory settings. This is well-recognised, with the Health Committee recommending that the government explore ways to provide culturally appropriate care and continuity of care.

We recommend that culturally grounded service models be embedded as core components of the aged care continuum. As part of this:

- all aged care services must be culturally appropriate and support language, identity, culture, spirituality and wairua, and community participation
- specific services for particular populations (for example, kaupapa Māori aged care services) should be supported to develop across rural and urban settings so that there is a diverse mix of care options that respond to a diverse range of values and preferences through appropriate funding and procurement.

Culturally grounded and safe services are an essential part of an effective and equitable aged care continuum. They support wellbeing through greater connection with family and whānau, cultural identity, wairuatanga and spiritual wellbeing, and a greater sense of belonging. During our review, we heard from Māori providers and researchers that engagement, trust, and outcomes are strongest where services are delivered through culturally resonant approaches, by people and organisations with deep connections to their communities.

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[74] Hikaka et al., 2024.

[75] Aged Care Commissioner, 2024; Hikaka & Kerse, 2021; Sapere, 2024a.

Culturally appropriate care must also be reflected in the design of residential and community-based environments. Future models could include smaller household-style units, spaces for whānau to stay or gather, community and cultural activity spaces, gardens for growing kai, and design features that support spiritual, cultural, and intergenerational connection. These models are likely to be particularly important for Māori, Pacific peoples, Asian communities, and other people whose expectations of care are relational and collective.

For Māori, evidence suggests that care models which prioritise relationships, care continuity, respect for mana,[76] and collective decision-making[77] are more likely to engage kaumātua Māori and support wellbeing and health outcomes over time.[78] Māori models of health, such as Te Whare Tapa Whā, highlight that wellbeing is inseparable from whānau connection, cultural identity, spirituality and wairua, and belonging. For Pacific peoples, evidence indicates that engagement improves when services are delivered or supported by Pacific providers, churches, and community organisations.[79]

The need for culturally safe and responsive care also extends to rainbow elders, including takatāpui and older LGBTQIA+ people. Rainbow elders may experience stigma and discrimination in health settings, which can create mistrust of aged care services and reluctance to access support.[80] Services should be inclusive and affirming of diverse identities.

Supporting the sustainability and scale of Māori, Pacific, and other culturally grounded providers requires deliberate system design. Explicitly embedding culturally grounded services within the service model will ensure they are integral to the system rather than peripheral, and will support more equitable access, safer care, and better outcomes for people and whānau across the system.

Because culturally grounded providers often operate at smaller scale or in rural and community settings, intentional system support is essential. Funding, contracting, and procurement settings must recognise different cost structures and delivery approaches for these providers, as well as the value and benefits they bring to the aged care continuum. Further work is needed to estimate costs as part of the next stages of work on detailed system design.

Nearly all submitters to our review process raised that care should be culturally grounded, and there should be resourced culturally safe practice, whānau engagement, and partnership in service design, governance and quality improvement. For example, Muslim elders currently do not have the guarantee that the food they are served will meet their cultural needs. It was also considered that care should be delivered through culturally appropriate environments (for example, marae-based).

Embedding culturally grounded services as a core part of the aged care continuum strengthens system equity by supporting access to the right care for people who may not engage readily with mainstream services. This has value beyond meeting clinical needs and cultural responsiveness and safety – it reduces escalation of unmet need, and supports all older people (including Māori, Pacific, Asian and other ethnic communities) to live and age well in ways that reflect their values and identities.

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[76] Moeke-Maxwell., T, Collier A., Wiles J., Williams, L., Black S., Gott, M. (2020). *Bereaved Families' Perspectives of End-of-Life Care. Towards a Bicultural Whare Tapa Whā Older Person's Palliative Care Model*. Journal of Cross-Cultural Gerontology 35(2). https://link.springer.com/article/10.1007/s10823-020-09397-6

[77] McBride-Henry K., Roguski M., Miller C., Wissen, K.V., Saravanakumar, P. (2022). *Re-orientating health and nursing care: a qualitative study on indigenous conceptualisations of wellbeing*. BMC Nursing 21(1). https://link.springer.com/article/10.1186/s12912-022-01063-1

[78] Ministry of Health. (n.d.). *Māori Models of Health*. https://www.health.govt.nz/maori-health/maori-health-models

[79] Sapere, 2024a.

[80] Dickson, S., Bennett, T., Bramwell, N., Brown, O., Cook, C., Divakalala, C., Fraser, B., Hickey, H., Matheson, L., Miller, K., Monise, M., Munroe, H., and Rodriguez, M., (2023). *Uplifting Takatāpui and Rainbow Elder Voices: Tukua kia tū takitahi ngā whetū o te rangi*. https://kahukura.co.nz/wp-content/uploads/2024/05/Uplifting-Takatapui-and-Rainbow-Elder-Voices-Tukua-kia-tu-takitahi-nga-whetu-o-te-rangi-compressed-copy.pdf

"Resourcing culturally safe navigation and whānau-centred support (including for Māori and Pacific families) helps reduce missed care, crisis-driven entry, and avoidable harm."

- The Royal New Zealand College of General Practitioners

More help to understand and navigate the system

Navigation must be strengthened. We consider this is an immediate and practical way to reduce confusion, support earlier engagement with the right services, support people with dementia, and better enable ageing well in place. This will require a mix of digital and face-to-face support.

These roles should be centrally funded and locally delivered. They may sit within community organisations, iwi and Māori providers, kaupapa Māori services, primary care, or NGOs, operating alongside existing services to reduce fragmentation and support continuity.

Multiple reports on the aged care system have identified the need for dedicated navigation support to help older people and whānau understand and access the system.[81] The current approach to navigation in New Zealand's health system is decentralised,[82] and information about supports and care options can be unclear, fragmented and dispersed across a variety of different sources, organisations and systems.[83] There is inconsistent and confusing terminology that makes it difficult for people to understand what services they are entitled to.

Too often, the burden of finding out what help is available falls on older people themselves, and their families and whānau.[84] Informal carers play a vital role but report difficulty understanding what support is available and who to contact, due to confusing information and fragmented funding, regulatory and accountability arrangements.[85,86]

We recommend that the national aged care pathway be clearly communicated through publicly accessible pathway maps and decision-support technologies that can be used consistently across providers and settings. This information should be accessible, for example using plain language and flowcharts, and available in multiple languages. One international example of this is My Aged Care in Australia.[87]

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[81] Aged Care Commissioner, 2024; Health Committee, 2025.

[82] Examples include GPs, primary care nurses, NASC care coordination managers, disorder specific NGO case manager roles, and HCSS coordination roles. In the acute care setting, navigation is carried out by specific community teams in which people access key worker support. Additionally, Seniorline, contracted by Health New Zealand, provides phone-based support to help older people navigate the system.

[83] There are multiple pathways across aged care services, depending on a person's needs, entry point, and support networks. The key pathway for older people to access Health New Zealand-funded and other community support services is through the NASC service. Information and pathway guidance are available through government websites and community organisations like Age Concern and Alzheimers New Zealand.

[84] Aged Care Commissioner, 2024. See also: https://www.healthnz.govt.nz/publications/future-of-ageing-well-service-and-funding-model-review

[85] Synergia. (2022). *The State of Caring in Aotearoa: A Report for Carers NZ and the Carers Alliance*. https://carers.net.nz/wp-content/uploads/2022/07/State-of-Caring-Report-Aug2022.pdf

[86] Submitters to the Health Committee's inquiry into aged care noted that people often do not know where to go for support, information can be difficult to find and understand, and clinicians do not always know which providers deliver which services.

[87] See: https://www.myagedcare.gov.au/

Evidence shows that clearly defined and well-communicated care pathways deliver benefits in their own right, including improved coordination, more efficient referrals, and better outcomes.[88] For people accessing care, a clear pathway reduces the risk of falling between services and missing out on appropriate support. This is especially important for older people with dementia, where accessing support earlier on can have better outcomes overall.

Digital tools alone are not sufficient. We also recommend that navigator roles be established within the community to support people who experience barriers accessing care – for example, those with high needs or hard to reach communities. Navigators would help these groups of people to understand the system, clarify pathways, explain options, and connect them to appropriate services at the right time.

Navigators for people with dementia are already being tested in practice; for example, the Dementia Mate Wareware Initiatives[89] includes navigator roles to support people and whānau to access services and ongoing support. We heard strong support for whānau-based navigation models such as Whānau Ora, where navigators engage with people in their homes, understand the wider whānau context, and identify not only clinical needs but also issues such as loneliness, transport barriers, fear, housing issues, and opportunities for reablement.

Effective navigators should be able to identify wider determinants of wellbeing, help coordinate access to practical supports and ensure that older people and whānau can move more easily between health, aged care, disability and community services. This is important where the person's needs sit across multiple systems (for example, for people experiencing social isolation and loneliness), and where whānau are trying to manage a transition from chronic condition support into dementia or more intensive aged care.

Virtual services – such as online meetings with navigators – could also be considered. One example of this is the ACC Way Finders service, which is a free service helping people to navigate complex ACC systems.

The navigation and care pathways we have recommended above must be culturally responsive, provided by Māori, Pacific, and other culturally competent navigators, and accompanied by public information available in a range of languages and formats. In a submission to the Group, the New Zealand Dementia Foundation noted that Hokonui Rūnanga's Kaiārahi / Navigators are an example of a culturally appropriate navigation resource.

Both digital tools and the establishment of navigator roles will require investment. Our initial modelling estimates that it could cost about $4 million to set up both digital and in-person navigation and about $7 million per year to operate. However, this investment is necessary for building a single, integrated pathway. Over time, we expect this cost would be offset by reducing delays to accessing care and reducing unnecessary hospitalisations.

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[88] McGeoch, G., Anderson, I., Gibson, J., Gullery, C., Kerr, D., Shand, B. (2015). *Consensus pathways: evidence into practice*. New Zealand Medical Journal, 128(1408). Microsoft Word - content.docx

[89] See: https://www.nzdementia.org/Network-and-Leadership/Budget-2022-Funding

Technology to support better care delivery

Technology is central to the future of aged care services. We recommend that aged care providers be encouraged and supported to adopt digital tools and technology to strengthen service provision. Its role is not to replace care, but to supplement care provided, improve coordination and support earlier intervention wherever care is delivered.

Adequate resourcing has been a barrier to taking up new technology. Health New Zealand's engagement with aged care providers highlighted that current margins have constrained providers' ability to invest in new technology, and emerging technologies are frequently high cost.

There are many examples of technologies which aim to support things like improved decision-making, remote access to care, and early intervention. Emerging benefits of health technologies include early detection of health issues, better medication adherence, reduction of hospitalisations, extended time living independently and improved quality of life.[90,91] There are also opportunities to leverage the enormous potential of AI in aged care.

Technology will be an important part of scaling up in-home care services, including digital care coordination (such as rostering), remote monitoring, and clinical oversight systems. This technology can support proactive risk management through remote monitoring and alerts, enable timely clinical oversight for people with fluctuating or higher acuity needs, improve coordination between in-home care, primary care, hospital, and whānau, and prevent escalation to higher intensity care.

In residential care, technology can support clinical governance and oversight for residents with complex needs, improve information sharing and smoother movement through short-term care (including between residential care, hospital, and home), and strengthen workforce capability through decision support, documentation, and escalation pathways.

Technology should link to an integrated digital health system and must be underpinned by strong privacy and consent safeguards.

Effective use of technology relies on adequate funding to trial new approaches and workforce training to adapt to new technologies. When aligned with service design and workforce capability, technology complements hands on care rather than replacing it.

Medical alarms and monitoring technologies

We recommend reviewing the way that medical alarms and other monitoring technologies are funded and commissioned, to ensure they are delivering maximum value and effectively supporting people to remain safely at home.

Current siloed approaches to funding medical alarms limit their functionality and usefulness and do not incentivise uptake of newer, more integrated technologies. A review should consider whether alternative funding or commissioning models could improve access, integration with wider digital systems, and overall effectiveness of monitoring technologies as part of in-home care.

This review should include consideration of how medical alarms can evolve from standalone devices to become part of a broader ecosystem of connected care and remote monitoring.

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[90] McDaniel, L., Essien, I., Lefcourt, S., Zelleke, E., Sinha, A., Chellappa, R., & Abadir, P. M. (2025). *Aging With Artificial Intelligence: How Technology Enhances Older Adults' Health and Independence*. Journals of Gerontology 80(7). https://doi.org/10.1093/gerona/glaf086

[91] Iten, R., Wagner, J., Röschmann, A. Z. (2025). *Do Expectations of Risk Prevention Play a Role in the Adoption of Smart Home Technology? Findings from a Swiss Survey*. Safety, 11(1). https://www.mdpi.com/2313-576X/11/1/3

Digital integration and information sharing

Delivering integrated aged care depends on timely access to accurate, shared information across multiple services and settings. This requires a deliberate shift toward a fully interoperable digital ecosystem that acts as the backbone of an integrated aged care system.

Health systems currently operate within a complex digital ecosystem shaped by legacy systems and historic delivery patterns, and a lack of coordination and mandated standards. This has resulted in fragmented platforms and variable practices across regions, limiting the system's ability to be connected for older people, whānau, clinicians, and informal carers.

Health practitioners have limited ability to access comprehensive patient histories, including information on what treatments have been provided, and interRAI information is not yet easily accessible to hospital and primary care clinicians in a usable way.

We recommend that work on developing new digital systems and information sharing be accelerated to form the backbone to an integrated aged care system, including:

- developing fully interoperable digital architecture that includes a database to record all admissions, casemix level, NHI, and provider, linked to other critical databases including interRAI assessments and medication management systems
- enabling sharing of health information with mandatory shared metadata and two-way interoperability standards, and robust privacy, consent, and information governance safeguards, so that health information can be shared consistently across services
- extending access to the Shared Digital Health Record (SDHR) to all aged care providers, hospices, and ambulances
- mandating standardised digital handover and discharge protocols, including a minimum dataset for transitions between care levels and settings, so that information is not lost transitioning between care settings
- integrating assessment data across health systems and services by enabling two-way interoperable pre-population of interRAI assessments from existing clinical records
- improving shared care planning where multiple providers and health professionals support a person's care.

Maia is 83 and receives in-home care services that enable her to remain safely at home. After a fall, she has to go to hospital and is assessed as needing more support at home.

Maia is repeatedly asked to explain her medical history, medications, care needs and support arrangements. She is frustrated and can't understand why her doctors from the hospital, her GP and in-home care provider don't all have the same information.

In the new system, Maia's care providers are able to securely access and contribute to a shared digital health record. Her GP, hospital team, in-home care provider and aged care clinicians can all access her current assessments, medications, allergies, care plans, advance care planning information and support history. Changes made by one provider are available to the others in real time, so Maia doesn't have to repeat any information.

When Maia's needs change, her care plan is updated without her provider needing to ask her questions she's already told them the answer to.

At some point, Maia needs to move into residential care. Once they become her authorised provider, they can access her assessment history, clinical records and support information.

Strengthening the digital foundations of the aged care system is essential to enabling an integrated, person and whānau centred continuum of care where information flows with the person across the full care journey. A nationally consistent digital architecture – linked across care providers, assessment tools, and core identifiers such as the NHI – will be critical to achieving this. Information sharing will also support people with dementia by ensuring that health professionals have the right information when caring for people with cognitive decline.

Aged care providers, healthcare providers and professionals, assessors, and other health specialists must be able to access and contribute to up to date clinical information as people move between services and settings. This includes the ability to record and track access to care, provider involvement, changes in care levels, and casemix complexity in a shared system. Without a nationally consistent digital backbone, transitional pathways will be fragile and fragmented, and there will continue to be bottlenecks across assessment, discharge, and care coordination.

We also support the work that the Public Service Commission is doing to drive digital integration through the Government Digital Delivery Agency, and the work of the Social Investment Agency in data leadership. Implementation of our recommendation should build off this work.

A new telehealth medical service for providers

Ageing well means keeping people well regardless of when care is needed. Access to virtual GPs (via telehealth) is enabled under the current contracts for residential care providers. However, it can be difficult for aged care providers to get the clinical support that they need after hours to keep people well.

Limited access to clinicians after hours has impacts for people where they become unwell and clinical oversight is needed for treatments. For example, while residential care providers might have medications on hand (like antibiotics), a GP or Nurse Practitioner needs to give approval before these medications can be administered. When there is no practitioner available after hours (or even sometimes during the day), the provider must call an ambulance and send the person to hospital. Hato Hone – St John highlighted in a submission to our review that limited after-hours clinical staffing in residential care facilities can result in ambulance services becoming the default response for issues, including for non-urgent issues.

> "Ensuring care is delivered in the right place at the right time is critical to improving outcomes for aged care residents while reducing unnecessary pressure on emergency services."
>
> *– Hato Hone St John*

We recommend that Health New Zealand should expand and promote access to a subsidised urgent telehealth service for aged care providers, enabling Registered Nurses (or designated staff members) to obtain timely clinical advice when a resident's usual primary care provider is unavailable. The service should support continuity of care, reduce avoidable hospital transfers, and build on the existing 24/7 telehealth service.

This would provide timely access to urgent medical assessment and advice for in-home and residential care providers when a client's usual GP or Nurse Practitioner is unavailable. The service should be intended for urgent, episodic care, not routine primary care, and should:

- be initiated by a Registered Nurse, clinician or designated staff member, in accordance with local provider policies and escalation processes
- be subsidised by Health New Zealand, with any payment contribution made by the provider rather than the resident or client

- support, not replace, continuity with the person's usual primary care provider, with consultation outcomes communicated back to the regular GP/NP
- make sure that telehealth providers have access to, or are provided with, relevant clinical information and medication records to support safe decision-making
- align notification and communication processes with existing arrangements for urgent clinical events and after-hours medical advice.

Quick access to GPs for in-home care providers would also support care to be delivered faster, more efficiently, and safely. Our initial modelling estimates that this could cost about $2 million per year to operate, and would result in reduced costs over time through increased ambulance capacity and less frequent call-outs.

Recommendations

4. Streamline assessment in the aged care system by:
    a) enabling aged care providers to undertake most assessments for in-home care and residential care, including reassessments
    b) redefining the role of Needs Assessment and Service Co-ordination (NASC) agencies within the system, to focus responsibilities and resources on:
        i. undertaking high acuity assessments in a timely way – such as entry into secure care
        ii. operating as an independent oversight function to provide monitoring and assurance for provider assessments
    c) increasing the use of lower intensity screening tools including self-assessments
    d) supporting assessments with transparent national standards and regular reporting about the timeliness
    e) establishing a national interRAI governance group to provide ongoing oversight and ensure the assessment framework remains fit for purpose.
5. Modify current assessment tools, or develop and implement new accompanying tools, to:
    a) identify and take account of the holistic wellbeing and cultural needs of those being assessed
    b) identify and take account of non-clinical social factors that can increase the cost to provide effective services to the person and their whānau
    c) improve the identification and assessment of dementia needs.
6. Invest in training and resources to increase the capability of providers to undertake assessments, and to ensure that all assessors can undertake culturally appropriate assessments.
7. Support people to age well in place by strengthening in-home care, including:
    a) allowing providers to take on additional functions and deliver higher intensity care with a restorative focus in the home, where it is clinically safe and economically feasible to do so
    b) strengthening collaboration with primary care and ensuring sufficient primary care capacity to support older people with increasingly complex needs in the community
    c) strengthening and scaling up short-term residential and in-home care options for rehabilitation and recovery, including providers delivering Early Supported Discharge services

d) reviewing the way that the government currently funds medical alarms, and other monitoring technologies and digital support, to determine whether there are better ways to fund and commission these services and maximise their value to support people to remain at home

e) ensuring that services are culturally appropriate, and support language, identity, culture, spirituality and wairua, and community participation, including innovative culturally based delivery models where appropriate.

8. Make support for carers accessible and consistently available by:
   a) standardising restorative respite across the system
   b) developing a package of support for carers, including options for contracted residential respite, in-home respite and day programmes, based on carers' needs identified through assessments and the casemix framework
   c) refocusing the Carer Support Subsidy as a flexible fund for equipment and items that carers need for respite, including paying for informal respite
   d) more government investment in training and education for informal carers so that they can support their family members more effectively.
9. Support people to better understand and navigate the system by:
   a) investing in navigator roles who can work with people and communities facing barriers to accessing information, and navigating the system
   b) ensuring navigation and care pathways are easier to travel and are whānau centred and culturally responsive
   c) developing a national aged care pathway map, clear public information, and shared tools such as websites, decision aids, and decision-support technologies that can be used consistently across providers and settings.
10. Health New Zealand should prioritise developing fully interoperable digital architecture built on strong foundations for how information is managed, including consistent data standards (including metadata), cybersecurity, and privacy protections, and including a national database to record admissions, casemix level, NHI, and provider, linked to other critical databases including interRAI assessments and medication management systems.
11. Health New Zealand should establish a subsidised urgent telehealth medical service for in-home and residential care providers, enabling health professionals or designated staff members to obtain timely clinical advice when a client's usual GP or nurse is unavailable.

Chapter 6 – Contracting, regulatory settings and workforce

Regulatory and contracting settings should balance **access, safety, flexibility and sustainability**, so that people can get the right care for their needs at the right time.

Changes to regulatory settings should improve efficiency and flexibility, while balancing safety and access to care, including:

- **extending maximum certification periods** where appropriate while retaining audit processes
- introducing a **regulatory framework for in-home care providers** under legislation, consistent with that for residential care providers
- **removing restrictions on dementia unit sizes** and instead allowing service configurations to scale based on staffing, environments, and clinical oversight, alongside capability and quality requirements
- **moving from fixed clinical review intervals** to more flexible intervals based on clinical judgement for clinically stable residents.

Changes are also needed to **achieve cost efficiency**, including allowing aged care providers to access Health New Zealand's procurement catalogue, and reconsidering consenting processes for residential care facilities.

An effective aged care system depends **on a capable, stable, well-trained and well supported workforce** which must be able to deliver care safely across home, community, hospital, and residential settings, and support people to move smoothly between them. We recommend the government work with unions, aged care providers, and consumer and community groups to develop a **cross-sector workforce strategy for aged care**.

Aged care must be efficient and effective, delivering safe and dignified care for older people. Currently, some of the rules governing aged care add cost and complexity without making people safer. There must be a better balance between rules-based and risk-based standards within the system.

In this chapter, we recommend changes that better balance access and safety – including easing unnecessary restrictions, like how often facilities are re-certified or how dementia units are sized, while keeping the safeguards that genuinely protect people. In some areas, more safeguards are needed, and we recommend introducing stronger regulation for in-home care providers. We also recommend changes to increase cost efficiency.

None of this works without a stable, well-trained and certified workforce able to follow people across care settings, and we argue that a workforce strategy must be developed.

Regulatory settings that balance access and safety

Fit for purpose certification and audit requirements

Maximum certification periods for residential care facilities, and for high-performing providers who open new facilities, should be extended where appropriate. All audit processes should be retained to ensure that care standards are maintained throughout.

Residential care providers are regulated under the Health and Disability Services (Safety) Act 2001. Currently, providers can be certified for up to four years (although most receive three-year certifications) and must be regularly audited against the Ngā Paerewa Health and Disability Services Standard.[92] Providers that already operate successful facilities can only be certified for shorter lengths of time when they open new facilities. Once the certification period ends, a provider must apply to HealthCERT, pay a fee, and be audited for certification renewal. The audit cost can be significant.

While regular audits against Ngā Paerewa provide important assurance, repeated certification can impose administrative and financial burden on providers. Oversight and assurance settings should operate on a proportionate, risk-based basis, focusing regulatory effort where it adds the greatest value for safety and quality.

We recommend that:

- the maximum certification length be extended to five years where appropriate
- existing, high-performing providers that take over a new facility should be subject to the same audit rules as their existing facilities where appropriate.

Any changes to regulation must maintain a high level of service quality and safety. We do not suggest any changes to the audit process, as regulators should have the ability to monitor, investigate and respond to emerging risks, including through issue-based and unannounced spot audits. We consider that the auditing process should take a continuous learning approach, where the focus is on building providers' capabilities. Issues-based audits or other interventions should still be triggered by evidence of risk, poor performance or non-compliance.

This approach will reduce compliance burden for well-performing providers and facilities and slightly reduce costs. We consider this change will better balance streamlining regulatory processes with public assurance of safety and quality.

This recommendation would require a change to legislation to ensure there is flexibility for providers while managing certification periods. While the Health and Disability Services (Safety) Act 2001 allows a provider to be certified for up to five years, the certification framework only allows certification up to four years. This is to enable some flexibility (such as the need to delay due to an unforeseen event), as under the legislation, a provider's certification cannot go over five years (even by one day).

Our initial modelling estimates this change would save residential care providers about $10,000 - $25,000 per certification audit, which would amount to about $2 million per year across all residential care providers.

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[92] Certification audits are required every one to four years, depending on how well a facility is performing. Once the certification period ends, a new audit is required for renewal. There are a range of audits that a provider may be subject to, including surveillance (spot) audits (unannounced audits that typically take place midway through a residential care facility's certification period), provisional audits (conducted when ownership changes), partial provisional audits (when new or reconfigured services are added to a certificate), and unannounced audits in response to serious complaints and other issues.

Importantly, standards should not be viewed as a compliance burden but as essential infrastructure that creates the conditions for safe, innovative, and responsive care.

- E tū

Stronger regulation for in-home care providers

We recommend that all in-home care providers should be required under legislation to be certified against Ngā Paerewa to deliver services, in line with requirements for residential care providers (and our recommended approach to certification above).

While all residential care providers are regulated under legislation, publicly-funded in-home care providers are instead required by their contracts to be certified against the Ngā Paerewa standards. Certification audits occur every three years, with audits between. Privately funded providers are not required to be certified at all.

As the system shifts toward supporting more people to live well at home for longer, in-home care providers will play an increasingly central role, including for people with more complex needs. The current regulatory framework must change alongside to support this transition, recognising that people receiving care at home can be particularly vulnerable.

We recommend establishing a regulatory framework for in-home care providers under legislation, aligned with the certification and audit requirements for residential care providers, and our recommendation for residential care certification above. The framework should be adapted to the in-home care context to retain flexibility and support evolving models of care.

Stronger regulation for in-home care providers is a necessary foundation for safely delivering more care in the home. Introducing a regulatory framework for in-home care providers would support more consistent safety and quality standards across all providers and funding types, increase transparency and public confidence in in-home care, and strengthen the ability to monitor quality and respond to complaints. It would also provide a stronger foundation for managing increasing complexity in care needs and service delivery as more care shifts into the community.

This change will support alignment between in-home and residential care providers, and bring oversight of in-home care provision up to a level on par with residential care. This is important to enable providers to deliver services across in-home and residential care.

We recognise there are a range of considerations to work through. Stronger regulation is likely to increase compliance requirements for providers and support workers, including expectations around training, documentation and supervision. In the short term, this may place additional pressure on provider capacity and workforce availability. We have taken this into account in our recommended price uplift for in-home care services. However, over time, it also presents an opportunity to lift workforce capability, consistency, and professionalisation, building on existing initiatives.

Risks can be mitigated through careful design and implementation. A phased approach to introducing regulation, proportionate requirements based on provider size and service type, and targeted support for providers (particularly smaller providers) would help to manage transition impacts. Careful consideration will be needed to avoid unnecessary complexity for Paid Family Carers and other individual arrangements.

Contracting settings that support more dementia care

Contracting settings for residential care have not kept pace with the rapid growth in the number of people living with dementia, or with rising levels of acuity and complexity. This is expected to increase, with evidence indicating that, by 2050, the number of people living with dementia in New Zealand is projected to nearly double to about 170,000 people.

Under current residential care contracts, dementia units are generally limited to accommodating no more than 20 residents (unless the provider has agreed a higher amount with Health New Zealand). More support, and more residential care capacity, is needed for people with dementia and psychogeriatric care needs who cannot be looked after at home.

We recommend removing the fixed dementia unit bed caps of 20 beds and instead taking a capability- and quality-based approach. Contracting and regulatory settings should allow dementia care service configuration to scale based on demonstrated staffing capability, physical environment, model of care, and clinical oversight, rather than rigid numerical limits.

Under this new approach, dementia care would move away from predetermined capacity rules and instead be assessed against clearly defined requirements aligned with Ngā Paerewa, including quality, safety, dignity, and person-centred care. Providers would be able to configure dementia services as single or multiple households, or co-located units, where evidence shows that outcomes can be maintained or improved. Greater flexibility could allow existing facilities, such as rest homes, to be converted to dementia-level care where appropriate.

A capability-based approach supports equity, quality, and sustainability by enabling the system to scale capacity safely in response to growing demand. Alongside sustainable funding for providers, this will improve access to dementia care for people and whānau across the country.

> "Dementia mate wareware is not a future problem – it is happening now. The government and the health system must make important choices about how to respond."
>
> *– The Dementia Mate Wareware Action Plan*

Risk-based rather than rule-based settings

We recommend shifting contract settings away from overly-frequent, fixed minimum timings and toward clinician-directed, needs-based review intervals, supported by strengthened pharmacist roles and increased use of telehealth. This approach would maintain safety and quality while enabling more efficient use of clinical resources and supporting better continuity of care.

Current contractual requirements governing how a person's medications are reviewed in residential care are based on fixed, time-based minimum frequencies. The residential care contracts outline that:

- residents must be examined by a GP or Nurse Practitioner within two to five working days of admission
- after admission, residents must be examined once a month, or if their condition is stable, at least every three months
- the resident's medication must be reviewed by a GP or Nurse Practitioner at least every three months.

While intended to promote safety and oversight, these uniform requirements do not adequately reflect clinical judgement, resident stability, or varying levels of risk. This results in review activity that does not always improve outcomes, contributes to GP workload pressures, and can increase system costs without commensurate benefit.

Rules governing medication review frequency should better reflect clinical judgement and stability, rather than relying on fixed, time-based requirements. Specifically, we recommend:

- clarifying admission examination requirements to allow clinical review within five working days, and use of virtual telehealth where appropriate
- replacing minimum resident medical examination timeframes with clinician-determined review intervals of up to six months for clinically stable residents
- aligning medication review requirements with clinician-determined intervals of up to 12 months, consistent with recently updated national prescribing guidance,[93] with more frequent pharmacist-led reviews between
- enabling pharmacists to take a larger role in medication reviews (at the discretion of the GP), including reviewing medications, making evidence-based recommendations to prescribers, and triaging as necessary.

Under this model, medication and clinical review frequency would be determined by clinical judgement, informed by resident stability, complexity, and risk. This approach also stresses greater use of telehealth for admission assessments where appropriate (for example, for people who have come into residential care from hospital, where they may have had a comprehensive assessment already). In-home care services already take a risk-based approach, undertaking more frequent reviews if needed.

Enabling pharmacists to play a larger role in medication reviews would reduce GP workloads and costs of GP-led medication reviews, reduce polypharmacy, reduce medicine wastage (by removing medicines from a regime when not required), and improve people's adherence to medicine regimes. To give effect to this change, pharmacists may require additional support or upskilling to maintain confidence and clinical capability. We also support the continued growth of the pharmacist prescriber workforce.

Protecting access to standard beds

We recommend retaining rules that protect people's access to standard beds (those without additional charges).

Historical underfunding has led to an increase in additional charges across all residential care facilities, where providers can charge residents more than the contracted price for extra services or accommodation options (for example, an ensuite, more space, or garden access). Additional charges are a mechanism for residential care providers to stay financially viable.

Contracts for residential care providers include a rule (referred to as the '10km rule') that limits the ability for providers to charge additional fees in some circumstances, to ensure that people with lower means would be able to access care facilities in their local community.[94]

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[93] See: https://www.health.govt.nz/strategies-initiatives/programmes-and-initiatives/primary-and-community-health-care/increasing-prescribing-lengths

[94] The 10km rule sets out that if there are no standard rooms available at a person's preferred rest home, the resident cannot be compelled to pay the additional charge unless the provider can demonstrate that a suitable standard room is not available at the facility, and that there is another facility within 10 kilometres or less from their facility that has a suitable standard room and the resident has decided not to be admitted to that room. If those conditions are not met, the provider must admit a resident to the premium room and cannot charge premium room services.

Later in this report, we recommend sustainable funding for residential care. We also recommend that providers seeking a higher funding rate for new rooms should be required to increase the number of rooms they provide without additional charges by at least 50% of the number of new rooms they build. We consider that these changes will increase the number of standard beds in the system, and create certainty of the availability of standard beds in the future.

However, regulatory protection is still needed to ensure good access to standard beds. We recommend that the 10km rule should be retained as a backstop in the system to do that.

We also acknowledge that this rule is not a perfect solution, as we have heard anecdotally that it can be difficult to enforce. The use of the 10km rule should be monitored and reviewed by the proposed Aged Care Pricing Authority (outlined in Chapter 7).

Contracting and regulatory settings that reduce cost

Driving cost efficient procurement

Aged care providers currently purchase equipment and supplies needed for care (such as bandages, continence products, and other medical equipment) at market rates, while Health New Zealand can purchase the same items at a lower rate because it buys in bulk.

We recommend allowing aged care providers to access Health New Zealand's procurement catalogue to enable them to purchase items at the same reduced rate. This would leverage the buying power of the public health system to reduce costs and strengthen supply of items needed for care across the sector and make procurement easier for providers.

Access to the procurement catalogue would drive cost efficiency in the system, and over time, would help address ongoing financial pressures within the aged care sector. Smaller providers would benefit by having access to supplies at a reduced cost. This change could also help to ensure greater consistency in the equipment and supplies used across health and aged care settings.

We estimate this could cost $2 million to set up, and could save around $3 million per year on providers' purchase costs. This is a practical change to reduce costs and improve quality in the aged care system.

Consenting processes should not get in the way of new residential care

New Zealand will need more residential care beds in the future. Without intervention, the system is unlikely to deliver the number of beds required to meet future need, particularly for beds without additional charges. New builds are essential to address this gap, but providers face a range of financial and regulatory barriers including planning constraints, infrastructure costs and limited financial returns relative to risk.

We recommend the government reconsider consenting processes to better enable residential care providers to build new capacity by reducing consenting burden. Some examples include:

- **Defining residential care facilities as a permitted activity under National Environmental Standards (NES):** The current Resource Management Act 1991 (and the Planning Bill that is intended to replace it) requires resource consent processes that can delay or deter development. Currently, under NES, a 'permitted activity' can be carried out without the need for a resource consent so long as it complies with any requirements, conditions and permissions specified in the Resource Management Act. Aged care facilities are defined as a 'discretionary activity', resulting in long consenting processes. Defining residential care as a permitted activity (as for detached minor residential units) would reduce consenting burden and increase certainty for providers.

