

# **Provision of Residential Care and Occupation Right Agreements by Retirement Village Operators**

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## EXECUTIVE SUMMARY

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It is estimated that between 18,500 and 20,100 certified residential care beds are provided through retirement villages (RVs). Around 17 per cent of those are delivered by way of Occupational Right Agreements (ORAs) for Residential Care.

For RVs, residential care opportunities are a powerful attractor to potential residents and triggers capital investment by way of ORAs in RVs and, more recently, ORAs for residential care itself. However, the interface between residential care and RVs is not well understood by residents, nor are lawyers confident about advising on that interface.

Those problems are exacerbated by:

- The dynamic and diverse nature of RV products.
- An opaque landscape in which the instruments, trajectories and practices at key transition points to RV residential care provision are uncodified.
- Loose use of language and terms which can muddy and confuse prospective residents, their families and the lawyers that advise them, particularly around the boundaries of residential care.
  - There is little detail or standardisation of terminology or information presented by RVs around residential care provision, conditions and trajectories for residents seeking independent living or serviced apartments.
  - The concept of ‘care’ is used within the RV sector in a variety of ways and straddles both:
    - residential care for qualifying individuals; and
    - services for non-qualifying individuals which broadly involve additional hotel service provision such as laundry, meal provision, and housework.
- Failure of ORAs for independent living and serviced apartments to deal adequately with the conditions, practices, probabilities and liabilities around any future transition into residential care, including clarity around:
  - Access to standard and premium rooms.
  - Certified levels of care.
  - Processes for, and an RV’s responsibilities and practices if, a residential care resident premium room user wishes to go into a standard room.
- Currently an ORA for residential care typically is the same as other ORAs and relies on the Admission Agreement to specify conditions of access to residential care.

We suggest:

1. There is value in incorporating a selection of key Admission Agreement clauses into the Disclosure Statement preferably by direct repetition or, as a minimum, by cross-referencing.
2. Guidance be developed for operators so that there is greater consistency across the RV sector in how ORAs for care and the practices surrounding them are described, applied, and disclosed.

3. CFFC continues to contribute to legal education to increase lawyers' awareness and understanding of the various pathways and transition to aged residential care and the disclosure requirements around ORAs for care.

Finally, this monitoring project has noted potential impacts of the ORA for care model on policy and funding settings beyond the RV sector, in relation to government financial assistance and aged residential care. While these matters are not central to the CFFC's responsibilities in regard to the RV Act, they are nevertheless pertinent to the CFFC's role in retirement income policy and financial education.

## 1. INTRODUCTION

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This report presents the findings of the monitoring exercise commissioned by the Commission for Financial Capability (CFFC) *Retirement Villages – Monitoring project 2018/19: The interface of retirement villages and aged care*. It sets out the context of that monitoring project, its focus and objectives. It reports on six sets of data collected and analysed over the monitoring project (Infobox 1).

The discussion is structured as follows:

- Section 2 sets out the focus, context and information needs of the CFFC.
- Section 3 provides data on size and characteristics of residential care in the retirement village (RV) sector in relation to residential care.
- Section 4 profiles the data related to the use of ORAs for residential care.
- Section 5 provides data related to the provision of standard and premium rooms in RV-attached residential care facilities.
- Section 6 presents findings from different data collection activities around the navigation of the RV-residential care interface.
- Section 7 comments on the findings of this monitoring project in relation to the Retirement Villages Act 2003 (RV Act) and sector practice and highlights the spill-over effects of the RV-residential care interface, particularly the developing use of ORAs in residential care, for the broader responsibilities of the CFFC in ensuring the adequacy of incomes for older people in retirement.

### Infobox 1: Key Datasets

- Data collection around the size and characteristics of the retirement village sector involved in residential care through analysis of the Ministry of Health register of residential care providers, customised data provided by Technical Advisory Services (TAS), and retirement village industry intelligence.
- Data from a survey of retirement villages providing residential care.
- Data from a survey of lawyers.
- Analysis from our legal review focusing on Occupational Right Agreements (ORAs) where residential care is provided within a village, with a particular focus on the transitions to residential care either through ORAs or traditional financial arrangements of periodic payment.
- Interviews with some key participants in the retirement village care sector.
- Interviews with key actors in residential care, health, welfare and the seniors sector.

A number of terms are associated with RVs and residential care provision and frame the relationship between RVs and residents. The key terms are listed in Infobox 2.

### Infobox 2: Some Key Terms

**Occupation Right Agreement (ORA):** The legal document that gives residents the right to occupy a residential unit or residential care bed in a retirement village.

**Admission Agreement:** The specific agreement between a residential care provider and resident setting out services and conditions for admission to a selected residential care bed.

**Age-Related Residential Care Services Agreement (ARRCA):** RVs providing residential care with contracts with a DHB are covered by the ARRCA, a nationally consistent agreement reviewed annually and specifying services for residential care negotiated between all RV and non-RV residential care service providers and DHB funders.

## **2. CFFC'S FOCUS, CONTEXT, INFORMATION NEEDS & DATA COLLECTION**

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The CFFC has particular statutory responsibilities set out in the RV Act to monitor the operation of that Act and the protections it is intended to deliver to RV residents. In carrying out those responsibilities the CFFC undertakes a programme of annual monitoring targeting different aspects of RV operations and their impacts on residents. The CFFC's current monitoring around the interface between retirement villages and aged care has been prompted by a significant shift in the focus of retirement villages and their service provision in residential care since the RV Act came into effect in 2003.

The CFFC has noted an apparent trend for some RVs to re-position themselves from providing lifestyle housing provision for independent older people to providing a continuum from independent villas through serviced apartments to the provision of residential care including rest home, hospital and dementia care. These are predominantly accessed by way of accommodation payments fully subsidised for eligible older people when accessing standard rooms (See Infograph 1, Section 3). Where older people access premium rooms, even when eligible for subsidy, they are liable for a co-payment.

In addition, within residential care facilities delivered by RVs, the CFFC had noted the development of ORAs as a pathway to purchasing residential care. The use of ORAs within the context of residential care means that those residential care residents with ORAs fall within the ambit of both the RV Act and the separate legislation and regulations for the residential care sector. This is the case even if they came directly into residential care. The aged care sector legislation and regulations include:

- Residential Care and Disability Support Services Act 2018 (in force from 26 November 2018, and replacing the Social Security Act 1964)
- Health and Disability Services (Safety) Act 2001
- Health and Disability Services Standards (NZS 8134:2008)
- Health and Disability Commissioner Act 1994 (and the Code of Health and Disability Services Consumers' Rights)
- Age-Related Residential Care Services Agreements: contract between the provider of residential services and the District Health Board
- Admission Agreement between the provider and resident.

Where RVs provide residential care, residential care services and associated facilities and staffing levels are specified through that legislation and supported by a range of standards around staffing levels, accreditation and audit processes, and complaint and investigation procedures. In addition, the Social Security Act defines government residential care subsidies and associated income and asset tests.

Complexities around the shift of older people in RVs to receiving residential care services, and the place of ORAs in that transition process have already been the subject of anxiety around funding and costs. Discussions between New Zealand Aged Care Association, the Retirement Village Association and the District Health Board Older People Steering Group led on 1 July 2013 to both agreed changes in the Aged Residential Care Agreement for RV

residents with ORAs and a Code of Practice for residential care and ORAs. In the context of its statutory responsibility for RVs, the CFFC has been concerned to explore this emerging landscape with a particular interest in the following questions:

1. Do RV residents and those seeking residential care within RV facilities:
  - a. Understand the different statutory regimes applying to independent living (including that sustained through in-home services available to older people when living outside a retirement village) and residential care respectively?
  - b. Understand their contractual rights, obligations, options under each regime and the processes and financial implications of transferring from one to another?
  - c. Have genuine choices between standard and premium rooms when moving to residential care?
2. Are RV residents able to access programmes to age in their ORA non-residential care accommodation in a manner equivalent to older people living outside retirement villages?
3. Does the current legislative and regulatory regime for retirement villages sufficiently protect the rights and interests of consumers as they progress from independent living under an ORA to aged residential care?
4. How do new types of village operator practices offering different types of care and integrating care facilities in villages impact on residents?
5. Is the definition of retirement village relevant and fit for purpose in the light of new forms of practice?
6. Does the legal framework for retirement villages is readily able to be understood by residents, intending residents and operators in the light of new forms of practice?
7. Are there gaps or risks in the current retirement villages regime and in the interface of it with the aged care regime that expose consumers in a potentially adverse manner?
8. Are representations to intending village residents by village operators regarding continuum of care, or progression from independent living are fair and reasonable, and are those representations sufficiently provided for in ORAs?
9. Is the legal framework is future-fit to handle existing and possible further growth and developments in the provision of care within villages.

Early in the monitoring project it became clear that the interface between RV and residential care is both dynamic and marked by considerable innovation and diversity. This meant that the monitoring had to establish the landscape of the interface between the RV and residential care. That landscape has been mapped through:

- Analysis of data reported by the RV sector.<sup>1</sup>
- Analysis of New Zealand Aged Care Association (NZACA) industry profile data. NZACA combines data from Technical Advisory Services (TAS) and NZACA member surveys. While not all operators are members of NZACA, members provide 93 percent of the total care beds.
- Extraction of data and analysis of the Ministry of Health register of residential care facilities.

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<sup>1</sup> In particular through the JLL (2019) *New Zealand Retirement Village Database*. New Zealand: Jones Lang LaSalle.



- Analysis of customised data provided by TAS data from Aged Residential Care (ARC) Health of Older People (HOP) quarterly bed survey.
- Surveying retirement villages identified as residential care providers in the Ministry of Health register. Seventy RVs providing residential care participated.

That data analysis has been supplemented by a series of interviews and a survey of lawyers. Those interviews and the lawyers survey have primarily informed our understanding of the impacts of this dynamic interface on residents and the adequacy of the current RV legislation. A legal review of the key legislation and the alignment of the primary documents required under the RV Act and the ARC Agreement was also undertaken.

A total of 18 interviews were conducted with 26 people. Organisations participating in the interviews included the Retirement Villages Association, New Zealand Aged Care Association, Retirement Village Residents Association, Seniorline, Ministry of Housing and Urban Development, Office of the Ombudsman, Ministry of Health, Ministry of Social Development, Office for Seniors, Department of Internal Affairs, Statistics New Zealand, DHBs, and Age Concern. Interviews were also conducted with a small number of retirement village operators, solicitors and statutory supervisors.

The lawyers survey was targeted to lawyers who had advised one or more clients in the last two years seeking advice around independent living in a retirement village or regarding an ORA for residential care within a retirement village. As we did not have a pre-identified survey population who met the eligibility criteria an open survey format was needed. A short online survey was developed so that lawyers could be directed to the survey through multiple sources.

