



The Royal New Zealand
College of General Practitioners
Te Whare Tohu Rata o Aotearoa

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David Cunliffe
Chair – Aged Care Ministerial Advisory Group
C/- Derek Senior
Pou Whakahaere (Manager) - Family and Community Policy
Strategy and Policy Group
Manatū Hauora | Ministry of Health
133 Molesworth Street
Thorndon
WELLINGTON 6011

By email: AgedCareAdvisoryGroup@health.govt.nz; derek.senior@health.govt.nz

Tēnā koe David

Aged Care Ministerial Advisory Group – Targeted consultation

The College welcomes the opportunity to provide practical and innovative solutions to the independent recommendations to Ministers on the changes needed to shape a sustainable, high-quality aged care system for the future.

The Royal New Zealand College of General Practitioners (RNZCGP) represents 6,018 Specialist GPs, who make up 40 percent of Aotearoa New Zealand's medical workforce. We are committed to achieving health equity for Māori, honouring Te Tiriti o Waitangi, and strengthening culturally safe practice across our membership. Our priorities are patient safety, a sustainable workforce, and equitable access to high quality primary care.

Equity and Te Tiriti o Waitangi framing

This submission is grounded in Te Tiriti o Waitangi and Māori health rights. We understand Te Tiriti to require (at minimum) partnership with Māori in design and oversight of the health system, active protection of Māori health and wellbeing, equitable outcomes (not just equal inputs), and support for Māori models of care and decision-making. In aged care, this includes ensuring that assessment, access, funding, quality standards, and monitoring are designed to reduce inequities for older Māori and to protect connections to whānau, culture, whenua, and identity across transitions (home, hospital, and aged residential care). We support commissioning and regulation that make culturally safe practice and Māori partnership measurable, resourced, and accountable.

Summary of key points

- **Continuous improvement** – Successful and practical innovations in primary care are the result of purposeful and proactive consideration. In general practice, they are built on systematic improvement over time to reduce health inequities, especially for Māori, people with higher health needs, and populations with specific needs. To achieve health and wellbeing gains, we prioritise initiatives that build cultural safety capability through targeted training, professional development, quality improvement, and continuing professional development.
- **General practice demand** – for patients and their whānau, general practice is the first point of contact for medical care. Collectively, 1,085 general practice teams manage 90% of all patient healthcare concerns in most localities across New Zealand, providing access to medical care in communities. Each year, 24 million patient contacts are recorded in general practice. Older people receive a significant portion of GP services. In

About the College

Level 4, 50 Customhouse Quay, Wellington 6011 | PO Box 10440, Wellington 6140, New Zealand
0800 965 999 | +64 4 496 5999 | rnzcgp@rnzcgp.org.nz | rnzcgp.org.nz

2025, approximately 875,000 patients enrolled with a general practice were over the age of 65 and responsible for the highest proportion of GP visits, consistently averaging 5.6 visits per year. During the 2024/25 period, 76.2% of older people visited a GP at least once (NZ Health Survey 2025). We welcome the adjusted population formula for capitation payments that now includes age; we would appreciate a greater focus on complexity, multimorbidity, and specific funding for aged care services including in the care home setting.

- **Co-design and local innovation** – practical and successful innovations build on existing systems. One pilot project aiming to improve care of older people provided additional nursing workforce funding, upskilling in gerontology skills, integrated IT platform for assessment and goal setting for older people: the KARE project (1, 2) and demonstrated a reduction in care home placement (1) and long term a shift to proactive care, a reduction in unplanned ED visits and enhanced GP and patient satisfaction. (2) Such locally designed system change should be funded and promoted. There are exceptional examples of co-design in general practice, where general practice multidisciplinary teams collaborate with hauora Māori providers, PHOs, primary and community teams, and patient communities to strengthen local care. ^{i ii}
- **Access barriers for older Māori** – Māori accessing general practice include cost, wait times, and missed appointments due to lack of transport. In the year to June 2025, 74.5% of Māori females and 67.8% of Māori males visited a GP at least once. As at late 2024, around 7.4% of the Māori population was aged 65 or older; based on an estimated Māori population of 922,800 (December 2024), this equates to approximately 68,000–75,000 Māori aged 65+ (MoH NZ Health Survey). The adjusted population formula for capitation does not include ethnicity and specifically including this as well as age would enhance primary care capability to better service older Māori.
- **Cultural safety** – indicators of wellbeing suggest that some older Māori experience worsening depressive symptoms and increased mobility support needs when moving from home to long-term care. This underscores the importance of culturally safe care and whānau-centred transitions that protect identity, connection, and decision-making, and that actively monitor and respond to wellbeing impacts. ⁱⁱⁱ
- **Equity concerns** – for the **2024/25** period, Māori and Pacific peoples generally visited GPs more frequently than European/Other and Asian groups, though they also faced higher barriers to access. Across all ethnicities, older adults (65+) consistently have the highest consultation rates, averaging more than **700 encounters per 1,000 people per month** for those aged 80 and over. (Health NZ) Higher consultation rates in older age and for Māori and Pacific peoples are consistent with higher underlying health need and complexity, but they should not be interpreted as ‘need met’: population survey measures continue to show inequitable barriers to accessing general practice (including cost and transport), indicating that unmet need can persist even in groups with high service use. ^{iv}
- **Enhanced system redesign for ageing** – development of local hubs (locality or regionally based) to enabled integrated service delivery of primary care, allied health, dentistry, pharmacy, the previously hospital cited multidisciplinary older peoples’ health teams and NASC functions would enable more wrap around care closer to home for older people (right care, right place, right time) including in regional ARC facilities. Integration with local Home and Community Care Service (HCCS) would enable more timely escalation of acute changes in health status for HCCS clients. Currently the waiting times for NASC services create bottleneck and increase whanau and patient distress. Attention to availability of NASC services is critical to timely care.