- **Separating residential care facilities from 'dwellings' in the National Policy Statement on Urban Development (NPS-UD):** Under the current NPS-UD, local authorities are required to provide sufficient development capacity for housing, with residential care facilities implicitly treated as standard dwellings. Recognising residential care as a distinct category would enable more active monitoring of demand, support better planning for infrastructure, and ensure that appropriately zoned land is available to meet current and future need.

Measures such as these address regulatory constraints that currently limit investment in residential care beds. They also support a more proactive planning approach, ensuring that care provision keeps pace with demographic change rather than responding reactively to shortfalls.

Workforce strategy is key

We recommend that the government work with unions, aged care providers, and consumer and community groups to develop a cross-sector workforce strategy for aged care.

The aged care workforce plays an essential role in delivering safe, compassionate and high-quality support to older people. While detailed workforce planning, remuneration and reform are beyond the scope of this review, workforce availability and sustainability are clearly central and critical to the aged care system. We have therefore taken a strategic, outcomes-based approach to considering workforce for this report.

From nurses and care workers to allied health professionals and support staff, this workforce provides not only clinical care but also emotional and social support that enables individuals to remain connected, independent and respected. Their skills, relationships and continuity of care are critical to identifying changing needs, responding to complex health conditions and delivering person-centred services.

The service model proposed in this report, and a focus on ageing well in place, cannot be delivered without a sustainable and well supported workforce. Current workforce pressures are already constraining service delivery and will intensify as demand grows. Without action, these pressures will limit the system's ability to expand in-home care, scale restorative short-term care, and provide culturally grounded person- and whānau-centred care.

A substantial expansion of the workforce will be required to meet future needs, alongside improvements in workforce capability, stability and utilisation. A sustainable workforce is also needed to support efficiency in the system, particularly for in-home care (including higher travel costs).

Workforce availability and stability are critical and are not issues that can be addressed within aged care alone. We also recognise that wider workforces, such as GPs, geriatricians, older persons psychiatry, allied health and clinical psychologists face capacity issues and should be supported to care for older people.

We recommend a workforce strategy should consider the elements set out below.

> "The solution is a skilled, well-resourced community support workforce, funded flexibly and guided by clinical expertise — enabling people to remain safely at home for longer and reducing reliance on residential and acute care.
>
> - *Royal Australian and New Zealand College of Psychiatrists (RANZCP) Faculty of Psychiatry of Old Age (FPOA)*

The right capacity and capability for the future

An effective aged care system depends on certainty that there will be a workforce with the right capacity and capability in the future. We know that we will need enough skilled workers who are capable of looking after more older people with complex needs, including people with dementia.

This will require a strong focus on planned recruitment, training, development and ongoing support to ensure high-quality and safe care, and a workforce that feels recognised and valued. This planning needs to take place now so that there is the right workforce available to meet future needs.

A sustainable workforce with reasonable remuneration and conditions

The workforce that cares for older people is highly skilled, carries significant responsibility and plays a critical role in supporting dignity and quality of life. Remuneration should appropriately reflect this.

While decisions on wages, remuneration and pay equity sit outside the scope of this report (recognising that decisions around this will be taken separately), there is a consensus view across the Ministerial Advisory Group that wages and conditions for professionals working in aged care should be sustainable and reflect the increasing standards of training and capability required.

There should be no structural incentives for workers to move between parts of the health and care system for comparable roles, and no disincentives to work in aged care. Remuneration that recognises the skill and expertise of this workforce would reduce churn across the workforce and support a more sustainable workforce over time.

Alongside remuneration, fair and standardised employment conditions – including stable hours, job security, and high job quality – are critical to improving job satisfaction and retention. We also recommend that support workers be protected under Part 6A of the Employment Relations Act 2000, which creates special protections for employees when their work is affected by restructuring. The high-frequency turnover of contracts that involve this workforce means that they should be eligible to be recognised under Part 6A as vulnerable employees.

Reviewing training and education

A workforce strategy should review workforce training requirements, including standardising training requirements across aged care settings.

Training systems must be better aligned with evolving models of care, particularly as services shift toward integrated and in-home care delivery. Workers will be increasingly expected to operate across a continuum of care, supporting people with more complex and diverse needs, including dementia. Training arrangements must better support staff to work across this continuum.

Training settings should enable flexibility, support integrated models of care, and align with the new service and workforce roles envisaged in this report. Reviewing and standardising training requirements across aged care settings would help ensure a consistent baseline of skills, knowledge, and care quality across the workforce, while supporting workforce mobility, integrated service delivery, and safer, more equitable outcomes for older people. Training should also include the development of skills related to caring for people with dementia.

The workforce strategy should also explicitly recognise and support informal carers through expanded access to training, education and resources. Carers should have access to community-based education and training opportunities, including health and safety, general health literacy and first aid, dementia care, suicide awareness, and person-centred care practices. Providers and NGOs should be funded to deliver this training.

Better utilising the workforce

Meeting future demand will require a more flexible and integrated workforce model that operates effectively across home and residential settings and can respond to higher complexity of needs at home.

We recommend expanding the scope of practice for support workers and healthcare assistants, so they can take on a wider range of tasks under delegation from Registered Nurses. This would allow care teams to respond more flexibly and safely as people's needs change, rather than being constrained by rigid role boundaries. This will support more responsive and efficient care, particularly as needs change over time, and is critical to enabling higher-acuity care to be delivered at home.

To support this, clinical supervision for support workers must be strengthened. This is currently variable across in-home care providers due to resourcing constraints and variable funding models. Stronger clinical oversight by Registered Nurses is essential to support safe delegation and maintain quality of care. The workforce strategy should highlight this need, and funding models for in-home care should incentivise appropriate clinical supervision to enable safe, consistent and high-quality care.

The workforce strategy should also set out the need for consistent delegation of medication administration and other tasks across support workers and healthcare assistants. There are currently different approaches to delegation across in-home and residential care settings – for example, medication administration is commonly delegated in community settings but more restricted in residential care. As the boundaries between in-home and residential care become more diffuse, it is important that there be consistent delegation frameworks across providers.

There should also be new models for aged care providers to utilise allied health, including direct employment or hub models.

Regulating the workforce

Regulation of support workers and healthcare assistants – in both home and residential settings – should be explored through options such as a regulator, certification or qualification requirements, and a workforce register. This could operate across sectors, with providers supporting workers to register, and include stronger safeguards for people receiving care to prevent unsuitable workers moving between roles unchecked.

This is particularly important given the shift to introducing user contributions for in-home care. It will be critical for people to have trust and confidence in the system, and that there are safety and quality standards in place for a workforce entering their homes.

Attracting people to the workforce

Expanding the workforce will require strong and coordinated action to improve attraction and retention.

Aged care should be actively promoted as a valued and viable career, with clear and accessible pathways for progression. This should include education and training pathways that support Māori and Pacific workforce participation and progression and could also include career pathways from support worker roles into nursing and other professions.

Wages, terms and conditions all play a critical role in attraction and retention of staff. As do cost pressures – for example, in-home care providers delivering care to people living with dementia have limited ability to absorb cost pressures, which impacts their ability to attract and retain a specialised dementia workforce.[95]

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[95] Health Committee, 2025.

Immigration settings also play a critical role. New Zealand is unlikely to meet future demand through domestic workforce supply alone, particularly in the short to medium term. Current immigration settings can create unnecessary barriers for support worker and healthcare worker recruitment, which in turn creates barriers to creating a sustainable workforce for the future.

Immigration settings should support timely recruitment of international workers to help prevent workforce shortages in aged care. We recommend that support worker roles should be included on the 'green list' pathway that connects the Accredited Employer Work Visa to New Zealand residency. This pathway streamlines the visa process and gives incentives for migrants to relocate to New Zealand.

This could also include streamlined immigration processes for support workers and healthcare assistants, recognition of the sector's ongoing workforce demand, and removal of job check requirements for support worker roles under the Accredited Employer Work Visa pathway.

Recommendations

12. Extend and standardise certification periods for aged care providers, while retaining surveillance and issues-based audit processes to ensure that care standards are maintained, so that:
    a) all aged care providers can be certified for a maximum of five years, rather than the current four years for residential care
    b) high-performing residential care providers who open new facilities have certification timeframes aligned to those for their other facilities where appropriate.
13. Regulate all in-home care providers (including those publicly and privately funded) against the Ngā Paerewa Health and disability services standard under the Health and Disability Services (Safety) Act 2001 and in line with requirements on residential care providers, to improve safety and quality and confidence in the system.
14. Remove fixed dementia unit size restrictions from residential care agreements and replace with flexible requirements based on staffing, environments, and clinical oversight, alongside capability and quality of care.
15. Move routine medical reviews (by a GP or Nurse Practitioner) and medication reviews for residents in aged care facilities from fixed minimum frequencies to clinician-determined, needs-based intervals, to target more frequent reviews to those with higher and more complex needs. This should be supported by increased use of telehealth.
16. Allow aged care providers to access Health New Zealand's procurement catalogue to purchase items and equipment at a reduced rate and drive cost efficiency in the system.
17. Reconsider consenting processes to better enable residential care providers to build new capacity by reducing consenting burden, including by considering reclassifying residential care facilities as a permitted land activity under national environmental standards, and ensuring land is zoned appropriately to meet current and future need.

18. The government should work with unions, aged care providers, and consumer and community groups to develop a cross-sector workforce strategy for aged care, which seeks to:
    a) ensure that the aged care workforce has the right capacity and capability for the future
    b) reduce staff churn through fair remuneration and standardised employment conditions, leading to greater job satisfaction, and sustainable career pathways
    c) extend protections under Part 6A of the Employment Relations Act to support workers to ensure employment continuity
    d) review training requirements, including standardising training requirements across aged care settings and ensuring training supports the workforce to care for people with dementia
    e) better utilise the workforce by expanding support workers and healthcare assistants' scopes of practice, supported by greater delegation with clear clinical governance
    f) explore regulation of support workers and healthcare assistants through options such as a regulator, certification or qualification requirements, and a workforce register, so that there are stronger safeguards and increased trust and confidence in the system
    g) promote aged care as a career to attract people to the workforce and expand the pipeline, such as through workforce development pathways that support Māori and Pacific workers and examining immigration policy settings.

PART THREE:
How do we pay for it?

Chapter 7 – Changing the funding model

New Zealand's aged care system is **underfunded**, as funding has not kept pace with the real cost of delivering care, and current funding approaches are **inconsistent**.

Funding levels need to urgently increase to build more services and capacity. A p**rice uplift for in-home care** is urgently needed to scale up services and **a price uplift for residential care** is needed to build new capacity, taking an approach that better reflects costs.

A redesigned funding model is essential.

More investment is needed in the right services and in a more efficient way, to create a more sustainable system that is **based on needs and the actual cost of care**.

Bespoke arrangements will be required for people with particularly **complex needs**.

Funding should provide **incentives for short-term and respite care**.

In-Between Travel settings must be **more efficient**.

Public funding should prioritise core care delivery.

Funding must recognise additional costs of rural services and take into account **non-clinical social factors** that influence costs.

Commissioning approaches should support more competition and choice.

Pricing for services **must reflect the cost** of services over time, backed by a strong mechanism for informing prices in the form of an independent **Aged Care Pricing Authority**.

Aged care is expensive, and costs are increasing. In 2024/25, the government spent about $2.5 billion on aged care across in-home and residential care, and New Zealanders in residential care contributed about $1.26 billion to the cost of care.[96] Despite this substantial expenditure, New Zealand's aged care system is still underfunded, and the consequences are already visible.

Successive reports and inquiries[97] have identified that funding has not kept pace with the real cost of delivering care, contributing to shortages of standard residential care beds, pressure on residential providers, and limiting the ability for in-home care providers to scale up services to meet demand. Underfunding has also contributed to a growing reliance on additional charges in residential care, including Occupational Rights Agreements, reinforcing a two-tier system of access and support.

At the same time, demand is rising as more people live longer and require more complex support. The result is a system under growing strain, with increasing risks to access, quality and sustainability.

As we have highlighted, adding funding into the system to meet demand without wider change will come at a significant and growing fiscal cost, while still leaving many underlying problems unresolved.

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[96] This does not include private payments for additional services, for example, 'premium rooms' in residential care, or privately purchased in-home care and support services.

[97] Including Grant Thornton's 2010 report '*Aged Residential Care Service Review*', Ernst & Young's 2019 report '*Aged residential care funding model review*' and Sapere's 2024 report '*A review of aged care funding and service models: A strategic assessment of aged residential care and home and community support services*'.

The package of reforms recommended in this report is intended to achieve two goals at once: to support older people to receive the right care, in the right place, at the right time, and to moderate the long-term fiscal pressure of an ageing population. The aim is not only to improve care, but to build a system that costs future generations of taxpayers less than continuing on the current path.

These goals will not be achieved without upfront investment. The government needs to act now to stabilise the system, build capacity, and put in place the foundations for a more effective and sustainable model of care. This includes creating the conditions for workforce development, innovation and technology-enabled care, and growing the services that we need in the future. Delaying reform will only increase both the human and fiscal cost.

Our Terms of Reference tasked us with investigating what funding models are needed to support sustainable services, particularly a sustainable supply of aged care beds. We have carefully considered what is needed, including ensuring that funding enables providers to meet the needs of the ageing population, while remaining financially viable and able to invest in future capacity.

We recommend a transparent, sustainable and evidenced-based funding model that reflects what care costs to deliver, and is regularly reviewed over time, combined with sustainable and equitable settings for individuals to contribute to the cost of care. Together, these shifts will provide greater confidence that funding and contributions that people make towards care reflect the true cost of that care, while supporting a high-quality aged care system that remains accessible and sustainable for future generations.

More information on the costing assumptions throughout this chapter is available at **Appendix 6**.

Funding levels need to urgently increase to build more services and capacity

A price uplift to stabilise in-home care services

We recommend that the government commit to a price uplift for in-home care providers in year one, followed by investment to grow the capacity of the sector in year two.

In-home care providers have been underfunded for many years, and funding increases haven't kept pace with rising costs.[98] This is partially driven by increasing client complexity. Provider data indicates that the proportion of clients requiring more complex care has grown from about 65% in 2021/22 to almost 80% in 2025/26, reflecting a broader shift towards supporting older people with higher needs in the community. This has increased the need for clinical oversight, care coordination, supervision and quality assurance.

Aspects of the current costing methodology also appear to understate workforce costs. More complex care requires a larger and more highly skilled nursing workforce, with associated costs such as continuing professional development, training and clinical support. Funding for nursing staff does not cover all costs that providers face and other aspects of the current funding model do not fully recognise the true cost of employing staff. For example, in-home care providers are only funded when care is delivered, but they continue to incur employment costs when workers are on annual leave, sick leave or public holidays.

The consequences of funding shortfalls extend beyond immediate operational costs. Many providers have limited capacity to invest in workforce attraction, retention, and development, digital systems (including client management systems and rostering platforms), emerging technologies that can improve efficiency and service delivery, and quality improvement (such as health and safety and risk management systems).

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[98] Sapere, 2024a. The report noted that prices for in-home care services have become disconnected from underlying costs, and that there should be a more transparent funding model that better links costs to prices.

As a result, underfunding is constraining the sector's ability to innovate and prepare for future demand, at a time when more in-home care services are needed to support New Zealanders to age well in place. Building the capability and capacity of the sector is therefore both an immediate priority and a long-term strategic necessity.

Urgent investment is needed. We recommend that this is applied in two steps.

First, there should be an uplift of 6% in 2027/28 above adjustments for inflation, wage growth and demand growth, to address rising service costs and funding shortfalls that constrain providers' capacity to deliver sustainable quality services. This would cost approximately $30 million.

The uplift amount is based on previous work undertaken by the Settlement Parties Action Group (SPAG).[99] The draft funding model was endorsed by Sapere as a suitable approach for updating sector-wide costs and informing pricing decisions.[100]

While this uplift would help providers to respond to current challenges, it is not intended to fully fund the broader investment required to deliver advanced in-home care services.

There should be a further investment in 2028/29 that will grow the capability of the sector to deliver care to people with more complex needs and deliver advanced in-home care (as set out in Chapter 5).

Pricing will need to evolve to reflect the higher cost of delivering more complex care in community settings, informed by casemix. As providers support more people with higher-acuity needs, average workforce costs will increase due to a larger mix of advanced support workers, nursing, clinical and specialist roles, supervision requirements, and the need for ongoing workforce development and regulation. Future pricing should sustain a more qualified workforce and increased use of technology while maintaining quality care outcomes.

The full cost of the advanced in-home care model is not just reflected in pricing. There are areas where targeted or centrally coordinated investment by the government makes sense – for example, developing technologies like digital care management systems and remote monitoring tools that improve care quality and coordination. Pricing should take the efficiency benefits of these into account, but ensure providers are funded sufficiently to use them.

We have done some initial work to model the costs and benefits of this approach, but further work and more data is needed to determine the right level of investment, in consultation with a sector working group that includes providers. The government should balance direct investment in workforce and technology capability with pricing arrangements that support providers to build the people, systems and clinical capability required to safely deliver more complex care at home.

An Aged Care Pricing Authority (described later in this chapter) should advise on a future transparent funding model and appropriate pricing framework that reflects the true cost of service delivery and aligns with system reform objectives.

A price uplift to build new residential care capacity

The government should also commit to a price uplift for residential care, focused on stabilising the sector in the short term, and incentivising the construction of the extra capacity needed to meet future demand, especially the supply of 'standard beds' for which residents do not pay premium charges above nationally contracted prices.

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[99] A group established in 2015 following the Director-General of Health's Reference Group review of the in-home care sector – see https://www.hcha.org.nz/assets/Uploads/DG-REFERENCE-GROUP-REPORT-FINAL-AUGUST-2015-1-v2.pdf.

[100] Sapere, 2024a.

Investment in residential care is needed now to both relieve current pressure on services and build capacity for the future. Demand for residential care services is projected to increase over the coming decades,[101] yet new capacity cannot be delivered quickly. It takes about five years to plan and build a new residential care facility, and investment must be attracted to build new capacity is needed urgently if future demand is to be met. Providers are already reporting difficulties covering core operating costs and retaining staff, and there is risk of bed closures or reductions in services if funding pressures are not addressed.

We recommend a price uplift for residential care that stabilises the sector in the short term and creates stronger incentives for investment in new capacity. To deliver funding where it is needed the most, we recommend moving to a pricing model that reflects pricing differences across care level, geographical region, and the age and characteristics of rooms in each facility.

While in the short term, funding can be targeted for care level and regionality, the current funding model does not allow for government funding to target incentives for new construction, or to reflect the age and characteristics of existing facilities. The government pays the same rate for all facilities regardless of their age, condition or value.

Because a funding model that differentiates pricing by room age and characteristics will take time to design and implement, we recommend a staged uplift across two years.

First, in 2027/28, prices paid per bed day through government subsidies and resident contributions should increase by an average of 7.1% above inflation. Our modelling suggests this is the level needed to stabilise providers.

This uplift should be differentiated by care level and region. Our analysis shows that current funding shortfalls are not distributed evenly across the sector. Rest home and dementia-level beds, as well as facilities in areas with higher land costs, face the greatest unaddressed funding pressures. We consider that larger percentage increases should be directed to rest home and dementia-level beds and facilities in areas with higher land costs. This will help to sustain existing services and address long-standing inequities in funding.

We have set out our modelled pricing approach in **Appendix 6**, but we stress that this is **illustrative only** and based on limited sector data.

In 2028/29, there should be a further uplift that introduces an approach to differentiated pricing by room age and characteristics. This would allow pricing to better reflect the cost of capital. Under this approach, new and recently upgraded rooms would attract higher prices (reflecting construction costs and the cost of capital for new builds), compared to existing and older rooms (where lower prices are needed to achieve commercial returns on investment). This would direct public funding to encourage investment in new supply while keeping overall costs to taxpayers down, and ensure providers receive a fair return relative to the value of their investment.

[101] Sapere, 2024a. The report notes that the proportion of individuals entering residential care at rest home level is decreasing, while the proportion entering at hospital, dementia and psychogeriatric level is increasing, highlighting a rising level of acuity upon admission into residential care.

In our modelling, we have used room size and characteristics as simple, objective proxies for age and depreciated value, resulting in three broad categories: legacy rooms, modern rooms, and new rooms. Our modelling suggests that the second phase of price uplifts should be set at:

- 13.8% above inflation for **new** rooms – this results in a 9.9% price premium for new rooms, to ensure the construction of new residential care capacity at scale is commercially investable
- 3.8% above inflation for **modern, existing** rooms to more accurately reflect their relative capital value
- a rate matching inflation for **legacy** rooms, to achieve the targeted level of price differentiation.

Contractual and regulatory settings should also incentivise providers to build new standard bed capacity. We recommend that providers be required to increase the number of rooms they provide without additional charges by at least 50% of the number of new rooms they build in order to receive the higher level of funding.

The percentage uplifts above are illustrative. They should be read as **an aggregate, estimated uplift** based on the best available information. **Further work is needed** to gather and refine cost information by care level and location, to determine detailed prices.

Together, these changes would increase prices for new residential care rooms by an average of 21% above inflation over two years, while increasing the prices for existing legacy and modern rooms by a weighted average of 8% above inflation. This approach would allow a substantial price increase for new capacity, while targeting appropriate levels of increase to existing facilities.[102]

A differentiated approach would achieve the same price uplift for new rooms at less than half the cost compared to the current pricing approach. Where a 21% uplift across the board in 2028/29 would cost the government **$529 million** (our 'Scenario B' approach), a differentiated uplift in 2028/29 with the pricing structure described above would cost **$243 million**. These comparative savings gradually decrease as new rooms make up a greater share of the total stock, but the approach remains a significantly more efficient way of supporting investment.

While a higher increase could be justified, we have sought moderation on the fiscal impacts for both individuals and the government. As such, we are proposing an uplift that would be fiscally prudent, and one that is staged over multiple years.

Once established, an Aged Care Pricing Authority should further consider the details of the future funding model and pricing adjustments needed over time to reflect changes in costs. Further detail on the price differentiation approach is provided in the section on unbundling costs later in this chapter.

Capital support could be considered where there is an investment barrier to building new capacity

While the price uplift is the key mechanism to enable providers to develop new residential care capacity, we recognise there will be some instances where specific support for capital may be needed – such as for providers in rural or remote communities, or for culturally-specific aged care facilities.

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[102] Recommended uplifts have been developed and costed using a facility-level discounted cashflow model. In determining this recommendation, the Group used the best available data and carefully considered an appropriate rate of return, taking advice across the industry. We recognise that this varies by subsector, and there are different views on what an appropriate level would be. Price uplifts are estimated to deliver a return on investment equal to weighted average cost of capital. Data was cross-checked using initial cost data gathered by the Aged Care Association in a survey of member providers.

The government should also explore targeted capital support for residential care providers on a case-by-case basis where there is clear evidence of an investment barrier (such as small economies of scale), where providers have otherwise viable business cases. This approach would enable tailored interventions that respond to specific funding challenges rather than applying a broad, one-size-fits-all solution.

Targeted capital support could involve mechanisms to provide capital directly (such as through grants or capital injections), facilitate access to capital (for example, by the government underwriting loans to reduce lender risk), or reduce the cost of capital (such as through concessional loans, with better terms for providers).

One example of capital support is the Community Housing Funding Agency, which has Crown support and helps community housing providers access lower-cost finance.

Any capital support provided should be designed to offset the price uplifts, ensuring that providers are not funded twice for the same underlying costs.

A new, sustainable funding model based on needs and costs

The cost of providing aged care is opaque and inconsistently defined across the system, limiting transparency, effective pricing and investment.

For residential care in particular, bed-day prices are fully bundled into a single daily rate that covers care services,[103] daily living costs, accommodation, and capital-related costs. Funding varies significantly between facilities, and arrangements are heavily shaped by historical settings rather than current cost drivers. This results in inequitable distribution of funding between people, low transparency, and exposure of smaller providers to greater financial risk.[104]

Bundled pricing obscures cost drivers and cross-subsidisation, and makes it difficult to address particular drivers of cost over time. Funding has not remained cost-reflective over time. A new and more transparent means of price setting is required that better enables resources to match resident needs.

Unbundling residential care costs

We recommend that residential care costs are unbundled into three components:

- **Care:** This component is linked to the integrated casemix framework recommended in this report. This includes both clinical care (such as nursing care) and personal care (such as support for independence, like dressing). Costs would vary with assessed need, though some baseline care costs (such as core staffing and overheads) would remain common across individuals.
- **Daily living or 'hotelling':** This component covers services such as meals, utilities, cleaning and laundry services that are relatively similar across people. These costs are not dependent on care intensity.
- **Accommodation costs:** This component covers costs related to land, buildings and facilities, including depreciation and maintenance, and the cost of invested capital.

[103] Care services include health services which are defined in the contract, for example, nursing, primary medical care, prescribed medication, and allied health.

[104] Health Committee, 2025.

Unbundling residential care into these components would provide greater transparency about what drives costs and what funding is paying for. This means that:

- funding can be more precisely linked to costs, which will support sustainability of residential care providers over time and improve investment decisions
- funding settings can better reflect regional differences in costs, such as land and property values.

Unbundling care costs will also de-link the costs of care that a person receives and the type or quality of the room they are in, and will help to ensure that public funding is purchasing and delivering core health services. For example, it would allow Health New Zealand to better understand and compare the costs of delivering 'care' across in-home and residential settings, rather than having costs obscured by accommodation and other non-care expenses. This would improve transparency, support more consistent funding decisions across care settings, and ensure public funding is being used for its intended purpose.

Greater transparency would also improve monitoring, benchmarking, and evaluation of costs and outcomes. This would help to identify emerging pressures earlier, support evidence-based decision making, and ensure public funding is focused where it delivers the greatest value.

For people receiving care, unbundling costs would provide a clearer understanding of what they pay for and support more informed decision-making. For example, it would make it easier to compare the costs of remaining at home with additional support versus moving into residential care. As explored in the next chapter, clear visibility of cost components also supports a more transparent approach to cost-sharing and enables subsidies to be targeted more effectively.

Submissions to our review were generally supportive of unbundling. Submitters highlighted that separating care, accommodation and daily living costs would provide greater transparency about the costs of delivering aged care, support more consistent funding decisions across the sector, and provide a clearer basis for determining which costs should be funded by the government and which should be met by individuals.

We considered whether to apply unbundling to in-home care. We sought advice on a range of funding approaches, which indicated that unbundling in-home care would result in a fee-for-service model and would increase costs substantially. We therefore do not recommend unbundling in-home care services – instead treating in-home care as analogous to the care component in the residential care system. This reflects that in-home care is delivered in an integrated and holistic way, with clinical care and personal care provided as part of a single service to meet a person's care needs and goals, often by the same workforce. In-home care can include other activities such as tasks associated with daily living.

We recognise this approach provides less transparency for funders and people receiving services. However, we consider that seeking to unbundle costs for in-home care would add too much complexity to assessment, funding and service delivery without reflecting how care is delivered in the home, as well as introducing a significant and unnecessary administrative burden, and limiting providers' flexibility to meet people's changing needs. We consider this would be inconsistent with the integrated and person-centred approach that underpins effective in-home care.

Linking pricing and funding to unbundled costs

We also recommend linking pricing and funding directly to costs for each of these components. This includes the proposed differentiated pricing approach to funding for accommodation costs, while ensuring care funding remains linked to assessed need. This will support transparent pricing, encourage upgrades and expansion of quality capacity of residential care (with a focus on standard beds), and promote equitable access and continuity of care across regions.

The approach for each part is set out below.

Funding for care should be linked to casemix

Funding for the care component across both in-home care and residential care should be underpinned by the single national casemix framework recommended in this report. This would align funding to assessed need and include both personal and clinical care.

Each casemix category would have an associated price that would inform funding, with funding adjusting as a person's needs change and they move between casemix categories. In this way, funding would follow the person, aligned to their assessed needs, and better reflect the cost of their care.

This would improve on the current system, where residents within the same care level can have significantly different care needs and costs, and providers must absorb this variation within a single funding rate.

We consider that a casemix category for people at the end-of-life should be introduced, and should have the highest level of funding, such as a case weight toward the greatest weighting. Funding should meet the wide-ranging, holistic needs of a person at the end of life, including closer supervision, support for families and quick responses required of service providers.

Submissions received during our review supported using casemix to inform care funding. They noted it would support person-centred, goal-based care planning, better reflect differences in acuity and complexity, and provide a more transparent and equitable basis for allocating funding according to need.

Funding for daily living costs should be set at a standardised national price

Funding for daily living costs should be based on a standardised national price. Unlike care costs, these costs do not vary substantially with residents' care needs or provider characteristics. A national price would provide a simple and transparent funding approach.

Providers should be able to charge additional fees where residents choose to purchase services above the standard level required under government contracts. This would allow residents to access higher levels of service where desired, while ensuring that all residents continue to receive a consistent baseline level of daily living support.

Funding for accommodation should take a differentiated approach

The objective of updating funding for accommodation is to make new supply, and in particular new standard beds, investable. In doing so we recognise that across the residential care sector, pricing has fallen below the reasonable costs of supply, and a general uplift is therefore also required. It is important that existing stock stay on the market while new and additional stock is developed. For this reason, we recommend a two-step approach to differentiated price uplifts in 2027/28 and 2028/29, with:

- a general uplift in 2027/28 which takes regionality and care level into account
- an uplift in 2028/29 which also takes room size and characteristics into account.

Funding for accommodation should be **differentiated by room size and characteristics** to better reflect the underlying capital costs of different facilities, including the value of land, buildings and invested capital. A differentiated pricing approach recognises there should be a fair return on investment proportionate to the value of the investment.

Currently, all residential care facilities are treated the same for funding purposes irrespective of asset value, age and condition. This removes incentives for providers to upgrade older facilities, and means that any uniform funding increases can result in higher valuation gains to owners of older depreciated facilities, while not providing a sufficient rate of return to attract new investment.

Providing a fair return on investment for all providers is necessary to avoid loss of beds through market exits, incentivise development of new facilities, encourage upgrades to existing facilities, and ensure that there are enough beds without additional charges.

Differentiating prices to reflect capital costs requires an objective measure against which accommodation prices can vary. In our modelling approach, we used room size and amenity standards as a practical proxy[105] for the underlying capital value of facilities, and developed three broad categories of room type: legacy rooms, modern existing rooms, and new rooms (see more detail in **Appendix 6**).[106]

Under this approach, individual rooms would be classified and priced accordingly, with a facility's revenue reflecting its overall mix of rooms. This preserves incentives to upgrade and expand existing facilities, as well as incentivising construction of new facilities.

Prices should also be differentiated by locality, to reflect differences in the cost of land in different parts of New Zealand. We recommend that the existing system of geographic price adjustments be reset. Current geographic funding variations are based on land values dating back to before 2001. They no longer reflect actual differences in land costs across New Zealand. Updating these settings would help to ensure that new residential care facilities are commercially viable in all regions.[107]

We carefully considered the question of premium bed charges, recognising the high social need for more standard beds to support affordable aged care, but also that current market settings and prices have depended on premiums to keep existing stock viable in the market. We considered that:

- providers should, within reasonable bounds, continue to be able to charge premium accommodation fees for rooms that offer additional amenities.[108]
- to support access to standard rooms (without additional charges), providers seeking a higher level of accommodation funding should be required to increase the number of rooms they provide without additional fees by at least 50% of the number of new rooms they build. For example, a provider building 20 new beds should provide at least 10 more (new or existing) beds without premium charges to get the 'new room' rate for the 20 new beds.

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[105] We looked at a range of modelling alternatives and was satisfied that while there was no perfect methodology, the approach used was the best available given current limitations on data availability. The assumptions and parameters within the approach were iterated by the Group based on sector experience and modelling outputs. The Group reached consensus on the approach adopted.

[106] Prices should be set at the individual room level, as facilities can have a mix of rooms of differing age and standards, and this allows prices to incentivise expansion and upgrades of existing facilities as well as new builds. We considered a range of ways to proxy the age and condition off different rooms within facilities, and recognise there are a range of ways this could be done. We have proposed using room size as this reflects general build practices and standards over time. Using facility age or depreciated value was considered, but neither approach will achieve the desired result.

[107] Despite these data limitations, the Group was clear that the modelling undertaken used the best data currently available and was, at the aggregate level, fit for purpose. The purpose of this modelling is to underpin a fair overall uplift – that is, it is an *estimation* tool, not an *allocation* tool that is accurate at the individual facility level.

[108] Our modelling assumes a moderate level of premium revenue when determining the accommodation funding required to support investment.

In considering our approach to accommodation pricing, we considered that the methodology used was the **best available for estimating the overall uplift** required to make new capacity investible while maintaining current supply, and to identify how current pricing shortfalls vary by care level and location. However, we emphasise that further work is required to develop final detailed prices. Aggregate-level estimation should **not be interpreted or applied as an allocation tool at the individual facility level**.

We recognise that differentiating accommodation pricing for new rooms and different classes of existing rooms will be more complex than the current funding model. Providers would need to submit independently verified information on the number and characteristics of their rooms and update that information when room configurations change. Supported by the proposed Aged Care Pricing Authority, Health New Zealand should develop and maintain a transparent pricing tool that determines facility-level accommodation prices based on data, and providers should be able to view and verify their information online. The Aged Care Pricing Authority should also consider what transition arrangements are required to provide certainty for providers. Further work is also required to determine how best to operationalise this reformed pricing approach where residents purchase a licence to occupy for 'care suites' or rooms with an up-front capital deposit.

We considered a range of alternatives for funding accommodation, including a single price for all rooms within each care level. However, any averaged approach would either create unnecessarily high funding increases for existing assets if prices were set at a level to incentivise new investment, or funding increases that are too low to incentivise new development if set at a level appropriate for older facilities.

Considerations

We are guided by the principle that pricing should be sufficient and sustainable enough to enable providers to innovate and respond to a range of needs (for example, to develop culturally appropriate services), and ensure there is the right capacity of residential care in place to meet the needs of people with dementia, while avoiding above-normal profits.

More broadly, implementation should balance transparency with administrative simplicity. Cost unbundling should improve transparency without shifting towards task-based reporting or fee-for-service models. Data collection should be limited to that required for efficient pricing and system monitoring, and publicly reported information should be aggregated to avoid identifying individual providers.