To recruit, CRESA provided the New Zealand Law Society (NZLS) with written information about the project and a link to the lawyers' on-line survey for their weekly electronic bulletin *Law Points*. To supplement that recruitment CRESA sent a direct individual email with a survey link to all lawyers who had completed a lawyer's survey for the *Retirement Village Intending Residents and the Effectiveness of Legal Advice* project in 2016/17 and/or the *Retirement Villages: Advice, Information and Education* project in 2015, as well as a small number of lawyers not in that set who were identified as specialists in retirement village contracts or Elder Law. All lawyers emailed were encouraged to share the survey with others in their practice or networks. The survey officially opened in early November 2018 and closed mid-January 2019. A total of 82 lawyers who had provided advice around retirement village living to clients in the last two years participated in the survey. Of those respondents, 43 had provided advice specifically around an ORA for residential care.

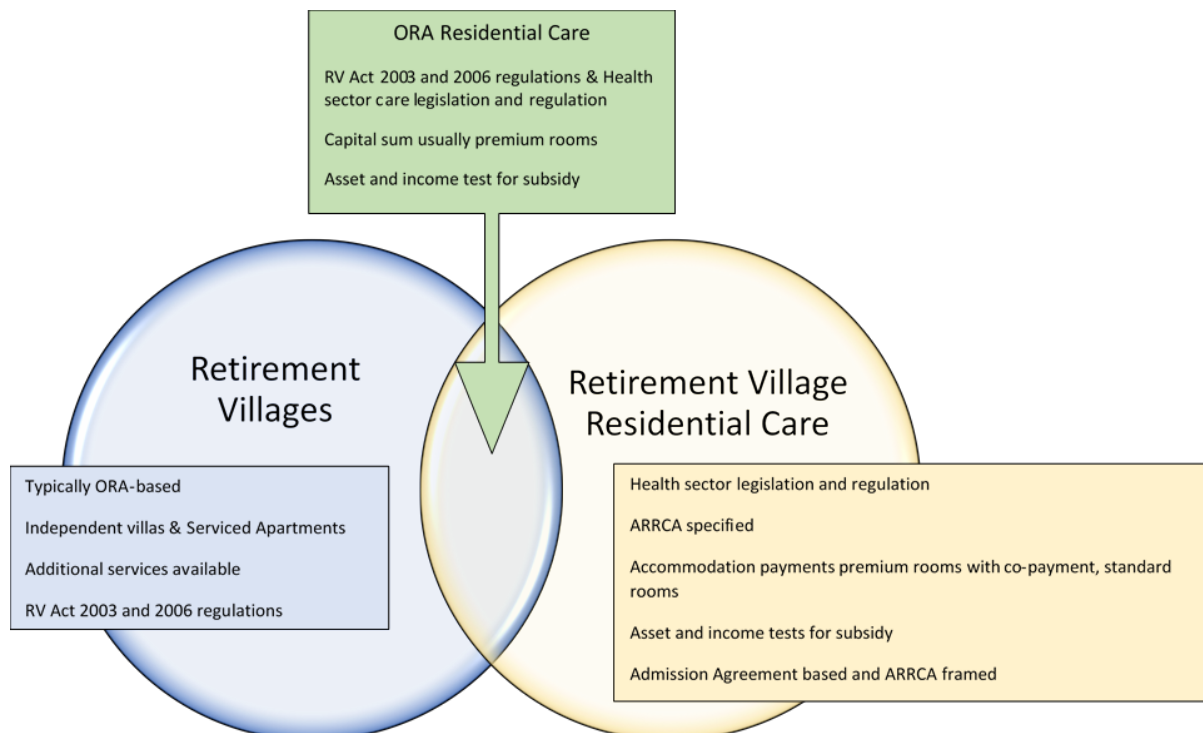
The retirement village survey targeted retirement village operators that provide both independent living units and have certified care beds on-site or in an adjacent complex. To identify a survey population a list of all Ministry of Health certified rest home providers was matched against a list of registered RV operators. Where a match was ambiguous company webpages and the Eldernet site were used to seek additional information, in order to include or exclude a provider from the survey population. In all a total of 238 retirement village providers were identified as likely to be eligible.

A draft survey was developed and sent to key stakeholders for the research, for their comment. As direct emails were not easily identifiable for all facility managers a decision was made to run the survey as a postal survey. All 238 providers were posted a hard copy survey to complete, along with a reply-paid return envelope. The mail-out surveys included a link to an online version of the survey, to allow providers to submit their return online. Surveys were posted out in the last week of April 2019 with a requested return date of 15 May 2019. One email reminder, including the link to the online survey, was sent out to all villages with a manager's direct email address. The survey closed at the end of May. Two were returned as non-deliverable and two villages got in contact to say they were ineligible. Returns were received in relation to seventy individual retirement villages. That is, 30 percent of retirement villages in residential care.

### 3. SIZE & CHARACTERISTICS OF RESIDENTIAL CARE IN THE RV SECTOR

Changes in positioning of RVs in residential care can be broadly summarised in two dimensions: involvement of RVs in residential care and the development of Occupational Right Agreements (ORAs) in residential care. ORAs in residential care, even where an individual's first and only contact with a retirement village is through that residential care ORA, activate the RV Act as well as all the health sector funding, service and regulatory settings associated with residential care provision (Infograph 1).

**Infograph 1: Interface of RVs and Residential Care**



The association between residential care units and RVs have been forged through diverse trajectories but three patterns appear evident:

- New-build RVs including residential care facilities – a pattern most pronounced in the corporates.
- Extension of existing RVs into the provision of residential care facilities – this pattern can include the acquisition of RVs by organisations previously specialising in residential care and subsequent addition of residential care facilities.
- Residential care facilities acquired by RV operators and site development to provide RV independent villas and serviced apartments.

As New Zealand's ageing population grows, we expect to see a rise in the number, although not necessarily the proportion of older people needing care. Indeed, the proportion of people needing residential care has declined over the last 10 years. The latter reflects extended life expectancies combined with a stronger focus on the provision of home-based care with the ageing in place policy. As of 31 March 2019, just over 39,000 people lived in aged residential care.<sup>2</sup>

Our analysis of the Ministry of Health's register of residential care facilities undertaken in August 2018 identified 238 RVs clearly delivering residential care with in excess of 18,500 beds. Around half of registered residential care beds in that data were associated with RVs. The services provided by these RVs through their registered residential care is diverse. Only a small proportion, around 15 percent, of the residential care facilities in RVs are confined to a single level of care. Those single level of care RV providers are almost entirely providing rest home care. The largest single category of provision involves what is described in the register as "rest home, geriatric and medical". This is followed by RVs that are providing those three service levels and in addition, dementia level care. That analysis showing the prevalence of RVs in all aspects of residential care provision is consistent with the RV sector's own business intelligence. JLL estimates that in November 2018, 20,100 aged care beds were in RV residential care facilities constituting around 51 percent of aged care beds.<sup>3</sup>

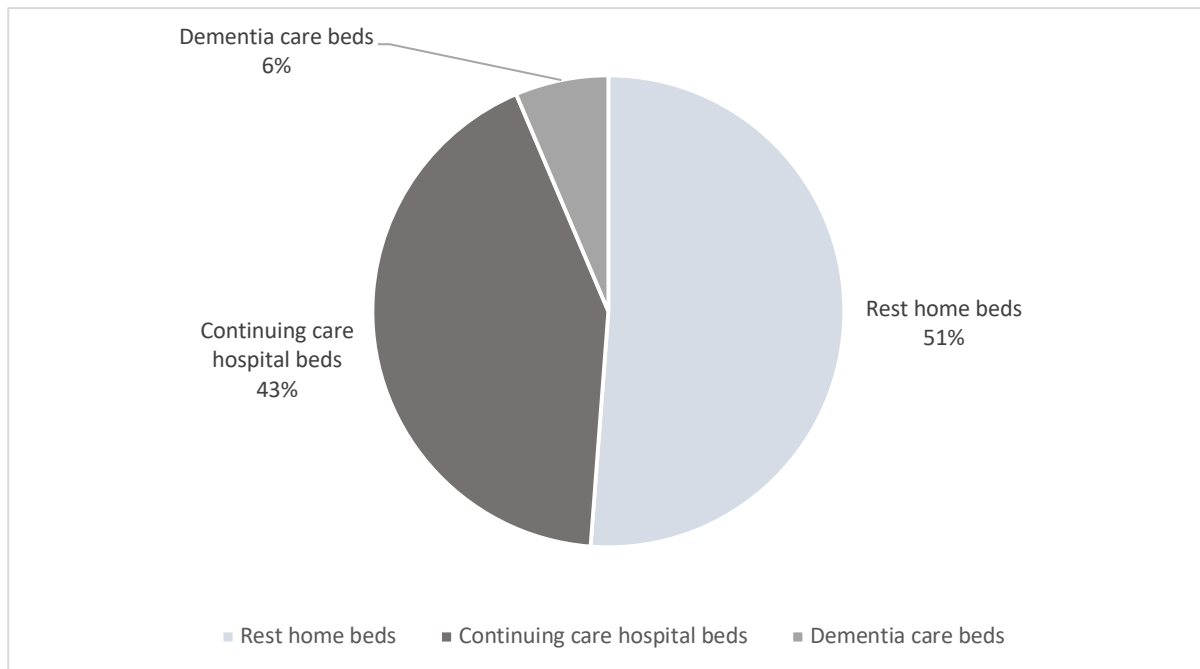
The identified 238 RVs involved in residential care were surveyed in the context of this monitoring project. Around 30 percent of RVs providing residential care participated in the survey. Almost half (47 percent) of those villages were owned and operated by a corporate. One fifth (20 percent) were not-for-profits while the remainder appear to be independents. One of the 70 participating villages reported that they provided rental units within the independent villas and serviced apartments. These 70 retirement villages accounted for 5,742 residential care beds. Figure 1 sets out bed proportions in each care level reported by the survey participants.

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<sup>2</sup> Customised TAS data.

<sup>3</sup> JLL (2019) *New Zealand Retirement Village Database*. New Zealand: Jones Lang LaSalle, p.1

**Figure 1: Proportion of Residential Care Beds Reported by Level by RVs in Retirement Village Survey**



#### **4. OCCUPATION RIGHT AGREEMENTS FOR RESIDENTIAL CARE**

The 2018 ANZ survey identified that “developing a care proposition under an ORA structure” was one of the three top priorities for operators.<sup>4</sup> Earlier commentary by Deutsche Bank on the New Zealand aged care sector also highlighted expected growth in the provision of care with ORAs as a way of operators increasing return on investment. They suggested that, in future, 30 percent of new beds would be provided with an ORA.<sup>5</sup>

We have explored the use of ORAs for residential care through both the survey of retirement villages and through Technical Advisory Services (TAS) data from Aged Residential Care (ARC) Health of Older People (HOP) quarterly bed survey. According to the TAS data 8.1 percent of residential care is accessed through ORAs at 31 March 2019. All ORAs for residential care are, by definition, within RVs. This means that around 16-17 percent of RV residential care beds are accessed by way of ORAs.

Almost a third of the 70 retirement villages participating in the survey used ORAs in association with some residential care. But the number of residents in ORA-purchased residential care is only 576. Three of the 70 retirement villages participating in the retirement village survey reported that they saw a future of heavy reliance on ORAs although 13 reported that they intended to provide only premium rooms in the future. However, 40 of 70 retirement village survey participants reported a future in which they envisaged providing residential care through ORAs mixed with traditional accommodation charges.