Question 1 - How could aged care settings better support care to be delivered in the “right care, at the right place, at the right time”?

Aged care settings can better deliver the right care, in the right place and at the right time by formalising shared-care arrangements between aged residential care (ARC), local general practice teams and locality networks, with clear roles and escalation pathways. Development of local hubs (locality or regionally based) to enabled integrated service delivery of primary care, allied health, dentistry, pharmacy, the previously hospital cited multidisciplinary older peoples’ health teams and NASC functions would enable more wrap around care closer to home for older people (right care, right place, right time) (see system redesign). This should be backed by stronger

clinical governance and safe staffing in ARC (including consistent RN coverage and access to gerontology, dementia and palliative capability), alongside geriatric outreach support for timely clinical advice when residents deteriorate.

Consistent with Te Tiriti o Waitangi, shared-care arrangements and locality pathways should include Māori partnership and support culturally safe, whānau-centred decision-making (including advance care planning) so that care plans reflect what matters to the person and their whānau. Transitions between hospital, ARC and home should be standardised, with timely discharge information and proactive follow-up, and telehealth should be routinely used to improve access in rural areas and facilities with limited on-site GP availability. Waiting times for NASC services create bottleneck and increase whānau and patient distress. Attention to availability of NASC services is critical to timely care.

Serving older Māori must also include ageing at home or place based residential care options. For Māori, living alone and older age have been identified as predictors for entry to ARC, however, if the preference for care is to be provided at home by whānau, or other services, there are significant barriers in some areas due to lack of access to services that meet their needs, including meeting their health needs at home.^v

Inadequate staffing and inconsistent clinical oversight in aged residential care are major drivers of preventable harm for older people with complex multimorbidity, including falls, pressure injuries and medication errors. Reforms in Australia to manage workforce shortages, developed approaches such as 24/7 registered nurse coverage, improved training in gerontology/dementia/palliative care, and national workforce planning, especially gerontology-skilled RNs.^{vi} Strengthening minimum staffing expectations and clinical governance would also improve safety and reduce pressure on general practice and hospitals. In general practice specifically, more consistent RN coverage in ARC would reduce after-hours GP burden, improve medication safety, and support earlier detection of deterioration.

Question 2 - What changes are needed to support people to live and age well for longer in their own residence or other non-residential settings?

To support people to live and age well for longer at home and in other non-residential settings, the system should invest in proactive, preventive primary care for older people, including routine frailty assessment and anticipatory care planning. One pilot project aiming to improve care of older people provided additional nursing workforce funding, upskilling in gerontology skills, integrated IT platform for assessment and goal setting for older people: the KARE project^{vii} and demonstrated a reduction in care home placement^{viii} and long term a shift to proactive care, a reduction in unplanned ED visits and enhanced GP and patient satisfaction. Such locally designed system change should be funded and promoted to include:

- Access to community-based allied health should be improved (for falls prevention, mobility, nutrition and occupational therapy environmental assessments), alongside medicines optimisation through routine medication reviews to reduce polypharmacy-related harm.
- Mental health and cognitive wellbeing pathways for older adults need strengthening, and locality-based planning should be used to co-design culturally safe services that reduce inequities for Māori and other groups with higher need, supported by better information sharing so care plans follow the person across settings.
- Falls related morbidity is expensive and falls prevention in the community is proven as well as in aged care. The biggest gap in the community at present is the reach of the lower leg strengthening and balance retraining exercise programme (currently long waiting lists in the Auckland region) and timely home hazard assessment with modification which can take up to a year, by which time further falls have occurred in home.
- In ARC, systematic training and locally adapted falls prevention prompting using IT tools is very successful but not available, increased protein and dairy intake reduced fractures by 33%, and Vit D supplementation is effective but variable currently. Support for systematic benchmarking groups to enhance falls prevention and quality improvement processes to be rolled out to all facilities would be necessary to impact outcomes.