We also considered a more individualised funding approach, where funding is allocated directly to a person rather than a provider. While this would increase consumer choice, there are high risks associated with this approach – including increased administrative burden, limited ability for providers to pool funding, and risks of overburdening older people and their families and whānau with managing their funding and understanding the system. We therefore recommend retaining provider-based funding arrangements that are linked to assessed need. This would support continuity of care while preserving flexibility for providers to meet individual needs.

Funding arrangements should also provide greater certainty for providers. Funding should commence when clinically required care begins rather than when administrative approval processes are completed. This would reduce financial risk for providers and support more timely access to care for older people.

While beyond the scope of this review, ACC, Disability Support Services, and Health New Zealand should work toward greater alignment of funding models, funding levels, and operational rules across aged care, disability, and injury support services. The Aged Care Pricing Authority should play a central role in informing core funding settings, while allowing flexibility in funding mechanisms where different client groups have different support needs. This should include alignment of funding settings for younger people in residential care.

> We need to invest – the growing ageing population demands this – but if we do it sensibly, the results will be better for individuals and better for the health system more widely. Policy decisions made today will play out in the lives of older New Zealanders now and into the future.
>
> *– Age Concern*

Bespoke arrangements for people with complex needs

Older people accessing aged care services are presenting with increasing acuity and clinical complexity, including some patients with particularly complex needs including bariatric and complex physical and mental health conditions.[109] Caring for these conditions can require specific equipment, environments, and skilled workers, and can result in increased carer stress.

Reviews have highlighted that residential care facilities are not adequately resourced to respond to this increasing level of need.[110] Some complex needs, such as bariatric care, require higher service intensity and one-off costs for providers, including larger physical environments, specialised equipment, higher staffing ratios, and stronger clinical oversight. However, these requirements are not consistently or transparently reflected in current standards, funding or expectations.

Notably, people with acute and chronic mental health need are falling through cracks in the system. Some people with very complex mental health needs are placed in aged residential care facilities, which can create significant risks for the individual and the provider.

Aged care providers must be equipped to safely support people with high or specialised care needs, including bariatric care and complex mental health needs. We recommend that Health New Zealand should retain and strengthen its ability to make bespoke funding arrangements with providers for individuals who have particularly complex or costly care needs which do not fit well within a population-level funding model.

Allowing bespoke arrangements for complex care to be available supports consistent, dignified care for people with higher needs, and enables pricing settings to transparently reflect the true cost of delivering complex care.

[109] Health Committee, 2025; Aged Care Commissioner, 2024; Ernst & Young, 2019b; and submissions to the Group.
[110] Ministry of Health, 2025.

Funding for short-term and respite care

We recommend that the additional costs of short-term care and residential respite should be funded through a new admission and discharge payment, alongside the clinically appropriate casemix payment. The payment should reflect the average additional costs of short-term and residential respite residents that cannot be fully recouped due to the short duration of stay. In our modelling, we have assumed providers would be funded an additional $250 per short stay.

Funding for contracted respite care in a facility should be consistent across the country and be funded in the same way as short-term care (including an admission and discharge payment). It should be part of a broader package of care, to support integration and alignment across the system, and recognise the value of carers in enabling older people to stay longer in their own homes.

Funding should recognise short-term and respite care as integral functions of an integrated system. Under current arrangements, these services sit outside core funding agreements and rely on multiple funding sources and mechanisms. Funding models based primarily on occupied bed-days, with limited adjustment for care complexity or length of stay, can discourage providers from offering this care.

Short-term and respite care are essential and support older people to remain healthy, independent and living at home for longer by providing recovery, rehabilitation, reassessment and support for carers. They also help avoid unnecessary hospital admissions, delayed discharges from hospital, and premature entry into long-term residential care.

Investment and incentive settings should also enable residential care providers to play a more flexible role across the care continuum. Recognising the distinct cost structures associated with short-term and respite stays through pricing or contracting mechanisms will support recovery, reassessment and return to the community wherever possible, rather than defaulting to long-term care placements.

We considered whether respite funding for contracted in-home care should be included in the bulk fund for in-home care providers. However, support for carers is critical in its own right and should not risk being displaced by competing funding demands within a capped funding allocation. We therefore recommend that respite funding be included within contracts for in-home care providers, but separately to the bulk fund allocation.

As we have discussed earlier, non-contracted carer support (accessed through the Carer Support Subsidy) should be separated from contracted care and have its own budget line to allow transparency.

An Aged Care Pricing Authority should periodically review these settings to ensure the pricing is at the right level to support service delivery and incentivise the right care, in the right place, at the right time.

More efficient In-Between Travel settings

We recommend a phased approach to developing a new system for In-Between Travel (IBT).

IBT is critical to delivering in-home care, ensuring that support workers are paid for time they spend travelling between clients and deliver care in people's homes. The IBT system was established in 2015, as part of a settlement agreement between the Crown, providers and unions. More information on IBT is provided in **Appendix 5**.

IBT costs have been steadily increasing over time, now representing 24% of service delivery costs for in-home care funded by Health New Zealand (a 41% increase since 2021/22). This has been driven by people's needs and preferences (where people require more visits and may prefer care and support workers who live further away) and a changing service landscape (fewer workers are living where people live, and Standard Travel sector averages no longer reflect workers' average travel times due to increasing traffic).

The current system also does not always create incentives for efficient workforce deployment. Exceptional travel costs, where support workers need to travel more than 15 kilometres, are particularly an issue as the current reimbursement model can create incentives for longer travel time and greater distances (with some workers travelling hundreds of kilometres a day).

At the same time, travel is an unavoidable consequence of providing person-centred care in people's home. The objective of reform should be to encourage more efficient workforce deployment, improve productivity, and better align incentives.

As demand for care at home grows, a more sustainable approach will be required to support productivity, maintain access to care, and ensure public funding is used efficiently. A redesigned system should be grounded in principles of transparency, consistency, fairness, and efficiency. It should support flexibility in workforce deployment, encourage innovation in scheduling and service delivery, and create incentives for providers to make greater use of technology-enabled solutions, including advanced rostering and route optimisation tools.

We acknowledge that IBT has a significant history and basis as part of a wider settlement agreement, and that any change to IBT should be carefully managed so that workforces, providers and funders are not disadvantaged. As such, we recommend a phased approach towards a new system for IBT. We also recommend that the redesigned system should be taken up by Disability Support Services and ACC (in addition to Health New Zealand), for consistency, workforce sustainability and coordinated service delivery.

Phase 1: Fix the biggest inefficiencies quickly through clear rules, thresholds and consistent definitions

This phase focuses on quick, practical interventions that introduce consistency and immediately contain costs without structural change. The key actions in this phase will be to:

- standardise definitions and guidance, including defining split shifts, redefining 'exceptional travel' within clear revised thresholds, and introducing consistent definitions of urban and rural locations
- tighten travel payment settings, including reviewing band thresholds and distance payments, introducing minimum distance exclusions, and addressing known overpayments
- introduce travel boundaries and client choice parameters, as set out in the recommendations below.

This first phase aims to control costs, ensure there is consistency across in-home care providers, and set clear rules and expectations for travel claims. This will provide a more controlled basis to build further reform on.

Phase 2: Shift incentives through funding and workforce model redesign

Sustainable cost control requires updating the funding model and workforce structure, while enabling a more efficient service model. This phase aims to build evidence on what service delivery models work well before scaling wider. The key actions in this phase will be to:

- move to a bulk funded travel model, using casemix categories and measurements of how rural or isolated a provider is as funding proxies, which would integrate travel costs into provider funding
- introduce individual contributions alongside wider funding reform (recommended in this report), with a focus on exceptional travel and client choice
- analyse and pilot new workforce models such as fixed shift models (for example, four-hour shifts that incorporate travel), capitation-style funding, or hybrid models for low-volume or rural settings.

This phase will strengthen cost control by shifting incentives towards more efficient travel. Moving to a bulk-funded model of IBT management would encourage providers to optimise scheduling and travel arrangements, improve workforce utilisation, and support providers to invest in technologies such as route optimisation, digital scheduling and AI-enabled rostering systems.

At the same time, reform should lower administrative complexity by reducing the claims that providers and workers make for travel, and support a more flexible and responsive workforce.

Phase 3: Lock in the new system through legislative reform

The current legislation providing for IBT is prescriptive and sets in place the perverse incentives we are recommending be addressed. To give effect to a new system for IBT once changes have been tested and evidenced, a new legislative framework will be needed. This will involve:

- updating legislative settings, including aligning union, worker, funder, and provider interests, updating legislation to set out bulk funding and a revised workforce model and aligning contracts and funding mechanisms to the new model
- embedding new funding and workforce models, including a national rollout of the bulk funded model and preferred workforce approaches.

This final phase will deliver a sustainable and modern framework for travel aligned to service delivery. It will support long-term cost sustainability, improve national consistency, and provide a platform for continued innovation in workforce and service delivery models.

Overall, our recommendations will improve efficiency, support more sustainable travel costs over time, reduce administrative burden, and create stronger incentives for providers to invest in workforce planning and technology-enabled service delivery.

Our initial modelling work estimates that it could cost about $4 million to implement our recommended changes. However, the fiscal impact would be significant – our modelling estimates a new system could reduce future costs by over $20 million per year because of better rostering and managing long-distance travel.

A phased approach enables change to be implemented gradually and informed by evidence of effectiveness. We expect that the combination of the proposed in-home care price uplift and more efficient IBT settings will improve provider viability and sustainability, strengthen workforce conditions, and support investment in workforce capability, technology and service innovation. This will better position the sector to respond to growing demand, support more older people to remain living independently at home and deliver care more efficiently over time.

Public funding should prioritise core care delivery

Choice is important for continuity of care, trust and wellbeing. However, current in-home care settings do not always appropriately distinguish between costs arising from assessed care needs and costs arising from personal preferences.

Under current settings, providers increasingly face requests for services that are more costly to deliver, such as care at specific times, care delivered by a preferred support worker, or care provided in circumstances that require additional travel. While these preferences may be important to individuals, they can increase travel time, reduce scheduling flexibility, constrain workforce utilisation, and increase costs. These additional costs are often borne by providers or publicly funded, regardless of whether they arise from clinical need or personal preference.

We recommend that public funding should prioritise essential, need-based care, while individuals contribute to the additional costs associated with personal preferences and discretionary choices. Specifically, we recommend that:

- where a person has chosen their own carer, publicly funded travel should be limited to clearly defined circumstances and reasonable distance thresholds (for example, a Health New Zealand-funded travel radius around a person), with individuals paying for travel beyond those limits
- where a person has a personal preference for care to be delivered at a particular time (e.g., showering at a specific time in the morning), an additional fee should apply
- where the total cost of supporting a person at home exceeds the cost of clinically appropriate residential care, public funding should be capped, with any additional cost met by the individual if they choose to remain at home.

No additional fees should apply where timing or service intensity is clinically determined.

Choice should continue to be supported where it improves continuity, trust, and outcomes. However, funding arrangements should better balance individual preferences with system sustainability, workforce capacity, and equitable access. Funding settings should also encourage efficient use of resources across the wider aged care system – for example, a person should not be funded to receive care in the home when it would be more cost effective for them to be in residential care.

These changes will enable public funding to focus on delivering timely, high-quality care based on assessed need, while still supporting individual choices that create additional costs, where people are willing and able to contribute to those additional costs.

Choice is already expressed and paid for privately in residential care through premium accommodation charges. We expect this will continue – however, as we have noted, standard beds should be more sustainable as a result of sufficient funding and mandating a proportion of standard beds over time.

Funding that recognises additional costs of rural services

Services must be reasonably available across the country, including in rural communities, so that older people can be cared for close to their family and whānau. However, rural providers face challenges with economies of scale, distance from other health services (including hospitals), and attracting and retaining a skilled workforce. These result in cost pressures that are not fully captured within the current funding frameworks.

We support the principle of a rural loading as a mechanism to support service viability. However, there is currently limited transparency about providers' underlying costs, including the actual differences in costs between rural and other providers. Further below, we recommend the establishment of an Aged Care Pricing Authority that would collect providers' cost information.

It would not be appropriate for us to pre-determine what these costs should be ahead of work by the Aged Care Pricing Authority. As such, we recommend that the Aged Care Pricing Authority should develop a sustainable, evidence-based long-term pricing framework that includes consideration of a rural loading for both in-home and residential care provision:

- For residential care, the Aged Care Pricing Authority should develop nationally consistent criteria to determine which providers are considered rural, based on factors such as remoteness, facility size, and workforce constraints, with a focus on supporting smaller rural providers.
- For in-home care, the Aged Care Pricing Authority should examine how rural or isolated services are funded to reflect clinical inefficiencies, support sustainability of rural providers, and consider higher funding rates for providers serving high-needs or geographically isolated communities.
- Across all care delivery, case-by-case funding should be reserved for exceptional circumstances.

In the short-term, the current rural loading framework used by Health New Zealand for residential care should change. Health New Zealand currently uses a set of defined criteria to identify isolated rural residential care facilities and funds an additional $5 per day for facilities it considers are isolated and rural. The criteria are discretionary and not always clearly defined or applied consistently, resulting in variability in outcomes across regions and uncertainty for providers.

We recommend replacing the current approach with an entirely rules-based model that directly reflects the structural pressures faced by rural providers. This includes anchoring eligibility and funding to a set of clearly defined and measurable drivers (such as facility size, remoteness, and financial viability), supported by standardised thresholds and a tiered funding approach. Over time, the framework should evolve so that funding levels are more explicitly aligned with scale-related vulnerability and increasing remoteness, while retaining a pathway for exceptional cases.

While we recognise that rules-based approaches can be difficult to develop, we consider this would better reflect the graduated nature of rural disadvantage, replacing the current binary structure with one that is more proportionate and predictable. Some examples of potential parameters for a rules-based loading scheme have been included at **Appendix 7**.

We also consider that commissioning and funding and commissioning for rural service provision should be flexible for rural and isolated areas where standard service models may not be viable.

Finally, the ongoing risk of closure of small rural facilities and services highlights the importance of ensuring that funding mechanisms are both well targeted and responsive to structural disadvantage. Without refinement, current settings may continue to be applied unevenly, potentially contributing to reduced access to care in already vulnerable communities.

Submissions received during our review noted that funding should target investment in regions to address barriers to care and additional time and costs related to workforce scarcity in rural areas. Submissions noted that financial sustainably in rural areas could include targeted use of capacity-funded beds, integrated contracting models, and funding approaches that reflect the true costs of rural service delivery.

Funding that accounts for factors that increase costs and result in inequitable outcomes

Funding for aged care services needs to recognise the inequities in outcomes for people seeking and receiving aged care. These inequities arise from a combination of structural, demographic, and system design factors that mean different population groups can require different levels and types of resource to achieve comparable outcomes. Current arrangements do not consistently account for these differences, resulting in uneven access, experience, and outcomes across the population.

The move to casemix-based funding represents an important step toward improving how pricing reflects underlying need in the aged care system. The casemix-based approach to funding could take account of **some** non-clinical factors which mean that the cost of delivering effective aged care services to some groups may be higher than others. This could be sought through the addition of weightings linked to need. For example, there is clear evidence to show that some groups of people (such as kaumatua Māori) experience higher and more complex needs relative to other groups, driven by earlier onset of long-term conditions, higher rates of disability, and barriers to timely access to services.

However, while casemix is a necessary step towards more equitable funding, it is not sufficient on its own. It does not fully capture wider drivers of inequity – such as social complexity, cultural needs, or barriers to accessing care.

We recommend that a person's assessment to determine their casemix and needs, and the amount of funding to meet their needs, should take into account of social factors that increase the cost to provide effective services to the person. This includes economic deprivation, social isolation, absence of carer support, and suitability of housing.

Where assessors identify significant non-clinical factors, this could be recorded as part of the assessment process, with some additional funding allocated to providers delivering services to these individuals. This would ensure funding is based on individual circumstances and need, rather than demographic characteristics alone.

Further work would be required to define these factors and the criteria used by assessors to determine where they apply, but we consider these could be based on:

- economic deprivation/socio-economic status
- access/lack of access to key services/transport
- presence/lack of carer support
- sufficiency/suitability of housing.

Targeting additional resource to people with these sorts of needs aligns with a social investment approach. If needs are left unmet, this ultimately results in poorer outcomes for people, and additional costs to government if people need to move to higher levels of care, residential care, or hospital. Addressing these factors through targeted funding may improve outcomes while reducing longer-term costs elsewhere in the health and care system.

Commissioning approaches that support competition and choice

Health New Zealand is currently transitioning all in-home care delivery from a fee-for-service to a restorative bulk-funded funding model. Under this model, Health New Zealand contracts with a certain number of providers to deliver services within a given region for a set period of time, with providers funded for the cohort that they serve.

Funding for cohorts rather than individuals offers a number of potential benefits, including enabling more holistic provision of care, supporting flexibility for providers, incentivising cost efficiency, and reducing costs to government through economies of scale. However, bulk funding can also encourage consolidation of providers into larger organisations to achieve cost efficiencies through scale, and limit the number of providers who can deliver services in a given area, which can reduce competition and opportunities for local service innovation.

Under current commissioning and procurement practices, residential care providers can only deliver government-funded in-home care services to residents of their co-located independent living villages if they are successful in a procurement process to deliver in-home services in a particular area, or sub-contract with successful in-home care providers.

Throughout our work, we considered what changes could be made to funding arrangements to support an integrated aged care system that encourages competition and is more effective and efficient.

We support the shift to a nationally consistent restorative bulk funded system for in-home care, and consider that this should continue, with adaptation. Over time, we recommend that Health New Zealand investigate transitioning in-home care, in all regions, to a more dynamic version of the restorative bulk-funded approach being progressed. This would support opportunities for local service provision and competition, and provision of rural, remote, or culturally specific services through targeted arrangements.

The following should be investigated and completed in consultation with the proposed Aged Care Pricing Authority once it is established, and be dependent on sustainability for the sector:

- Reducing the size of the geographic areas or cohorts that Health New Zealand uses for bulk funding, and adopting shorter commissioning cycles of 3 – 5 years. This will potentially enable more providers to complete to deliver services in these smaller areas, or parts of them, and in so doing encourage more competition, and support communities to develop local solutions with flexible contracts where there is a need for a different approach to care provision.
- Updating populations of people within each cohort more frequently, so that funding pools adjust in real time to reflect changes in the cohort, including where a person changes casemix level or leaves a cohort. This will mean the model will be able to more quickly account for shifting demand in the system.
- Allowing residential care providers to deliver in-home care to people where this is a person's preference (for example, a person in a retirement village that is co-located with a rest home). This will allow the model to adapt over time and keep people at the centre of care delivery.
- Allowing for locally and culturally specific models of service provision – for example, isolated community or iwi-based providers – within larger scale contract catchment, where the funder considers there are strong practical reasons to do so.

This approach will deliver the benefits of a bulk funded system, including cost efficiency and flexible service delivery, while enabling competition and choice for people accessing services by allowing more aged care providers to participate in the system.[111]

This work should weigh the cost of increased overheads associated with managing more commissioning processes with the benefits of increased competition, with a view to creating a more dynamic, innovative, integrated and technology-enabled system.

There will also need to be consideration of the trade-offs and risks of smaller scales and shorter contracts, including potential increases in pricing due to reduced economies of scale, as well as impacts on providers' ability to invest in workforce development, technology and service innovation. These risks must be considered by Health New Zealand and the Aged Care Pricing Authority in developing the future commissioning model.

In developing this recommendation, we considered whether New Zealand should move to a fee-for-service funding model (and versions of such a model) for in-home care. While fee-for-service approaches may allow funding to more closely follow the person and increase consumer choice, they can be more expensive than bulk funding, weaken incentives for integrated care, increase administrative costs, and reduce incentives for providers to invest in preventative and restorative approaches (as they reward delivery of services, rather than improved outcomes). We concluded that a more dynamic bulk-funded model provides the best balance between efficiency, flexibility, competition and person-centred care.

[111] Delivering services in smaller areas also aligns with international models, such as the Amsterdam-based Buurtzorg model, which demonstrates how small community care teams operating in defined local areas can deliver high-quality, person-centred care efficiently.

An Aged Care Pricing Authority

Sustainable funding settings require pricing that is independent, transparent and evidence- based. Providers need certainty of funding, and confidence that funding will continue to reflect the true cost of delivering care over time. Equally, as the aged care system evolves and individuals are expected to contribute more towards some aspects of their care, older people and their families need confidence that prices are fair, transparent, and based on objective evidence of costs.

Without independence and transparency of pricing, trust in pricing and funding decisions will continue to erode, funding will be mismatched with the cost of services over time, and aged care services will continue to face financial strain and underinvestment. This will ultimately impact the availability of aged care services for all who need them in the future.

We recommend that the government develops an independent Aged Care Pricing Authority (ACPA), or equivalent function, to improve transparency, consistency and trust in pricing decisions. The ACPA should:

- collect and analyse sector-wide cost data, supported by consistent provider reporting
- make recommendations to the government on appropriate pricing for in-home and residential care services (rather than binding recommendations) to inform its funding decisions, including casemix-informed care prices and standard bed prices in residential care, with clear separation between care, daily living, and accommodation cost components
- develop transparent methodologies for updating prices over time that adjusts for dynamic supply conditions, so that pricing becomes dynamic rather than static and reflects real and evolving cost drivers (such as workforce costs, rising acuity, costs associated with rural or isolated service provision, and capital and land costs).

The function should be established in a way that means it is independent of aged care funders and providers, and can therefore be trusted by both. By separating technical cost assessment from policy and Budget decisions, the ACPA would help identify emerging cost pressures, distinguish unavoidable cost drivers from performance issues, and reduce the risk of pricing becoming disconnected from the realities of service delivery in future.

The ACPA is a critical piece of infrastructure for a future aged care system in which both public funding and individual contributions play a greater role. As individuals are increasingly asked to contribute towards accommodation, daily living costs, some care costs, and preference-based choices, there must be confidence that prices are linked to genuine costs and are not determined through opaque or inconsistent processes. Independent pricing provides assurance that both government funding and consumer contributions are fair, evidence-based and consistently applied across the sector.

The ACPA would also play a central role in developing cost-reflective pricing methodologies, and improving consistency across care settings, including the application of the national casemix framework. Pricing should be assessed at a whole of system level, recognising that funding decisions in aged care affect demand for hospitals, primary care and other health and social services. Over time, this will support appropriate investment, workforce sustainability, service quality, and confidence that funding decisions are evidence-based and aligned with both inputs and outcomes.

We consider that the ACPA should be advisory rather than binding, preserving the government's responsibility for Budget decisions across the health system as a whole. Nor should it perform a regulatory role. Instead, any regulatory concerns should be referred to the appropriate authorities such as the Health and Disability Commissioner or HealthCERT.

The ACPA should consider our recommendations for a future funding model in its work. Once sufficient data has been collected and analysed, it should provide advice on a range of matters including those we have referenced throughout this report, and:

- sustainable funding for psychogeriatric rooms (noting that more information is needed to inform accurate pricing for these rooms)
- an approach to sustainable funding for rural or isolated residential care facilities and in-home care provision in rural areas
- how high-cost, low-frequency expenses should be funded (including ambulances), and how people's choices for care impacts costs for providers.

There are a range of alternative options for the type of function or entity that could be developed, including:

- as above, an Aged Care Pricing Authority that learns and adapts from the Australian model – this would be the most resource intensive to establish, but would result in the most transparency and independence
- an independent body that sits within the Ministry of Health – this would be easier to establish, but may reduce perceived independence of the function
- a confidential and trusted mechanism managed by an outsourced information provider that periodically reviews costs and pricing – noting that this approach may reduce transparency and continuity in the process of how prices are determined over time
- reviewing the current contracts for aged care providers to ensure there is an annual process for setting pricing based on clear and independent evidence of actual costs – noting that this approach is the weakest of all options.

Each option involves trade-offs between independence, transparency, cost and ease of implementation. The government should consider which model is best able to provide credible, ongoing advice on the costs and pricing of aged care services.

Submissions to the review process were generally supportive of an independent pricing function, although some cautioned against transposing the Australian model into the New Zealand context. The Home and Community Support Association and the Aged Care Association said an independent pricing function would support transparency.

It is difficult to estimate what this might cost to set up without determining the mechanism, but our initial estimates suggest an ACPA could cost about $1 million to establish and $9 million to operate.

Independent pricing and cost stewardship will strengthen system integrity and support integrated care delivery as service models and demand evolve, and provide consumers, providers and government with greater confidence that funding and pricing decisions are fair, transparent and sustainable over the long term.

Recommendations

19. The government should commit to significant price uplifts within two years to ensure that the sector can deliver the quality and quantity of aged care services New Zealand needs to meet rapidly growing demand:
    a) For in-home care:
        i. In 2027/28, a 6% increase above adjustments for inflation, wage growth and demand growth, to address rising service costs and funding shortfalls that constrain providers' capacity to deliver sustainable quality services.
        ii. A further investment in 2028/29 that will grow the capability of the sector to deliver care to people with more complex needs, and which includes funding for a sector-wide technology platform, increased wages for more and higher-skilled workers, enhanced carer support systems, and other measures to underpin the capability lift required for higher acuity clients.
    b) For residential care:
        i. In 2027/28, an uplift in the prices paid per bed day (through government subsidies and resident contributions) which our modelling estimates should average 7.1% above inflation, to stabilise current provision and address current funding shortfalls. This should be differentiated by care level and region and provide larger percentage uplifts for rest home and dementia-level beds, and facilities in areas with higher land costs, where our analysis indicates that current funding shortfalls are greatest.
        ii. In 2028/29, implement differentiated funding rates based on the age and characteristics of rooms in each facility, which our modelling estimates should be:
            1) for new-built rooms, a price uplift of 13.8% above inflation, to ensure the construction of new residential care capacity at scale is commercially investable
            2) for existing modern residential care rooms, a price uplift of 3.8% above inflation to more accurately reflect the relative capital value of older legacy and more modern stock
            3) for older and smaller 'legacy' rooms, a price uplift matching inflation to achieve the targeted level of price differentiation.
20. Explore targeted capital support for residential care providers on a case-by-case basis where there is clear evidence of an investment barrier (for example, for smaller rural or remote providers or culturally specific providers with otherwise viable business cases):
    a) Possible capital support could include loans, underwrites, or equity injections
    b) Any capital support should be offset against price uplifts to avoid duplication of public funding.
21. Fundamentally restructure the funding model for aged care services by:
    a) unbundling residential care funding into three cost categories: care costs (which include both clinical and personal care), daily living costs, and accommodation costs, while retaining an integrated funding approach for in-home care
    b) linking pricing and funding directly to costs for each of these categories with:
        i. pricing for all levels of care directly linked to costs set through a single casemix framework
        ii. pricing for daily living costs set at a standardised national price
        iii. pricing for accommodation based on a differentiated approach.

22. A common casemix model should provide a framework for identifying need across all aged care settings, where:
    a) costs are determined for each level of the framework based on case weights
    b) non-clinical social factors are recognised where these increase the cost of delivering effective services to some people, such as economic deprivation, lack of access to services, level of carer support, and housing.
23. Develop a differentiated approach to accommodation funding in residential care, using objective measures of accommodation quality and capital investment to better reflect underlying accommodation costs, which could include:
    a) funding older and smaller rooms at lower 'legacy' rates
    b) funding rooms that meet a defined threshold at a new 'modern room' rate
    c) funding new rooms that are added to the system at the highest 'new room' rate.
24. Support the improved supply of affordable residential care options by requiring providers to increase the number of rooms they provide with no premium charges by at least 50% of the number of new-built rooms to receive the highest 'new room' rate.
25. Introduce a new admission and discharge payment to meet the additional costs of admission and discharge for people entering residential care for short-term care and respite care.
26. Modernise In-Between Travel (IBT) so that it is fit-for-purpose and cost effective, taking a phased approach that involves:
    a) fixing the biggest inefficiencies quickly through the introduction of clear rules, thresholds, and definitions
    b) shifting incentives through the incorporation of IBT into bulk funding and a workforce model redesign
    c) locking in the new system through legislative change
    d) ensuring that efficiency gains from IBT reform contribute to sustainable workforce conditions, provider viability, and investment in workforce capability and service delivery.
27. As a principle, public funding should prioritise essential needs-based care, and individuals should be expected to contribute towards the additional costs associated with personal preferences that increase the cost of providing care, such as:
    a) allowing travel costs to be funded within a defined limit where a person has chosen their carer (including Paid Family Carers), with travel costs for personal preferences beyond this limit to be self-funded
    b) capping public funding where the cost of supporting a person at home exceeds the cost of clinically appropriate residential care, with any additional costs met by the individual if they choose to remain at home.
28. Redesign the current discretionary rural loading framework used by Health New Zealand for residential care providers into a rules-based model aligned to key cost drivers.

29. Health New Zealand should investigate transitioning in-home care, in all regions, to a more dynamic version of the restorative bulk-funded approach being progressed to support opportunities for local service provision and competition, and provision of rural, remote, or culturally specific services through targeted arrangements. The following should be investigated and completed in consultation with the proposed Aged Care Pricing Authority once it is established, and be dependent on sustainability for the sector:
    a) Reducing the size of the geographic areas or cohorts used for restorative bulk funding.
    b) Updating populations within each cohort with increasing frequency so that funding dynamically adjusts to population movement.
    c) Adopting commissioning cycles of 3 – 5 years.
    d) Allowing residential care providers to deliver in-home care where this aligns with consumer preferences or supports integrated service delivery.
    e) Allowing for locally and culturally specific models of service provision.
    f) Grandparenting existing contracts through the transition.
30. Develop a clear, evidence-based approach to improving transparency, consistency and trust in pricing decisions by establishing an Aged Care Pricing Authority that provides confidence to consumers, providers and government that funding levels and consumer contributions are based on objective evidence of costs, and that:
    a) is independent of aged care funders and providers, and can therefore be trusted by both
    b) has authority to collect and analyse data from aged care providers on their costs, and has powers to make recommendations to government on appropriate pricing for aged care services to inform its funding decisions (but not to mandate prices for aged care services)
    c) develops a methodology to update prices over time, and a long-term pricing framework that considers rural loading for both in-home and residential care provision based on evidence on differences in the cost of delivering services in rural areas
    d) learns from the Australian model and is adapted to the New Zealand context, rather than being a direct transposition.
31. Alternative options to the Aged Care Pricing Authority could include:
    a) an independent body within the Ministry of Health (similar to Medsafe)
    b) a confidential and trusted mechanism managed by an outsourced information provider
    c) reviewing the current contracts for aged care providers to ensure there is an annual process for setting pricing that is based on clear and independent evidence of actual costs.

Chapter 8 – Rebalancing how we share the cost of care

High quality aged care should be available for **every New Zealander** in the right place and right time **regardless of ability to pay**. Public healthcare should remain publicly funded across the system.

People who can afford it should contribute to their care and should **know what they are paying for**, such as accommodation costs, daily living costs and non-clinical care costs.

Costs should be **shared more consistently** across all types of care, including at home, with contributions based on both care needs and ability to pay.

The current system needs to be **rebalanced**, with more people paying where they can, determined by asset and income testing, with a more **graduated** approach and fairer rules to make sure the system is sustainable.

People should **not be required to contribute** to the cost of **short-term care up to a set time limit**, or where they have **entered residential care for end-of-life care**.

There should be **a lifetime cap on care-related contributions** in residential care, so that people accessing care for more than five years are not unfairly disadvantaged.

Our ageing population means the costs of aged care are escalating so fast that on current settings, aged care will not be affordable in future.

Changes must be made and, inevitably, some people will have to pay more towards the cost of their own aged care (while preserving access to publicly funded clinical healthcare).

We argue that people who can afford to contribute more to the costs of their aged care should do so fairly and transparently, so a sustainable aged care system is still there for younger Kiwis who will need it in the future.

Contributions to the costs of aged care from individuals and government can make a big difference to the quality, timeliness and the financial sustainability of services. Alongside our recommendations to make the system more effective and efficient, a rebalancing of cost-sharing arrangements is required to ensure the system remains viable.

We recommend a more consistent approach to contributions for both in-home and residential care, where contributions toward costs would be based on both care needs and ability to pay, determined through asset and income testing, with a more graduated approach than currently exists.

We have sought to land on a fair approach through preservation of publicly funded clinical care throughout the system, appropriate and consistent means testing where individuals have the ability to contribute, as well as some specific protections for situations where charging wouldn't be appropriate (such as where someone stays in residential care for an extended period).

Many older people already pay additional charges across the sector, highlighting that there is capacity for contributions towards the cost of care. A more consistent and graduated approach to this is needed to promote greater transparency and fairness across the system. People need to know what they are paying for, whether that is accommodation costs, daily living costs or non-clinical care costs.

We recognise that there are important social considerations here. Access to quality, publicly funded clinical healthcare is seen as a right of citizenship. Care must support a holistic view of the individual, their families and whānau and their interaction with communities in which they live.

Family and social support has a significant impact on the types of care people need and receive, and when they choose to access that care. Socio-economic factors, such as home ownership and household income, are critical enablers or barriers to ageing well in place and the ability of people to afford care when needed. We recognise that a growing number of people are renting or still paying a mortgage in older age, and there are significant differences in home ownership rates across ethnic groups and for those who live alone or with a partner. These factors impact how older people prepare for ageing and how much they can reasonably contribute to the cost of their care.

We need to ensure that our aged care system is sustainable for future generations, recognising the cost pressures of our aging population. To achieve this requires a better and more effective and efficient aged care system, which we have sought to map out above, and a clear, fair approach to sharing costs of aged care between individuals and the government, applied consistently across care settings. Our recommendations below have therefore been guided by principles of equity, fairness, sustainability and access.

We recommend protections for people with limited means, and no charges in situations where it's not appropriate, such as some short-term care, or for people entering residential settings for end-of-life care. We also recommend a lifetime cap on care-related contributions to residential care. Contribution settings should also recognise that for many Māori and Pacific families, resources, caregiving, and decision-making are shared across whānau.

What people contribute to the costs of care in the current system

In the current system, in-home care is fully funded by Health New Zealand for those who have an assessed health need to support them to remain at home. This is not means tested and is fully-funded irrespective of people's ability to pay. Providers deliver services to the person to meet those care needs, and services vary from one person to another and may change over time. Some people may pay for additional services that they want, or may pay completely privately.

Funding for residential care is different and, under legislation, primarily the responsibility of the resident. When people are assessed as requiring long-term residential care, they are assessed for eligibility for the Residential Care Subsidy.