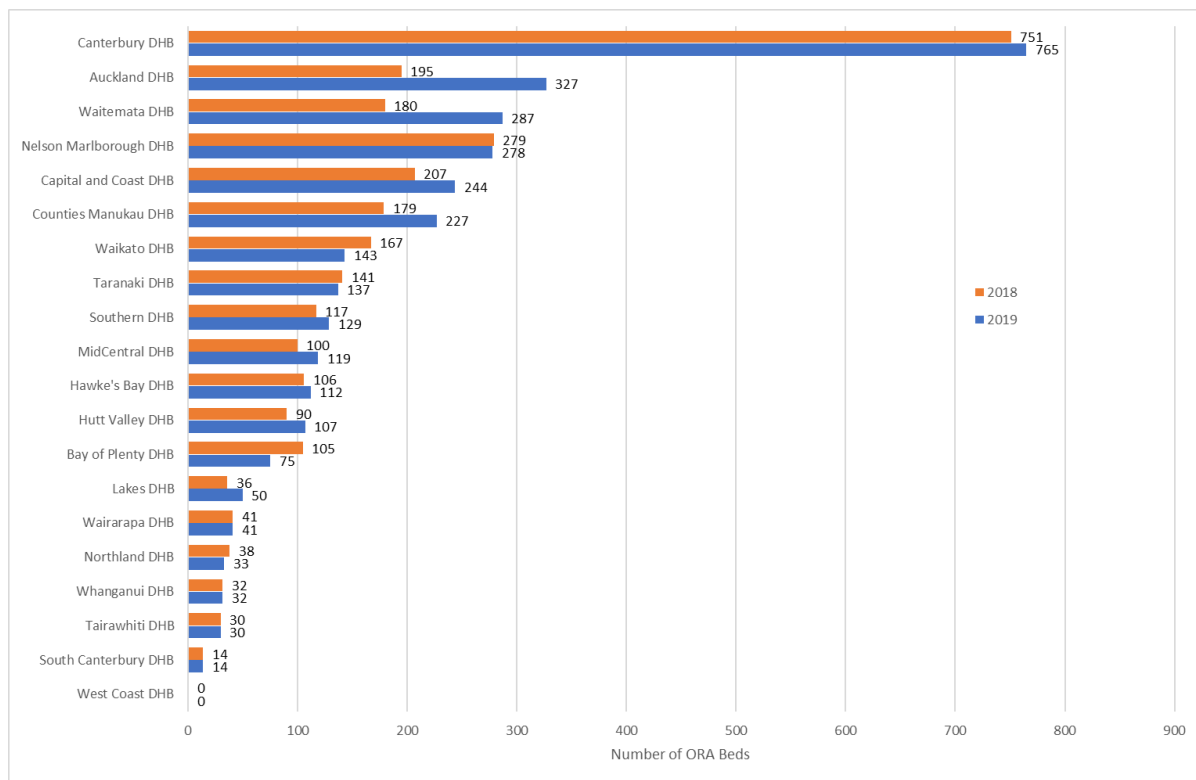
<sup>4</sup> ANZ Healthcare (2018) *ANZ Retirement Villages Association Survey Report*. New Zealand: ANZ, p. 1.

<sup>5</sup> S. Ridgewell and J. Dale (2015) *NZ Aged Care Sector*. Sydney: Deutsche Bank AG and Craigs Investment Partners Ltd, p.1.

The increase in ORA use is evident in the TAS data. The number of ORAs for care has gradually risen since 2014. At 31 March 2019, there were 3,150 beds with ORAs. In comparison, there were 2,808 ORA beds at 31 March 2018, an increase of 342 beds. In March 2014 there were 2,184 ORA beds. At 31 March 2019, 8.1 percent of total aged care beds were ORA beds, compared to 6.9 percent of aged care beds in March 2014.<sup>6</sup>

From 2018 to 2019, half of the DHB regions experienced an increase in ORA beds (Figure 2). The largest increase was in Auckland DHB (132 ORA beds), followed by Waitemata (107 ORA beds). Five regions had a drop in the number of ORA beds, with Bay of Plenty DHB experiencing the largest decrease in ORA beds, at 32. The number of ORA beds remained the same in five regions.

**Figure 2: Number of ORA Beds in DHB Regions (2018, 2019) (TAS data)**



There is considerable regional variation in proportions and numbers of ORA beds (Table 1).

<sup>6</sup> NZACA *Aged Residential Care Industry Profile 2017-2018*; customised TAS data from Aged Residential Care (ARC) Health of Older People (HOP) quarterly bed survey.

**Table 1: Numbers and Proportions of ORA Beds provided in DHB Regions (2019) (TAS data)**

District Health Board	ORA Bed	Total beds	% Residential Care Beds
Auckland DHB	327	3994	8.2%
Bay of Plenty DHB	75	2029	3.7%
Canterbury DHB	765	5636	13.6%
Capital and Coast DHB	244	2146	11.4%
Counties Manukau DHB	227	2767	8.2%
Hawke's Bay DHB	112	1464	7.7%
Hutt Valley DHB	107	1199	8.9%
Lakes DHB	50	856	5.8%
Mid Central DHB	119	1867	6.4%
Nelson Marlborough DHB	278	1573	17.7%
Northland DHB	33	1312	2.5%
South Canterbury DHB	14	612	2.3%
Southern DHB	129	3288	3.9%
Tairāwhiti DHB	30	403	7.4%
Taranaki DHB	137	1392	9.8%
Waikato DHB	143	3304	4.3%
Wairarapa DHB	41	544	7.5%
Waitemata DHB	287	3848	7.5%
West Coast DHB	0	255	0.0%
Whanganui DHB	32	609	5.3%
<b>Total</b>	<b>3150</b>	<b>39098</b>	<b>8.1%</b>

At 31 March 2019, the highest proportion of ORA beds was in Nelson-Marlborough DHB at 17.7 percent of total aged care beds in that region. This was followed by 13.6 percent in Canterbury DHB. The lowest proportions of ORA beds were in Northland (2.5 percent), South Canterbury (2.3 percent) and West Coast (0.0 percent). At 31 March 2019, the highest number of ORA beds, 765, was in Canterbury DHB, followed by 327 in Auckland DHB. In contrast, West Coast DHB had no ORA beds.

According to TAS data, ORAs for care are mainly associated with rest home level care. At 31 March 2019, 68 percent of ORA beds (2,151) were certified for only rest home care, and 32 percent of ORA beds (999) were certified for both rest home and hospital level care (Table 2). No ORA beds were certified for only hospital level care. Three DHB regions only offered ORA beds at rest home level. These were South Canterbury DHB, Tairāwhiti DHB and Whanganui DHB.

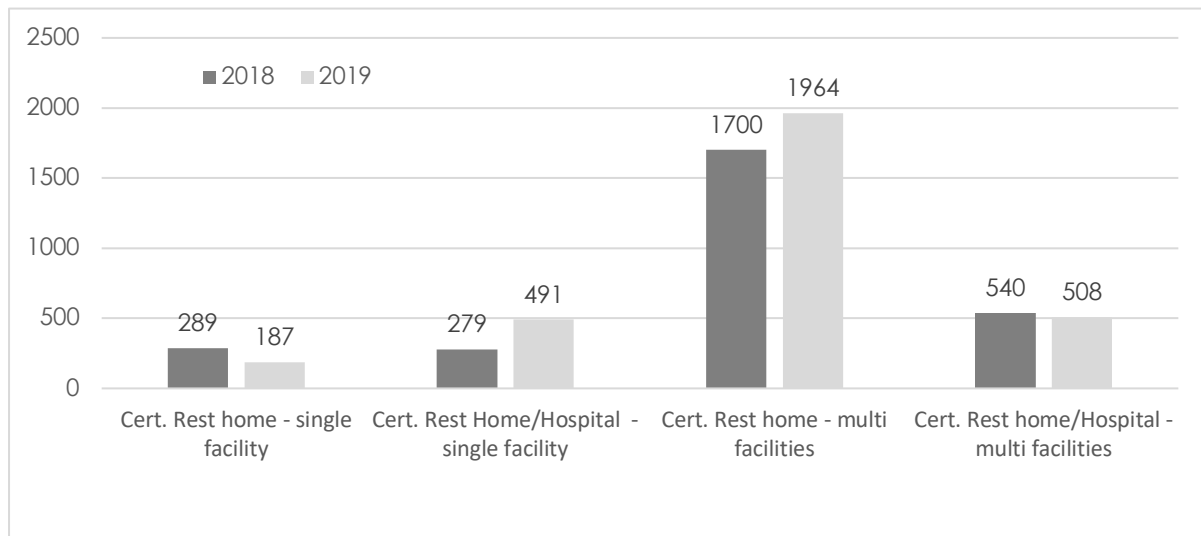
**Table 2: Number of ORA Beds by Type in DHB Regions (31 March 2019) (TAS data)**

District Health Board	ORA Rest home/hospital	ORA Hospital only	ORA Rest Home only	Total
Auckland DHB	153	0	174	327
Bay of Plenty DHB	25	0	50	75
Canterbury DHB	246	0	519	765
Capital and Coast DHB	48	0	196	244
Counties Manukau DHB	48	0	179	227
Hawke's Bay DHB	20	0	92	112
Hutt Valley DHB	17	0	90	107
Lakes DHB	16	0	34	50
MidCentral DHB	94	0	25	119
Nelson Marlborough DHB	53	0	225	278
Northland DHB	3	0	30	33
South Canterbury DHB	0	0	14	14
Southern DHB	12	0	117	129
Tairāwhiti DHB	0	0	30	30
Taranaki DHB	47	0	90	137
Waikato DHB	33	0	110	143
Wairarapa DHB	12	0	29	41
Waitemata DHB	172	0	115	287
West Coast DHB	0	0	0	0
Whanganui DHB	0	0	32	32
<b>Total</b>	<b>999</b>	<b>0</b>	<b>2151</b>	<b>3150</b>

We have already noted in Section 3 two recent, slightly different but consistent, estimates of the number of beds delivered by RVs in the aged residential care sector. Our estimate based on Ministry of Health data accessed in August 2018 is around 18,500 beds. JLL estimated 20,100 beds as of November 2018. Those estimates and the TAS data suggest that 16-17 percent of RV associated residential beds are under ORAs. This penetration rate is lower than that speculated upon by Deutsche Bank but can be expected to increase.

ORA beds are more likely to be found among providers that operate multiple facilities. This includes both for-profit and not-for-profit operators. Figure 3 shows that between 2018 and 2019, the mix of ORA beds certified for both rest home and hospital care and ORA beds certified for rest home only care has changed. Providers that operate multiple facilities have increased the number of ORA beds certified for rest home only care, and slightly reduced the number of ORA beds certified for both rest home and hospital care. The opposite has occurred in single facilities, where the numbers of ORA beds certified for both rest home and hospital care have increased.