Sustainable analysis positions for this, IT infrastructure and upskilling could be facilitated through regional HOP managers, interRAI services processes and Health Quality and Safety Commission focus.

Living at home requires care and support for on average 60% of those aged 80+. Over time in the LiLACS NZ project (Māori and Non-Māori octogenarians followed over 10 years) ^{ix} show that the about 40% received government funded community support, with non-Māori women more able than other groups to access this. More informal, whānau support was given over time. Men and Māori women are more likely to receive informal support than other groups.

- Care at home is a huge contribution of whānau and families to society. The value of informal care for the 220,000 citizens aged 80+ years and older in 2025 who receive informal care was estimated at \$3.6 billion based on hours of care reported by LiLACS NZ carers. ^x This cost is being contributed by communities and whānau.
- Those living at home with whānau had high levels of disability and were more likely to report that they thought they could have received more practical and emotional support than they received indicating that more carer support is needed ^{xi}. This strongly suggests improved carer support is required particularly for Māori. Such support should be flexible, accessible and co-designed with communities.

Integration across the care continuum

Fragmentation between primary care, hospitals, community services, and aged residential care is a key driver of avoidable harm. Reducing fragmentation is also an equity issue: when information, coordination and advocacy are weak, whānau often carry the burden and those with fewer resources face higher risk of poor outcomes.

Why it matters for 65+:

Older adults are at higher risk of preventable harm in institutional care, and that stronger, more transparent safety and quality systems help whānau, clinicians and communities make informed choices and drive improvement. Options such as locality-based multidisciplinary planning (including geriatric outreach, telehealth support and shared digital records) and an independent Aged Care Safety and Quality Authority, alongside public-facing mechanisms like mandatory incident reporting, facility star ratings and transparent quality indicators.

From an equity and Te Tiriti o Waitangi perspective, these settings should embed culturally safe complaints and advocacy pathways, enable Māori partnership in design and oversight, and report outcomes in ways that can be disaggregated (including by ethnicity) so inequities are visible and can be addressed. For general practice, clearer quality signals would complement (and improve on) the current ARC certification system by helping GPs guide families, identify facilities needing closer clinical oversight, and reduce avoidable harm across care transitions.

Question 3 - What changes are needed to ensure that aged care services are financially sustainable over time?

Financial sustainability will improve when aged care is funded and organised to prevent avoidable deterioration, reduce avoidable hospital use, and retain a skilled workforce. This requires:

- Stable, indexed funding that keeps pace with wages, acuity and inflation.
- Investment in safe staffing, clinical governance and medicines optimisation to reduce preventable harm.
- Capacity planning that maintains an appropriate supply and mix of beds and community options, reducing delayed discharge and crisis-driven entry.
- Stronger integration with primary and community care so work is not cost-shifted to general practice or hospitals without resourcing. Evidence that hospitalisations rise in the lead-up to long-term care entry and reduce after entry ^{xii} supports investment in both timely access to appropriate ARC and in targeted community “step-up” supports that avert crises and stabilise people earlier.

Financial sustainability of the ARC sector will be improved by modest investment in carer support and increased community care in more flexible ways. ARC owners would be better focused on quality rather than profit. Ownership should have beneficence, and this would be aided with flexibility in funding so rehabilitation

needs can be recognised and the complexity of care needs funded equitably. A revision of the currently three level funding model to include more nuance may achieve this.

Question 4 - What changes to the funding settings for aged care services would support high-quality, sustainable aged care services, and why?

Funding settings: needs-based, quality-linked, and integration-enabled

Funding settings should be adjusted so they reliably support quality and safety and reflect assessed complexity and risk. A needs-based approach should fund safe staffing and clinical oversight in ARC (including RN coverage and access to gerontology, dementia and palliative expertise), as well as allied health and preventive supports that reduce functional decline and avoidable acute presentations. Funding should also explicitly cover the integration functions that sit between services—care coordination, information sharing and transition support after hospital discharge—and include targeted investment in culturally safe models of care that reduce inequities for Māori and other groups with higher need.