The assessment begins with an asset test. Asset thresholds ensure that people with high value assets pay for their residential care. The asset thresholds are adjusted annually to reflect changes in the Consumer Price Index (CPI). The thresholds are currently (as of 1 July 2026):

- $300,811 for a single person, a couple where both partners are in residential care, or a couple where one partner is in residential care and they have chosen to include the value of their house and car
- $164,731 for a couple where one partner is in residential care, and they have chosen not to include the value of their house and car.

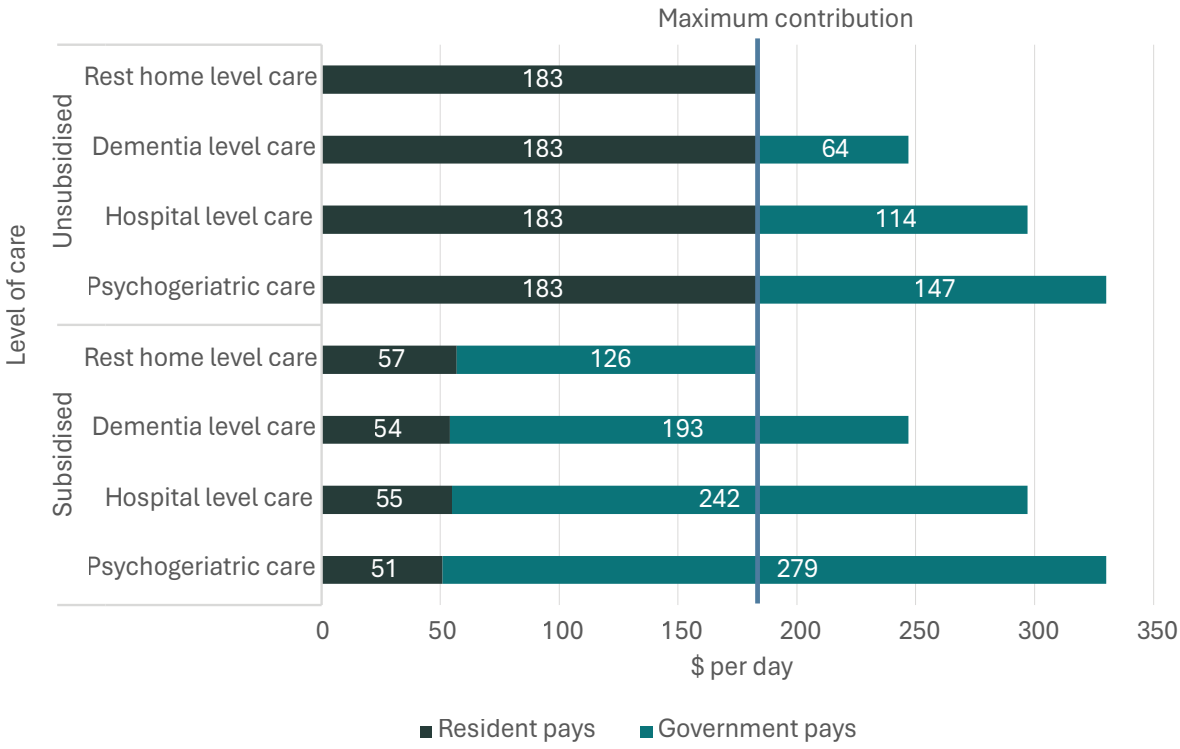
If people have assets above the asset threshold, they must pay the full cost of their care. However, the full amount per week they need to pay is capped at a 'maximum contribution', which is the same as the rest home rate for their location. Health New Zealand covers the difference in cost if they need a higher level of care (for example, dementia or hospital care).

If a person has assets under the threshold, the next step in the financial means assessment is an income assessment to determine how much people should contribute towards their care. Most of their income (including New Zealand Superannuation, Veteran's Pension or any other benefit) will go towards their care, except for a personal allowance of about $57 a week. The remainder of the cost of care is subsidised through the Residential Care Subsidy, paid by Health New Zealand. About 60% of people receive the Residential Care Subsidy.

Once a person under 65 in residential care turns 65, they should be subject to a financial means assessment. However, administration of this across regions can be variable and there is a lack of clarity between agencies about this process.

Figure 10 outlines where contributions to residential care are made between individuals and government.

Figure 10: Average contributions towards the cost of care per day in 2024/25 (excl. GST)



Note *the income test for all subsidised residents is the same. The average amounts shown in the above figure differ from $51 to $57 because the residents in rest home care over 2024/25 had higher incomes than those in other forms of care*

The single, blunt asset threshold means that while a person with assets under the limit can receive substantial financial assistance for care, people who might have assets just over the asset limit must pay for all of their care. For example, a single person with assets of $350,000 would need to pay the full cost of their care until their assets are below the threshold, and a person with assets of $300,000 would get financial assistance and retain the remainder of their assets.

People who are not eligible for the Residential Care Subsidy can apply for a Residential Care Loan. This is an interest-free loan agreement under which Health New Zealand funds the cost of residential care for people who are not eligible for financial assistance but wish to retain ownership of their family home. This scheme recognises that for many older people, their family homes are their principal assets, which they may wish to retain when they enter residential care. The Residential Care Loan is paid back when the person passes away or their home is sold.

Care costs shared consistently across care settings

Currently, contributions towards costs differ significantly between in-home care and residential care. While generally people receive in-home care fully funded for as long as they need it, people in residential care have a responsibility to fund their own care and to contribute what they can.

There should be a single, connected care journey across in-home and long-term residential care, with expectations that people contribute towards their care regardless of setting. The way that people contribute to the costs of care should be fair and consistent across settings and enable people to move between settings as their needs change over time.

We recommend that what individuals pay towards their care should be **based on their casemix level**, which is linked to their acuity and how much care or support they need. Contributions should increase when care needs increase in a proportional way, to reflect the higher costs of providing and funding care, but only if they can afford to do so.

Across all settings, a portion of the care that every person receives should be fully funded, recognising that clinical care needs should be primarily funded by the government.[112] We want to ensure that the system is future-proofed so that publicly funded clinical care continues to be available to all New Zealanders.

Because the care that everyone receives will be different, the portion of care that responds to clinical needs and the portion responds to personal care needs will vary in every case. Further, because these are delivered together under the banner of 'care', the line between clinical and personal care may be hard to exactly define in all instances. To address this, we propose that both in-home and residential care include a notional proportion of care costs that is ringfenced and paid for by the government, irrespective of the means of the individual.

What people should contribute to in-home care costs

We recommend that people should make a contribution towards some of the costs of in-home care as well as residential care. We think this is a necessary shift to make sure that the aged care system is sustainable into the future, and that everyone is contributing fairly to costs where they can afford to.

Because this is a new cost for people receiving care in the home, and we recognise that many older people are on fixed incomes, we suggest that the contributions to in-home care are set at a low rate for those with the ability to pay. More detail on this is set out in the next section.

We recognise that, for in-home care, one of the trade-offs of a bulk funded system is that it requires flexibility, which limits transparency of the exact services a person will receive and the breakdown of costs. Notional contributions towards costs must be related fairly to the services that people receive. To achieve transparency, there must be robust support plans agreed between people and providers that set out what services people are expected to receive. The government and providers should ensure that services are as transparent as possible to support a fair notional contribution system.

We acknowledge also there is a risk that requiring people to contribute to the cost of in-home care might deter some people from accessing services. However, we consider that this risk can be mitigated by setting the contribution levels at low rates and having the right income testing approach.

[112] The provision of state-funded clinical healthcare is seen by many as a right. This report recognises and endorses the fundamental principle of publicly funded clinical care in New Zealand's healthcare system but notes the matter of rights-based versus other approaches to care is best addressed in another forum.

What people should contribute to residential care costs

For people in residential care, contributions should be applied across all three unbundled components of service – accommodation, care and daily living. Requiring people to contribute to their care costs based on their casemix level would remove the current maximum contribution cap linked to rest home level care, to allow contributions to reflect the cost of care received.

This approach aligns with a system where funding is driven by need, while ensuring that those with means contribute more where they are receiving more intensive services. However, in line with our principle that clinical care should be primarily funded by the government, in our modelling, we have assumed that about 30% of the costs of care (averaged across casemix levels) will be ringfenced and paid for by government as a notional proportion of clinical care costs.

A consistent approach to cost-sharing means that people contribute to comparable costs in comparable ways, regardless of whether they receive care at home or in residential settings. A more unified system of co-payments supports the shift to a more integrated system of care.

Fair and equitable contributions to care

Contributions towards costs for aged care must be fair, equitable and clearly linked to people's ability to pay. No one should be prevented from accessing the right care, in the right place, and at the right time, because of their financial circumstances. At the same time, people with the means to contribute toward the cost of their care should make a fair contribution to the services they receive.

Well-designed cost-sharing can support sustainability and transparency. We recommend that ability to pay should be determined through a structured and transparent assessment, applied consistently across in-home and residential care.

When people should contribute to the cost of in-home care

The way that people contribute to the costs of care must be proportionate – settings should prioritise access to in-home and preventative care, and avoid incentives to entering residential care. This is key to ensuring people are able and encouraged to access the right care at the right time, and avoid residential care and hospital when it is not needed.

People who entirely or mostly rely on New Zealand Superannuation as their source of income and who hold limited assets should not be required to contribute beyond their means. We know that there is a growing number of older people who are renting or paying a mortgage in later life and the introduction of a new cost will have an impact on their ability to afford other costs, such as groceries and housing costs. For this group, public funding should continue to cover the full cost of care.

We also recognise that many of those with incomes just above Superannuation may have limited means to make ends meet.

We therefore propose that:

- Care should be fully funded for those with a Community Services Card. This aligns with other areas of the health system and ensures low-income older people can access the support they need. Our modelling indicates that the majority of people aged 75 and over would not be required to pay under these settings.
- For those on incomes between the Community Services Card income threshold and twice that level, co-payments should be set at a maximum of 25% of the nominal average costs of their care (as indicated by their casemix category). Indexing the income threshold to pay a higher contribution to the Community Services Card threshold means it will update over time.

- For those on incomes above twice the Community Services Card income threshold, co-payments should be set at 50% of the casemix-indicated nominal average level.
- Under this proposal, no co-payments would be sought for the publicly funded clinical care component.

We considered whether there should be an asset test for in-home care. On balance, we decided that this would not be appropriate, as many people's largest asset is the home they are living in. Introducing an asset test would also introduce complexity, and the administrative burden could act as a barrier to accessing care, particularly for people who only need in-home care for a short time.

We note that income testing may also create a barrier for discharging people quickly back home and lead to longer length of stay in hospital while people wait to have their income assessed. It is critical that income testing should not be a barrier to transitioning home from hospital. Careful implementation design work should consider this and ensure that there are no unnecessary delays created by income testing.

Cost contributions should also be clear, transparent and straightforward to understand, with proportionate and predictable assessment processes. Information about contributions, protection, and entitlements should be accessible and communicated consistently across the system. Administrative arrangements should minimise burden on individuals, whānau, providers, and assessors, while ensuring decisions are explainable, safeguards are visible, and confidence in the system is maintained over time.

Taken together, these settings ensure cost-sharing supports equity, access, and sustainability, while reinforcing the principle that care should be delivered in the right place and at the right time.

This is an interim and principle-based recommendation, and we expect further refinement will be needed to get the right balance of settings, making sure that people contribute to the cost of care only where they are able to.

When people should contribute to the cost of residential care

The current asset threshold is blunt and not aligned with broader welfare settings, resulting in situations where some people with means are not required to contribute proportionately to the cost of their care. When contributions do start, they can be abrupt and disruptive. We also recognise that aged care is expensive, and people are already required to contribute a significant amount to their care.

We recommend a suite of changes to make contributions to residential care fairer:

- The asset threshold at which people with assets need to contribute more towards the cost of their care should be lowered to $100,000.
- There should be a new stepped approach based on asset bands above that level to determine the contribution people need to make, up to a maximum of $350,000. Above that level, people should be required to make a maximum contribution (excluding a notional amount paid by government to recognise clinical care costs).
- This would replace the current hard asset threshold with a more proportionate approach to contributing to the cost of care, improving fairness and transparency. This also means that more people will be eligible for financial support through the Residential Care Subsidy. Under this system, for example (and what we have assumed in our modelling):
    - people with assets between $200,000 and $350,000 would pay 80% of their total costs
    - people with assets between $100,000 and $200,000 would pay 60% of their total costs.

- There should be a **five-year cap on the total contributions to the care component for residential care**, to ensure that those who require care for longer periods or who enter care at a younger age are not disproportionately disadvantaged. This recognises that people should be able to retain and pass on a portion of their assets to future generations.

This change will mean that more people will pay more than currently, but at a rate proportionate to their assets, and continue to retain their assets under the new lower threshold. There should also be consideration for increasing the personal allowance so those paying from their NZ Superannuation keep a bit more.

Alongside, we recommend reviewing and tightening the current rules and exemptions within asset and income testing settings to close any loopholes and make the system fairer, including rules around trusts and gifting.

Currently, some forms of assets are not included in the asset assessment for the Residential Care Subsidy, including up to $8,000 of assets gifted each year in the last five years (from application for the Subsidy), and up to $27,000 a year of any assets gifted longer than five years from the application. Amounts over these gift amounts are interpreted during asset testing as a person 'depriving' themselves of assets and/or income. The gifting rules are in place to stop people from arranging their affairs to reduce the amount that they need to contribute to their care (for example, by selling their assets to a trust and forgiving the debt as a gift).

The current rules around trusts and gifting should be examined and (where appropriate) further tightened to ensure the system is equitable and fair, and that those with the means to pay do so. A system that is robust and not easily circumvented is critical to ensuring that all people are contributing fairly to the costs of care.

We also recommend changes to the treatment of the family home where one partner is in residential care. Currently, if a person aged 65 or older has a partner who is not in long-term residential care, they can choose whether to include the value of the family home and car in the asset test or be assessed with a lower asset threshold. This setting is in place because the partner who is not in residential care will continue to live in the family home and use the car. However, it can lead to people meeting the lower asset test for financial assistance, even though they have high value assets.

It is important that the family home remain an exclusion to the asset test, but that it not become a way to inappropriately hide or protect assets. We recommend that, where a couple with one partner in care exclude their family home from the asset test, there is a maximum amount that is able to be excluded. Any value above that amount should be included in the asset test. This would require the couple to use some of that asset to pay for their care where it exceeds a threshold. The threshold should be set at a level that avoids the average family home and only targets very high value assets.[113]

Together, these changes represent a foundational shift toward a more transparent, equitable and financially sustainable aged care system, while preserving access to essential care and supporting individual choice within clear and fair boundaries.

[113] We considered setting a proposed dollar-denominated threshold level, such as $2 million per family home. However, recognising that this required further analysis of income distribution, possible regional variation, and adjustment over time, we considered it more prudent to recommend a principle-based approach and call for further development of detail during the implementation phase.

No contribution towards costs where a person enters residential care for short-term or end-of-life care

We recommend that there should be no contributions required for short-term care or residential respite up to a set time limit, or where a person has entered residential care specifically for end-of-life care (for up to six weeks).

We recognise that end-of-life care can often continue for longer than this. There should be clear but flexible processes to allow funding to continue beyond this point where needed, depending on people's individual situations and circumstances. Further work is needed on the design of this approach. This represents a change to the current system, where funded care can end if a person lives beyond the timeframe of their contracted support.

Short-term care, including respite, is key to enabling people to age well at home and preventing unmet health need, and end-of-life care is a difficult time for family and whānau that should not be made more difficult by the means testing process. Where an existing resident moves into this category, they should continue to contribute toward the costs of care, recognising that residential care providers are primary providers of end-of-life care.

Wider considerations

Cost-sharing design must be culturally responsive by taking collective forms of financial responsibility and decision-making into account, particularly for Māori and Pacific peoples.

For many Māori and Pacific families, resources, caregiving, and decision-making are shared across whānau. The system should be designed in ways that support whānau-centred communication and culturally responsive engagement, while maintaining fairness, consistency and access to care. Where appropriate, assessment and payment mechanisms should accommodate collective approaches, with culturally responsive safeguards.

Equity considerations apply consistently across residential and in-home care and should be integrated into broader funding and cost sharing design. These arrangements support equitable access, participation, and trust for Māori and Pacific peoples, and avoid creating barriers to timely engagement or appropriate care.

There also needs to be consideration of equity and integration across groups of people receiving the same or similar services. This is important for people receiving services funded through Disability Support Services and ACC and providers delivering services. People who need support should be able to access support when and where they need it, and the funding and contribution settings should be integrated and aligned as much as possible.

Based on the settings above, we expect that changes to settings for the amount that people contribute to their care would result in reduced future costs for taxpayers of **$145 million in the first year** of implementation (assumed to be 2028/29), rising to $408 million after a 3-year phase in of changes to residential care contributions, and to **$531 million** by 2037/38.

Careful transition planning is needed for any new arrangements

In making any changes to how people contribute toward the cost of care, the government will need to strike a balance between fairness and certainty for older people currently in residential care, and equitable treatment of future residents.

For people already in residential care, a sudden change to their financial obligations may be difficult to manage. At the same time, exempting current residents from making increased contributions could create inequities between residents with otherwise similar circumstances, and could require complex and confusing rules.

We recognise this is a challenge, but have not made a firm recommendation. The government will need to consider both fairness and the practicality of transitional arrangements as changes to resident contributions are implemented.

Our modelling estimates take a conservative approach, and assumes that the proposed changes to residential care charges are phased in over three years during which existing residents' payment obligations are based on the current policy settings.

Recommendations

32. The government should take the following approach to balancing contributions to care:
    a) What individuals pay towards the cost of their care should be based on their casemix level with contributions increasing when care needs increase to reflect the higher costs of providing and funding care. This should be aligned across care settings.
    b) A portion of the care that every person receives through aged care should be funded by the government, recognising that clinical care needs should be primarily funded by the government.
    c) Those who have the means should contribute towards other care costs (personal care), as well as daily living costs and accommodation costs, while the government should support those who cannot afford to pay to ensure they receive the same level of care.
33. The government should institute arrangements that support fairness in the system by:

For in-home care:

    a) continuing to provide fully-funded in-home care to people with incomes below the Community Services Card (CSC) threshold
    b) requiring people receiving in-home care who have incomes above the CSC threshold to contribute to the cost of their care – with those on income between the CSC threshold and twice the CSC threshold required to pay a low set amount based on their casemix level (up to 25% of care costs), and those with incomes more than twice the CSC threshold required to contribute up to 50% of care costs

For residential care:

    c) lowering the threshold at which people with assets need to contribute more towards the cost of their care to $100,000
    d) introducing a new stepped approach based on asset bands above that level to determine the contribution people need to make, up to a maximum of $350,000 of assets above which people are required to make a maximum contribution (excluding a notional amount paid by government to recognise clinical care costs)
    e) where people elect to exclude the family home from asset testing, limiting this exemption to exclude the value of the family home only up to a maximum level, the value above which would be included in the asset test
    f) reviewing and tightening current rules and exemptions within asset and income testing settings to close any loopholes and make the system fairer.
34. People should not be required to contribute to the cost of short-term care up to a set time limit, or where they have entered residential care specifically to receive end-of-life care (where they are expected to pass away relatively quickly).
35. Introduce a lifetime cap set at the equivalent of five years of contributions to the care component for residential care, so that people needing care for longer than the norm are not unfairly disadvantaged.

Chapter 9 – Bringing the reform package together

Scenario A – continuing with the current state – and Scenario B – adding money to the existing system – result in **huge costs and worsening health outcomes** for older people.

The package of reforms we recommend – Scenario C – will build a more i**ntegrated system and better services** for older people.

Scenario C will also reduce the growth in future costs to the government by just over $830 million by 2037/38 while improving the care available for older people to live and age well.

The growth in government costs from 2026/27 to 2037/38 is **57% lower under Scenario** C than under Scenario B.

We will still need a long-term solution that gets us beyond the next 20 years: a **save-as-you-go social insurance scheme** should be explored.

Throughout this report we have argued that New Zealand's aged care system faces an unavoidable reality: demand is growing faster than the system's ability to respond. Population ageing will drive substantial growth in the need for care over coming decades, while the existing system is already struggling with fragmented services, funding settings that do not reflect the true costs of care, and diminishing capacity. As a result, the system is becoming both more expensive and less effective over time.

Doing nothing is not a neutral option. It is a choice that leads to greater unmet need, rising pressure on hospitals, worsening inequities and escalating costs.

We tested three broad futures for aged care. The first was a future where the system continues largely unchanged and capacity fails to keep pace with demand. The second was a future where government simply spends more money preserving existing arrangements. The third was a future based on structural reform of the system itself.

Our conclusion is clear: while systemic reform requires investment and difficult decisions, it is the only path that improves outcomes while containing long-term costs.

This chapter gives an overview of how the reforms work together to achieve that.

Comparing the three futures

To understand the impact of this package, we tested three scenarios. These are set out in more detail in Chapter 3, but are summarised below.

Scenario A: Doing nothing

Under this scenario, the system would continue largely unchanged. Funding would remain insufficient to grow new capacity, particularly residential care beds, leading to increased hospital stays, worse health outcomes for older people, and unsustainable pressure on family and whānau carers.

The costs of inaction would be displaced into other parts of the system, particularly hospitals. By 2037/38, this scenario would add around $589 million per year in additional costs to the government (in 2025/26 dollars), and the total costs to the government rise to around $4.4 billion.

Scenario B: Spending more without reform

In this scenario, government increases funding to expand capacity within the existing system, without changing how that system operates.

This approach would improve access to aged care in the short term. However, it would not address the underlying drivers of cost, and costs would rise steeply. By 2037/38, government spending would reach around **$4.6 billion per year**.

Scenario C: Structural reform

The third scenario reflects the full package of reforms set out in this report. It combines **increased investment with structural change to improve the care people can access while reducing long-term costs**.

The key distinction between this scenario and the alternatives is that it does not simply fund more of the current system. Instead, it **invests in creating a different system that supports people to remain well at home for longer, reduces avoidable demand for higher-cost services, and uses funding more efficiently**.

Achieving this system requires significant immediate investment for both in-home and residential care, to stabilise existing services and create capacity for the future.

Investment is also needed to implement the wider reform programme outlined in this report. This includes improvements to assessment and care pathways, navigation support, advanced in-home care, stronger support for carers, investment in technology and digital integration, and changes to contracting and regulatory settings. Collectively, the initiatives required to deliver these changes have an estimated net cost to government of approximately **$168 million**.

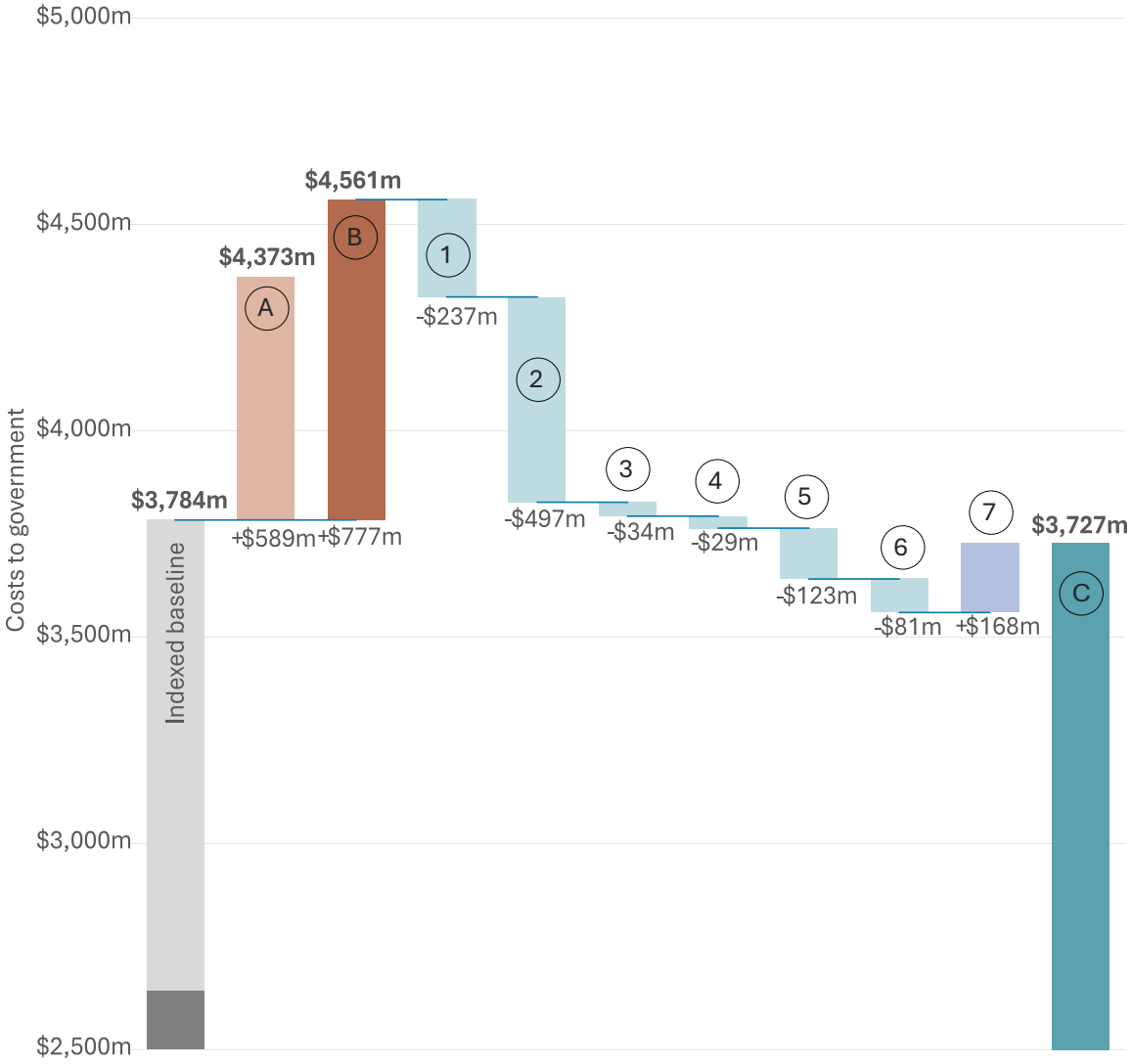
Together, these investments would result in a system that delivers better care and improves health outcomes for older people. Reforms would also improve how funding is targeted and reduce unnecessary hospitalisations and demand for residential care.

A significant part of Scenario C is rebalancing the contributions people make towards the cost of care. We estimate that these changes would reduce government costs by approximately **$531 million** by 2037/38.

Our modelling estimates Scenario C would cost around **$3.7 billion** in 2037/38. Compared to Scenario B, our package of reforms under Scenario C is estimated to reduce the growth in costs to government by **57%** between 2026/27 and 2037/38. This means reduced costs of just over **$830 million**.

The following figure summarises the cost differences between the baseline projection (with demand growth and indexed prices), and the three scenarios we have modelled. This figure presents projected values for the 2037/38 fiscal year, by which time our proposals would be implemented.

Figure 11: Projected costs to government under the modelled scenarios ($millions in 2025/26 dollars)



The key figures within this diagram are:

- **The 'indexed baseline' of projected government costs** for aged care services. This rises from $2.643 billion in 2026/27 (dark grey) to $3.784 billion in 2037/38 (light grey) as demand grows with an ageing population and prices increase slightly faster than CPI inflation. Our scenarios are developed from this baseline, but it is not in itself a plausible future state.
- **Scenario A:** Demand for residential care beds outstrips supply and creates added costs to government reaching $4.373 billion per year in 2037/38.
- **Scenario B:** Funding increases by enough to meet demand. Costs to government reach $4.561 billion per year by 2037/38.

The next lines set out the key fiscal changes within **Scenario C:**

1. Targeting the prices paid for new and existing residential care beds through price differentiation reduces government costs by approximately **$237 million per year** by 2037/38 by targeting investment where it is needed, rather than applying higher prices uniformly across the sector (recommendation 19).
2. Changes to the way that people contribute to the costs of residential care reduces government costs by approximately **$497 million per year** by 2037/38 (recommendations 32-35).

3. Introducing individual contributions for in-home care reduces government costs by approximately **$34 million per year** by 2037/38 (recommendations 32-34).
4. Demand responses to the new residential care contribution settings reduce government costs by around **$29 million per year**.
5. Strengthening in-home care and other supports can reduce demand for residential care by approximately 6,000 beds per year, reducing government costs by a net **$123 million per year**.
6. Comprehensive, responsive and timely care in the community, including early supported discharge from hospital to residential care or to home can reduces avoidable hospital stays by around 30,000 bed nights per year, reducing resource and capacity pressure on the hospital system by **$81 million per year**.
7. Improving care in the community and other actions proposed in this report have an estimated cost to government of **$168 million per year**, while unlocking the benefits in (5) and (6) above and improving in-home care quality.

The final line shows the total net cost to government of Scenario C, which our modelling estimates would be approximately **$3.7 billion** in 2037/38. We note that these estimates are approximate and based on the best available data currently available. Our methodology is set out in **Appendix 6**.

Figure 12 below shows the impact of the new model over time, compared to Scenarios A and B, and Table 1 on the following page sets out the costs and reduced costs over time in more detail.

Figure 12: Aged care costs to government (including health system capacity impacts), Scenarios A, B and C

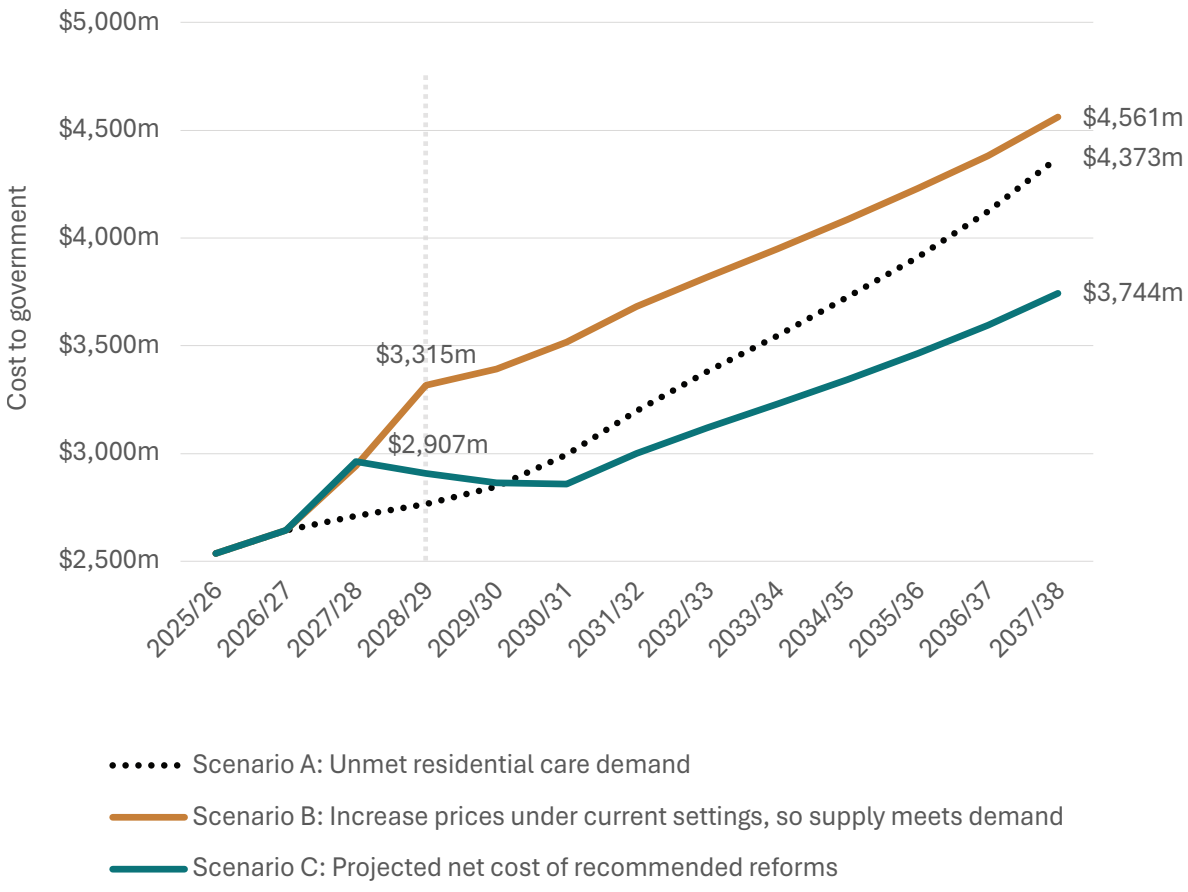


Table 1: Projected costs to government under the modelled scenarios for aged care services ($millions in 2025/26 dollars)

	2026/27	2027/28	2028/29	2029/30	2031/32	2033/34	2035/36	2037/38	2047/48
Baseline Projection Demand Growth, Indexed Prices	**$2,643**	**$2,708**	**$2,756**	**$2,817**	**$3,053**	**$3,278**	**$3,515**	**$3,784**	**$5,001**
Scenario A: Unmet demand for residential Care Increase over indexed baseline	-	$1	$9	$29	$145	$269	$397	$589	$1,312
Total government costs for Scenario A	**$2,643**	**$2,710**	**$2,765**	**$2,846**	**$3,198**	**$3,547**	**$3,912**	**$4,373**	**$6,313**
Scenario B: Untargeted uplifts to meet demand Increase over indexed baseline		$235	$559	$574	$630	$671	$715	$777	$1,014
Total government costs for Scenario B	**$2,643**	**$2,943**	**$3,315**	**$3,391**	**$3,682**	**$3,949**	**$4,230**	**$4,561**	**$6,015**
Scenario C: All proposals in this report (reduced costs compared to Scenario B)									
1. Target residential care pricing to new builds			-$285	-$282	-$271	-$260	-$249	-$237	-$181
2. – 4. Changes to private contributions									
2. Contributions to residential care			-$118	-$244	-$400	-$428	-$459	-$497	-$661
3. Contributions to in-home care			-$26	-$26	-$28	-$30	-$32	-$34	-$44
4. Demand response to residential care prices			-$7	-$14	-$23	-$24	-$27	-$29	-$40
5. Reduce residential care demand by 6,000 beds by 2037/38 by improved in-home care services and carer support			-$12	-$22	-$45	-$69	-$94	-$123	-$160
6. Reduce avoidable hospital capacity pressure by 30,000 bed nights			-$15	-$33	-$68	-$71	-$77	-$81	-$105
7. Proposals to improve aged care services and deliver the reduced costs in 5 and 6									
Set-up costs for initiatives		$20	$30	$30	$25				
Ongoing government expenses			$46	$92	$185	$240	$254	$271	$335
Govt reduced costs (additional to 3 and 4 above)			-$11	-$23	-$46	-$60	-$63	-$67	-$83
Health System costs avoided			-$6	-$12	-$25	-$32	-$34	-$36	-$44
Net costs to government (of 7.)		**$20**	**$58**	**$87**	**$140**	**$149**	**$157**	**$168**	**$208**
Other aged care system benefits (no fiscal impact)		$0	-$21	-$43	-$86	-$111	-$118	-$125	-$155
Scenario C: Total cost to government	$2,643	$2,963	$2,909	$2,585	$2,988	$3,215	$3,450	$3,727	$5,031
Scenario C: Government cost change from Scenario B	**$0**	**$20**	**-$406**	**-$534**	**-$694**	**-$734**	**-$780**	**-$834**	**-$984**

Looking further into the future: a social insurance model to guarantee access

Our funding recommendations respond to rising demand, more people needing care for longer with more complex needs, and higher expectations of quality and access. But the deeper challenge facing the aged care system is demographic.