**Figure 3: ORA Beds by Facility of Residential Care in RVs (2018, 2019) (TAS data)**



## 5. PREMIUM AND STANDARD ROOMS

The emergence of ORAs for aged care needs to be understood in the context of the changing mix of care provision and financial arrangements, with residents increasingly paying for accommodation and components of care more generally.

In 2014, five percent of aged care facilities offered only premium rooms for which the resident pays additional charges, whereas by 2018, 18 percent of facilities offered only premium rooms. Many facilities offer a mix of premium rooms and standard rooms. In 2018, 83 percent of facilities offered premium rooms, or a mix of premium and standard rooms. Across all facilities, premium rooms now make up the majority of all rooms, at 51 percent.<sup>7</sup>

That data are consistent with the findings of the retirement village survey. Sixty of the 70 survey participants reported on their provision of standard and premium rooms. Only four villages (6.7 percent of reporting villages) provided only standard residential care rooms. Over a quarter of villages (30 percent of reporting villages) reported only providing premium residential care rooms while 63.3 percent of the 60 villages reported providing both standard and premium residential care rooms.

The retirement village survey and the interviews highlight a great deal of fluidity around charges for rooms. A number of retirement villages reported that they charged premium rooms at standard rates. Of the 56 retirement villages that reported on premium rooms and their charging practices, the majority (34 villages) only used accommodation charges while only two used ORAs with the remaining twenty using both accommodation charges and ORAs. The number of residents reported by the retirement villages participating in the survey as accessing premium rooms by way of accommodation charges is 1,396. By contrast, 576 residents were described as accessing their premium room by way of an ORA.

<sup>7</sup> NZACA *Aged Residential Care Industry Profile 2017-2018*, pp.30-31.



Fifty-eight villages in the retirement village survey commented on their future intentions around premium and standard rooms. Around three-quarters (74.1 percent) of those villages reported that they intended to provide a mix of standard and premium rooms. Only two villages reported that they intended to provide only standard rooms while thirteen villages reported that they intended only the provision of premium rooms in the future.

## **6. NAVIGATING THE RV-RESIDENTIAL CARE INTERFACE**

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This section explores the ability of RV residents to navigate the interface between RVs and residential care. The CFFC is concerned with the adequacy of the RV's current legislative framework and the ability of residents with ORAs to navigate the interface between RV and residential care.

The discussion starts by setting out the legislative framework that governs the interface and provides a legal review of the key documents. That discussion is followed by data from the lawyers' survey, interviews, and the survey of retirement villages focusing on the ability of residents to navigate the interface.

### **6.1 Legal Review of the Interface**

The interface between RVs and residential care is regulated through two separate legal frameworks:

- Retirement Villages are governed by:
  - The Retirement Villages Act 2003, and the Regulations and Code of Practice it provides for; and
  - The Occupation Right Agreement with the resident.
- Residential care is governed by the:
  - Residential Care and Disability Support Services Act 2018 (in force from 26 November 2018, and replacing the Social Security Act 1964);
  - Health and Disability Services (Safety) Act 2001;
  - Health and Disability Services Standards (NZS 8134:2008)
  - Health and Disability Commissioner Act 1994 (and the Code of Health and Disability Services Consumers' Rights)
  - Age-Related Residential Care Services Agreements: contract between the provider of residential services and the District Health Board
  - Admission Agreement between the provider and resident.

#### *RV Act*

The RV Act is concerned primarily with protecting the financial and occupation rights of residents who have invested capital in the RV to acquire a home (and intending residents who are considering do so). The protection of residents has been a longstanding preoccupation, even when RVs operated under the Securities Act 1978. It was in 1999 that the Law Commission recommended separate legislation to provide RV residents with protection as *consumers, residents and investors*.

In addition to the definition of retirement villages in the RV Act there is specific reference to “rest home and hospital care institutions” (section 6(3)). A residential unit within a residential care facility may be captured by the definition of a retirement village, but in that case limits the retirement village to those particular residential units and the common areas available to residents under their ORA.

It is this reference to the ORA that has an impact when an individual seeks to access residential care through an ORA compared to when an individual accesses residential care within a RV under periodic, non-ORA instruments. Notably the Justice and Electoral Committee, when reporting on the proposed RV bill in May 2003, commented on the potential for confusion around residential care provision within RVs.<sup>8</sup> They argued that the definition of “retirement village” needed to be of “maximum inclusivity”, with the grounds for inclusion focusing on the financial arrangements and investment issues associated with residency, but that those “arrangements, or a lack of clarity about how they work in effect, potentially represent the most risk to residents.”

The Justice and Electoral Committee anticipated a complex interface between RVs and residential care and, indeed, the development of ORAs for residential care. The Committee’s report states:

“If a residential or hospital care facility in the village is occupied under the ordinary weekly fee system, it should remain excluded from the definition as the resident has no financial investment in the unit and his or her right to receive appropriate care services is protected under the Health and Disability Services (Safety) Act 2001. In the event that the resident has made a capital contribution to a residential care unit or hospital care facility within a village, that Act will continue to apply in respect of the services but the financial protections under the Retirement Villages Bill will apply to the resident’s occupancy interest.”<sup>9</sup>

The only other specific reference to residential care made under the RV Act is a requirement under section 31(1) of the Retirement Villages (General) Regulations 2006 for a village’s Disclosure Statement to include the following information:

“If a retirement village shares premises with a rest home or hospital care institution, a disclosure statement for an occupation right agreement relating to the village must include:

- (a) A statement indicating whether the agreement also allows the resident to leave the residential unit and receive either rest home care in the rest home or hospital care in the rest home or hospital care in the hospital care institution; and
- (b) If the agreement allows that, an explanation of the terms on which that is allowed.”

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<sup>8</sup> Justice and Electoral Committee Commentary on the Retirement Villages Bill. Retrieved from: [https://www.parliament.nz/resource/en-NZ/47DBSCH\\_SCR2432\\_1/a383d459bad81d65c70323d8e2fa34be0208b1a9](https://www.parliament.nz/resource/en-NZ/47DBSCH_SCR2432_1/a383d459bad81d65c70323d8e2fa34be0208b1a9)

<sup>9</sup> Justice and Electoral Committee Commentary on the Retirement Villages Bill, p.3.

It is notable that the RV Act imposes no specific obligations to provide information about residential care services on offer under the ORA itself other than the same general obligation for an ORA to include information, including within the Disclosure Statement, about services and facilities, the associated charges and the basis for charging, frequency and extent of access to prescribed services.

The specific services for which the prescribed information must be provided in the Disclosure Statement are set out in s19(3) of the Retirement Villages (General) Regulations 2006 and include: gardening, lawn mowing, repair & maintenance, nursing and medical services, provision of meals, shops and other services for the provision of goods, laundry services, hairdressing and other personal care services, transport, recreation and entertainment, security services, other services. *Information about residential care services, which incorporate many of the specified services, is not specifically required to be detailed in the ORA or the Disclosure Statement.* This appears to be the case even where an individual has purchased an ORA specifically directed to them accessing residential care.

The complaints processes under the RV Act applies to those elements of service provision, including so-called 'care packages' provided by some RVs to people outside of the regulated residential care system. Complaints related to residential care specified by various health legislation are covered by the legislated complaints processes applying to the health and disability sectors in general and the residential care sector in particular. Residential care services are health and disability services to which the Code of Health and Disability Services Consumers' Rights applies. Accordingly, section 53 of the RV Act prevents a resident bringing any dispute notice under that Act about residential care services provided by the RV, even if the services are being provided under an ORA specifically for the provision of residential care.

There is no requirement to explain that complaints about those services cannot be dealt with under the RV Act dispute process. Nor is there any requirement to provide information about the other avenues available for a residential care service complaint, that is, via the Office of the Health and Disability Commissioner, or the District Health Board if the RV has an Age-Related Residential Care Services Agreement with the DHB.

#### *Residential Care Services*

RVs delivering residential care are subject to the Health and Disability Services (Safety) Act (H&DSS) 2001 including compliance with applicable regulations and standards approved by the Minister of Health under section 13. Those currently comprise of:

- Health and Disability Services (General) Standard, NZS 8134.0:2008
- Health and Disability Services (Core) Standards, NZS 8134.1:2008
- Health and Disability Services (Restraint Minimisation and Safe Practice) Standards, NZS 8134.2:2008
- Health and Disability Services (Infection Prevention and Control) Standards, NZS 8134.3:2008

An RV providing residential care will, then, be subject to the same standards, certification and audit obligations under H&DSS as any other residential care provider, but only in relation to the rooms/facilities providing residential care. The results of certification and other audits of providers of aged residential care against the H&DSS are available on the Ministry of Health's website.

Protections for RV residents in residential care are also found within the Health and Disability Commissioner Act which is intended (Section 6) to promote and protect the rights of health consumers and disability services consumers and facilitate the resolution of complaints around infringements of those rights. That Act provides for the Code of Health & Disability Services Consumers' Rights and the obligations and duties of providers to comply with the Code.

What is more complex is the array of legislation and conditions surrounding residential care service access and liabilities associated with it. The specification of residential care services, irrespective of whether accessed through an ORA or a periodic payment instrument, is governed by a range of health sector legislation, policy and operational specifications of service. There are a variety of parameters that arise for older people seeking to access residential care including:

- Eligibility for publicly funded care established through needs assessment ('qualifying person');
- Liabilities for individual (defined by asset and income testing) and funder payment of long-term residential care;
- Maxima around the contributions that funders (District Health Boards (DHBs)) are required to pay for contracted provision of long-term residential care to older people assessed with a residential care need; and
- Requirements on DHBs to ensure 'qualifying persons' are not liable to pay more than the maximum contribution towards the cost of contracted care services, regardless of their assets or income.

Those parameters can lead to an array of permutations for any older person in relation to residential care and their cost exposure. Those permutations are further complicated by choices associated with the consumption of standard or premium rooms, whether in a RV or through another residential care provider. In the case of RVs there is also, in some villages, choices regarding an ORA or periodic payment for residential care as well as diversity around the levels of residential care services provided and the sites registered for the provision of those different services. In addition, recipients of care services contracted by a DHB of a provider for a qualifying person may also be charged for services outside the "contracted care services" under the Age-Related Residential Care Services Agreement (ARRCA).

ARRCA is effectively the service specification of residential care at different levels struck between residential care service providers and DHB funders. RVs providing residential care with contracts with a DHB are covered by the ARRCA. The ARRCA is a nationally consistent agreement that is reviewed annually. It requires:

- The provider to provide the relevant category of age-related residential care services to all residents of the facility (clause A1.1a) and confirms that those services are “contracted services” for the purposes of the Social Security Act (now Residential Care and Disability Support Services Act 2018) (clause A1.2);
- The DHB to pay for those services for “subsidised residents” (i.e. those for whom the DHB is liable under the Residential Care and Disability Support Services Act 2018 (clause A1.1.b);
- The provider to be certified by the Director-General under the H&DSS to provide rest home services and hospital services at their facility (clause A1.7.a), and requires compliance with “all relevant” legislation (including a specific list of 12) (clause D1.1), and all approved service standards (clause D1.3) (currently the Health and Disability Services Standards NZS 8134:2008).