The document highlights disparities in long-term care (LTC) in New Zealand, which may have implications for Māori communities. While the paper does not explicitly mention Māori, it does raise broader equity issues that could be relevant:

- **Access to LTC Services:** The document notes that many countries, including New Zealand, have adopted policies promoting "ageing in place" to delay or prevent entry into LTC facilities. However, it acknowledges that the effectiveness of these policies in reducing costs and improving outcomes has been mixed. For Māori, who often face barriers to accessing healthcare services, these policies may exacerbate existing inequities if community-based care is not adequately resourced or culturally appropriate.
- **Hospitalization Rates Before LTC Entry:** The study found that hospitalizations increased significantly in the months leading up to LTC entry, suggesting functional and medical instability as a precipitating factor. This could indicate that some individuals, potentially including Māori, may not be receiving adequate support in the community to prevent hospitalizations and delay LTC entry.
- **Community Care Challenges:** The paper discusses the "woodwork effect," where expanding community services can lead to increased costs without significant reductions in LTC admissions. For Māori, this could mean that community care services are not effectively addressing their specific needs, leading to higher rates of hospitalization and LTC entry.
- **Cultural Appropriateness of LTC:** The document briefly mentions the importance of improving care following hospitalization to delay or avoid LTC entry. For Māori, culturally appropriate care that aligns with their values, such as whānau-centred care and holistic approaches, is critical. The lack of such care in LTC facilities could contribute to disparities in outcomes.

While the paper does not directly address Māori-specific issues, these broader findings highlight areas where disparities in LTC access and outcomes could exist for Māori. Addressing these disparities would require targeted interventions, culturally responsive care models, and policies that consider the unique needs of Māori communities.

Funding should reflect assessed need and complexity (acuity, cognitive impairment, multimorbidity, palliative need) and should explicitly purchase the inputs required for safe care (workforce, clinical oversight, allied health) as well as the coordination functions that prevent fragmentation.

In Aotearoa New Zealand this aligns with Pae Ora and locality commissioning and should be designed with an equity lens and Te Tiriti o Waitangi obligations. In practice this means funding and contracting settings should acknowledge Māori health need and unmet need as well as unmet need that may not be fully known by the health system. Further it must support Māori partnership and Māori-led service design where appropriate, to explicitly address barriers to access, and enable monitoring of equity of access, experience and outcomes. A needs-based

model should also be paired with transparent indexation and capital settings to maintain a sustainable supply of aged care beds and viable non-residential options.

- Introduce a transparent, needs-based case-mix model for ARC and community packages that adjusts for acuity and complexity.
- Index funding to wages and inflation, with mechanisms that support provider viability and bed supply (including capital settings where needed).
- Link a portion of funding to quality and safety indicators that matter (e.g., preventable hospital transfers, medicines safety, falls/pressure injury prevention), with support for improvement—not punitive-only settings.
- Fund integration: care coordination, discharge planning, medicines reconciliation, and shared-care activities between ARC, general practice and hospital services.

Why it matters for 65+

- Funding settings drive whether people receive timely, preventative support or enter care in crisis, and whether facilities can provide safe, clinically competent care.
- For older Māori, funding and quality settings need to protect rights and wellbeing across transitions (including whānau connection, culturally safe practice, and support for Māori preferences and models of care).
- Needs-based funding that recognises complexity (including dementia, multimorbidity and palliative need) and rural delivery costs supports equitable access and reduces avoidable hospital use.

Relevance to New Zealand

- Improved staffing
- Reduce GP workload caused by under resourced facilities
- Support proactive care rather than crisis management

Relevance to general practice

- When funding does not purchase adequate staffing, clinical governance and coordination in ARC and community services, unmet need and clinical risk are cost-shifted to general practice.
- Funding settings should explicitly resource ‘interface’ work undertaken by general practice (e.g., medicines reconciliation, case conferences, advance care planning, and virtual ward rounds), rather than relying on unfunded goodwill.
- Resourcing culturally safe navigation and whānau-centred support (including for Māori and Pacific families) helps reduce missed care, crisis-driven entry, and avoidable harm.

Question 5 - Which changes to regulatory or contractual settings for aged care services would better support innovation and sustainability, while maintaining safety and quality?

Regulatory and contracting settings should protect safety and quality while enabling providers to innovate and remain viable. The most useful changes are those that specify the “non-negotiables” (rights, staffing, clinical governance, transparency) and then give services flexibility in how they meet them.

Regulatory and contractual settings should set clear, consistent minimum expectations for safety, staffing and clinical governance in ARC, while creating space for locally tailored innovation. Quality oversight should be strengthened through more consistent reporting and greater transparency of key indicators, supporting learning and accountability. Contracting should prioritise multidisciplinary, integrated models that connect ARC with general practice and locality networks, enable telehealth and shared digital records, and embed a rights-based and culturally safe approach so innovation improves outcomes without worsening inequities.