The number of older people needing care is growing quickly, while the number of working-age people available to pay for it is shrinking. This is going to be a challenge over the next 15 – 20 years, but things get significantly harder beyond that. In 2020 there were there were 4.2 working aged people in New Zealand for every person aged 65 and over,[114] which will decrease to 3.1 by 2038, and 2.0 by 2073.

Fewer taxpayers will be carrying the cost for many more people. This challenge has also been raised by the Retirement Commission, which has raised the need for a long-term planning approach for retirement income policy.[115]

While future Superannuation settings are outside our scope, the reforms proposed in this report go some considerable way to addressing fiscal sustainability issues over the medium term, but they are not a complete long-term solution.

We recognise however that the current 'pay-as-you-go' approach to funding aged care services is not sustainable in the long term. In our view, more consideration is needed of a further fundamental shift towards a system where more aged care costs are pre-funded and spread across the population and across time.

We therefore recommend the New Zealand explore an additional aged care social insurance scheme as a long-term mechanism to fund the cost of aged care, to guarantee access to aged care for future generations.

Governments could consider a range of approaches and seek to build a mandate around a preferred model. New Zealand has had positive experience with contribution-based schemes that seek to address long-term costs, with examples including ACC, KiwiSaver, and the New Zealand Superannuation Fund.

Countries such as Germany, Japan, and the Netherlands have also successfully implemented social insurance models for aged care. These systems provide valuable lessons for New Zealand: they demonstrate that forward funding, collective risk pooling and guaranteed entitlements can deliver high-quality, sustainable care even as populations age.

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[114] Statistics New Zealand. (2020). *National population projections: 2020(base)–2073*. https://www.stats.govt.nz/information-releases/national-population-projections-2020base2073/

[115] See: https://assets.retirement.govt.nz/public/Uploads/Retirement-Income-Policy-Review/2025-RRIP/Review-of-Retirement-Income-Policies-2025_WEB.pdf

While we are not recommending a specific approach, our view is that a scheme that is collectively funded, and which provides aged care services for whoever needs them, is likely to offer a range of benefits including:

- **fairness** (by spreading the cost of care over a person's lifetime and across the entire population)
- **guarantee of access** (by providing an entitlement to care, reducing uncertainty and enabling older New Zealanders to plan for their later years with confidence)
- **equity** (as all New Zealanders, regardless of income or background, would have access to aged care)
- **efficiency** (as dedicated funding streams can be managed and invested for long-term returns).

A collective, save-as-you-go system could help to avoid intergenerational inequity in access to and funding for aged care, and provide a guarantee to younger people that the system will be sustainable and there when they need it.

These types of schemes can also have significant spillover benefits for the wider economy, by increasing savings and the depth of capital available to support innovation and wider economic activity in New Zealand. This could include requiring (or guiding via governance processes) a share of local reinvestment as a core principle of any future save-as-you-go scheme.

If such a scheme is considered, careful thought would need to be given to transition planning to avoid an unfair financial burden on some cohorts of workers.

Recommendations

36. Explore a save-as-you-go social insurance scheme, with a recommended common pool, to provide a guarantee of access to aged care for future generations by forward funding the costs of aged care.

PART FOUR:

The critical path ahead

Chapter 10 – Implementation and delivery of reform

Major reform is needed with a staged approach which must **start immediately**. There must be an end-to-end reset for the aged care system, with one coherent funding and supply model to support an integrated and person-centred care journey.

This change cannot be made in a piecemeal way but **must follow a critical path** which is prioritised, including **legislative change, stabilising capacity, establishing the system architecture and an Aged Care Pricing Authority**.

A **steering group and set of sector working groups should be established** to support implementation through a **time-bound transition programme**.

Transition risks and system dependencies will need to be actively managed.

Delivering system change requires a well-coordinated implementation programme, **establishing clear transition management and accountability arrangements**.

The case for substantial system reform has already been established. Minor adjustments and policy change alone are insufficient, and the consequences of inaction are dire.

We recommend a clear, staged plan starting immediately, with a dedicated steering group supported by sector working groups to influence the transition and to keep aged care running safely for the people who need it right now while the system changes around them.

While appropriate engagement around operational design will be needed, we do not recommend a fully co-designed process at the policy level, due to the need for clarity of direction and urgency of action. The longer implementation is delayed, the more difficult and costly it becomes to address the pressures facing the system and support the growing number of older New Zealanders who rely on it.

Implementation must be anchored around a clearly defined critical path. This path should focus on establishing the legislative, funding and system foundations required to reset the aged care system. Delivering these foundations early and at pace will create the conditions for wider system changes, support long-term sustainability, and enable ongoing improvements in how care is delivered and experienced.

Start immediately

The need for reform is urgent. New Zealand cannot materially change the number of older New Zealanders who will enter the aged care system over the coming decades, but we can change how effectively the system responds to that demand.

Delaying action will make the challenge harder and more expensive to address. As demand grows, the gap between system capacity and need is likely to widen, increasing pressure on access, quality, providers, the workforce, and public funding. This risks reducing the range and availability of services, increasing inequities in access to care, and placing greater pressure on older people, whānau and the wider health system.

Major reform is needed, not piecemeal or incremental improvement. The objective is not simply to adjust existing services, but to reset the foundations of the aged care system so it can remain sustainable, responsive and person-centred in the face of rising demand.

Acting early creates the best opportunity to improve outcomes and experiences, maintain system sustainability, and support future generations. We urge the government to begin reform immediately, with early action focused on establishing the foundations required for long-term change and a sustainable system.

Prioritise the critical path

Implementation should prioritise the critical path: the legislative, funding and system changes required to reset the foundations of the aged care system. Sustained commitment and investment in these reforms is essential to deliver the structural change needed for long-term sustainability and system transformation.

Not all elements of the reform have the same role in implementation. While improvements in service delivery and consumer experience are important, they depend on a set of structural changes that establish how the system is funded, organised and sustained over time. These changes form the critical path.

The critical path should be prioritised because it delivers the structural reset required to place the aged care system on a more sustainable footing. It establishes the foundations upon which broader improvements can be built.

We submit that the critical path should incorporate the interconnected elements below.

Legislative change

Legislative change is one of the first steps in the critical path. It provides the authority and policy settings required to implement new funding arrangements, contribution mechanisms, pricing approaches and system functions.

Without legislative change, many of the structural reforms cannot proceed. Early legislative action will reduce implementation risk, provides certainty to the sector, and create a clear mandate for change. Legislative consideration needs to take place in parallel to funding and detailed system redesign elements.

Stabilise capacity through pricing uplifts

Structural reform will take time to implement. Maintaining provider viability and workforce capacity during this period is essential to ensuring continuity of care and avoiding further deterioration of the system.

Pricing uplifts for in-home and residential care should be implemented early in the transition. These measures are intended to stabilise the existing system, support provider sustainability, and maintain workforce capacity while longer-term reforms are being established.

Without early stabilisation, there is a risk that providers exit the market, workforce shortages worsen, and service access deteriorates before the benefits of broader changes are realised.

Establish the system architecture

The system requires a consistent architecture linking people's needs to funding decisions. This includes the casemix model, unbundling mechanisms, assessment pathways, and supporting system design.

Establishing this architecture will create the foundation for a more transparent and equitable system. It will ensure that funding is aligned with assessed need, provide consistency across service settings, and create a clearer basis for planning and investment.

The system architecture should be designed early and progressively implemented alongside legislative changes and stabilisation measures. Much of the subsequent funding and pricing design depends upon it.

Establish an Aged Care Pricing Authority

An independent Aged Care Pricing Authority (ACPA), or equivalent function, should be established to provide the capability, expertise, and institutional arrangements needed to support a long-term national pricing framework.

The ACPA would play a central role in developing cost-reflective pricing methodologies, improving transparency, strengthening confidence in funding decisions, and reducing the need for ad hoc pricing negotiations. It would also provide an independent source of advice on the costs of delivering aged care services and support more consistent pricing across care settings.

Establishing this capability should be prioritised early in implementation. While many of its functions will mature over time, creating the institution and building pricing capability is a prerequisite for the successful implementation of broader funding and pricing decisions. Without an independent pricing function, it will be difficult to sustain confidence in the new funding arrangements and maintain alignment between funding, service costs, and needs.

Implement funding and pricing reform

With the legislative framework, system architecture and ACPA established, the system can transition to new funding and pricing arrangements.[116] This includes introducing casemix-informed funding, implementing cost-reflective pricing approaches, and aligning funding more closely with assessed need. Together, these changes put the structural reset into operation and place the system on a more sustainable footing.

Establish a steering group and sector working groups

A steering group, supported by sector working groups, should be established to support the implementation of reform by providing cross-sector coordination, delivery expertise, and stakeholder engagement while maintaining focus on delivery of the core structural changes. Rather than taking a full co-designed approach, the groups should ensure that implementation of the reforms works well across a range of stakeholders.

Implementation requires shared ownership

Successful implementation will require coordination across government agencies, providers, workforce representatives, unions, older people and their whānau, Māori, Pacific communities, and other sector stakeholders. While accountability for implementation should remain centrally allocated, delivery will be strengthened through a structured mechanism that enables ongoing collaboration and problem-solving.

A steering group and set of sector working groups should be established to support implementation, identify emerging risks and issues, and provide practical advice on the design and delivery of key initiatives.

[116] Our modelling work for residential care pricing and funding has been based on beds funded on a daily basis. Implications for models such as Occupational Rights Agreements and care suites will need to be worked through in further detail in the next stages of work.

The steering group should support the implementation of the recommendations in this report. It could include some members of the Ministerial Advisory Group to ensure continuity in the implementation of recommendations, and cross-representation across the process.

Underneath the steering group we recommend a set of working groups focused on particular areas of reform – for example, workforce requirements and strategy, cultural responsiveness and equity, and development of the casemix framework. The groups should help ensure implementation decisions remain informed by operational realities and the experience of those delivering and receiving care.

The working groups should be made up of experts in different areas, including representatives from consumer groups, unions, clinicians, providers, and iwi and Māori.

These groups would have an expert advisory function, rather than a decision-making function. The groups would support the change, ensuring reform is practical and feasible while meeting the overall reform objectives.

Support operational design and implementation

Many aspects of implementation will require detailed operational design, including assessment pathways, funding arrangements, service interfaces, provider readiness and transition planning.

The working groups should provide a forum for testing implementation approaches, identifying unintended consequences, and advising on pragmatic solutions to delivery challenges. Their focus should be on enabling implementation rather than revisiting policy decisions.

Build on existing capability and partnerships

Implementation should leverage existing expertise, relationships and delivery capability across the sector wherever possible. Providers, communities, and sector organisations have significant experience in delivering care and responding to changing needs. This capability should be incorporated into implementation planning.

Building on existing partnerships can also accelerate implementation, improve sector readiness, and strengthen confidence in the reform programme.

Support design of culturally appropriate models

While the structural elements of the reform should be implemented consistently, some aspects of service delivery will require local adaptation and culturally appropriate design.

The working groups should support engagement and design processes with Māori, Pacific providers, and other communities where implementation requires adaptation to local circumstances or culturally specific models of care. This will help ensure the future system remains responsive to the diverse needs and preferences of older New Zealanders.

Maintain focus on measurable improvement

Engagement should drive outcomes. The role of the steering group and working groups should be to help remove barriers to implementation, support continuity of care, and contribute to measurable improvements in system performance, service quality and user experience.

Most importantly, the groups should help maintain alignment between the objectives of the reform and the realities of implementation, while ensuring that delivery of the critical path remains the primary focus. Sustained engagement and collaboration will be important to successful implementation, but they should support timely delivery of the structural changes required to reset the system.

Implement reform through a time-bound transition programme

Major reform should be implemented through a structured, time-bound transition programme that balances urgency with continuity of care. Delivery should occur across three horizons: establishing foundations; implementing structural change; and enabling market-led system change.

A staged approach to implementation

Some changes are required immediately to stabilise the system and establish the foundations for reform, while others depend on those foundations being in place before they can be successfully implemented.

A structured transition programme will provide a clear roadmap for delivery, manage dependencies between initiatives, and reduce the risk of implementation becoming fragmented or losing momentum. While the horizons are presented sequentially, many activities should proceed in parallel wherever possible to accelerate delivery and maintain progress.

Horizon 1 (2026–2028): Legislative and system foundations

The first horizon focuses on establishing the foundations required for implementation and stabilising the existing system.

Key priorities include:

- Legislative changes required to enable the future system.
- Establishment of the implementation steering group and working groups.
- Establishment of the ACPA (or equivalent pricing function).
- Targeted pricing uplifts to support system capacity and provider viability.
- Development of the system architecture: the casemix framework, cost unbundling settings, and assessment pathways.
- System readiness and implementation planning.

The objective of this phase is to create the institutional, funding and system foundations necessary to support structural change while maintaining continuity of care.

Horizon 2 (2028–2032): Structural reform

The second horizon completes the structural reset of the aged care system.

Key priorities include:

- National implementation of the casemix framework.
- Introduction of casemix-informed funding arrangements.
- Implementation of new pricing methodologies.
- Roll-out of delegated assessment model and NASC functions.
- Establishment of advanced in-home care services.
- Design and implementation of funding and contribution and means testing changes.
- Completion of core funding and system architecture reforms.

The establishment of advanced in-home care services should be implemented progressively across this horizon and the next, allowing providers and workforce capability to mature alongside service expansion.

By the end of this horizon, the aged care system should be operating within a more transparent, consistent, and sustainable framework that better aligns funding with need and creates stronger foundations for future improvement.

Horizon 3 (2032 onwards): Ongoing system change

Once the structural foundations are established, responsibility for ongoing improvement increasingly shifts to providers, communities and the wider market.

Key priorities include:

- Greater consumer choice and service flexibility.
- Improved care coordination and navigation.
- Technology-enabled service delivery.
- Culturally responsive and locally adapted models of care.
- Innovation in advanced service models and care delivery.

In this phase, providers and system participants respond to the new incentives, funding arrangements, and system settings established. Competition, innovation, consumer preferences, and ongoing service improvement become increasingly important drivers of performance.

Maintain pace

A time-bound transition programme is essential to maintaining momentum and avoiding prolonged periods where legacy and future arrangements operate alongside one another. Extended transition periods increase complexity, uncertainty, and implementation costs, while delaying the benefits of change.

Implementation should be managed against clear milestones and outcomes, with a continued focus on completing the critical path as quickly as is practical. Delivering the structural reset by the end of Horizon 2 is essential to creating the conditions for long-term system change and realising the benefits set out in this report.

Actively manage transition risks and system dependencies

Successful implementation depends not only on delivering the recommendations in this report, but also on managing the broader system dependencies that influence whether the intended benefits can be realised. Government should actively monitor and manage these transition risks throughout implementation.

Reform alone cannot deliver all outcomes

The recommendations outline the foundations for a more sustainable, responsive and person-centred aged care system. However, many of the intended benefits depend on factors that sit outside the direct scope of the aged care system itself. While these dependencies should not delay implementation, they will influence the pace, scale, and extent of future system change.

Recognising these dependencies early allows risks to be managed proactively and ensures expectations remain realistic about what aged care reform alone can achieve.

Housing and ageing well in place

A central objective of the future system is to support older people to remain living independently in their homes and communities for longer. However, this outcome depends on the availability of safe, affordable and age-appropriate housing.

Without sufficient housing options, accessible homes, community infrastructure, and support services, older people may have limited ability to remain independent regardless of improvements made within the aged care system. The success of policies aimed at supporting ageing well in place will therefore depend partly on progress in housing and community development initiatives beyond the scope of this report.

We are aware the number of people experiencing homelessness is growing, and hospitalisations of these people have doubled in six years. There were 1954 hospitalisations of people experiencing homelessness in 2024/25, up from 971 in 2018/19.[117] The seniors among this group clearly need to be given much more help.

We urge the government to prioritise ensuring there is an adequate supply of warm, affordable and accessible homes for older people.

Health system integration

Many of the benefits sought through reform rely on better integration between aged care, primary care, hospitals, community services, disability support and other parts of the health and social sector.

Continued progress toward a more integrated health system will be important for better outcomes and experiences for older people.

Advanced in-home care

Achieving the anticipated benefits depends greatly on requires a workforce with greater clinical capability, robust clinical governance, effective service integration, provider readiness, and confidence that technology-enabled approaches are delivering safe and effective care.

If these conditions are not met, there is a risk that people with higher and more complex needs experience poorer outcomes. The relevant working group should maintain close oversight of implementation and monitor impacts on hospital utilisation, emergency department presentations, consumer outcomes, safety, and workforce capacity as the model is expanded.

Digital and technology enablement

The future system envisages greater use of technology-enabled services, improved data sharing, better service navigation, and more connected care pathways.

Many of these opportunities depend on broader digital investment and transformation occurring across the health sector and government. Interoperable systems, shared data standards, digital infrastructure, and modern information platforms will be important enablers of many of the improvements described throughout this report.

Workforce sustainability

An effective aged care system ultimately depends on the people who deliver care.

While workforce policy is largely outside the scope of this report, the availability of a sufficiently large, skilled and stable workforce remains one of the most significant determinants of successful implementation.

Implementation should remain closely connected with wider workforce planning and development initiatives across the health and care sectors.

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[117] RNZ. (9 July 2026). *Homeless and hospitalised: The deadly impact of sleeping rough*. Homeless and hospitalised: The deadly impact of sleeping rough | RNZ

Fiscal and policy commitment

The benefits of reform will be realised over many years, while much of the investment and implementation effort is required upfront. Maintaining commitment across funding, planning and electoral cycles will be critical to sustaining momentum and providing certainty to providers, the workforce and consumers.

Changes in direction, delays in implementation, or inconsistent investment could undermine confidence in the reform programme and slow progress towards the intended outcomes.

Monitor dependencies without delaying action

These risks and dependencies reinforce the need to begin implementation immediately. While many factors influencing success sit outside the aged care system, the structural changes recommended here remain necessary regardless of how those wider issues evolve.

The proposed steering group should maintain oversight of key system dependencies and emerging implementation risks, while ensuring attention remains focused on delivery of the critical path. Managing these dependencies will not remove the need for reform, but it will improve the likelihood that the full benefits of system change are realised over time.

Establish clear transition management and accountability arrangements

Implementation should be supported by clear transition management arrangements that provide certainty for providers, the workforce, and consumers, while maintaining strong accountability for delivery, performance and outcomes.

Managing transition is as important as managing change

The aged care system must continue to deliver safe, reliable and timely care while reform is being implemented. This creates a dual challenge: building the future system while continuing to operate the current one. Managing this transition will be critical to maintaining confidence in the reform programme and ensuring continuity of care for older people and their whānau.

Without clear transition arrangements, there is a risk that uncertainty, duplicated processes, and inconsistent implementation undermine the intended benefits of change. A structured approach is needed to guide the system from its current state to the future model.

Establish time-limited arrangements for legacy systems

Some existing systems, funding arrangements and operational processes will need to remain in place during the transition period. However, these arrangements should be explicitly transitional and retained only where necessary to support continuity and stability.

Implementation should avoid creating a prolonged period where legacy and future arrangements operate indefinitely alongside one another. Clear transition milestones and end dates will help maintain momentum and encourage timely adoption of new system settings.

Provide certainty for providers and the workforce

Providers and the workforce will play a central role in the success of implementation. They need sufficient certainty to plan, invest, adapt and prepare for future changes. Implementation should be accompanied by clear communication about:

- what is changing
- when changes will occur

- what new responsibilities and expectations will apply
- how progress will be monitored
- what support will be available during transition.

Providing clarity and predictability will help maintain sector confidence and support ongoing investment in service delivery capacity throughout implementation.

Provide targeted transition support

The impact of reform will not be experienced uniformly across the sector. Some providers, workforce groups, and service settings may require additional support to adapt to new funding arrangements, operating models or system requirements.

Targeted transition support should therefore be available where implementation risks are greatest. This may include capability-building initiatives, implementation guidance, change management support, workforce development activities, and assistance with new operational processes.

The objective should be to support successful adoption of the new system while minimising disruption to service delivery.

Establish strong accountability for delivery and outcomes

The proposed steering group and sector working groups should sit at the centre of implementation governance, providing oversight of progress, identifying implementation risks, coordinating action across stakeholders, and maintaining focus on delivery of the critical path.

While formal accountability for implementation should remain with government, the steering group should act as the principal mechanism for monitoring progress and supporting successful delivery. Its role should include:

- monitoring implementation against agreed milestones and outcomes
- identifying and escalating risks, barriers, and dependencies
- supporting coordination across government agencies, providers, workforce representatives, and sector stakeholders
- advising on implementation priorities and sequencing
- providing transparency on progress and emerging issues
- supporting continuous improvement throughout the transition.

The steering group should maintain a strong focus on outcomes as well as activities. Monitoring should extend beyond whether individual initiatives have been completed to whether the intended benefits of the reform are being realised. This should include oversight of:

- financial sustainability
- provider stability and capacity
- workforce sustainability
- access to services
- quality and safety outcomes
- consumer and whānau experience.

Regular reporting against these measures will help maintain transparency, strengthen accountability, and enable early intervention where implementation challenges emerge.

Maintain focus on outcomes

Implementation success should ultimately be judged not by whether individual initiatives are completed, but by whether the aged care system **delivers better outcomes for older New Zealanders and their whānau**. The purpose of the recommendations is to create a system that is more sustainable, more responsive to changing needs, easier to navigate, and better able to support people to live independently and well as they age.

The recommendations in this chapter provide an **implementation approach that combines urgency with discipline**. They recognise the need to begin immediately, focus on the critical path, engage the sector in delivery, manage key risks and dependencies, and maintain strong oversight throughout the transition.

The success of this reform, and the benefits it seeks to deliver, will depend on **sustained commitment to the critical path and disciplined execution** of the transition from today's system to the system needed for tomorrow.

The opportunity is significant. By delivering the structural changes required to reset the foundations of the system and maintaining commitment through implementation, New Zealand can create an aged care system that is better equipped to meet future demand, delivers a better experience for older people and their whānau, and remains sustainable for future generations. **The decisions now required are not whether change should occur, but how quickly and effectively it can be delivered**.

Recommendations

37. Reform should begin immediately, and implementation should prioritise the critical path: the legislative, funding and system changes required to reset the foundations of the aged care system. Sustained commitment and investment in these reforms is essential to deliver the structural and system change needed for long-term sustainability.
38. Establish a steering group and set of sector working groups to support implementation of reform:
    a) The steering group should oversee implementation of the recommendations in this report, and could include some members of the Ministerial Advisory Group.
    b) The working groups should provide cross-sector coordination, delivery expertise and stakeholder engagement on specific areas of work, and could include representatives from consumer groups, unions, clinicians, providers, and iwi and Māori.
39. Implement reform through a structured, time-bound transition programme that balances urgency with continuity of care. Delivery should occur across three horizons:
    a) Horizon 1 - legislative settings and system foundations (2026-28)
    b) Horizon 2 – structural reform (2028-2032)
    c) Horizon 3 – system change (2032 and beyond)
40. Establish clear transition management that provides certainty for providers, the workforce, and consumers, while maintaining strong accountability for delivery, performance and outcomes, and actively managing transition risks and system dependencies.

Chapter 11 – Conclusion

Building a stronger system: what needs to change now

New Zealand has reached a juncture. Everything we have set out in this report flows from that single, unavoidable fact: the system as it stands was not designed for the rapidly ageing population it now serves, and the gap between what it was built for and what it now needs to do is widening every year. People are living longer. The complexity of the care many people need is increasing. Left alone, the inequities in who can access good care and how quickly will only get worse. The cracks are already showing. Bed shortages, providers closing their doors and a strained workforce.

Without decisive action, the system will not keep pace with demand. This means older people being unable to get care when they need it, providers being unable to sustain services, more strain on family and whānau carers, and the wider health system absorbing hospital admissions that should never have been necessary, with spiralling costs.

This report charts a different course. It sets out a comprehensive and integrated reform package that moves the system away from fragmentation, reactive crisis management, and funding that no longer matches costs, towards a more coherent system organised around people and whānau, with realistic funding and personal contributions.

Reform cannot be achieved with any single recommendation, or isolated 'fixes'. Our recommendations work together as a package to deliver a coordinated set of changes across pathways, services, workforce, funding, and regulation that collectively reshape how care is experienced and delivered over time.

The result is a more efficient system, that puts investment where it is needed the most. While some new investment will be required, the new system will result in lower costs over time compared to the considerable costs if nothing changes. Critically, our modelling shows this approach moderates long-term cost growth rather than entrenching it. It reduces avoidable hospitalisations and uses resources where they do the most good, not simply by spending less.

The key changes envisioned in this report include:

- **shifting to an integrated system centred on people** – including transitioning from a system organised around service settings to one organised around people, a nationally consistent casemix framework, more services delivered by aged care providers, and flexible contracting
- **better services to support ageing well in place** – including a more flexible assessment model delivered by providers with strong oversight, help for people to navigate the system, strengthened in-home care, short-term care, and respite, culturally appropriate and responsive services that meet the needs of a diverse population, and technology and digital integration
- **more effective contracting and regulatory settings** – including reorienting settings to better balance safety, access and innovation, introducing stronger safeguards like regulation for in-home care providers, and a workforce strategy to develop a well-trained, supported and certified workforce for the future

- **funding a system that meets people's needs** – including real investment in aged care to stabilise providers and start to build capacity for the future, a new funding model so that funding is used well and that providers are financially sustainable, differentiated funding for residential care to target spending and reduce government costs, and an Aged Care Pricing Authority to ensure that funding is sustainable into the future
- **rebalancing contributions towards costs for a sustainable system** – including a structured and transparent approach to sharing costs between individuals and the government that is based on the principle that those who can contribute to their own care should do so, with strong protection built in for those who cannot.

Taken together, our recommendations create a coherent system for ageing well in place. This system supports people to remain safe, independent and connected in their communities for as long as possible, while making sure they can access higher levels of care when needed.

Critically, the new system will moderate long-term cost– by an estimated $834 million per year by 2037/38[118] – by reducing avoidable hospitalisation, rebalancing residential and in-home care, and improving system efficiency.

We have a responsibility to make sure our aged care system is ready and capable, not just for the older New Zealanders relying on it today, but for everyone who needs it in the future.

It will be up to government to decide what it does next. However, if it proceeds with these reforms, it will require considerable commitment, collaboration and collective effort from all facets of the aged care sector and wider health system. New Zealanders will also need to consider how these proposed changes would affect and benefit them. Our hope is that this report sparks a wider and sustained national conversation about the steps needed to move to a better aged care system for all, not only in the near term but for generations to come.

[118] Modelled in 2025/26 dollars. The modelled estimate is approximate and subject to caveats, as shown above and detailed in **Appendix 6**.

APPENDICES

Appendix 1: Glossary

A

- **ACC (Accident Compensation Corporation):** Public insurer and funder for injury related care; an interface to align with aged care pathways.
- **Aged Care Pricing Authority (ACPA):** Steward that recommends to the government transparent, evidence-based prices, and guards against distortions (e.g., market concentration).
- **Aged care services:** This can refer to a range of health and community services that support older people to live and age well. In this report, 'aged care services' primarily refers to Aged Residential Care and Home and Community Support Services, and services that directly function in connection with those (for example, respite and carer support).
- **Aged Residential Care (ARC):** Referred to as 'residential care' in this report. Facility-based care for people who can no longer be safely supported at home, delivered across rest-home, hospital (also called continuing care), dementia, and psychogeriatric care levels.
- **Ageing Well in Place:** Enabling people to live safely and independently at home (or a preferred setting) for longer through reliable, restorative, culturally grounded, well-coordinated services.
- **Assessment:** People are currently assessed for aged care services through a needs assessment, usually done by a NASC agency (see **NASC**), which determines a person's eligibility and level of need for aged care services. Assessments for older people use the International Resident Assessment Instrument (**interRAI**) assessment tool to inform clinical decision-making and care planning.
- **Asset testing:** The first part of a financial means test undertaken by the Ministry of Social Development (MSD). If the value of a person's assessable assets exceeds the relevant threshold, they are ineligible for the Residential Care Subsidy and must pay the full cost of their care, up to the **Maximum Contribution**. Some assets (e.g., a vehicle and some equity in a family home) may be excluded.

B

- **Bulk Funding:** Funding that is paid to a provider as an aggregate amount, rather than being individually itemised or attached to specific people. Funding is typically based on expected demand or population characteristics meaning more provider flexibility and lower administrative burden; accountability is at the system or contract level. (Distinguished from **Fee-for-Service** funding).

C

- **Capitation:** A fixed payment per enrolled person to cover their expected care needs, with extra activity-based payments and rural loadings; encourages proactive, planned, community-based care.
- **Carer Support Subsidy:** A subsidy that pays for some of the costs of care and support while a person's informal carer takes a break. This can be used to contribute to respite stays, compensate another carer to take over the care duties for a period, or purchase items or services that provide relief.
- **Casemix:** A classification system that groups individuals based on their assessed level and type of need, using consistent criteria (e.g. functional status, clinical complexity, care intensity). Individuals with the same case mix category are assumed to require similar level of resources. The interRAI assessment determines what casemix category a person is in.

- **Casemix-based funding:** A funding approach where public funding is informed by the person's case mix category. Funding can be attached to the individual or aggregated at provider level (e.g., weighted bulk funding). The payment structure (bulk, individualised, hybrid) is a separate design choice.
- **Culturally Grounded / Culturally Safe care:** Care that reflects and is built from Māori, Pacific, and other cultures' values and worldviews, and family and whānau based decision making. Examples include Whānau Ora and Te Whare Tapa Wha.
- **Culturally responsive care:** Care that actively acknowledge, respect, and supports each person's unique culture, beliefs and worldviews. Care providers ensure these are incorporated into how services are delivered and how people and their whānau are engaged.

D

- **Dementia-level care:** A secure part of an Aged Residential Care facility that provides specialist dementia services.
- **Differentiated pricing:** In this report, means replacing uniform prices for residential care accommodation with prices that reflect asset value and the cost of capital. This approach reflects that there should be a fair return on investment proportionate to the value of the investment. This approach requires an objective measure against which accommodation prices can vary.
- **Disability Support Services (DSS):** Disability Support Services sits within the Ministry of Social Development and provides funding and support for disabled people and their families and whānau, including housing modifications. Disability Support Services funds Home and Community Support Services and residential care for disabled people, and some disabled people in Aged Residential Care facilities where there are no immediately accessible alternatives for residential care in the community.

E

- **Early Supported Discharge:** Short-term, intensive, community-based rehabilitation service for medically stable people that supports earlier hospital discharge or hospital avoidance while maintaining clinical oversight. Rehabilitation may be delivered in a patient's home or short-term residential care.
- **Economies of Scale:** Efficiency gains from providing the same service to more clients (whether in a single location or across multiple sites).
- **Equity:** In the context of this report, equity refers to ensuring that all people who need aged care services are able to access appropriate, high-quality services that are responsive to their needs, and experience similar health and wellbeing outcomes, regardless of their means, location, culture, ethnicity or other factors.

F

- **Fee-for-Service Funding:** Payment to providers for specific activities and input costs, following delivery of pre-defined services for individual clients based on assessed needs (e.g., specified hours of specific types of in-home care, and associated travel costs). Distinguished from bulk funding.

H

- **Home and Community Support Services (HCSS):** Referred to as 'in-home care' in this report. Client-centred, culturally appropriate, and responsive services that support people to remain living in their homes and communities that maintains or enhances functional ability, health, and social connectivity, and provides support at the end of life. The objectives are to:
  - maximise and maintain a client's independence for as long as possible
  - enable clients to actively participate in setting personal goals and planning care
  - determine flexible service delivery required to support client's goals and respond to their changing needs
  - engage in continuous quality improvement within a 'best for person, best for system' framework.
- **Healthcare assistants:** Healthcare assistants (sometimes called caregivers or Kaiāwhina) form the largest workforce in residential care. They perform tasks focusing on individual personal supports and, where trained, take on additional tasks (such as providing medication and health tests). While no training is required, residential care providers must ensure a minimum level of in-house induction training on facility procedures, care expectations and close supervision, and take reasonable steps to provide workers with the opportunity to attain qualifications. Most providers retain pay steps linked to qualifications as they were required by the Support Workers Pay Equity Settlements Act 2017.
- **Hospital care:** Care delivered in a hospital setting, including medical, surgical, diagnostic and emergency services, provided either to admitted patients (inpatients or day cases) or to people attending specialist outpatient clinics.
- **Hospital-level care (continuing care):** Residential care level for people with significant disability, medical concerns, and/or cognitive decline, requiring oversight by Registered Nurses. Most require the help of two care staff to move about.

I

- **In-Between Travel (IBT):** Comprises of time and cost for workforce travel between clients receiving Home and Community Support Services, including wages, reimbursement of mileage, oncosts, and provider margins.
- **In-home care:** Home and Community Support Services funded by Health New Zealand (see above).
- **Indexation:** Regular adjustment of prices to track input costs (referencing a broad price index, and/or specific cost pressures such as pay parity, IBT, capital) and prevent drift from efficient cost.
- **Individualised funding:** Refers to a funding model in which people are allocated a budget which they can choose how to spend within specific funding policy guidelines. This aims to give people and their families and whānau more flexibility and control over the services they receive.
- **Informal carers:** Informal carers are individuals, family, whānau and āiga providing unpaid care for someone close to them who needs assistance with their everyday living because of a disability, health condition, illness or injury. Carers play a crucial role in enabling older people to live and participate in their communities. Carers that provide more than four hours a day of unpaid care may be eligible for support.