It also, as previously noted, allows the provider to charge non-subsidised residents for the contracted services – provided the charge is no more than the maximum contribution (i.e. under the RC&DSS) (clause A1.1.c).

The current version of the ARRCA does anticipate that residential care services may be provided to a resident already in possession of an ORA. In that case, the ARRCA makes specific provision to prevent the provider from ‘double-dipping’ for accommodation service charges. Clause A14 of the ARCCA imposes the following specific obligations on providers of residential care services who are also party to an ORA with the resident:

- For *subsidised residents*, where payments made under the ORA result in the provider “effectively receiving payment, benefit, or value... for the supply of services” the provider must either:
  - Alter the arrangement (the ORA) so that they do not receive any such payment, benefit or value: i.e. the weekly or monthly village fees; or
  - Terminate the arrangement (the ORA).
- For *non-subsidised residents*, the provider is required to pay the resident 18% of the maximum price for rest home services (inclusive of GST) specified in clause C2.1 of the ARRCA (being the maximum contribution under the RC&DSS). The provider may then also charge the resident the charges for accommodation specified in the ORA: i.e. the weekly or monthly village fees.

The movement of RV residents with an existing ORA in residential care, more particularly potential residents not currently living within a RV, can be complicated by the issues of additional charges for premium rooms and other services. While the ARRCA specifically allows the provider to charge all residential care residents for ‘additional services’, there are limits imposed on that power to charge. Clause A13.2.a.to g., states that:

- The provider cannot require, as a condition of admission to or residence in the facility, that a resident or potential resident agree to receive and pay for any additional services (clause A13.2.a);
- The resident is able to decide to cease to receive and pay for any premium room services in accordance with clause A13.5 (clause A13.2.d);

- If a resident chooses to receive additional services (including premium room services), the Admission Agreement must expressly record that the resident acknowledges that they were offered a choice whether or not to receive the additional service, and chose to receive and pay for it (clause A13.2.g).

Under clause A13.3, compliance with the clause 13.2.a, restriction is not required provided that on the date of admission:

- There is not a standard room (or a premium for which premium room services are not charged) available at the provider's facility from which the required category of service can be provided (A13.3.a.i); and
- The occupancy level of rooms at the provider's facility from which the required category of service can be provided is 90% or more (A13.3.a.ii), but excluding rooms certified for aged residential care and under an ORA (A13.4.b); and
- The provider has identified another facility within 10 kilometres of their facility that has a standard room (or premium room for which the premium room services are not charged) available for the required category of care (A13.3.a.iii); and
- The resident decides not to be admitted to that room at the other facility (A13.3.a.iv); and
- The Admission Agreement expressly records (A13.3.b):
  - that the resident has chosen not to take the room at the other facility and instead to accept and pay for the premium room; and
  - the resident's rights and obligations in relation to the premium room services, the charge for that service, and the resident's right to cease to receive and pay for the premium room.

## **6.2 Lawyers' Perspectives**

Under the RV Act lawyers are required to certify that purchasers of an ORA understand the implications of that ORA, the responsibilities, rights and protections for residents and understand the financial and other implications of the ORA in relation to their RV-related financial assets, demands on income and their access to services. Within the context of ORAs for RV's independent living villas and serviced apartments, it has taken some time for lawyers, individuals and the families of prospective residents, and RVs themselves to ensure mutual understanding among all those stakeholders in RV independent living.

The CFFC has, along with consumer groups, operators and the New Zealand Law Society, made considerable efforts to raise understanding of the sector, its products and operations. This is inevitably challenging in what is a dynamic, competitive and innovative industry. The lawyers survey was designed to establish whether lawyers saw the increasing involvement of RVs in residential care as having implications for prospective residents or their own ability to advise prospective residents.

There are two points where this might occur in relation to ORAs:

- One is where a lawyer is advising on an ORA for independent living villas or serviced apartments.

- The other is where a lawyer is advising on an ORA for a client moving directly into residential care.

A lawyer dealing with the latter is doing so under the requirements of the RV Act by virtue of the ORA. The survey sought to explore whether lawyers found RV residential care involvement:

- Increased the complexity around advising on ORAs either for independent living or for residential care or both;
- Presented prospective residents and their families with new challenges of understanding either for independent living or for residential care or both;
- Demanded changes in practice, information provision or the RV Act itself if the protective intent of the RV Act was to be sustained in the context of the use of ORAs in the residential context.

Similar to findings from previous research with lawyers around RV advice,<sup>10</sup> a persistent theme emerged in which prospective residents were seen as either highly engaged in RV selection or passive and disengaged. Lawyers saw clients in both categories as being interested in the opportunities believed to be presented by RVs with residential care facilities. Among disengaged prospective residents, however, lawyers frequently found clients unreceptive to considering details around either the services delivered in residential care or the process of transition from RV independent living to residential care. Consistent with previous research with lawyers about the provision of advice to prospective residents, lawyers continue to report that clients are price sensitive to getting advice. They note that clients often come for advice after making their choice of a preferred RV and can be disinclined to face up to aspects of RVs in general or around the specific RV they have selected.

In the context of RV ORAs for independent living, lawyers typically recognise that the attraction of some RVs are enhanced by provision of residential care. They recognise, as do their clients, that RVs are increasingly presented as a setting in which there is a continuum of independent to supported housing culminating in residential care. That idea of a progressive continuum suggests to some lawyers that residential care should be given attention even when advising on an ORA for independent living. Indeed, the Disclosure Statement is specified as needing to include information about whether the resident can progress to residential care provided in the village and an explanation of the terms on which this is allowed.

However, lawyers noted that their ability to advise on that continuum was limited. The dynamic nature of the industry in general combines with the inevitable changes in

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<sup>10</sup> See K. Saville-Smith, B. James and R. Fraser (2017). *Retirement Village Intending Residents and the Effectiveness of Legal Advice*. Auckland: Commission for Financial Capability; and K. Saville-Smith and B. James (2015) *Retirement Villages: Advice, Information and Education*. Auckland: Commission for Financial Capability.

circumstances experienced in individual villages to make it difficult to advise on issues around residential care (the use of which may never eventuate) in an RV in the future during the process of giving advice on an RV occupation right agreement that is anchored in the present.

Over half of the 82 lawyers participating in the lawyers' survey indicated that they had advised specifically on an ORA for residential care, but some lawyers refuted that existence of ORAs used by RVs with residential care. Others were aware of ORAs being used in RV residential care but reported that they were not used by RVs in their practice area. Nevertheless, many of the lawyers were involved in dealing with residential care either in relation to a client:

- moving into independent living in a RV; or
- moving from independent living in a RV to residential care; or
- moving into residential care.

There were a group of lawyers who either admitted confusion, or it was evident from their responses that they were confused about the nature, conditions and dynamics associated with residential care funding, access and operations. They considered the processes of access to residential care, whether in a RV or not, as too complex and difficult for older people and, often, their families.

Lawyers reported that it could be difficult to discuss with prospective purchasers of independent living ORAs the transition processes from independent living to residential care within a RV when these could change or were not clear at the time of the original entry to an RV. It was noted that transition processes from independent living and residential care within a RV could vary over time and were often not well documented. Indeed, some lawyers expressed a view that transitions to residential care were outside the scope of their role. That position is consistent with previous findings in CFFC monitoring projects that lawyers tended not to advise on health service availability, conditions of access and costs when advising on RV ORAs for independent and serviced apartment living.

Nevertheless, some lawyers did express a desire for better information and improved clarity around aspects of the residential care provision. This was particularly the case where a client was seeking advice on:

- An ORA for an independent villa or serviced apartment where transition into residential care appeared to be likely in the short- to medium- term rather than in the long term;
- An ORA specifically for residential care.

Among the information needs raised by lawyers in that context were:

- Clarity around standard and premium room availability and costs in relation to the residential care subsidy.
- Information around probabilities of getting a bed in the residential care facility or a certified residential care bed in the context of a transition from non-residential care in the RV.



- The incidence of RV residents who, on needing residential care bed, needed to leave the specific retirement village they are considering as an independent resident in independent villas or serviced apartments.
- Information about the quality of residential care services or health-related complaints associated with the residential care in a specific RV or operator.
- Information about the geography and configuration of the village which would allow clients to be aware of such aspects of care as staff response times.
- Exposure to multiple deferred maintenance fees associated with ORAs where there was the likelihood of multiple transitions.

There must be some concern about the ability of some lawyers to deal with the more complex advice associated with ORAs for residential care when persistent themes in the responses of the lawyers in the survey were that:

- Even ORAs for independent living are often too complex and generic and there is a need for a plain language ORA.
- Disclosure statements for ORAs specifically for residential care are loaded with details about services for independent living residents for which the client is likely to have only limited interest and use.
- Clients need a comparison tool to assist them to make better selection choices, not simply better understand the contractual conditions of the selected RV both in relation to independent living and the conditions around future residential care.

Of most concern must be those lawyers who report that they merely advised their clients to read the Village Rules and Disclosure Statements and did not advise directly on those or other documents.

### **6.3 The Key Interviews**

A total of 18 interviews were conducted with 26 people. Organisations participating in the interviews included the Retirement Villages Association, New Zealand Aged Care Association, Retirement Village Residents Association, Seniorline, Ministry of Housing and Urban Development, Office of the Ombudsman, Ministry of Health, Ministry of Social Development, Office for Seniors, Department of Internal Affairs, Statistics New Zealand, DHBs, and Age Concern. Interviews were also conducted with a small number of retirement village operators, solicitors and statutory supervisors.

The key issues emerging from the interviews highlight two broad areas:

- Implications of RV involvement, including but not only the use of ORAs for residential care, for older people's access to aged residential care and the provision of government financial assistance to older people.
- Issues concerning the practices and processes around the ORA for care model.

In this section we focus on the latter. We discuss the former in section 7. While addressing the former there are set of issues that are not within the purview of the CFFC's responsibilities under the RV Act. Nevertheless, in our view they fall within the CFFC's wider responsibilities concerning financial education and capability and retirement income

policy. In addition, the policy interface between practices and implications of the ORA for care model and other sectors may require the CFFC to be involved with other government agencies in examining the extent to which those practices are resulting in unintended consequences for other policy and funding settings.

Questions around the operation of the ORAs for care as well as for ORAs where prospective residents believe they have the prospect of entering residential care associated with that village, identified three areas of concern:

- A lack of common terminology regarding the ORA for care, which has the potential to generate confusion about the service being offered.
- A lack of knowledge and understanding of the ORA for care model and the associated need for appropriate and effective disclosure for both prospective residents in RVs seeking independent villas and serviced apartments as well as those who might take up residential care through an ORA either directly or through transition within an RV.
- Potential inconsistencies or conflicts between the ORA contract and the Admission Agreement that may confuse the extent or jeopardise residents' protections.

#### *Lack of common terminology*

Examples of terms used to describe an ORA for care include: care suite, assisted living suite and care apartment. There is no standardised term to consistently refer to the same product. This lack of consistent terminology contributes to confusion about the ORA for care model associated with certified residential care.

Further confusion is added by the use of the terms 'care package' or 'lifestyle care package' by some retirement villages for additional services that are not part of certified residential care. It is almost axiomatic that these terms will suggest provision of care services to older people and their supporters, although these terms do not mean that the bed/unit is certified by the Ministry of Health for the delivery of aged residential care. While some care packages may be delivered in conjunction with rest home level care, generally the term care package refers to a basket of goods and services that can be purchased from the operator for an additional fee. Packages may include items such as all meals, 24-hour nurse call monitoring, medication management, housekeeping and personal care assistance. For those RVs that use those terms in the context of independent living or serviced apartments, there is high risk that residents will be further confused around the RV-residential care interface. In our view it is the responsibility of RVs to make very clear to prospective residents in independent living and serviced apartments where the boundary lies between their residential care provision and the provision of additional services.

#### *Lack of knowledge and understanding of the ORA for care model*

Both prospective residents to independent villas and serviced apartments and those directly seeking residential care need to understand whether a RV offers an ORA for residential care or not and the implications of an ORA for residential care. Interviewees pointed out that while the ORA for care model has been used for several years by some operators, it is not

widespread. Consequently, there is little familiarity with the model among village residents, prospective residents and families.

Adding to a lack of familiarity with the ORA for care model, is some remaining confusion about the ORA concept, despite increased public understanding of the use of ORAs in retirement villages. Confusion about this type of tenure adds to misunderstanding about the ORA for care model as well as exacerbating existing confusion around entry to residential care generally from RV independent living. The purchase of an ORA for the purpose of accessing residential care services adds another dimension to understanding the variety of care options now available in villages and aged residential care facilities, and the different conditions and requirements under which they are offered.

Almost all interviewees emphasised the need for clear disclosure to prospective residents and their families about both the conditions of future access to residential care for those purchasing ORAs for independent villas and serviced apartments as well as for any ORA for care model. There needs to be particularly careful explanation of the ORA for care to those who have not purchased an ORA before, when they move directly to residential care from living in the general community. In a situation where admission to care is urgent, particular attention is needed to explain the model to the prospective resident and their family. The use of ORA for higher care levels, including dementia care, suggests it is crucial to include the prospective resident's enduring power of attorney in discussions.

The complexity of what is offered through the ORA for care model reinforces the need for clear and careful disclosure to avoid misunderstanding and confusion. Various aspects of the model are complex and a selection identified in the interviews is noted here:

- The resident signs two contracts, the ORA contract, and the Admission Agreement for residential care. These two contracts set out the different rights and responsibilities of operator and resident respectively, and different requirements. The resident must obtain legal advice about the ORA contract and the legal advisor must certify that the contract has been fully explained to the resident. Moreover, the resident has a 'cooling off' period of 15 working days where they can decide not to take-up the ORA. In contrast, it is not mandatory to obtain legal advice about the Admission Agreement, and it must be signed within 48 hours.
- The ORA is paid for as a capital sum and gives the resident the right to occupy the physical space in which the care services are provided. Included in the ORA is a deferred management fee, which is paid when the ORA is terminated.
- In addition to the ORA, daily fees are charged for residential care services that the operator is contracted by the DHB to provide. These include accommodation, food, laundry, nursing care and other services.
- The operator can make additional charges for goods and services that are not covered in the daily residential care fees. These additional charges should be detailed in the Admission Agreement.
- The operator can charge a weekly retirement village fee in conjunction with the ORA. Information about this should be detailed in the ORA.

- The operator must ensure that the resident is not charged twice for the same set of services, for example, accommodation services that are covered by the ORA and under the Admission Agreement (daily fees). A resident who has an ORA for care is entitled to receive a refund on the accommodation component of their care, because accommodation is provided through the ORA. This refund is to avoid double payment of accommodation costs. The refund is 18 percent of the gazetted Maximum Contribution rate that the resident may be required to pay, and this amount varies across territorial authority areas. Maximum Contribution rates are adjusted annually, with occasional ad hoc adjustments, so these calculations can be complex.<sup>11</sup> It is up to the operator as to how the refund is paid to the resident. Some operators pay the refund annually, while others pay it as part of final exit arrangements.<sup>12</sup>
- The resident with an ORA for care may be eligible for a residential care subsidy or residential care loan (funded through vote Health) to help with the cost of fees. The subsidy and loan are not available for the purchase of an ORA. Some prospective residents and their families may not be aware of the subsidy. The existence of the subsidy, and how the ORA is treated in the assessment of income and assets for a subsidy must be clearly explained to the prospective resident, including the different implications for the assets of single people and couples. The impacts of receiving the subsidy on the resident's payment of fees to the operator also need to be clearly explained.
- The closure or downsizing of a residential care facility has caused difficulties for residents, as evidenced by the Merivale retirement village construction of a new care facility.<sup>13</sup> Guidelines to ensure a consistent approach by operators, applicable to all residents, whether subsidised, paying privately or with an ORA for care, are expected in July 2019. This information will be essential to include in disclosure to prospective residents.

There is no consistent practice around the point at which disclosure about care options should be provided to prospective residents. A common view among interviewees was that information should be given to prospective residents and their families about aged care options and pathways available to village residents, as part of disclosure required for ORAs associated with independent living. While some operators appear to provide information about care and the transition to care at that early stage, it is not apparent whether this practice is widespread.

For a resident who is transitioning from an ORA for an independent living unit in a village to an ORA for care, the transition process needs to be explained. For example:

- The sale of the independent-living ORA and the purchase of the ORA for care.
- Whether the resident has priority over non-residents for transfer to residential care.

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<sup>11</sup> <https://www.health.govt.nz/our-work/life-stages/health-older-people/long-term-residential-care/maximum-contribution>

<sup>12</sup> Code of Practice Residential Care and Occupation Right Agreement. This is a code of practice agreed between the NZACA and RVA.

<sup>13</sup> <https://www.stuff.co.nz/the-press/news/110666300/this-is-the-last-straw--chch-rest-home-residents-given-six-weeks-to-find-new-place>

- What happens to the ORA for care on the transition to a higher level of care.

#### *Inconsistencies between ORAs and Admission Agreements*

Interviewees suggested a number of inconsistencies or potential conflict between the ORA contract and the Admission Agreement. These include:

- Complaints processes differ for the ORA and for aged residential care services. Aged residential care services are defined as health and disability services under the Health and Disability Commissioner Act 1994. The Retirement Villages Act explicitly prevents retirement village residents taking a dispute about a health and disability service. This includes residents with an ORA specifically for the purpose of providing care. If the resident wishes to make a complaint about their care (for example about the standard of care), then they must make it to the DHB or Health and Disability Commissioner. The Admission Agreement should provide information to the resident about how to make a complaint about their care, however there is no requirement in disclosure about an ORA for care to explain the avenues for complaint with regards to care. Clarifying the processes for different complaints in both the ORA and the Admission Agreement would help to avoid confusion.
- The notice periods for termination of the ORA and the Admission Agreement differ. The notice period for termination of the Admission Agreement is 21 days. Timeframes and grounds of termination of an ORA by either the resident or the operator must be specified in the ORA agreement. These can differ from village to village, but generally the resident must give one month's notice of termination. The operator may terminate the ORA on medical grounds, default or damage. The ORA would also specify the termination process on the death of the resident.
- Under the Admission Agreement the resident can transfer to another residential care facility, including in another DHB area.<sup>14</sup> It is not clear what would happen if a resident wished to move and continue to have an ORA for care in a different location.

#### **6.4 Retirement Village Survey**

The dynamic nature of the RV sector and its products in general and, in particular, new ways of delivering the interface between RVs and residential care delivered by RVs are not trivial issues. Nor do they affect a minority of older people on the margins.

In this discussion we highlight three factors that emerge from the retirement villages survey that make people vulnerable when navigating the RV-residential care interface. They are the:

- Age profile of the people attempting to navigate the interface;
- Lack of experience of many older people seeking residence residential care in a RV residential care facility; and
- Fluidity in the labelling of service packages in the RV independent living context.

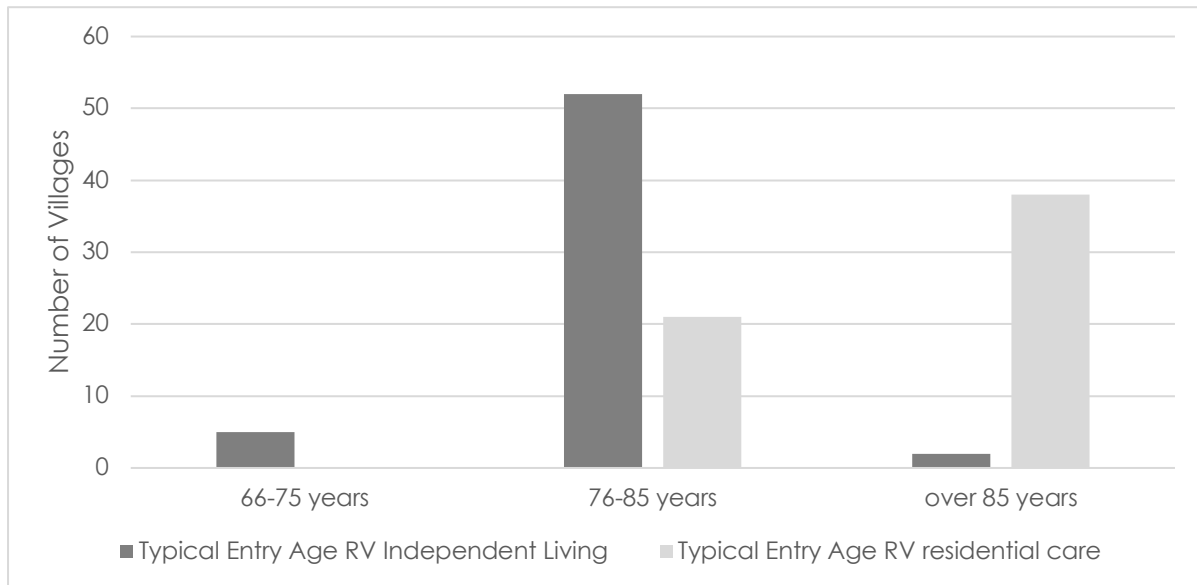
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<sup>14</sup> <https://www.govt.nz/browse/health/residential-care/moving-in-rest-home/transfer-rest-home/>

### Age profiles of people seeking RV residence and RV residential care

Fifty-nine participants in the retirement villages survey reported on the age profile of residents. As Figure 4 shows, the typical age of residents into the independent villas or serviced apartments is significantly younger than the typical age of people coming to the RV specifically for residential care or shifting from RV independent living to RV residential care.