- **Integrated care pathway:** A person and whānau-centred care journey that ensures continuity of experience and outcomes across services and settings, enabling access, needs based support, and smooth transitions over time through coordinated practice, shared information, and aligned funding.
- **Interoperability Standards:** Technical rules enabling secure, reliable data exchange across providers/systems.
- interRAI (International Resident Assessment Instrument): The nationally mandated standardised assessment system used to assess the needs of older people in New Zealand and inform clinical decision-making and care planning.

M

- **Maximum Contribution:** The maximum amount that people in residential care need to pay towards the cost of their care. It is set equal to the rest home price for the location. Set under section 53 of the Residential Care and Disability Support Services Act.
- **Means testing:** the assessment of assets and income undertaken by the Ministry of Social Development to determine whether a person qualifies for financial support or subsidy.
- **Minimum dataset:** Agreed minimum information required at transitions to ensure safe, predictable transfers.

N

- **Needs Assessment and Service Coordination (NASC):** NASC agencies work with people to help identify their needs and what informal support they have access to, and to outline what support services are available to help meet their needs, maximise their quality of life, and support their independence. People can either self-refer or be referred to NASC via their GP or other health service.
- **Navigators:** Navigators help clarify pathways, explain options and entitlements, and connect people to appropriate supports at the right time.

O

- **ORA (Occupational Rights Agreement):** Upfront payment for the right to occupy a unit/room in retirement villages or a residential care facility.

P

- **Premium Room/Bed:** A room in a residential care facility with additional features of a permanent or fixed nature with amenities priced above the standard features and services (for example, a larger room with an ensuite, more space, or garden access).
- **Pricing Signals:** Targeted price features to reward desired behaviours (e.g., short stay capacity, timely respite, early community intervention).
- **Primary care:** Health services that operate in the community, and usually the first point of contact a person has with the health system – for example, General Practice, Nurse Practitioners, pharmacy, and dentistry.
- **Psychogeriatric-level care:** A secure part of an Aged Residential Care facility that provides care for people with dementia or a mental health disorder who require a high level of nursing care and management of behavioural challenges.

R

- **Rehabilitation:** Support to help an individual return to their previous level of functioning, and restore independence.
- **Residential care:** Refers to Aged Residential Care (see above).
- **Residential Care Subsidy (RCS):** Means-tested financial support for people in residential care, funded by Health New Zealand. The RCS covers the difference between the means-tested amount a resident pays and the **Maximum Contribution**.
- **Residential Care Loan:** An interest-free government loan for people in residential care who do not qualify for the RCS. A loan is secured against the person's property to pay for their care.
- **Respite:** Care that may be provided in a residential care facility, as part of a day programme, or in the person's own home to provide short-term relief for primary carers to give them a break from their caring role. In some regions it can be used for services or items to provide carer support, like purchasing of monitoring equipment.
- **Rest home-level care:** Aged Residential Care for people with some ability to get about on their own or with some help.
- **Restorative care:** Timebound, goal-oriented support that helps individuals become as independent as possible following a period of illness or a life change.
- **Rural Loadings:** Payments or supports (e.g., loadings, demand guarantees, capital support) to sustain rural delivery and access.

S

- **Shared Care Plan:** A living, accessible plan capturing goals, supports, roles, and contingencies across providers.
- **Standard Room/Bed:** A room in a residential care facility without additional features, for which residents are not charged additional fees beyond the standard public rate. Currently, providers must provide care and support services, lodgings with all furniture and fittings, a food service that reflects the person's nutritional requirements and preferences, cleaning and laundry services, some recreational activities, and radio, TV and mail services, an accessible garden, a homelike and comfortable environment, and some access to health services specified in the contract.
- **Short-term care:** Pathways enabling timely transitions between home, hospital, and residential care, and preventing the need for long hospital stays and long-term residential care. These include short stays in a residential care facility between hospital and home or for temporarily increased needs, rehabilitation. While in the context of this report, it does not include respite (at home or in a residential care facility).
- **Stewardship:** Oversight aligning incentives to ageing in place, including transparent dashboards, monitoring, and periodic redistribution.
- **Support worker:** The largest workforce for in-home care (Home and Community Support Services). Support workers work directly with people in their homes to support their wellbeing. This is an unregulated role.

U

- **Unbundling (Cost):** The practice of separating total service cost into distinct components, typically care, accommodation, and support services. Cost unbundling is about transparency and policy clarity; it does not automatically determine pricing, subsidies, or who pays. Essentially, it shows what cost exists, not who should pay.
- **Unbundling (Funding):** Separating the components of a care package and purchasing them separately – including from different providers. For example, Disability Support Services clients (or their agents) holding a personal budget with which they can purchase a variety of Home and Community Support Services (including paid family carers).

Appendix 2: Terms of Reference

Background

There have been a number of reviews of aged care in New Zealand, most recently including Health New Zealand's Aged Care Funding and Service Models Review, which began in July 2023. While New Zealanders generally have access to a range of aged care services that provide a good standard of care, these reviews have highlighted a number of challenges in the system, including that:

- the way services are funded is outdated, and does not support providers of aged care to sustain service levels, or to invest and build new services
- there is no cohesive and integrated aged care system that provides the care that people need at the right time and in the right place
- access to the right services can be inconsistent and inequitable across different groups of people, and in different parts of the country, with some shortages and variable quality.

This work seeks to address these issues.

Purpose and scope

The purpose of the Ministerial Advisory Group is to provide independent advice to Ministers on the aged care system (Home and Community Support Services and Aged Residential Care), within the scope directed by Cabinet. Specifically, the group is expected to provide advice on the following:

- What specific funding model components and mechanisms are needed to support sustainable aged care services,[119] particularly a sustainable supply of standard aged care beds in a way that:
    - enables sustainable and effective service provision across different regions of New Zealand, including rural and remote areas
    - ensures sufficient care provision, including sufficient workforce, to meet varying levels of need
    - encour ages innovation in service delivery while maintaining consistent quality standards
    - considers the role of both supply and demand for different aged care services.
- How the costs of providing aged care could be reasonably shared between individuals receiving care and the government, to support sustainability while ensuring timely access to aged care services for all of those who need them, including means testing and asset thresholds.

[119] For the purpose of this work, aged care services are defined as including Aged Residential Care (ARC) services (including respite and transitional care), and Home and Community Support Services (HCSS).

- What changes are needed to contracting arrangements and regulatory settings for aged care services, to remove red tape, support cost-effective delivery of services, support service innovation, and increase cohesion and integration between aged care services, wider health services, and Disability Support Services. This includes, for example:
    - regulatory settings that place restrictions on how services are delivered, including in the Health and Disability Services (Safety) Act 2001, the Nga Paerewa service standard, and the Residential Care and Disability Support Services Act 2018
    - contracting conditions and agreements for services that restrict how aged care providers deliver their services, including in-between travel settings
    - consistency between funding for Disability Support Services and Health New Zealand aged care services, including consideration of individual needs-based thresholds for eligibility rather than age-based thresholds.

Out of scope

The group is not being asked to provide Budget advice, or advise on issues outside of those listed above, including but not limited to:

- workforce requirements, training and accreditation – noting that future work and implementation may consider workforce requirements
- Changes to means-tested assistance or settings that sit outside of aged care (e.g. New Zealand Superannuation, benefits, supplementary assistance, income-related rent, etc).
- Disability Support Services and other government services, except where this relates to cohesion and integration with aged care services.

Appendix 3: The Ministerial Advisory Group

Brien Cree

Brien is the founder and Chair of Radius Care, which offers both Home and Community Support Services and Aged Residential Care. Brien is a past board member of both NZACA and the Retirement Villages Association.

Shelley Cunningham

Shelley is the Chief Executive of Te Whare o Rehua, the medical arm of Te Puna Ora o Mātaatua, a kaupapa Māori provider delivering integrated health and social services to whānau and the community in Whakatāne and the wider Eastern Bay of Plenty.

Suzanne Dvorak

Suzanne is the Chief Executive of Oceania Healthcare, and brings extensive executive leadership experience across aged care, retirement living, healthcare and community services in both for-profit and not-for-profit sectors in New Zealand and Australia.

Dr Richard Lowe

Dr Lowe is a General Practitioner and Co-Owner at GP Central, a 100% GP-owned, high-needs clinic in Mt Roskill, Auckland. He brings broad knowledge in rest home care, palliative medicine, and primary care systems and funding.

Murray Penman

Murray is the Director of Health Services at Visionwest Community Trust, and Chair of the Board of the Home & Community Health Association. Murray has spent 24 years working in the health and disability space and has a strong understanding of the sector.

Mike Peters

Mike is the Chief Executive of the New Zealand Health Group, the largest provider of age-related care services outside of aged residential care in New Zealand. Prior to this, Mike was Chief People Officer working closely with unions and funders in the sector.

Max Robins

Max is the former Chief Executive of CHT Care Homes and former Deputy Chairman of New Zealand Aged Care Association. He is currently a consultant in the aged care sector and has strong expertise in aged care management and modelling. Max was key to the modelling process for this report

Allan Sargeant

Allan is the owner and Chief Executive of Ambridge Rose, an independent family-owned residential care provider in East Auckland. Allan has extensive expertise in residential care funding and innovation, dementia care, clinical governance, and workforce development.

Helen Watson

Helen is the Co-Owner and Director of Waihi Lifecare, comprising Waihi Lifecare Hospital and Rest Home and Waihi Lifecare Village, and is a previous Owner and Director of Athenree Lifecare. She has significant experience providing high-quality aged care.

Hon David Cunliffe – Chair

Hon David Cunliffe QSO is the Chair of The Selwyn Foundation, a former Minister of Health and Associate Minister of Finance, and former leader of the New Zealand Labour Party. He is a founding partner of strategic advisory firm, Polis Consulting Group.

The Aged Care Policy Team within the Ministry of Health gave substantial time and effort to supporting the Group's work, including delivering secretariat services, providing policy advice on a range of subjects, undertaking analysis, modelling and forecasting, gathering and providing evidence, facilitating meeting co-ordination and stakeholder engagement, and drafting this report. The work was led by the Manager – Aged Care Policy, and at various points, four principal policy analysts, a senior policy analyst, three policy analysts, economists, modellers, data analysts, clinical experts, operational experts, and other staff from the wider Ministry, as well as contracted roles.

Project management support, including programme planning, coordination, and delivery oversight, was provided by Deloitte.

External support with report drafting, modelling, and communications advice was also provided to the Group.

The Advisory Group's role and approach

The Group resolved early to take a **logically structured and evidence-based approach** to its work. It sought to make decisions and recommendations by consensus wherever possible – which it achieved throughout. It was supported by a dedicated Secretariat boosted by external expertise and capability (see **Appendix 4** for details).

The early work of the Group included a careful investment in issue identification, resulting in a structured set of 'issue trees'. The Group established early a project management timetable that would allow it to cover its extensive workplan within the required six-month period.

To progress the work efficiently, the Group divided into **four sub-groups**, which each investigated a core area of the Terms of Reference while maintaining a whole-of-system perspective and a solutions-based approach. The four sub-groups focused on:

- **Service mix, capacity, and care setting:** Examining what care people need, and what mix of services must be available to deliver the right care in the right place, including at home and in residential settings.
- **Pathways and system integration:** Considering how people access services, move through the system, and transition between care settings, and how information, roles, and coordination can better support continuity of care.
- **Funding, incentives, and cost-sharing:** Assessing costs in the system, how the costs of care are split between individuals, government and providers, and how funding and incentive settings can be structured to support financial sustainability.
- **Contracting and regulatory settings:** Reviewing the rules, standards, and contractual arrangements that govern aged care services, with a focus on safety, consistency, and enabling innovation.

Each sub-group identified the analysis required to address the issues within its scope and drew on relevant evidence sources (see **Appendix 4**). Sub-group findings were regularly reported back to the full Advisory Group to enable collective discussion, testing of assumptions, and consensus based decision making. Finally, each sub-group put forward recommendations for consideration and testing with the wider Advisory Group, which have formed the final recommendations in this report.

The Group focused on making all decisions by consensus. Where differences of view surfaced, we worked through these, took an evidence-based approach, and found workable middle ground. All recommendations are supported by the whole Group, without abstention.

To support this process, the Group had access to expert advice and highly committed secretariat support from the Ministry of Health, including access to the Ministry's core modelling and forecasting expertise. This was supported by independent project management and communications and editorial capacity. Officials gave substantial time and effort to supporting the work of our Group, including gathering research, developing modelling, organising stakeholder engagement, and supporting drafting processes. The Advisory Group could not have done our job without their support.

We recognise the Crown's obligations under Te Tiriti o Waitangi – the Treaty of Waitangi and have sought to reflect the importance of culturally appropriate care in our recommendations, taking advice from Māori health leaders and academics, kaupapa-Māori providers and other organisations supporting Māori health needs.

Appendix 4: Evidence and information sources

Evidence approach

In developing our recommendations, the Ministerial Advisory Group drew on a broad range of evidence sources including government datasets, demographic projections, sector reports, published research, stakeholder submissions, expert advice and financial modelling. The Group deliberately focused on identifying practical solutions to well-documented system challenges rather than repeating previous reviews of the aged care sector.

The Group was supported by analysis and information provided by the Ministry of Health and Health New Zealand, including population projections, demand forecasts, utilisation data, workforce information and preliminary modelling of future aged care costs and system pressures. This evidence was supplemented by information from providers, consumer groups, professional bodies, unions, Māori and Pacific organisations, researchers, clinicians and subject matter experts.

The Group also considered findings from a substantial body of existing work, including the Health Committee inquiry into aged care, reports of the Aged Care Commissioner, Health New Zealand's Aged Care Service Model and Funding Review, independent sector reviews, and research relating to ageing, dementia, workforce sustainability, health equity and models of care. Particular attention was given to evidence concerning ageing well in place, integrated care models, residential care capacity, carer support and sustainable funding arrangements.

The Group invested heavily up-front in issue diagnosis, using pyramid logic techniques to develop a series of issue trees that guided our subsequent analysis. These were used at the sub-group level to guide the analysis and eventual recommendations, and were cross-checked against the emerging report content.

Engagement with stakeholders included written submissions, meetings with sector representatives, workshops with experts and discussions with consumer and community organisations. These engagements provided practical insights into the experience of older people, whānau, carers, providers and the workforce, and helped test the feasibility of proposed reforms.

The Advisory Group recognises that some recommendations will require further development, modelling and consultation. The Group worked within a six-month timeframe and was constrained by limitations in available sector data in some areas. Accordingly, this report should be regarded as establishing a strategic direction and reform framework, with further detailed design and implementation work required through the proposed transition and sector working group processes.

Key evidence

The Advisory Group built on, rather than replicated, previous reviews and analysis of aged care in New Zealand. Key sources of evidence included:

- The Health Committee's Inquiry into the aged care sector's current and future capacity to provide support services for people experiencing neurological cognitive disorders.
- Health New Zealand's Aged Care Service Model and Funding Review (2024), including:
    - Phase 1: A strategic assessment of aged residential care and home and community support services.
    - Phase 2: Modelling options for improved funding and service models.
    - Summary of sector and public engagement.

- EY's (2019) 'Aged residential care funding model review'.
- EY's (2019) 'Recognising the Contribution of the Home and Community Support Sector to New Zealand'.
- The Aged Care Commissioner's (2024) 'Amplifying the voices of older people in Aotearoa New Zealand'.
- The Helen Clark Foundation's (2025) 'Age-Proofing Aotearoa: Rethinking our infrastructure for an ageing population'.

These reports provided a strong foundation of evidence on system performance, user experience, cost drivers, and future demand, allowing the Group to focus on system design and solutions.

The Ministry of Health and Health New Zealand provided further data and analysis to support our deliberations, including updated population and demand projections and cost modelling.

Who we heard from

To supplement existing evidence and ensure our recommendations were evidence-based, the Group sought detailed information and advice from a range of sector experts, industry representative bodies, and representatives of patients, providers and workforce (for example on casemix, gerontology issues and culturally specific care models).

Information was primarily gathered during March 2026 through written submissions, stakeholder engagement and meetings with subject matter experts. These groups were asked to focus on practical, innovative solutions to the challenges in the aged care system that would enable sustainable and high-quality service provision into the future.

The Group also engaged with several subject matter experts, to ensure our recommendations were grounded in deep sector and clinical knowledge and expertise. This included input from the Aged Care Commissioner, the Chief Executive of the Aged Care Association, Māori and Pacific experts, geriatricians, funding and health system experts, and aged care specialists. We would like to thank these groups and experts for their time and valuable expertise.

Information was sought from the following organisations to support the review:

- New Zealand Aged Care Association
- Home and Community Health Association
- Dementia New Zealand
- Alzheimers New Zealand
- New Zealand Dementia Foundation
- Neurological Alliance New Zealand
- Carers New Zealand
- Age Concern New Zealand
- Palliative Care Collaborative Aotearoa
- General Practice NZ
- Royal New Zealand College of General Practitioners
- Royal Australian and New Zealand College of Psychiatrists

- New Zealand Nursing Council
- New Zealand Medical Council
- Allied Health Aotearoa New Zealand
- Australian and New Zealand Society for Geriatric Medicine
- New Zealand Nurses Organisation
- Needs Assessment Service Co-ordination Association
- E tū
- PSA
- Grey Power New Zealand Federation Inc
- Needs Assessment Service Co-Ordination Association
- Hato Hone St John
- Hauora Taiwhenua Rural Health Network
- Stroke NZ
- National Council of Māori Nurses
- National Nurses Leadership Group.

The Group also received submissions from:

- Ryman Healthcare
- Stroke NZ
- The Village Architect
- Diversional & Recreational Therapy Aotearoa NZ
- MyCare
- FrankGroup
- Funeral Directors Association
- Community Housing Aotearoa
- Some individuals and other aged care organisations.

In addition to formal submissions, the Group sought targeted advice from subject matter experts in gerontology, dementia, Māori and Pacific health, funding models, health system commissioning, residential care provision, workforce issues and health economics:

- Hon Tracey Martin – Chief Executive, New Zealand Aged Care Association.
- Erin James – Aged Care Commissioner.
- Professor Matthew Parsons – Clinical Advisor for Health New Zealand and Professor of Gerontology.
- Dr Victoria Henderson – Geriatrician and clinical director for older people's health at Whangārei Hospital.
- Grant Corderoy – Consultant Partner, StewartBrown.
- Michael Gunn – Senior Director Retirement Housing & Healthcare, CBRE.
- Rangimahora Reddy – Chief Executive, Rauawaawa Kaumatua Charitable Trust.
- Professor Ngaire Kerse – University of Auckland.
- Dr Joanna Hikaka – University of Auckland.
- Margaret Milne – Development & Service Delivery Manager, interRAI.
- Hamish Crooks – Chief Executive, Pacific Homecare.
- Richard Williams – Director of Contracting and Funding, New Zealand Health Group.
- Steve Greene – National Manager, New Zealand Health Group.
- John Mills – Strategic Business Manager, Visionwest.

The Group also engaged informally with the main opposition party during the review process to explore options capable of achieving broad and durable support across successive governments. Given the long-term nature of demographic change and aged care reform, the Group considers ongoing cross-party engagement will be important to sustaining reform momentum over time.

Limitations

While the evidence base available to the Group was substantial and drew on a broad range of reports, datasets, submissions, expert advice and sector engagement, some limitations existed.

In particular, there were constraints in the availability and consistency of cost data, population health data, and information on interactions between aged care services and the wider health system. The Group also notes that the aged care sector's data systems and analytical capability remain less mature than some other parts of the health system, limiting the ability to consistently measure costs, outcomes, service utilisation and the wider impacts of interventions across the full continuum of care. In all cases, our report seeks to be transparent about the limitations of data or other estimation constraints, and caveats to that effect are noted throughout the report.

We also sought to be clear about the intended applicability of our approach. For example, in modelling pricing uplifts, our approach was the best available to **estimate general uplifts**, but we were clear throughout that the resulting estimates should **not be applied as an allocation tool** at the individual facility level. We disclaim that they should not be used as a basis for making individual or corporate business decisions.

Where robust evidence and data were available, they have been incorporated into the analysis and recommendations. However, some recommendations should be viewed as establishing a strategic direction for reform, with further modelling, data collection, policy development, costing and implementation work required through the proposed transition process.

Appendix 5: The current situation

This Appendix provides an overview of the state of older people's health and the current aged care system.

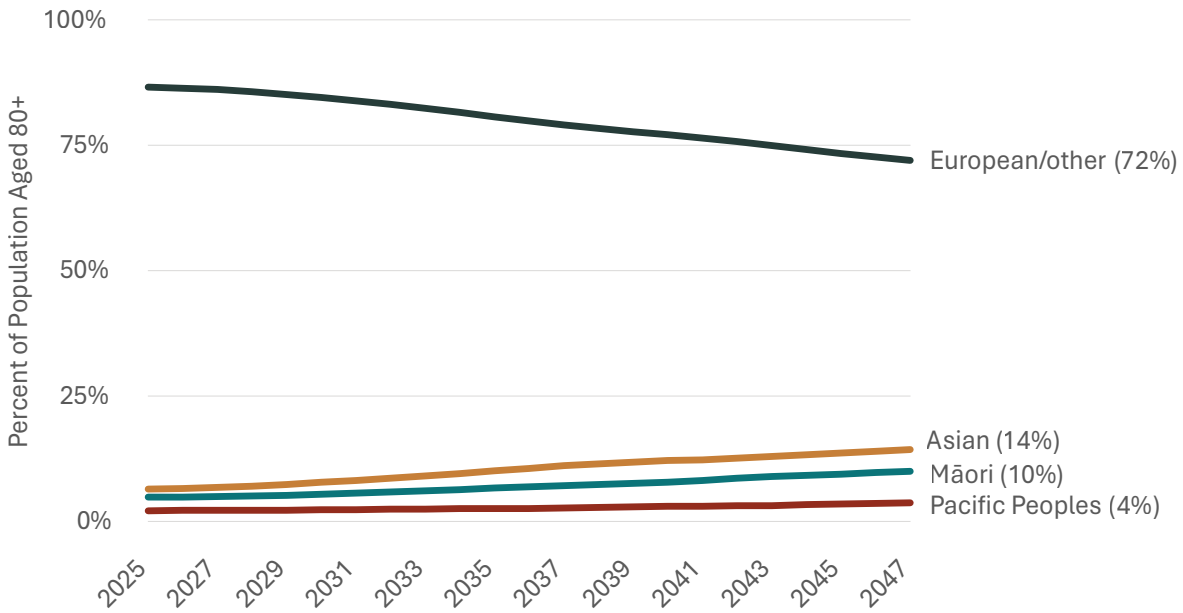
State of older people's health

The older population will be increasingly diverse in future

Regional and ethnic diversity among older New Zealanders will increase over time. Between 2025 and 2047, the number of people aged 80 years and older is projected to increase by about 355% for Māori, 280% for Pacific peoples, 390% for Asians and 85% for European and other ethnicities. Cultural and ethnic diversity within these broad groups will also increase. The proportion of the population aged 80 years and over who are European/other will decrease from 87% to 72%.

Figure A1 below shows the ethnic composition of people aged 80 years and over to 2048.

Figure A1: Projected change in the ethnic composition (prioritised ethnicity) of the population aged 80+ (2025 – 2047)[120]



Analysis based on 2023 Census population data found that 21.7% of people aged 65 and over lived in rural areas.[121] Over the next 25 years, rural areas are projected to continue to have an older population structure compared to urban areas, with people aged 65 and over projected to make up 28.6% of the population in rural areas by 2048 (compared to 20.6% for the most urban areas).

[120] Statistics NZ 2025 population projections for Health New Zealand (2023 Census base).

[121] Ministry of Health, 2024.

The older population will have higher rates of disability and complex health concerns

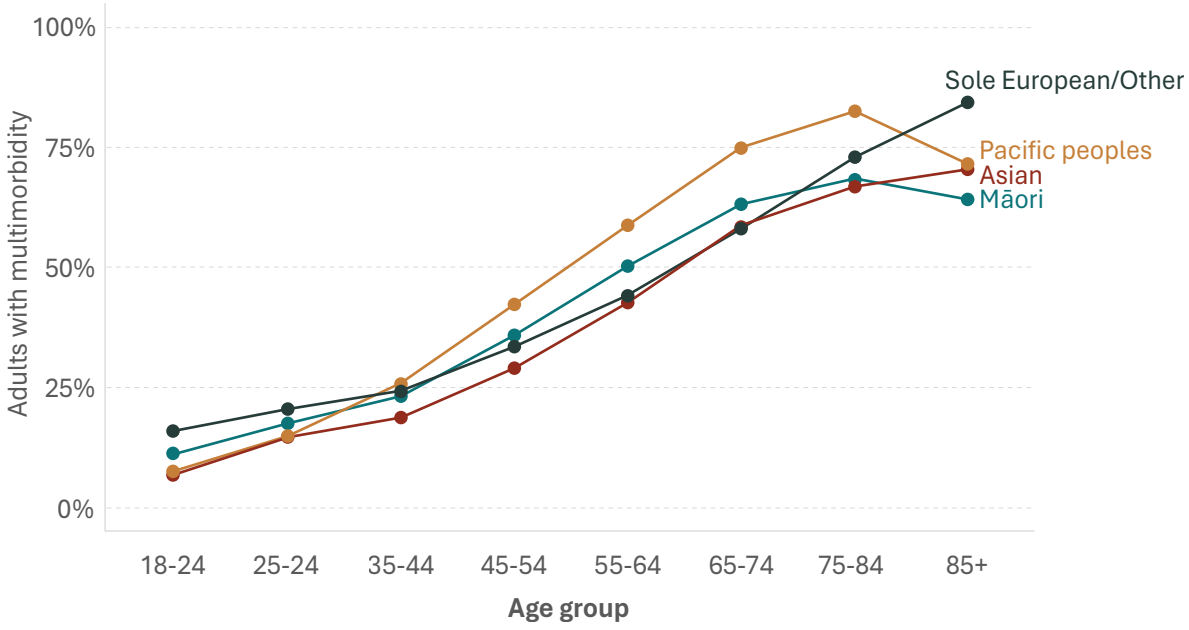
As people live longer, they are more likely to spend a portion of their later years with some form of functional limitation or disability, and multimorbidity.[122] Over time, there will be increasing numbers of people living longer with more complex conditions and comorbidities that require more specialised care and support.[123]

Some groups of people will have higher health needs in older age. Māori and Pacific peoples, for example, experience ageing earlier and have lower life expectancy and fewer years of good health, with higher health needs, rates of disability, and long-term conditions compared to non-Māori/non-Pacific.[124] Further, while women have a higher life expectancy than men, they live longer in poor health.[125]

Māori and Pacific also age in whānau and collective care systems. These differ from mainstream systems and expectations and assumptions of service use. Patterns of engagement with the health system and other services may differ from many non-Māori older people. Kaumātua and Kuia Māori also play an important social and cultural role in Māori society, providing care for whānau members and the wider community.[126]

In 2024, 60% or more of people aged 65 years and over had two or more long-term conditions (Figure A2). Pacific peoples have the highest levels of multimorbidity at ages 75-84, with 3 in 4 people having multimorbidity. The proportions decrease for Māori and Pacific peoples over 85 due to lower life expectancy, with Māori and Pacific peoples more likely to pass away at younger ages.

Figure A2: Percentage of people with multimorbidity, by age group and ethnic group[127]



Disability also becomes more frequent with age, and at higher rates for Māori and Pacific peoples.

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[122] Multimorbidity is the presence of two or more long-term health conditions that collectively influence a person's health. Having multimorbidity is associated with reduced quality of life, higher mortality, and polypharmacy (concurrent use of multiple medicines that can lead to increased risk of complications).

[123] Pinto, S., Mok, P., Warn, V. (2023). *Older people experiencing vulnerability and multiple disadvantage in New Zealand*. Social Wellbeing Agency. https://www.sia.govt.nz/assets/Document-Library/Older-people-vulnerability-and-multiple-disadvantage.pdf

[124] Hikaka & Kerse, 2021.

[125] Ministry of Health, 2024.

[126] Hikaka, J. & Kerse, N, 2021.

[127] Ministry of Health, 2024.

People living with disabilities are more likely than people without disabilities to have poorer health outcomes and be disadvantaged in terms of the determinants of health, such as poverty, inadequate housing and access to health care. People ageing *with* disability (as opposed to into disability) can age earlier and differently and have more complex needs.

Dementia rates are also increasing

Notably, dementia mate wareware is becoming more prevalent in New Zealand. In 2025, around 83,000 people in New Zealand were living with dementia. By 2050, this number will almost double to at least 170,000 people, comprising around 3% of the total population and around 11% of the population aged over 65.[128] It is estimated that there are about 22,000 new cases of dementia per year, and there will be 29,500 new cases per year by 2040.[129] Māori and Pacific have higher dementia rates than New Zealand European and Asian people, and have a younger age of diagnosis.[130] Dementia numbers are also increasing at a faster rate and at a younger age among Māori, Pacific peoples, and Asian populations than among European New Zealanders.[131]

Older people are more isolated

Older people are also at higher risk for social isolation and loneliness. Living alone increases the risk of social isolation, loneliness and risk of mortality.[132] In New Zealand, about 10% of people over the age of 65 are lonely all or most of the time, rising to 50% among those over 80.[133] Almost a quarter of those people who are lonely may be at risk of premature death.

Older people experience more emergency department visits, hospitalisations, and delayed discharges from hospital

Due to increased health conditions associated with age, emergency department event rates are consistently highest among people over 65, with those over 85 years of age having the highest event rates (see Figure A3 below).

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[128] Ma'u, E., Cullum, S., Yates, S., Te Ao, B., Cheung, G., Burholt, V., Dudley, M., Krishnamurthi, R., Kerse, N. (2021). *Dementia Economic Impact Report 2020*. University of Auckland. https://cdn.alzheimers.org.nz/wp-content/uploads/2021/09/Dementia-Economic-Impact-Report-2020.pdf

[129] Ma'u, E., Callum, S., Mukadam, N., Davis, D., Rivera-Rodriguez, C., Cheung, G. (2024). *Estimating the incidence of dementia in New Zealand: a cohort study applying capture-recapture modelling to routinely collected linked health datasets*. The Lancet Regional Health – Western Pacific, 52. https://www.thelancet.com/journals/lanwpc/article/PIIS2666-6065(24)00210-4/fulltext

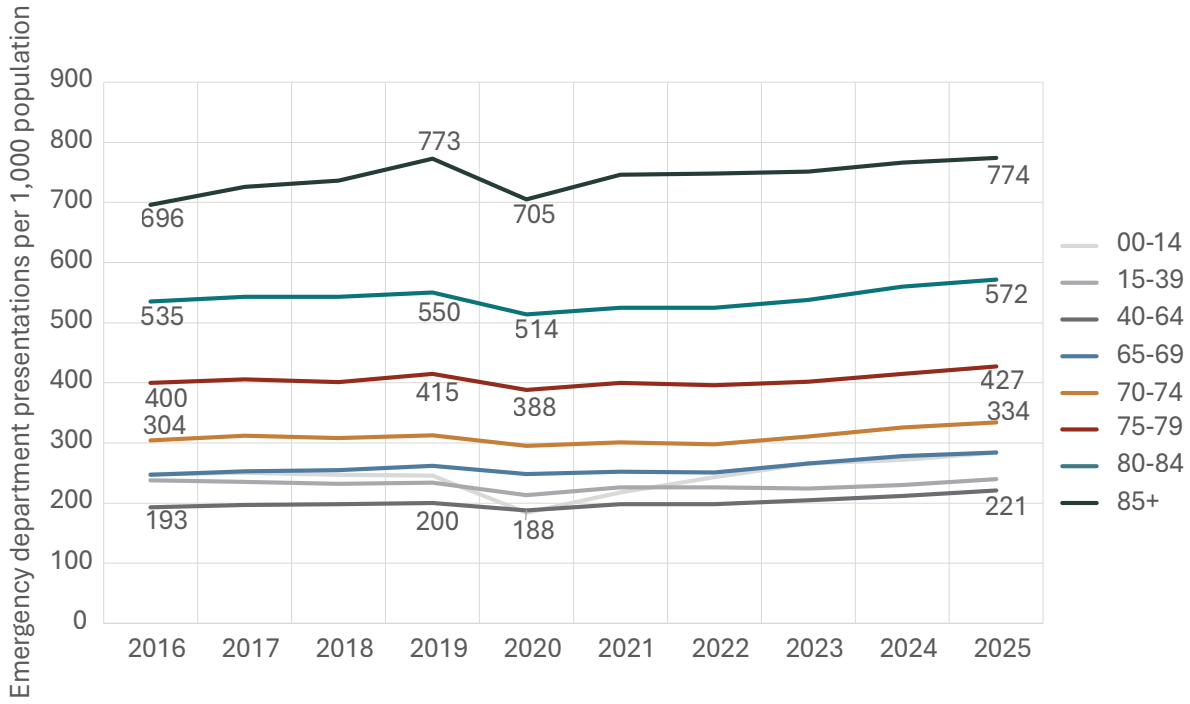
[130] Cheung, G., To, E., Rivera-Rodriguez, C., Ma'u, E., Chan, A. H. Y., Ryan, B., Cullum, S. (2021). *Dementia prevalence estimation among the main ethnic groups in New Zealand: a population-based descriptive study of routinely collected health data*. BMJ Open, 12(9). https://pmc.ncbi.nlm.nih.gov/articles/PMC9454053/

[131] Alzheimers New Zealand. (n.d.). *Facts and figures*. https://alzheimers.org.nz/explore/facts-and-figures/

[132] Nakou, A., Dragioti, E., Bastas, N., Zagorianakou, N., Kakaidi, V., Tsartsalis, D., Mantziukas, S., Tatsis, F., Veronese, N., Solmi, M., Gouva. (2025). *Loneliness, Social Isolation, and Living Alone: A Comprehensive Systematic Review, Meta-Analysis, and Meta-Regression of Mortality Risks in Older Adults*. Aging Clinical and Experimental Research 37 (1). https://doi.org/10.1007/s40520-024-02925-1

[133] M. Gott. (n.d.). *Social Isolation: How Isolation and Loneliness are Putting Older New Zealanders at Risk*. https://www.ageingwellchallenge.co.nz/research/social-isolation/

Figure A3: Emergency department event rates per 1,000 population by age group and calendar year[134]



When older people do present at emergency departments, they often have higher needs than other age groups and are triaged at higher acuity levels.