**Figure 4: Age of residents at entry to RV living and residential care**



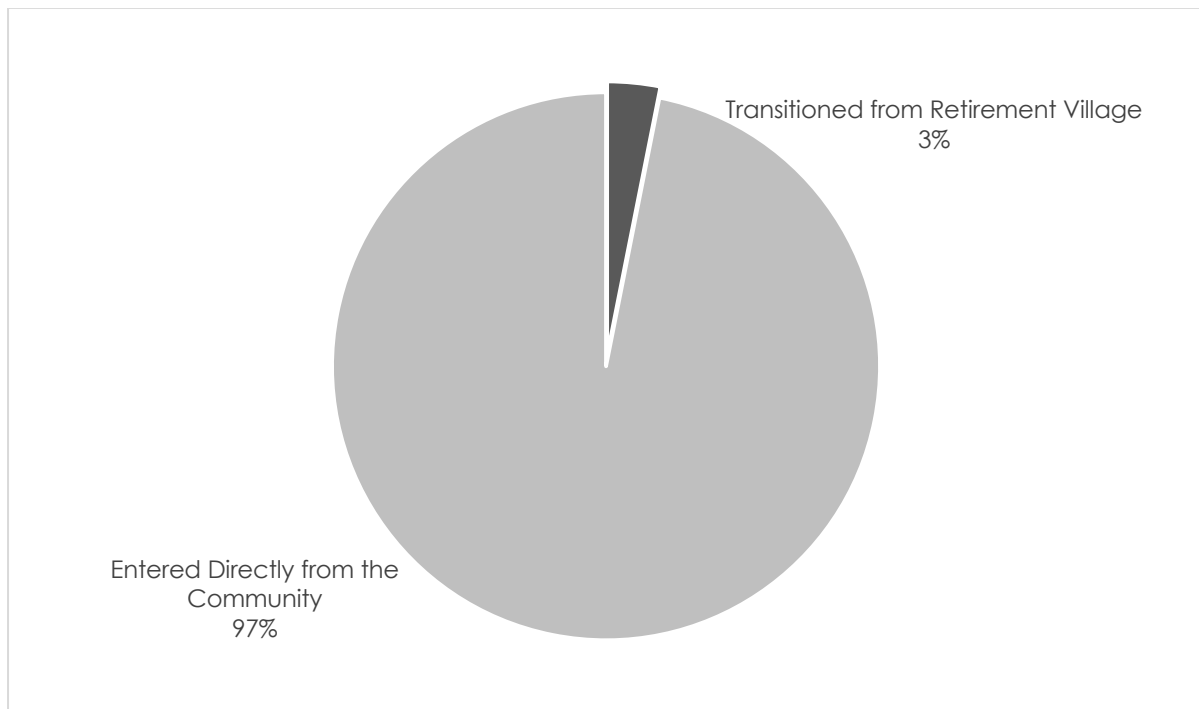
### RV experience of people entering RV residential care

The RV sector involved in residential care promotes RVs as a relatively seamless pathway through a continuum of independent housing, housing with a flexible array of additional services including serviced apartments and then transition into residential care at a variety of different levels. Some RVs with residential care have certified accommodation at a range of different residential care levels. This includes some dwellings, particularly serviced apartments, that may be used for independent living.

It might be assumed from the way in which RVs with residential care have positioned themselves that the majority of entrants into RV residential care were from the village or, at least, from another retirement village. If that was the case, a higher level of understanding and experience among prospective residents and their families of both the nature of village life and instruments such as ORAs might be assumed. On the other hand, the dominance of RVs in the provision of aged care beds suggest that many of those moving into residential care will have come from market housing rather than housing within retirement villages. In that situation, it is less likely that the intending resident will be familiar with the ORA as an instrument.

The retirement village survey asked villages to estimate the proportion of their residential care residents coming from different origins prior to entry to residential care. Forty villages responded. In general residents entering RV residential care are not familiar with RVs. Only 3 percent of retirement villages disclosing this data reported that the majority of their residents came from an RV. The vast majority of villages reported that the majority of residents came from living in the community either in owner occupied or rental housing.

**Figure 5: Origin of residential care residents**

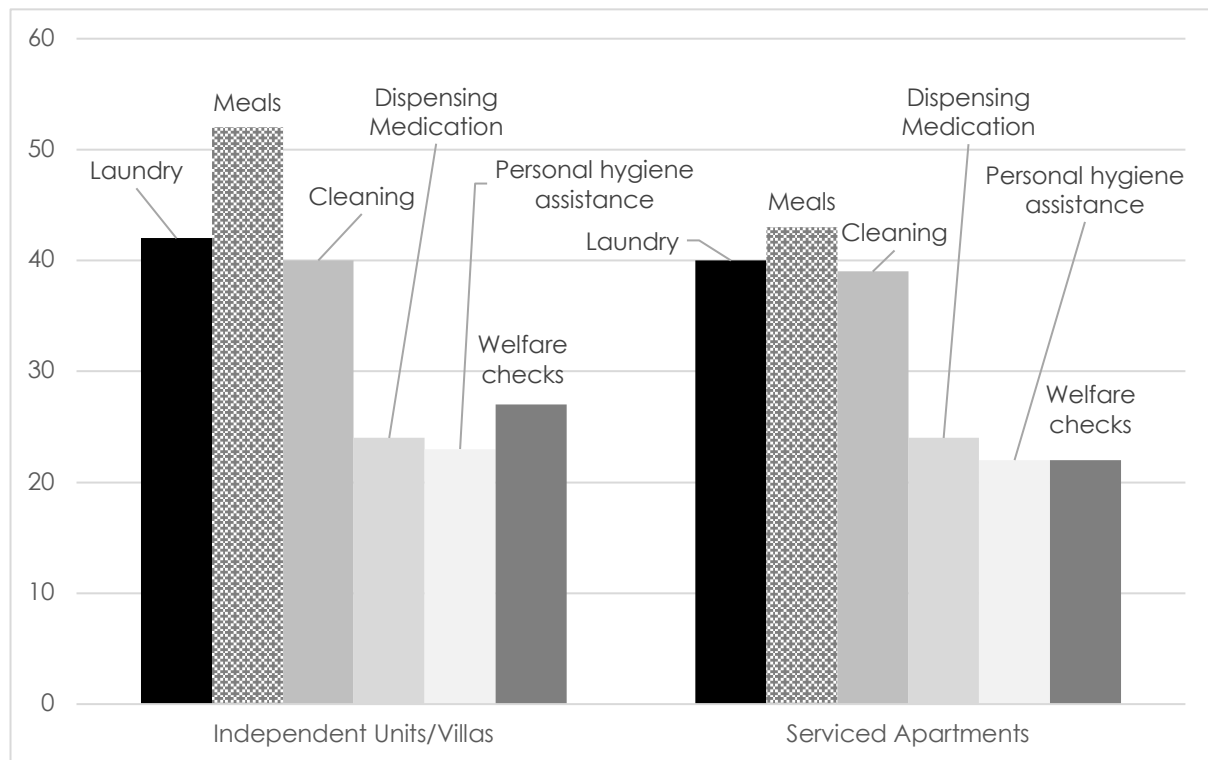


#### *Terminology, Clarity and Understanding*

RVs provide residents with ORAs for independent villas and serviced apartments. There are a range of core services associated with each situation. There are also typically a range of additional services that residents can purchase. Over three quarters (76 percent) of those villages reported providing opportunities for residents to compile a set of 'pick and mix' services through a purchase process.

Figure 6 presents those additionally purchased services reported by villages participating in the retirement village survey. In addition, a smattering of RVs report providing other purchased services, among which are transport, pet care, shopping, hairdressing, emergency pendants, gardening and handyman services, and wound care.

**Figure 6: Types of additionally purchased services**

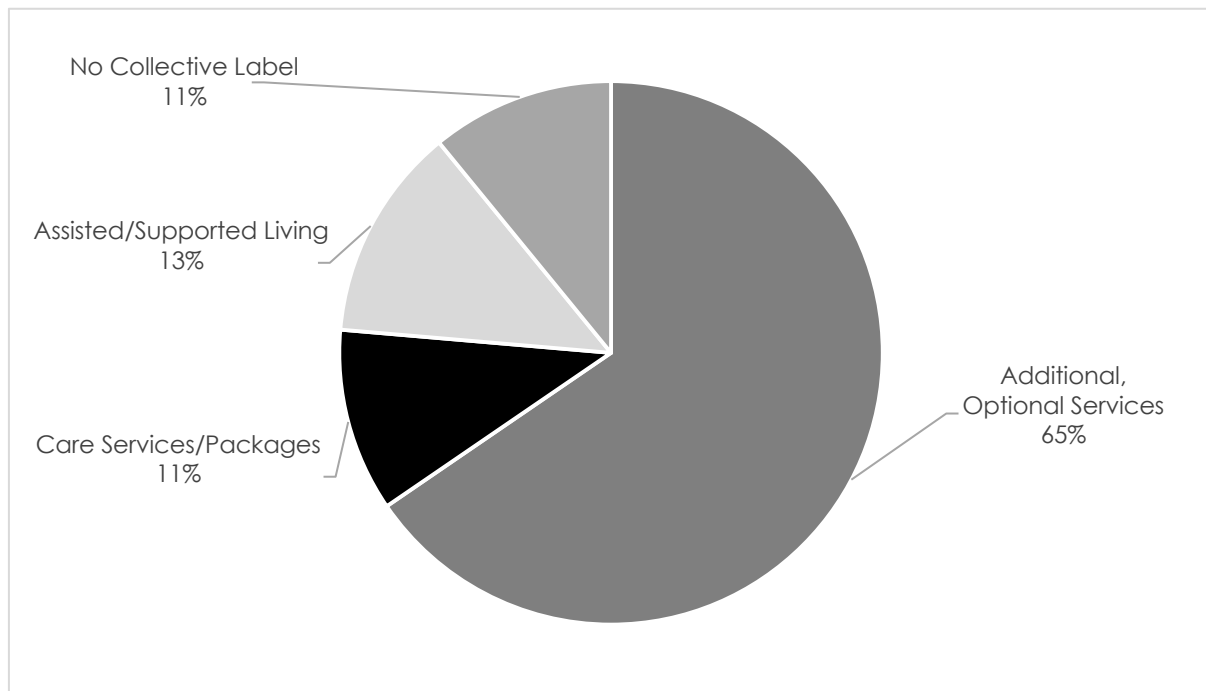


These purchased services provided outside the ORA are delivered within the context of the continuum of services that RVs promote as part of the RV product. Some RVs keep their nomenclature for these simple and direct, using terms such as add-on services, additional services, optional services or service packages. Some do not refer to these with any collective terminology. As Figure 7 shows, villages using simple terms or no term make up around three quarters of the RVs reporting on these packages in the retirement village survey.

Figure 7, however, also shows that almost a quarter of reporting RVs use terms such as care packages, assisted living or support services or supported living. In a context of navigating the complexities of the aged care sector for both in-home and residential care funding and provision, the use of the latter terminologies can present fertile grounds for confusion and misunderstanding.



**Figure 7: Nomenclature used for additional services**



## 7. SUMMARY OF FINDINGS AND CONCLUSIONS

Interest in and provision of residential care is growing in the RV sector. This tends to be dominated by premium rather than standard rooms. There is a growing proportion of beds also being delivered under ORAs. We estimate those to currently lie at around 16-17 per cent of residential care beds in RVs. However, the implications of this model have not been systematically identified and analysed. This monitoring report provides a baseline for understanding the interface between RVs and residential care. It has set out the current landscape of practice, issues and areas for further investigation.