A high proportion of older people who present at an emergency department go on to be admitted to hospital. For those aged 75 and over, 53% of emergency department events end in admission to hospital compared to 29% across all ages in 2024.

In the hospital system, people aged 75 and older currently account for 22% of emergency department events, 20% of hospital admissions, and 40% of bed days. This will increase further as the population of older New Zealanders continues to grow more rapidly than the population as a whole.

Once hospitalised, older people have longer lengths of stay than other age groups. In 2023, the average hospital bed days per 1,000 population was 440 days. For those aged between 65-69 it was 696, and for people over 85 years it was 3,831.[135] People aged 75 and older who entered Aged Residential Care after hospital discharge had stayed in hospital for an average of 20.2 days (median 12.3 days), compared to an average of 6.8 days for other patients aged 75+, and an overall average of 3.5 days per hospital stay.[136]

[134] Analysis undertaken by Ministry of Health using hospitalisation records covering the 12 months following the index date, defined as the first date a person enters residential care or the first date they receive in-home care.

[135] See https://www.health.govt.nz/statistics-research/system-monitoring/planning-and-performance-data/acute-hospital-bed-days

[136] Ministry of Health analysis using data from Health New Zealand.

Older people often experience barriers to safe discharge, resulting in prolonged hospital stays beyond what is clinically necessary. There has also been a decrease of acute hospital beds in New Zealand[137] and older people are having more complex medical treatment and surgery at older ages than in the past.[138] Delayed discharges can have a significant impact on older people, in terms of increased risk of hospital-acquired infections, decline in physical function and reduced independence, and strain on carers, family, and whānau.

Delayed discharge also places pressure on hospitals and the health system, including constraining the capacity needed to provide timely elective surgery and reducing hospital patient flow and the ability to admit patients from the emergency department.

The current aged care system

The aged care system in New Zealand currently comprises a range of services to enable people to live and age well, in their homes or in residential settings and through a mix of formal and informal supports (for example, family members and community networks). The system is structured to respond to varying levels of need, with services spanning Home and Community Support Services (HCSS), Aged Residential Care (ARC), as well as respite care and carer support, transitional care, and Early Supported Discharge services.

Surrounding the aged care system are wider health services, including primary care and hospital care, and a network of community supports and service providers. Other services link into the aged care system in a variety of ways, including Disability Support Services, and Accident Compensation Corporation (ACC) services.

Figure A4 on the following page provides an overview of the aged care system and the range of interconnected services and factors surrounding it.

[137] OECD. (2023). *Number of Hospital Beds in New Zealand 2009 – 2022*. https://www.helgilibrary.com/indicators/number-of-hospital-beds/new-zealand/

[138] Becher, R. D., Vander Wyk, B., Leo-Summers, L., Desai, M. M., Gill, T. M. (2023). *The Incidence and Cumulative Risk of Major Surgery in Older Persons in the United States*. 277(1). https://pmc.ncbi.nlm.nih.gov/articles/PMC8758792/

Figure A4: Overview of the aged care system

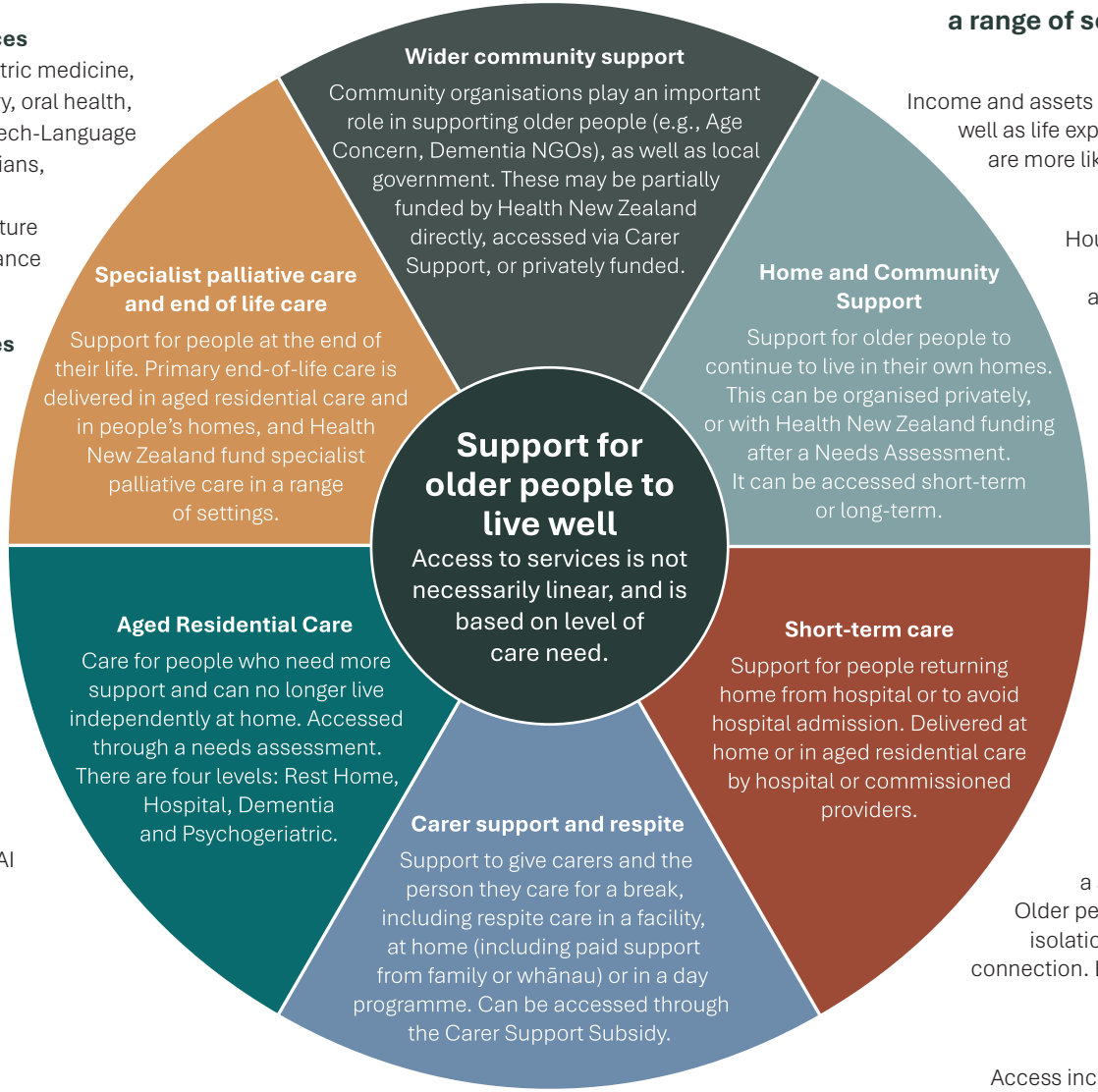
Aged care interacts with other healthcare

Primary and community health services
Including general practice, nursing, geriatric medicine, pharmacy, optometry, audiology, podiatry, oral health, allied health (e.g., Physiotherapists, Speech-Language Therapists, Occupational therapy, Dieticians, and social work), preventative care (e.g., immunisation, falls prevention, and Fracture Liaison Services), laboratory and ambulance services.

Secondary and tertiary health services
Including emergency departments, planned and unplanned hospital care, specialist services, allied health (as above), and District Nursing.

Transitional support
Including community older persons health services, pathways to prevent people needing to go to hospital, and early supported discharge from hospitals.

Needs assessment and service coordination (NASC)
Funded aged care services are generally accessed through a needs assessment, provided by NASC agencies using interRAI assessments.



Older people's health is strongly influenced by a range of social and environmental factors

Financial security
Income and assets can affect overall health and wellbeing, as well as life expectancy. People who are financially stable are more likely to experience better health outcomes.

Housing
Housing is a significant determinant of health outcomes. Good quality, appropriate and accessible housing is essential for physical and mental health.

Accessible environments
Availability of accessible environments and age-friendly communities ensure people are actively engaged within and across their communities. This can have a significant effect on people's wellbeing. Accessible environments include affordable and accessible transportation.

Agency and inclusion
Engagement with community, autonomy and self-determination, ageism, and elder abuse are factors that influence older peoples' wellbeing.

Social connection
Family supports and social networks play a significant role in supporting older people. Older people can experience loneliness and social isolation, which can contribute to a lack of social connection. Both can lead to poor mental and physical health outcomes.

Access to services
Access includes availability of system navigation and advocacy services, culturally responsive care, and access to preventative services.

Accessing aged care services and assessments

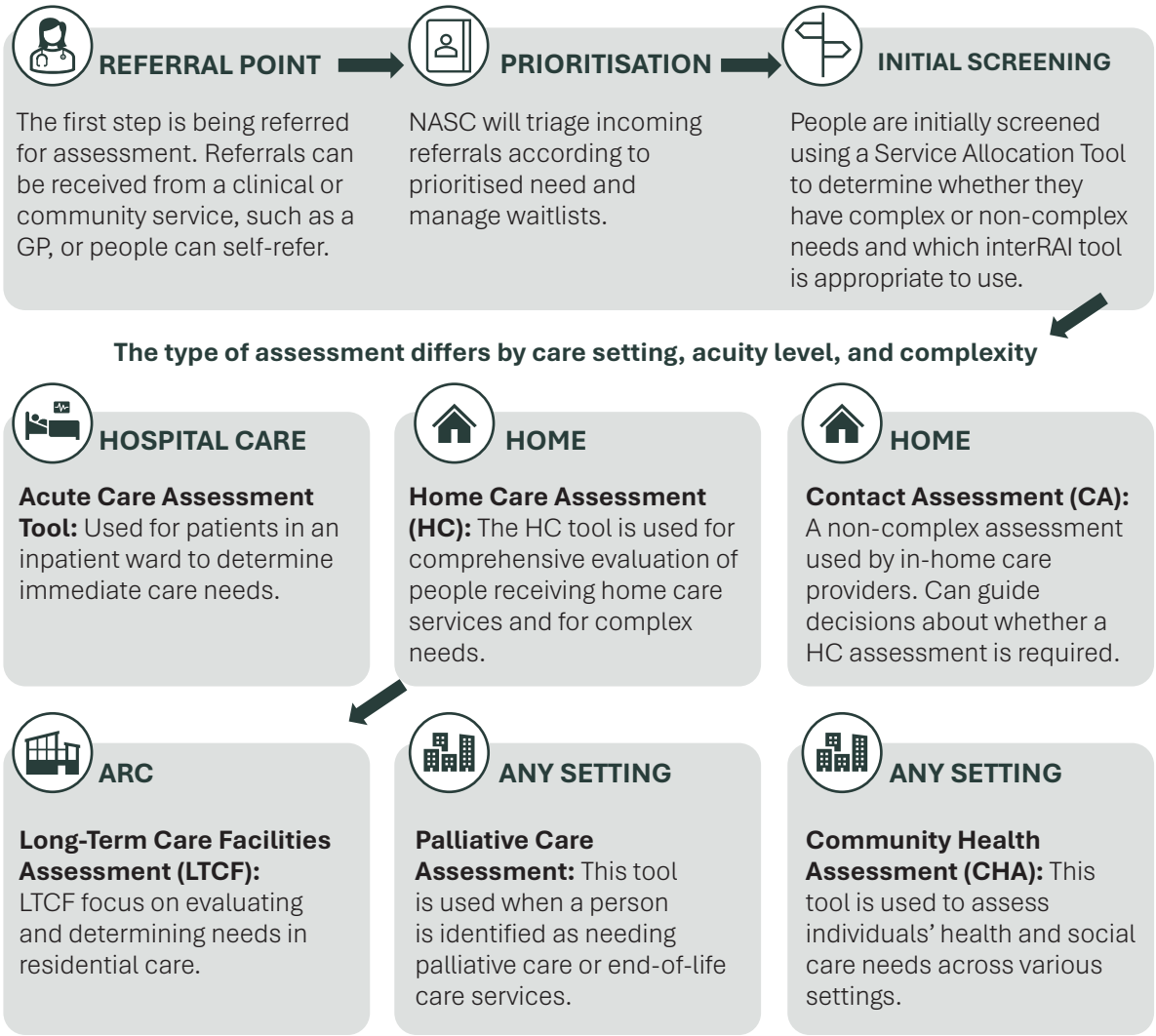
To access aged care services, in most cases, a person must have their needs assessed by a Health New Zealand Needs Assessment and Service Co-ordination (NASC) agency. Many people are referred for a needs assessment by their General Practitioner (GP) but may also self-refer. These assessments identify the person's needs and what support services are available to help meet those needs.[139]

There are a range of needs assessments for different services. Disability Support Services, for example, is accessible through Disability Support Services-funded NASC agencies for people with a lifelong disability. These use different assessment tools to those used for aged care services.

Assessments for older people use the International Resident Assessment Instrument (interRAI) assessment tool to inform clinical decision-making and care planning. The interRAI assessments provide a comprehensive and objective picture of a person's functional, cognitive, psychological, social, and environmental status. Information is gathered collaboratively from the individual, their whānau, and health professionals.

Figure A5 provides an overview of the assessment process.

Figure A5: Illustrative picture of assessment process and interRAI assessment types



[139] One exception to this is under the new bulk-funded casemix model for HCSS, where people can self-refer directly to a provider, and if they are screened as having non-complex needs, they will be assessed by the provide. In this situation, a NASC agency would not interact with the person at all.

Since 2015, approximately 1.4 million assessments have been completed nationwide. interRAI assessments provide a comprehensive and objective picture of a person's functional, cognitive, psychological, social, and environmental status.

There are four key interRAI assessment instruments that are used in New Zealand:[140]

- Contact Assessment: A non-complex assessment for people in the community used by providers of HCSS, which guides decisions about whether a Home Care assessment is required.
- Home Care Assessment: Used for comprehensive evaluation of people receiving in-home care services and for complex needs (including assessing whether residential care is required).
- Palliative Care Assessment: Used when a person is identified as needing palliative care or end-of-life services.
- Long-Term Care Facilities Assessment: Used to evaluate and determine a person's needs once they have entered residential care.

InterRAI tools are also used for reassessments. NASC agencies are required to complete an interRAI assessment every three years for HCSS clients. In districts and regions that have bulk-funded casemix models of care, providers are required to reassess non-complex people using the Contact Assessment annually.

ARC providers are responsible for assessing and regularly reviewing residents' needs using interRAI tools, after an initial needs assessment by a NASC agency. Currently, a person in an ARC facility is required to have a needs assessment every six months, or earlier if a move between care levels is required. If the person requires a higher level of care, the rest home or hospital manager will contact the NASC agency for a needs assessment to confirm the appropriate level of care.

interRAI provides a single national platform, meaning assessments follow people regardless of location. This supports regional transfers, consistent access to information, and emergency response coordination. New Zealand is an active member of the international interRAI network, which includes 45 countries.

To access aged care services, the person must be over 65 or their needs must be considered age-related. Under some circumstances people may be considered for age-related needs earlier than 65 if they have been clinically assessed as 'close in interest' to persons aged 65 and over (e.g., early onset dementia).

Home and Community Support Services (HCSS)

HCSS are services that support people to remain living in their homes and communities. Government agencies fund different groups of people to access these services:

- Health New Zealand funds HCSS for older people, and long-term support for people with chronic health conditions, and medically fragile children, with some variability across the country in eligibility requirements.
- Disability Support Services funds HCSS for disabled people under the age of 65. If the primary condition is funded by Disability Support Services prior to age 65, Disability Support Services will continue to fund services after the age of 65.
- The Accident Compensation Corporation (ACC) funds HCSS for people with injuries.

[140] Some other assessment tools, such as the Acute Care Assessment Tool and Community Health Assessment, are available but are not currently widely used.

There were around 72,000 people receiving Health New Zealand-funded HCSS across the year in 2025/26.

A person can receive HCSS (funded by Health New Zealand) if:

- they are eligible for publicly funded health and disability services
- their needs have been assessed using an interRAI assessment tool
- they have support needs because of an age-related condition aged over 65 years, or are aged 50 to 64 years, and like in age and interest

The purpose of HCSS is to provide client-centred, culturally appropriate, and responsive support that maintains or enhances functional ability, health, and social connectivity, and to provide support at the end of life. The objectives are to:

- maximize and maintain a client's independence for as long as possible
- enable clients to actively participate in setting personal goals and planning care
- determine flexible service delivery required to support client's goals and respond to their changing needs
- engage in continuous quality improvement within a 'best for person, best for system' framework.

HCSS clients receive services based on their assessed level of need, and work with providers to develop their care plan. An individual care plan details the support service users will receive, and when they will start receiving them. The person receiving care funded by Health New Zealand can choose to have a family or whānau member, or an external carer, provide this care (referred to as Paid Family Carers). The carer can then be employed by a HCSS provider to deliver the agreed services.

HCSS is funded through a mix of fee-for-service and bulk-funded contracts across the country:

- Under fee-for-service arrangements, the NASC determines hours of specific tasks for each client (e.g. support activities of daily life such with dressing, showering, eating), based on their assessed needs. Providers are paid in blocks of time for services delivered at agreed hourly rates.
- Under the bulk-funded casemix model, providers are allocated a proportion of a total amount of funding based on the total funding pool, which is determined by the volume and casemix of clients seen by providers. This model includes delivery of the Contact Assessment and restorative goal setting supported by registered health professionals. This is monitored by Health New Zealand through reporting of service delivery and patient outcomes.

Health New Zealand has a transition process underway moving from the traditional FFS funding and service model to a nationally consistent restorative[141] bulk-funded casemix model.

In-Between Travel

HCSS is delivered in the home, and support workers are paid for time spent travelling between clients (called In-Between Travel (IBT)).

The current IBT system was established in 2015, as part of a settlement agreement between the Crown, providers and unions.

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[141] The definition of the Restorative Home and Community Support Services model within the Home and Community Support Service Tier 2 Service Specification is: "Restorative is a person-centered, holistic approach that aims to enhance an individual's physical and/or other functioning, to increase or maintain their independence in meaningful activities of daily living at their place of residence and to reduce their need for long-term services. Restorative consists of multiple visits and is delivered by a trained and coordinated interdisciplinary team. The approach includes an initial comprehensive assessment followed by regular reassessments and the development of goal-oriented support plans. Restorative supports an individual to achieve their goals, if applicable, through participation in daily activities, home modifications and assistive devices as well as involvement of their social network. Restorative HCSS is an inclusive approach irrespective of age, capacity, diagnosis or setting."

The agreement aimed to ensure in-home care remained a cost-effective alternative to residential care and set out how funding would be provided for ongoing wage costs for the time that home and community support workers spend travelling to deliver in-home care and a mileage rate (IBT). There are two components of IBT Settlement:[142]

- **Part A** established a mechanism to pay support workers for time spent travelling and a mileage rate for the use of a personal vehicle to travel between clients. Part A is supported by the **Home and Community Support (Payment for Travel Between Clients) Settlement Act 2016**) which specifies minimum worker entitlements.
- **Part B** included a commitment to regularise the support workforce (including employers being responsible for workers having guaranteed hours of work, training, a fair and safe allocation of clients and wages linked to training and qualifications). Employers are also responsible for finding workers alternative work if a client cancels a visit. Health New Zealand contributes to employers' training costs and funds the cost of the cancelled visit if the employer cannot find alternative work.

IBT is paid via a centrally administered, claims-based reimbursement model, where in-home care providers lodge IBT claims directly with Health New Zealand, which then reimburses the provider. Under this agreement, the Crown funds all providers' costs of paying support workers for time travelling between clients, as well as a percentage-based margin, and overhead and administration costs.[143]

Workers are compensated based on a mileage rate and an hourly rate. Workers may also be paid IBT for the period between split shifts (where a support worker has a break in their schedule between clients). Travel under 15 kilometres is funded based on sector averages (set a decade ago). Travel over 15 kilometres is known as exceptional travel, and is funded by time taken and distance travelled using the most efficient route.

Providers' obligation to pay travel time and a mileage rate to support workers is enforced under the Home and Community Support (Payment for Travel Between Clients) Settlement Act 2016.

Aged Residential Care (ARC)

ARC is care provided in a certified facility for people who are unable to be cared for safely in their own home. This is distinct from retirement villages, which are accommodation for retired people to live independently in a community.

To be eligible for care long-term ARC:

- the person must be needs assessed as having high, or very high needs which are indefinite (i.e., the person's condition cannot be reversed)
- the needs assessment must determine that the person cannot be safely supported within the community
- the person must be aged 65 or over; or aged between 50 and 64 and be deemed as close in age and interest[144]
- the person must be eligible for publicly funded health and disability services.[145]

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[142] See: https://www.tewhatuora.govt.nz/for-health-providers/claims-provider-payments-and-entitlements/in-between-travel-settlement/about-the-in-between-travel-settlement

[143] Each HCSS provider receives a 6% margin on travel mileage (to meet margin, overhead and rostering costs), and up to a 36% margin on the hourly rates for travel (to meet margin, overhead, Kiwisaver, ACC and statutory leave costs).

[144] Note that Disability Support Services does not fund support for disabled people who first present for assessment for long-term supports at age 65 or over (CAB Min (03) 5/5 refers).

[145] Health and Disability Services Eligibility Direction 2011.

In 2024/25, there were around 34,530 people in ARC, and a total of around 12.6 million bed days delivered throughout the year. A range of agencies fund different groups of people in ARC, including Health New Zealand, Disability Support Services, and ACC (in addition to residents themselves):

- Around 33,670 people were included in Health New Zealand aged care contracts. Of this number, 33,240 were in long-term residential care (including around 32,460 older people and people with disability needs that are 'close in age and interest' to older people),[146] and 770 younger people with long-term chronic health conditions.[147] This group also includes a fluctuating number of short-term residents, including those accessing respite care, end-of-life care, and transitional care (e.g., those transitioning between hospital and home).
- Disability Support Services funded around 870 people in ARC facilities who require residential care, and where there are no immediately accessible alternatives in the community.
- ACC funded around 50 residents on average, in whole or in part. ACC funds interim care when a client is unable to return home after an injury, and long-term care for those with high and complex support needs.

ARC facilities may be certified to provide up to four levels of care set out below.

Table A1: Four levels of care provided in ARC facilities

Level of care	Description
Rest Home *Around 39% of total long-term residents*	Those who require this level of care usually have some ability to get about on their own or with some help. They require some assistance with personal care and general day-to-day activities. Many have a degree of memory loss. Rest home services must maintain continuous Registered Nurse (RN) oversight, but do not require a 24/7 RN onsite.
Hospital *Around 44% of total long-term residents*	This level of care is for those who have a significant disability, medical concerns, and possible cognitive decline, that requires the oversight and support of RNs. Most require the assistance of two people to move about.
Dementia *Around 14% of total long-term residents*	This level of care is for those who need a secure home, usually because there are safety concerns for themselves or others. Dementia rest home services must maintain continuous RN oversight but do not require a 24/7 RN onsite. All staff working at this level of care must have received dementia-specialist training.
Psychogeriatric *Around 3% of total long-term residents*	This level of care is designed for people with dementia or a mental health disorder who require a high level of nursing care and management of behavioural challenges. They need a secure environment and the skills of specially trained staff.

[146] There are around 430 people on average aged 50-65 in ARC who are considered close in age and interest to older people and funded by Health New Zealand. When a person presents for assessment for Disability Support Services between the ages of 50 and 65, the Disability Support Services NASC also screens the referral to determine whether the person is likely to meet the 'close in interest' criteria.

[147] People aged under 65 with long-term chronic health conditions (assessed by a NASC). These people may receive financial support for ARC via the Residential *Support* Subsidy, rather than the Residential Care Subsidy. See here for the service specifications.

The price per bed day, combining government funding and private contributions, depends on which of four levels of care a resident is assigned to (see Table A2 below).

Table A2: Average price per year per occupied bed in residential care, 2025/26 (excl. GST)

Care Level	Average government subsidy	Average resident contribution (including Superannuation)	Total per resident per year
Rest Home	$28,494	$40,972	$69,466
Dementia	$51,959	$41,734	$93,693
Hospital	$72,121	$40,640	$112,761
Psychogeriatric	$89,720	$35,464	$125,184
Other (e.g., respite, ACC clients)	$85,980	$7,031	$93,011

There are currently around 690 ARC facilities in New Zealand, providing around 43,300 beds, with a range of ownership structures and facility sizes.[148]

Most facilities are owned by for-profit businesses (80%). They have a wide variety of ownership arrangements including chains owned by publicly listed companies or private equity firms (some multinational), small privately-owned chains, and individual owner-operators. Around 20% are owned by not-for profit organisations (e.g., charities and local trusts).[149]

ARC providers may deliver a range of other services alongside long-term care for older people, which are not covered under the long-term care agreements. These services are contracted under aligned contracts (which align the care price with the long-term contract care price). These include end-of-life care, respite care, and short-term care.

ARC are primary palliative care providers and the contractual agreements include most general end-of-life care. Some people may be admitted for 'end of life' in ARC facilities, for example being transferred from public hospital, and most people who enter ARC for long-term care will also die there. However, the long-term care agreements do not cover specialist palliative care at the end of life. These services are covered under separate, regional contracts (and not at all in some regions).

Respite and short-term care options

Short-term care options help people to move between home, hospital, and residential care when their needs change for a short time. These can include:

- where a person transitions through a residential care facility between hospital and home – this includes where rehabilitation is needed (utilising ESD services – see more on this below)[150] or 'interim care' (sometimes called 'transition to home') where no rehabilitation is needed but the person needs time to recover in a facility or is waiting for equipment in their home
- where a person living at home has a planned or urgent short stay in a residential care facility when their needs have increased for a short period (e.g., where they need rehabilitation, or have a planned post-operative stay).

[148] See: https://www.health.govt.nz/regulation-legislation/certification-of-health-care-services/certified-providers/rest-homes.
[149] New Zealand Aged Care Association, 2026.
[150] An example of this is the Non-Acute Rehabilitation Pathway service (NARP).

Short-term or interim care needs are met differently across the country. In some areas, dedicated transitional care contracts or services have been established, while in others, this support is delivered through ARC respite arrangements i.e., a person may be discharged from hospital and receive transitional care under an existing ARC respite contract.

Respite services are a core component of the current package of care that some people receive while living in their own home. Respite is primarily allocated to enable a carer to take a break from their caring role. Respite can include:

- **residential respite**, where a person may enter a residential care facility for either emergency or planned stays. In exceptional circumstances, a person living by themselves may enter into a residential care facility to take a break from managing their day-to-day care. Residential respite can also be considered as 'short-term care' in a residential care setting.
- **in-home respite**, where a primary carer can pay a family member or other carer to provide care whilst they take a break
- **day programmes**, which provide activities for older people to socialise and also provide informal carers with a break. Some programmes provide specific support for kaumatua and older people with dementia.
- **equipment** that supports carers to take a break.

There are two system that used to allocate resources and funding for respite, depending on the region that the older person is in:

- In some regions, Health New Zealand has contracts with residential care providers for a set amount of respite days. These can be allocated to a person following a NASC assessment of the older person and their carers needs. Allocations per person are capped at 28 days per year and are approved in blocks of 7,14, 21 or 28 days.
- In other regions, respite is funded through the Carer Support Subsidy. This is an individualised budget that is provided directly to the carer to allow them to choose the type of respite they want (in-home, residential, or to pay for equipment). The Carer Support Subsidy is capped at $80 per day up to 25 days.

Early Supported Discharge

Early Supported Discharge (ESD) teams operate in most of New Zealand. ESD teams provide a package of intensive support and rehabilitation for older people to help them transition from hospital to home. Older people are referred to ESD teams either through health professionals working at hospitals or directly by GPs which may protect them from entering hospitals in the first place.

The Supported Transfer and Accelerated Rehabilitation Team (START) in Waikato and the Community Rehabilitation Enablement & Support Team (CREST) in Canterbury are two examples. START was launched in 2010 in Waikato, and CREST was launched in 2011 in Canterbury. START and CREST have the same service model, with the only difference being that within CREST, the RNs and support workers are employed through community providers (rather than employed by Health New Zealand).

Wider Hospital and Primary Care

Hospitals and primary care providers play a crucial role in the aged care system, delivering acute medical interventions and ongoing health management. Integration between hospital, general practice, and community services is essential for holistic support, with formal and informal communication channels facilitating coordinated care.

Accident Compensation Corporation (ACC) support

ACC provides injury specific support within the broader aged care and health system It funds treatment, rehabilitation, and support services where needs arise from a covered injury, including home and community support, equipment and home modifications, and, in some cases, short- or long-term residential care.

ACC eligibility is based on the rules set out in the Accident Compensation Act 2001. These rules determine eligibility based on the type of injury, and exclude health needs based on age, disability, or underlying health conditions.

ACC services are designed to promote recovery, independence, and participation following injury. Older people may receive support from ACC for injury-related needs and from the publicly funded aged care system for non-injury related needs.

Disability Support Services

Disability Support Services, funded by the Ministry of Social Development, is responsible for providing essential support to around 50,000 disabled people and their whānau, as well as equipment and modification services for approximately 100,000 New Zealanders including for older people.

Disability Support Services funds home and community-based supports for people with long-term impairments (Physical, Intellectual, and/or Sensory), including some older people whose needs arise from disability rather than age-related decline or injury. Access is typically through an assessment process, with eligibility based on the presence of a long-term impairment and its impact on independence, rather than age alone.

Older people receive support funded by Disability Support Services where their needs are disability-related until their primary need is aged related.

Appendix 6: The modelling approach

Overview

This Appendix sets out the methodology and techniques used for all material modelling exercises used for figures in the report. It describes in detail the population and demand projections that underpin the cost estimates in this report, and the three cost scenarios built on them. It also describes the modelling of changes to means-testing for the Residential Care Subsidy, means-testing in-home care costs, and the bottom-up modelling on the effects of more fine-grained recommendations.

The projections run in stages. A **population projection** estimates the number of older New Zealanders each year to 2047/48. A **demand projection** turns that population into projected volumes of residential and in-home care. A **baseline cost projection** applies current prices, indexed for sectoral cost inflation slightly above general consumer price inflation, to those volumes. Three scenarios then depart from the baseline:

- **Scenario A** estimates the cost of failing to meet rising demand, when the supply of residential care beds grows too slowly.
- **Scenario B** estimates the cost of meeting demand under current settings, including the price increases needed to bring new supply forward.
- **Scenario C** estimates the costs and benefits of the advisory group's reform package.

To develop these scenarios, the core demand and cost projection model draws on inputs from separate models developed to address specific questions:

- **Aged residential care facility pricing:** a discounted cashflow model is used to estimate the shortfalls between current prices and the prices at which residential care facilities can fully cover their costs, including the cost of capital.
- **Private contributions:** models estimating aggregate and distributional impacts of (a) changes to residential care contribution rules and means-test settings, and (b) the introduction of means-tested contribution requirements for in-home care.
- **Service and system change initiatives:** modelling the estimated costs and benefits of the range of system and service delivery reform proposals proposed in this report.

Population projections

Method

The population model projects the resident population aged 65 and over each year to 2047/48, divided into **480 sub-groups** defined by age in five-year bands, health district across 20 districts, and ethnicity across four groups (Māori, Pacific, Asian, and European or other). It draws on Health New Zealand's 2025 regional population projections, which are based on Statistics New Zealand's projections from the 2023 Census. The population in each sub-group ages forward each year under assumed rates of mortality and net migration.

Projections for people aged 65 and over depend little on assumed fertility and are relatively insensitive to migration. After the size of each cohort, their main driver is life expectancy. Following Statistics New Zealand's central assumptions, the model assumes that age-specific death rates keep falling, adding about 0.13 years of life expectancy a year.

Key results

The population aged 75 and over is projected to grow by about 42% over the decade to 2034/35, roughly twice the rate projected for the population aged 15 to 64. By 2047/48 it is projected to be about 95% larger than in 2024/25. Growth is fastest at the oldest ages: the population aged 85 and over is projected to more than double by 2047/48, passing a quarter of a million people.

Table B1: Projected population aged 65 and over, by age band (in thousands)[151]

Age band (thousands)	2024/25	2034/35	2047/48	% change to 2047/48
65 to 69	271	303	325	20%
70 to 74	225	290	291	30%
75 to 79	182	234	284	56%
80 to 84	116	171	233	101%
85 to 89	63	108	161	155%
90 and over	35	49	94	170%
Total 65+	891	1,155	1,388	56%
Total 75+	396	562	772	95%
Total 85+	98	157	255	161%

Sensitivity

The projection is sensitive to the assumed path of life expectancy. Under Statistics New Zealand's low-mortality scenario, the population aged 85 and over would reach about 324,000 by 2048.

Demand projections

Residential care

The residential care model estimates a utilisation rate, the share of a population sub-group in care in a year, for each of the 480 sub-groups at each of five care levels:

- rest home
- dementia
- hospital (or continuing care)
- psychogeriatric
- a residual category covering respite, end-of-life, short-term and transitional care and some ACC and Disability Support Services (DSS)-funded clients.

[151] Numbers in this table are slightly different from the numbers in Figure 1 in Chapter 2 because the modelling was conducted prior to an updated series being released. That series is used in Figure 1, Chapter 2.

Each sub-group's utilisation rate multiplied by its projected population gives projected demand, measured in bed years, or equivalent full-time residents.

There are two material adjustments:

- First, residents under 65 with disabilities, funded through DSS rather than aged care, are excluded; they accounted for about 860 bed years in 2024/25.
- Second, the administrative data omit rest home residents who did not qualify for the Residential Care Subsidy and paid the full regulated price. Utilisation rates are adjusted upward to account for this group. Without the adjustment, the projection would understate rest home residents by about 9%, and total residential care costs by about 3%.

Per-capita utilisation rates for residential care have fallen over the past decade, most clearly at rest home level. The baseline assumes these recent trends continue for five more years and then stabilise, after which demand moves with the size of the population. This assumption has a large effect on projected demand and on when the sector reaches capacity, and it is discussed under sensitivity below.

Key results: Residential care

Residential care demand is projected to grow by about 11,600 bed years, or 33%, over the decade to 2034/35, and by about 91% by 2047/48. Demand grows fastest for hospital and dementia level care, because the oldest and highest-acuity age groups grow fastest.