It should be noted that this monitoring project has taken place prior to publication of the review of the way that aged residential care is funded.<sup>15</sup> The purpose of the review is to examine the strengths and weaknesses of the current funding model, and to identify a preferred funding model. As part of this work, the review is considering the alignment between aged residential care funding and policy settings, and those settings in health and social services. Preliminary scoping of the review notes that resident care costs, including through ORAs, was one of the fourteen most common issues raised by aged residential care stakeholders.

This section is divided into two parts. The first part provides our conclusions regarding some of the specific questions with which the CFFC is concerned within the context of its statutory responsibilities under the Retirement Village Act. The second part briefly comments on the wider issues raised through the increasingly dominant position of retirement villages in the

<sup>15</sup> Ministry of Health 2018 *Aged Residential Care Funding Model Review*. Wellington: Ministry of Health.

provision of residential care and the provision of housing for the CFFC's broader mandate around the adequacy of retirement incomes and the wellbeing of older people in general.

## 7.1 Conclusions for CFFC Monitoring of Retirement Villages

The main themes that have consistently emerged are as follows:

- Both residential care in RVs and the use of ORAs for residential care setting are:
  - evolving spaces for the RV sector;
  - increasingly grabbing the attention of operators; and
  - marked by diverse practices and product mixes.
- The reach of RVs into more complex levels of care is increasing.
- The interface between residential care and RVs is not well understood by residents, potential residents and their families. Nor is it well understood by some lawyers.
- Health services in residential care are governed and regulated by the health sector.
- Both the RV sector and the public health system have interests in RV provision of residential care:
  - For RVs, residential care opportunities are a powerful attractor to potential residents and triggers capital investment by way of ORAs in RVs and, more recently, ORAs for residential care itself.
  - For the public health system, RV participation has provided a pipeline for private investment in residential care infrastructure and has allowed government to suppress aged residential costs and demand for public capital investment in infrastructure.
- ORAs for residential care are likely to be promoted by the RV sector into the future and currently around 16-17 percent of RV residential care beds are under ORAs for care.
- Where ORAs are used for residential care, the provider is regulated by both health sector legislation and the RV Act.
- There are numerous trajectories by which individuals can move to residential care and, consequently, the handling of ORAs for existing residents as well as ORAs specifically for residential care either by existing RV residents or other older people directly entering residential care.
- The dynamic and diverse nature of RV products, including the development of residential care delivery and ORAs specifically for residential care respectively, means that the:
  - Landscape of RV residential care provision is opaque; and
  - Instruments, trajectories and practices at key transition points are diverse and uncodified within the sector.
- Currently ORAs' for independent villas and service apartments have disclosures that typically do not deal with the conditions, practices, probabilities and liabilities around any future transition into residential care, including clarity around:
  - Access to standard and premium rooms.
  - Certified levels of care.
  - Processes for, and an RV's responsibilities and practices if, a residential care resident premium room user wishes to go into a standard room.

- Currently an ORA for residential care typically is the same as other ORAs and relies on the Admission Agreement for specifics around residential care services. There is value in incorporating a selection of key Admission Agreement clauses into the Disclosure Statement preferably by direct repetition or, as a minimum, by cross-referencing. Processes for, and an RV's responsibilities and practices if, a residential care resident premium room user wishes to go into a standard room is of particular import in this context.
- There is little detail or standardisation of terminology or information presented by RVs around residential care provision, conditions and trajectories for residents seeking independent living or serviced apartments.
- The concept of 'care' is used within the RV sector in a variety of ways and straddles both:
  - residential care for qualifying individuals; and
  - services for non-qualifying individuals which broadly involve additional hotel service provision such as laundry, meal provision, and housework.

We suggest that there needs to be guidance for operators so that there is greater consistency across the RV sector in how ORAs for care and the practices surrounding them are described and applied. Currently, those operators using the ORA for care are developing their own definitions and disclosure practices. There appears to be little focus on consistency in definitions and disclosure across the sector. Furthermore, the interfaces between the ORA for care and the Admission Agreement are not well defined. There is no guidance on how interface issues are to be managed. The lack of familiarity of most residential care prospective residents with RVs means particular attention must be given to assisting these individuals to understand ORAs in the residential care context.

Given that lawyers themselves are often unaware or inexperienced in ORAs for residential care and some struggle with residential care policy and funding, there must be doubts as to the extent to which current processes and protections are and will be efficacious in the context of RV residential care ORAs.

Those problems are exacerbated by the:

- Mis-targeting of disclosure content for those prospective residents who are only taking up an ORA specifically for the purpose of accessing residential care.
- Range of misalignments evident in the range of documentation with which lawyers and prospective residents must deal.
- The existing complexities for older people not only at the RV-residential care interface but the RV sector and the aged care sector respectively.

For many prospective residents the attraction of RVs and a specific RV lies in the potential of residential care access, In that context:

- It is important that the RV sector takes responsibility for clearly stating the conditions, services, costs and profile of its rooms to all prospective residents at the point that they are looking at an ORA whether in independent living or in residential care.

- Lawyers need to be able to advise on services, instruments and processes of transition. We suggest that the CFFC continues to work in the area of legal education to increase the awareness, understanding and commitment of lawyers to advise around RVs residential care transitions and conditions.

## 7.2 Implications beyond the retirement villages sector

In the context of the CFFC's responsibilities for retirement villages, the CFFC is concerned with the minority of older people who take up residence in a retirement village, currently around 13 percent of older people aged 75 years and over.<sup>16</sup> This set of older people will continue to be a minority, in part because older people typically prefer to age in their existing dwelling or a dwelling within the community and partly because of the cost structure of retirement villages and the limited incomes of most older people. Indeed, arguably the proportion of future cohorts of seniors who move into retirement villages are likely to decline. Rapidly falling rates of owner occupation and consequent dependence on the rental market means that around half of those turning 65 years in twenty years' time are unlikely to have the assets that currently enable older people to purchase ORAs. By definition, then, the CFFC in its retirement village role is, and will be, concerned with the conditions of comparatively wealthier and income richer seniors.

But the CFFC also has wider statutory responsibility and that is the well-being of older people in retirement and the adequacy of their retirement incomes to providing for their core living standards and for accessing appropriate housing and health services. It is in this context that we draw CFFC's attention to the impacts of RVs increasing involvement in residential care, particularly if it is dominated by premium bed provision and increasingly using ORAs. In the course of this monitoring project a number of impacts on policy and funding settings in relation to the provision of governmental financial assistance and aged care appear to be emerging. These are briefly noted below.

As section 4 above shows, the use of ORAs for care is gradually growing. Between March 2014 and March 2019 there was a 44 percent increase in the number of ORAs for care. At 31 March 2019, 8.1 percent of total aged care beds were ORA beds.<sup>17</sup> There is considerable regional variation in the proportions of ORA beds provided. At 31 March 2019, the highest proportion of ORA beds was in Nelson-Marlborough DHB at 17.7 percent.

The increase in ORAs for care is happening at the same time as significant growth in the number and proportion of premium rooms, for which additional charges are made. Premium rooms now make up the majority of all rooms, at 51 percent.<sup>18</sup>

The increasing numbers of rooms with additional payments, either in the form of premium room charges or ORAs for care, have implications for the ability of prospective residents to afford aged care. There is potential for a two- or even three-tier system of care provision

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<sup>16</sup> JLL (2019) *New Zealand Retirement Village Database.*, p.10

<sup>17</sup> Customised TAS data.

<sup>18</sup> NZACA *Aged Residential Care Industry Profile 2017-2018*, pp.30-31

based on the resident's ability to pay; i.e, whether they can afford a standard room, a premium room with periodic payments, or a room provided through an ORA for care. The implications of these changes for affordability and resident choice is particularly an issue in areas with rapid growth in rooms attracting additional charges. It is also an issue in communities where older people do not have sufficient assets to pay for an ORA for care or for additional room charges. The latter places are unlikely to be attractive for investment in new-build or renovated facilities, suggesting that such locations may struggle to generate the number of care beds required in future.

The policy framework governing the availability of aged residential care established the rules relating to premium room charging with the intent to “ensure that access to a standard room is always available in each local area, for those residents who choose not to pay for premium room services.”<sup>19</sup> The rules under the Age-related Residential Care Services Agreement (ARRC) between the DHB and care facility state that as a condition of the resident's entry, a care facility must be able to offer a standard room, or if it cannot, it must meet certain requirements, including identification of a suitable room 10 km or less from the facility.<sup>20</sup> This means that if certain requirements are met, a provider can refuse to admit a person if they do not want to pay for a premium room. An ORA for care is not covered by those requirements.<sup>21</sup> This raises a question about how do operators that only offer ORAs for care work in relation to rules regarding premium room charging and the policy intent to ensure access to standard rooms.

It is unclear how access to residential aged care for all will be achieved if the numbers of premium rooms and ORA for care increase to such an extent in a region that a standard room is not available within the 10 km requirement. It is also unclear what are the levers that DHBs have to manage the availability of rooms at a regional level to ensure an adequate number of standard rooms at all levels of care, and to meet ARRC rules. A major lever is the ARRC, which sets out the funding agreement and contracted services that the operator provides to residents under the Public Health and Disability Act 2000. However, this agreement does not forbid the provider charging for services outside of the services contracted under the ARRC. Nor does the agreement regulate the numbers and types of rooms available. These are private commercial arrangements decided by operators.

Associated with RVs being involved in residential care including when they use ORAs for care, are implications and potentially unintended consequences for policy and funding settings including financial assistance given directly to individual residents. For example:

- A resident not receiving a residential care subsidy may possibly qualify for the Accommodation Supplement, if they have an ORA and if they meet a cash assets and income test, and are able to provide a breakdown/verification of their accommodation-related costs. In the course of this monitoring project we were given examples of

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<sup>19</sup> TAS Fact Sheet New rules related to the charging for premium room services

<https://tas.health.nz/assets/Health-of-Older-People/New-rules-related-to-the-charging-for-premium-room-services-in-aged-residential-care.pdf>

<sup>20</sup> Age-related Residential Care Services Agreement, 2018, Clause A13.3.

<sup>21</sup> Age-related Residential Care Services Agreement, 2018, Clause A13.4.

residents with an ORA for care applying for the Accommodation Supplement because they are unable to cover their housing costs.

- A bridging loan from the Ministry of Social Development can be paid in cases where the homeowner wants to purchase an ORA for an independent living unit and is waiting for their house to sell. The Ministry takes out a caveat on the house. Such a bridging loan may also be possible in regards to purchase of an ORA for care.
- Those who have an ORA for care and who do not qualify for a residential care subsidy are generally eligible to receive the winter energy payment.
- The rates rebate is available for residents with an ORA who live in a retirement village and who qualify under the conditions of the scheme.<sup>22</sup> Whether this rebate could be applied to a resident with an ORA for care needs further investigation.

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<sup>22</sup> Rates Rebate (Retirement Village Residents) Amendment Act 2018