Table B2: Projected residential care demand by care level (in bed years)[152]

Care level (bed years)	2024/25	2034/35	2047/48	% change to 2047/48
Rest home	13,994	17,587	25,613	83%
Hospital	4,870	7,070	9,672	99%
Dementia	13,985	19,059	27,881	99%
Psychogeriatric	868	1,076	1,388	60%
Other	1,192	1,705	2,021	70%
Total	34,909	46,497	66,574	91%

The composition of demand also shifts. The share of residential care residents identifying as Māori, Pacific or Asian is projected to nearly double by 2047, from about 13% to about 24%. Most of the growth in demand falls in urban centres: more than 60% of it is in the districts covering Auckland, Christchurch and Hamilton.

In-home care

Demand for in-home care (Home and Community Support Services) is projected from average per-capita service hours in each health district, adjusted for projected population change by age group. Two changes now under way in the sector are built into the baseline.

[152] Note the percentage change figures differ slightly from Figure 4 in Chapter 2 due to a different start year.

Contracting arrangements for in-home care provision are currently transitioning from fee-for-service contracts to a nationally consistent, bulk-funded restorative model. The baseline assumes this transition continues and is completed by 2030/31, with districts yet to complete the transition reducing per-capita hours and costs to align with those districts where the bulk-funded approach is fully implemented.

Separately, the number of lower-need clients receiving funded in-home care is assumed to fall from 2025/26, as services are targeted more consistently across the country.

Key results: In-home care

In-home care volumes are projected to grow by about 1.7 million hours, or about 18%, over the decade to 2035/36, and by about 57% by 2047/48.

Sensitivity

The demand projections turn on two assumptions in particular. If the recent decline in residential care utilisation continued for ten more years rather than five, projected residential care demand in 2047/48 would be lower by between about 1% and 8% depending on whether the trend is measured over the past five or ten years. In-home care projections are more sensitive again to the assumed effect of the move to bulk funding: if per-capita hours in fee-for-service districts did not fall, projected care hours in 2047/48 would be about 20% higher than the baseline.

The baseline cost projection

The three scenarios share a common baseline. That baseline applies current prices, indexed for inflation, to the projected demand volumes, and assumes for the purpose of costing that supply grows to meet demand. Base-year expenditure comes from Health New Zealand administrative data (the Client Claims Processing System) for 2024/25, which records government payments to providers and residents' contributions for each demand sub-group. Residents' contributions cover means-tested payments toward the regulated standard-room price only, and exclude optional premium charges.

Costs are projected by multiplying each sub-group's projected volume by its 2024/25 average price, indexed forward. Prices for 2025/26 and 2026/27 are indexed to reflect government budget and funding decisions. For future years, residential care prices are indexed annually at CPI +0.3% per year, in-home care atCPI+0.65%, and In-Between Travel at 1.5%.

The out-year rates reflect labour cost inflation for the health care and social assistance sector, which was about CPI plus 0.65% over the decade to December 2025.

Scenario A: The cost of failing to meet demand

Approach and assumptions

Scenario A models residential care supply growing at 1% a year in districts without significant excess capacity, while demand grows at about 2.9%, so a shortfall widens over time.

When demand exceeds supply, beds are assumed to go first to people needing dementia, hospital or psychogeriatric care, so that the people left waiting are those with the lowest acuity, who would otherwise enter rest home level care. This assumption minimises both the costs to government (in hospitalisation and in-home care costs) and the savings to government (in Residential Care Subsidies not paid) due to unmet demand for residential care. Because the consequences would be unsustainable over the full projection horizon, the costing focuses on the twelve years to 2037/38.

Cost per person waiting for care

Each person waiting for a residential care place is estimated to cost the government about $59,000 a year more than if they were in residential care. This includes the cost of in-home care and additional hospital care while waiting, and the additional New Zealand Superannuation and secondary benefits paid to people living at home rather than in care, against the Residential Care Subsidy that is not paid.

Table B3: Estimated cost to government for each person waiting for a residential care place

Cost component (2025/26 dollars)	Annual cost per person
In-home care while waiting at home	$17,400
Hospital care while waiting in hospital	$56,100
Additional hospital stays while waiting at home	$11,600
NZ Superannuation and secondary benefits	$2,300
Less: Residential Care Subsidy avoided	($28,500)
Net cost to government per person per year	$59,000

The estimate assumes 90% of total waiting time is spent at home, on about 5 hours of in-home care per week, and 10% of total waiting time is spent waiting in hospital. The Residential Care Subsidy cost avoided is about $28,500 a year, the average government cost of a rest home place.

Hospital time is costed at two different rates in the wider modelling depending on the context. This is because a hospital bed is not always being used for the same purpose.

A person who is medically stable but remains in hospital only because no residential care place is available is costed at $1,540 a day. That is the average cost of a hospital day for someone aged 70 or over whose stay ends in a move to residential care. It is lower than the cost of an acute admission because the person no longer needs acute treatment and is occupying the bed only due to the lack of a suitable alternative.

A person who is not waiting for a place in residential care under current settings is costed at $2,150 a day, the average cost of a hospital stay for people aged 70 to 89. Using the lower, stabilised rate for people who are only waiting for a residential care place avoids overstating the cost of a delayed discharge.

Results

By 2037/38, the projected shortfall reaches more than 9,000 places, about 18% of demand. Meeting the associated hospital needs would take nearly 400,000 additional bed-days, close to 7% of public hospital capacity. The net cost to government rises to about $590 million a year by 2037/38, most of it in the hospital system. Because the level of ‘excess demand’ is the difference between two large estimated numbers, it is sensitive to assumptions about the rate of future supply growth at indexed prices, and to assumptions driving the demand projections, discussed above. Older people and their families also bear a wide variety of costs when they cannot access appropriate and timely residential care: the direct financial costs alone are estimated at a minimum of about $12,300 per person per year in additional care and lost earnings.

Scenario B: the cost of meeting demand without reform

Approach and assumptions

Scenario B assumes that supply grows to meet demand at every care level. To induce the required level of investment in building new residential care supply, step changes in residential care prices averaging 21% are applied on top of annual indexation. These price uplifts are phased over two years to match the proposed approach under Scenario C. Home-care prices are increased by 6% above inflation as proposed in Scenario C. The uplifts represent the Advisory Group's judgement of the minimum needed to make new residential care facilities investable and to keep quality in-home care commercially viable. They are applied in the current way, so the same price is paid for all new and existing residential care beds at a given care level and location.

Scenario C

Differentiated pricing

Scenario C, the Advisory Group's reform package, replaces the uniform price increase for new and existing residential care beds in Scenario B with a 'differentiated' one.

New-build beds receive a higher increase. Existing beds are sorted by age and depreciated value, proxied by room size, into two groups that receive smaller increases. This reflects the lower capital cost of older, generally smaller-roomed facilities, which need a smaller increase to earn a fair commercial return.

This results in three room categories: legacy rooms, existing modern rooms, and new-built rooms. A room's category is set by how much of the building's useful life remains and by the floor area of the room. An older, smaller room has less remaining capital cost to recover, so it needs a smaller price increase to earn a fair commercial return.

Table B4: Room categories used in differentiated pricing

Room category	Room size	Facility GFA	Remaining economic life
Legacy rooms	Smaller than 12.5 m^2, and any room with two or more residents.	28 – 34 m^2	40% (14 years)
Existing modern rooms	Larger than 12.5 m^2. This category captures other older rooms in facilities with lower capital value	36 m^2	57% (20 years)
New-built rooms	Larger than 12.5 m^2	36 m^2	100% (35 years)

Legacy rooms are assumed to be replaced by new-built beds at a rate of 3% per year.

These categories are separate from the distinction between a standard and a premium room. The regulated price covers a standard room. A premium room has an additional charge agreed between the resident and the provider, which sits outside the regulated price and is not counted in the contribution estimates.

The price increase is delivered over two budgets:

- In 2027/28, there is an average increase of 9.1% (7.1% real) across all providers, because price differentiation by room category is not yet in place. We consider that there should be larger increases for rest home and dementia-level beds and facilities in areas with higher land costs, but more work is needed to determine how this would be allocated.
- From 2028/29, the increase is differentiated by room category. The shortfalls behind these figures are calculated to meet a 6.66% weighted average cost of capital, with no premium revenue.

The tables below are modelled outputs, and should not be taken as expected uplifts. Further work is needed to gather data and refine the assumptions, and all recommendations are subject to government decisions. These estimates should not be applied at the individual facility level and should not be used as a basis for individual business decisions.

Table B5: Residential care price uplifts by room category

Room category	2027/28 (all rooms)	2028/29 nominal	Target uplift over indexed baseline after two budgets
Legacy rooms	+9.1% (7.1% real)	+2.0% (0% real)	6.4%
Existing modern rooms	+9.1% (7.1% real)	+5.7 (3.7% real)	10.5%
New-built rooms	+9.1% (7.1% real)	+15.8% (13.8% real)	21.9%

Legacy rooms receive only baseline indexation in 2028/29, at 2% nominal with no real increase, because the 2027/28 increase already achieved the target uplift in real terms.

Table B6: Target uplift over the indexed baseline, by room category and care level (national weighted average)

Room category	Hospital	Rest home	Dementia	Psychogeriatric	Overall
Legacy rooms	3.2%	9.1%	8.6%	−1.5%	6.4%
Existing modern rooms	6.5%	14.4%	12.0%	1.2%	10.5%
New-built rooms	15.4%	28.8%	21.7%	9.4%	21.9%

Rest home and dementia level care receive the larger percentage increases, which narrows the price difference with hospital level care. Current price differences between the care levels are wider than the estimated differences in the cost of providing them. Uplifts vary less by locality than expected, because the modelled shortfall is more sensitive to care wages, price inflation and building costs than to the cost of land.

The residential care facility financial model

The residential care price uplifts in Scenarios B and C are derived from a financial model of residential care facilities' costs and revenues, built for the Advisory Group. For a stand-alone facility of a given care level, size and location, the model estimates construction costs, operating revenues (government funding, residents' contributions and premium charges), operating costs, depreciation and asset replacement, and the resulting return on capital. It calculates the internal rate of return from the discounted present value of net cash flows, to find the price per bed day at which this return equals the weighted average cost of capital- the price at which a new facility is investable.[153]

The model's main output is the calculated shortfall between current prices and investable prices per bed day. For new-built facilities, the weighted average price uplift across different care levels and localities is about 21%. Older existing facilities with depreciated buildings with a shorter remaining economic life require lower average price uplifts to cover their cost of capital.

The model's results indicate that current price shortfalls and required uplifts are generally larger for rest home and dementia level care than for hospital-level care, as current price differences between care levels are greater than the difference in operating costs. They also show generally larger price shortfalls and required uplifts in 'metro' urban areas, mainly because current locality-based pricing does not reflect difference in the cost of land.

This modelling approach provides a robust assessment of specific projects or for a representative facility. However, New Zealand's residential care providers are a diverse mix of for-profit and not-for-profit organisations operating at widely varying scale in different market segments. Many operate residential care services alongside independent living apartments, and some are substantial land and property development businesses. Providers' actual operating and capital costs, profitability and investment thresholds will vary widely. The modelled results are not estimates of the likely financial performance of any specific facility.

Key inputs and assumptions are summarised in the following table. Results are primarily sensitive to operating costs (including carer wages), expected future price adjustments, occupancy rates, the weighted average cost of capital, and the treatment of premium room revenues.

[153] This approach is consistent with that used in Sapere's July 2024 report *Aged care service model and funding review. Phase 2: Modelling options for improved funding and service models*.

Table B7: Key variables and assumptions in the residential care facility financial model

Variable	Options and base model assumption	Comment
Facility Characteristics		
Care level	Modelled for stand-alone facilities providing rest home, hospital-level or psychogeriatric care, and a dementia wing in a larger facility.	Determines prices, staffing and other operating costs per bed day, and construction costs (eg required area per bed).
Number of beds	Base results modelled for facilities of 60 beds, or a dementia wing of 20.	Influences construction and depreciation costs. 60 is an efficient scale given fixed costs, and staffing efficiency (e.g., rostering, nurse coverage).
Occupancy rate	Base case modelled at 95%	Assumes an efficient facility operating near capacity (allowing for resident turnover, etc).
Location	18 locations were modelled: 6 rural, 6 provincial, 6 urban.	Current prices land costs are the key variables that differ by location.
Building characteristics	Site coverage (50%), Storeys (2 if land cost over $700/m2), Ground floor area (GFA) per bed. Modelled results assume 32m2 legacy rooms and 36m2 existing and new standard rooms.	Influences cost of land, construction, and depreciation.
Depreciated capital value	In Scenario B all new and existing facilities are funded based on buildings valued at 100% remaining life. In Scenario C, the remaining economic life is 40% for 'legacy' rooms, 57% for other existing rooms and 100% for new rooms.	Assumed remaining economic life of the building. New facilities modelled with a life of 35 years. Influences capital value and price required to achieve a return on investment equal to cost of capital.
Financial inputs		
Price per bed day, baseline indexation	Current and projected revenue per bed day from government subsidies and means-tested resident contributions.	2025 prices, inflated 4% per Budget 2026 announcements, then indexed at 2.3%pa
Premium revenue	Average premium revenue per bed per day.	The modelled price shortfalls assume no premium revenue contributing to the baseline weighted average cost of capital of 6.6%.
Operating costs per bed day	Vary by care level. Care staff wages and non-wage costs per bed day, based on Sapere (2024) estimates, indexed by LCI and ACPI	Non-wage inflation at CPI 2% Wages indexed at 2.4%pa (0.4% above CPI, reflecting the average LCI-CPI variance over the period 2009-2025.

Variable	Options and base model assumption	Comment
Land prices and inflation	Prices sourced from LINZ database. Facilities are modelled as leasing land at a yield of 5% equal to the rate of land price inflation.	Land prices vary widely by locality, from $300 to $2000 per m2 and are the main driver of price differences by locality.
Construction costs	Building, fitout, plant and landscaping, and disposal value.	Building cost inflation 2.54%pa Plant, fitout, landscaping costs grow at CPI 2%pa
Depreciation, asset renewal and facility life	Fitout, plant and landscaping are replaced throughout the facility's life. Building is fully depreciated over its 35-year life.	Depreciation rates and asset life • Building 2.86%pa, life 35 years • Plant 6.67%pa, life 15 years • Fitout 10.00%pa, life 10 years • Landscape 6.67%pa, life 15 years

Table B8: Weighted Average Cost of Capital and contributing variables

Variable	Modelled value	Comment
Weighted average cost of capital (WACC), post-tax, nominal	6.66%	WACC determines the internal rate of return on investment required to make a facility investable. It is also the discount rate used to calculate present value of future cashflows. Derived from the financial variables below.
Capital Structure	Debt: 37.4% Equity: 62.6%	Consistent with Sapere 2024. Varies widely across different providers in the New Zealand aged residential care sector
Risk free rate of return	4.67% pa = 3.36% post tax	Consistent with Sapere 2024: CPI+2.67% NZ Treasury's 2025 accounting valuation guidance revised its long term forward real rate up from CPI+2.3% to CPI+2.8.[154]
Market equity risk premium	7.50%	Consistent with Sapere 2024. EY (2019b) used 5.5%. At 50/50 debt:equity, a 1% lift in ERP raises WACC by 0.45%.
Risk beta	Asset beta: 0.35 Geared beta: 0.56	Consistent with Sapere 2024. Measures volatility of earnings and valuations compared to other investments. High values increase required return on equity as debt gearing increases. The model assumes a land lease, removing capital valuation risks. Reducing asset beta to 0.3 would reduce WACC by 0.37%.

[154] Risk-Free Discount Rates and CPI Inflation - Assumptions for Accounting Valuations - June 2025

Variable	Modelled value	Comment
Size premium	zero	Adjusts cost of equity for higher risk for smaller providers. The model is indifferent to source of investment and provider scale.
Cost of equity	7.56%	Risk free rate + (equity risk premium x geared beta) + size premium.
Company credit spread	2.50%	Consistent with Sapere 2024.
Cost of debt	7.17% 5.16% post tax	Risk free rate plus company credit spread.

How the other reform estimates fit together

The reform estimates come from two separate pieces of modelling.

The first, the efficiency and cost-avoidance estimates, values the resources that the service and system recommendations would free or save: hospital bed days, clinician time, care hours, and travel. These are real changes in the resources the system uses.

The second, the resident contribution estimates, estimates how the cost of care would be shared between the government and residents under the redesigned means test and the in-home co-payment. These are transfers between parties, not changes in the resources the system uses.

The main assumptions and limitations behind both are collected in the limitations section below.

Efficiency and cost-avoidance estimates

Estimation approach

The service and system recommendations comprise about forty distinct changes to how care is assessed, delivered, staffed and contracted.

Those recommendations are described more fully in the report. The primary modelling challenge is that while it is likely that each recommendation has a positive effect on a particular output, many affect more than one aspect of interest, and there is very little (or often no) evidence on which to base an estimate of the size of the effect. Therefore, the modelling approach was to decompose each recommendation into its intended component charges and estimate each component separately.

For example, reablement is short-term support to restore a person's ability to manage at home. Hospital records identify about 77,000 bed days per year occupied by older people who no longer need hospital-level care but cannot yet be discharged. Because better estimation would require both more policy and operational design of the specific intervention, the result is modelled as ranges on improving the key measure we have, which is the occupied bed days of older people who do not require hospital-level care. Reablement and Early Supported Discharge services are estimated to clear 20% to 45% of these days, with a central estimate of 30%, and each bed day is valued at its average provision cost of about $2,150.

How each lever is modelled

The table below sets out, for each lever, what the model estimates and the central figure it produces, at the settings used in the report's integrated fiscal projection.

Table B9: Summary of the modelling approach by lever, at the settings used in the report's integrated fiscal projection

Lever	What the model estimates	Central estimate
Reablement and Early Supported Discharge *	Clearance of the delayed-discharge bed-day pool of about 77,000 days, at 20% – 45% (central 30%), valued at $2,150 a bed-day, net of the cost of running the teams.	$50m benefit; $32m cost
Shifting demand from residential to home care *	People supported at home rather than in rest home-level of care, the avoided Residential Care Subsidy of about $28,300 per person, less 4.5 hours a week of in-home care at $51 per hour plus travel.	$170m benefit; $85m cost
Casemix-informed funding	Care hours freed by casemix-based funding; set to zero in the integrated projection, because the efficiency of the move to bulk-funded contracts is already counted in the baseline demand projection.	Counted in the baseline
Aged Care Pricing Authority	A 1% – 3% price-discovery efficiency on the government residential care funding base of about $1.883m.	$48m saving; $9m operating
In-between travel modernisation	The travel envelope multiplied by a per-trip optimisation rate.	$24m benefit
Support for carers *	Avoided hospital bed-nights and emergency presentations from a package of carer support.	$35m benefit; $15m cost
Single continuum of care *	A proxy from UK integrated care, applying the low end of the observed reduction in avoidable admissions to the aged care hospital cost base.	$21m benefit
Digital infrastructure and interoperability	The sector-wide administrative base, reduced by 2% – 5%.	$14m benefit; $60m set-up
Navigation support	Provider clinical resource efficiency, plus a navigation-specific administrative aspect.	$12m benefit; $7m cost
Delegated assessment pathways	Avoided admissions from timely access at about $1,800 a person, plus freed assessor time.	$6m benefit; $5m cost
Clinical review optimisation	Clinician time freed by taking a risk-based rather than a rules-based approach.	$6m benefit
Expanded clinical response capability in the community	A reduction in emergency presentations.	$5m benefit; $4m cost
Remote monitoring (event response)	Fall and event detection converted to avoided ambulance and hospital costs.	$4m benefit; $4m cost
Remote monitoring (clinical)	Platform and devices at 0.5% – 3% enrolment.	$1m benefit; $7m cost

Lever	What the model estimates	Central estimate
Telehealth services	Consultations multiplied by a diversion rate, valued at about $700 per emergency presentation.	$4m benefit; $2m cost
Technology-enabled rostering and routing *	A 10% reduction in the labour cost of rostering and routing.	$15m benefit
Nationally standardised contracts *	Integration efficiency, at the midpoint of a $20m to $50m range.	$35m benefit
Certifications and audits	Provider audit costs saved by a longer certification cycle.	$2m saving
Provider procurement ("piggyback")	A 5% – 10% provider input-cost saving on catalogue categories.	$2.5m benefit; $2m cost
Culturally responsive care models	About 0.5% of system spend for kaupapa Māori and Pacific capability.	$12m cost
Exceptional and complex needs funding	A top-up for very high acuity cases at about $280 to $292 a resident-day.	$10m cost
Respite funding	Residential respite volume up 5%, and delayed residential entry of about 365 person-years of the Residential Care Subsidy.	$10m saving
Short stay funding	Entry and exit payments.	$2m cost
Dynamic bulk-funding	A standing commissioning function.	$3m saving; $6m cost

Note: Costs and savings for levers that are marked with an asterisk are recorded but not added to the lever totals, either because the activity they act on belongs to another lever, or because their saving is captured in the system-wide layers (e.g. the shift of demand to home care and the avoided hospital bed nights).

Valuation and overlapping benefits

Some benefits are expenditure (e.g. travel reimbursement) no longer incurred, but most are not assumed to reduce government expenditure on health. These include benefits like released capacity (e.g., hospital beds, clinician hours, and care hours freed for other patients).

Released capacity is valued at the average provision cost of the resource. This basis assumes that, at the service volumes modelled, freed capacity is reused to treat waiting patients whose care is valued at that cost. This may overestimate the value of released capacity because the 'marginal' use of the freed capacity is likely to be lower than its average use.

The biggest analytical risk in adding these estimates up is double-counting, because several recommendations act on the same people. Better assessment, advanced in-home care, reablement and remote monitoring can each help one person to avoid the same hospital admission, so summing their gross effects would overcount that person's bed day. To prevent this, each pool of avoidable activity has a single lever which is counted once.

The hospital capacity estimate and the simulation

Freed hospital capacity is the largest single benefit in the package. Because it is so material to the overall modelling result, it was estimated in three ways.

The first is a recommendation-by-recommendation aggregation of non-overlapping components described above. This produced the lowest figure.

The second is a top-down estimate that applies a plausible reduction to the measured pool of avoidable hospital activity among older people. This is to avoid a situation where the recommendation approach adds up to a large number that would be implausible but also not cost effective.[155]

The third is the relevant output of the Monte Carlo simulation described below.

The central estimates of the three methods fall within a band of about $75 to $100 million per year, and the range quoted in the report is the span of those three central estimates.

The Monte Carlo simulation treats every uncertain input as a range and runs the whole package thousands of times, drawing a fresh value for each input on every run, so the output is a distribution of the package total rather than three chosen points.

Roughly 25 inputs are treated this way. Examples include the cost of an acute bed day, the fraction of low-acuity presentations that can be diverted by telehealth, and the reduction in provider administration from digitization. Each is modelled as a range.

Simulating across the full range matters because the inputs are largely independent: simply adding all the low ends or all the high ends of a range would overstate the true spread of the total.

Residential to home care

The number of people who would live at home rather than in residential care is the combined outcome of the whole package. It was set by reference to three external benchmarks.

The 2024 Sapere *Review of Aged Care Funding and Service Models* estimates the diversion of 19% of new residential admissions to home care. That diversion results in a standing-stock reduction of roughly 4,000 fewer residents by 2039/40, which Sapere describes as an upper bound.

Because Sapere's figure is already a standing-stock reduction, it is directly comparable to the model's cases. A comparison with similar countries, rebuilt for this exercise from OECD and national data, places New Zealand at about the average for residential care utilisation. New Zealand differs in funding less in-home care, so the comparison might support the case for expanding care at home.

New Zealand trials of restorative home care provide a third reference point: a pre-planned meta-analysis of three randomised controlled trials, covering 567 older people assessed as at risk of permanent residential care entry, found that restorative support reduced the combined risk of death or permanent residential care entry by 31%, a hazard ratio of 0.69, over 24 months, with a 95% confidence interval of 9% to 47%.[156] Those trials measure effects at the margin of entry for an at-risk population; they do not measure the share of the existing residential population that could be supported at home.

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[155] For example, it is likely to be extremely inefficient to try to ensure that there are zero hospital bed days occupied by people who do not require hospital-level residential care, as the monitoring and excess capacity required to be available elsewhere would become very expensive as the bed days declined.

[156] Parsons, M., Senior, H.E.J., Kerse, N., Chen, M., Jacobs, S., Vanderhoorn, S., Brown, P.M., Anderson, C. (2012). *The Assessment of Services Promoting Independence and Recovery in Elders Trial (ASPIRE): a pre-planned meta-analysis of three independent randomised controlled trial evaluations of ageing in place initiatives in New Zealand*. Age and Ageing 41(6):722–728.

The modelling for this report uses 3,800, 6,000 and 9,300 people as the low, central and high cases, measured against the population projected for the mid-2030s. The low case of 3,800 is just below Sapere's stock reduction. The central case of 6,000, adopted in this report, is a target conditional on advanced in-home care, the design of which requires further work.

The costs of the shift are counted against it in a consistent way, at 4.5 hours per week of in-home care per person plus the associated travel. This was cross-checked with industry participants. The avoided Residential Care Subsidy accrues to the Crown only for subsidised residents, so the fiscal saving from the shift is materially smaller than its resource value. Beyond this, we have estimated that $110 million is required for additional services above the 4.5 hours of the current model of in-home care we have accounted for, to achieve a 6,000 person target.

Reporting basis, discounting and exclusions

Benefits and ongoing costs are steady-state annual figures stated at the service volumes projected for 2037/38, when the population aged 65 and over is projected to be over one third larger than today. Where the report expresses them as present values, the steady-state annual figure is inflated by expected aged care cost inflation of 2.3%, and then discounted from 2037/38 to 2026/27 by the Treasury real discount rate of 2%.

Private contribution estimates

Synthetic population

Outside of the Integrated Data Infrastructure (IDI), there is no New Zealand dataset that records assets, income, partnership status, care level, and length of stay together at the level of individual residents. Administrative data from the Residential Care Subsidy system covers only people who apply for the Subsidy. Household surveys cover the general population, not the residential care population, and no dataset covers self-funding residents who do not apply for the Subsidy.

The modelling therefore uses a synthetic population: a set of constructed records that reproduces the statistical properties of the real resident population, applied one record at a time through the rules of each option (a microsimulation). The population comprises approximately 33,000 records representing the residential care population at a point in 2024/25, each with 14 attributes, including financial assets, home and car values, the asset base assessable under each test, partnership status, care level, weekly income from New Zealand Superannuation and other sources, modelled length of stay, and the contribution payable under current rules.

No record is, or is derived from, the record of any actual person. The inputs are aggregate tables and published statistics only; no individual-level data from any government system was accessed or used at any stage.

Construction, sources, and validation

The population is built in two segments. Subsidised residents (20,396 records) are constructed to match banded administrative aggregates from the Residential Care Subsidy system: the distribution of financial assets, and the joint distribution of financial and total assets including the home, partnership status, and care level. Self-funding residents' (12,501 records) asset distributions are fitted to the Statistics New Zealand household net worth survey for the year ended June 2024, for the population aged 65 and over. Supporting sources fill the remaining attributes: home-ownership rates by partnership status from the 2023 Census; income distributions from administrative aggregates; and published Ministry of Social Development income research.

The central validation test is that the synthetic population, run under current rules, reproduces current outcomes. It reproduces the aggregate contribution currently collected from subsidised residents, the banded asset and partnership distributions in the administrative data, and Census home-ownership rates. The modelled correlation between income and assets matches the observed data.

Contribution caps and asset-based tests

A single-year snapshot overstates contribution revenue under an asset-based test, because paying the contribution depletes the assets on which the next assessment is made. The model therefore follows each resident week by week through their expected stay. Financial assets fall by the contribution net of income each week; no return is assumed on the remaining balance, and the home is not drawn down. As financial assets fall, residents move down through the contribution bands, and cumulative contributions are tracked against the proposed five-year cap on contributions to care costs for those in residential care.

The in-home care co-payment

The in-home co-payment proposal is modelled based on the actual population – about 48,000 people receiving in-home care at a point in time – rather than a synthetic population. Around three-quarters of recipients are estimated to be eligible for the Community Services Card exemption at the Superannuation income threshold, a share derived from the estimated income distribution of this population, which is poorer than the general population aged 65 and over.

The proposal is that recipients above the Community Services Card threshold pay a weekly co-payment set by their assessed level of need, at roughly half the funded cost of their care, with a higher contribution above twice the card threshold. Those who cannot afford the charge are assessed on income and outgoings and pay a reduced amount.

Prices and the reporting year

Because the contribution model is a point-in-time cross-section rather than a multi-year projection, it requires consistent use of prices, thresholds, and incomes of a particular year.

The estimates are stated on a 2027/28 basis. The per-care-level prices are the Ministry's settled 2027/28 average prices, which incorporate the provider price uplift we are recommending. The price uplift therefore sits in the baseline.

The saving is the change from the current means testing rules, with the current rules and the reform both applied at those same post-uplift 2027/28 prices, so the estimate isolates the effect of the rule change rather than the price change.

Key assumptions, uncertainty and limitations

Changes in how people may structure and manage their assets in response to higher contribution requirements are not modelled. A graduated asset test changes the incentive to restructure assets, or time entry into care. Each response would reduce revenue relative to the estimates here.

The central residential-to-home-care shift is an ambitious, policy-conditional stretch target. At 6,000 people, it is the outcome the package is designed to achieve conditional on advanced in-home care being operational. The evidence-supported figure absent that offer is the low case of 3,800.

Fiscal saving and resource value differ on the residential shift. The shift is valued at the resource cost of a residential place, but the Crown saves the cost of the Residential Care Subsidy only on residents it was subsidising. Sapere's Phase 2 report[157] finds that about half of the divertible rest-home cohort self-fund, so the fiscal saving to the Crown is materially smaller than the resource value; the report presents the resource value as the headline and the fiscal share as a range.

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[157] Sapere. (2024b). *Aged care service model and funding review. Phase 2: Modelling options for improved funding and service models*. https://www.healthnz.govt.nz/publications/sapere-report-aged-care-service-model-and-funding-july-2024

Appendix 7: Illustration of a rural loading approach

The following table provides an illustration of what rules could be put in place to determine whether a residential care facility could receive additional an additional rural loading (i.e., increased funding to recognise the extra costs associated with rural care provision).

We recognise there are trade-offs in a rules-based system, and this would be an area for further work and development.

Table C1: Possible rules for a rural loading approach

Components	Possible rules
Overarching parameters	Whether a facility is rural should be based on structural drivers of rural disadvantage, and supported by clear definitions using: • Remoteness. • Facility size. • A structured financial viability test.
Measurement of remoteness	Remoteness could be defined using the drive time to the nearest tertiary hospital and key suppliers, with structured bands: • Band 1: 45 minutes – 1.5 hours. • Band 2: 1.5 – 2 hours. • Band 3: Over 2 hours. Bands would determine a graduated level of funding, reflecting increasing operational cost and complexity when hospitals and suppliers are further away.
Facility size	This could be defined using three tiers: • Tier 1 (priority): Under 20 beds. • Tier 2: 20 – 40 beds. • Tier 3: 41–55 beds. Facilities over 55 beds would generally not be eligible. Loading amount could be calibrated to the tier, recognising that smaller facilities face greater financial vulnerability and reduced ability to cross-subsidise operations.
Financial viability	Defined assessment criteria could include: • Ability to fund maintenance and refurbishment. • Capacity to meet regulatory care standards. • Ability to attract and retain workforce. • Evidence of structural financial pressure not explained by facility size or remoteness.

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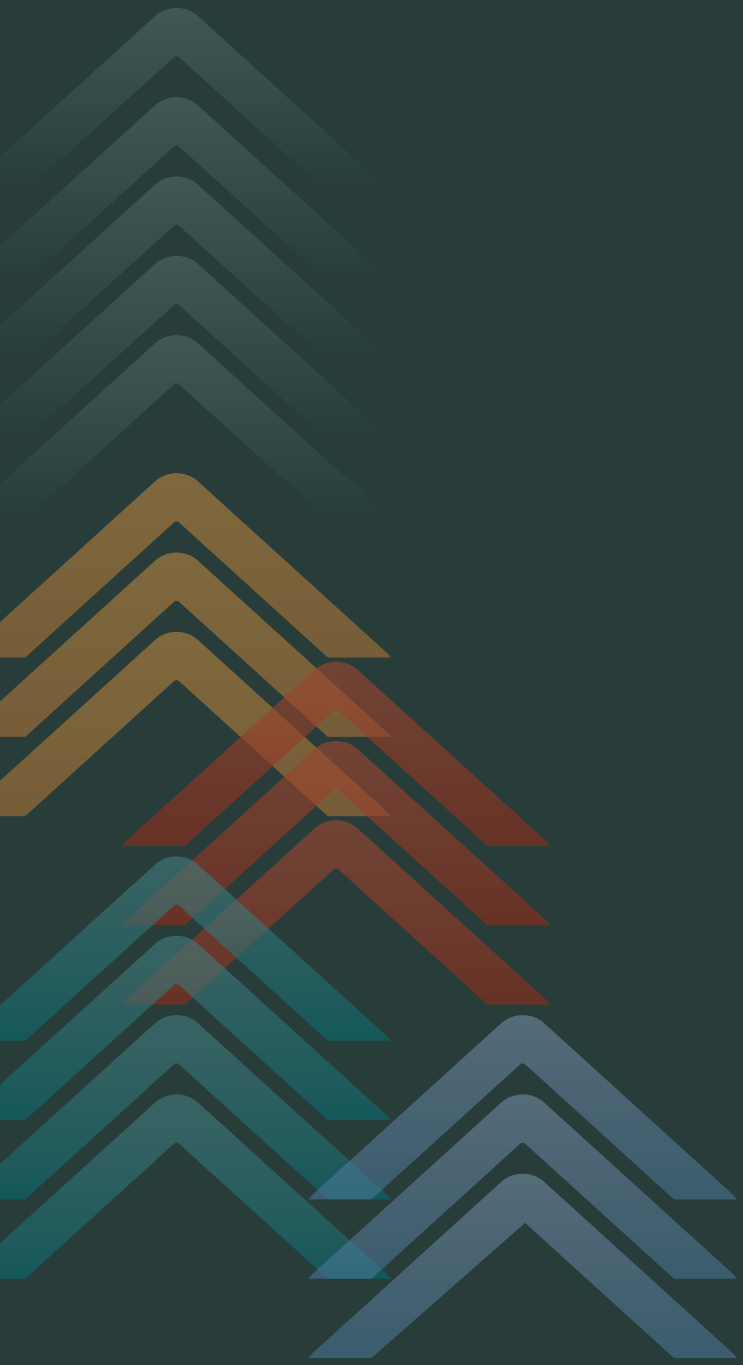
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