Continuity of care should be emphasised between provider (individual GP/NP) and patient across sectors. Family meeting are most valuable and currently almost impossible due to funding constraints – time space persons allied health.

- **Clarify minimum safe standards:** consistent minimum expectations for staffing and skill mix (including RN coverage), clinical governance, escalation pathways, and medicines management.

- **Outcomes-focused contracts:** commission against measurable outcomes (e.g., reduced avoidable hospital transfers, improved wellbeing/experience, safer medicines use) rather than narrow task lists, with safeguards against risk selection.
- **Fund and require integration:** include contractual requirements and funding for shared-care arrangements with general practice, timely information transfer (especially at admission/discharge), and participation in locality pathways.
- **Reduce administrative burden:** standardise contract reporting and audit requirements across regions to avoid duplication; make reporting proportional to risk and aligned to a common set of indicators.
- **Enable innovation safely:** allow pilot clauses (time-limited, evaluated), support telehealth and hospital-in-the-home/virtual ward models, and encourage allied health-led prevention (falls, frailty, nutrition) within clear safety frameworks.
- **Embed equity and cultural safety:** require and resource culturally safe practice, whānau engagement, and Māori partnership in service design, governance and quality improvement, consistent with Te Tiriti obligations. This should include measurable expectations (e.g., workforce cultural safety capability, whānau participation, equity-focused quality indicators, and processes for responding to inequities identified through monitoring).

Question 6 - What changes could be made to better align funding, regulation, and service delivery across aged care services, Disability Support Services, and other health services?

Funding, regulation and service delivery can be better aligned across aged care, Disability Support Services and other health services by reducing fragmentation and designing pathways that span providers. Locality planning should be used to co-design shared pathways, clarify responsibilities and escalation processes, and implement interoperable shared care records so care plans, medicines and key risks follow the person. Contracting and funding should explicitly support coordination and multidisciplinary team-based care for people with complex needs (including cognitive impairment), and transition support should be standardised, especially for hospital discharge to home, ARC or supported living.

Alignment requires shared accountability for outcomes across settings (home, supported living, ARC, hospital) and practical mechanisms that reduce fragmentation. A rights-based approach should be embedded across the system (including consistent advocacy pathways and complaints mechanisms), but the immediate opportunity is to align funding and contracts, so coordination is resourced and information follows the person.

Funding should follow need

- **Commissioning and funding** should follow the person across settings (home, supported living, ARC, hospital) with clear responsibility for coordination and outcomes.
- **Pooled or aligned locality budgets** for older people with complex needs, including those who also receive Disability Support Services, to reduce cost-shifting and enable flexible supports.
- **Contracts that fund multidisciplinary team-based** care and care coordination rather than paying only for discrete service episodes.
- **Single care plan and shared record** used across ARC, general practice, hospital and community teams, with timely medicines reconciliation and clear escalation pathways.
- **Standardised transitions** (hospital-to-home, hospital-to-ARC, home-to-ARC) with funded coordination, rapid follow-up, and clear responsibility for actions.
- **Interface funding** that pays for shared-care activities (case conferences, virtual ward rounds, medication reviews, advance care planning) rather than assuming this work is absorbed by general practice or facilities.
- **Navigation and whānau support** for people moving across services, including culturally safe navigation for Māori and Pacific families.

Cross-sector alignment

- Evidence on hospital use around long-term care entry supports better cross-sector alignment. Boyd et al. found hospitalisations increase in the months before long-term care entry and then reduce after entry, consistent with crisis-driven entry and the potential for well-resourced long-term care to substitute for some

acute demand.^{xiii} This strengthens the case for integrated planning and funding settings that (a) support timely access to appropriate ARC beds when needed, (b) invest in “step-up/step-down” supports in the community to prevent avoidable deterioration, and (c) explicitly include culturally safe transition and wellbeing supports for Māori, recognising mixed wellbeing changes after entry (Hikaka et al.) and the need to prevent depression and disconnection.

Invest-to-save

- A key financial issue is the way costs are currently shifted between sectors. The Auckland cohort study^{xiv} (often presented as a figure showing hospitalisations before and after entry to long-term care) demonstrates a marked reduction in hospitalisations after admission to aged residential care. This indicates a potential “invest-to-save” opportunity: where well-resourced ARC reduces acute hospital demand, Te Whatu Ora can reasonably reinvest a portion of the estimated avoided hospital costs into sustainable ARC capacity (including bed supply) and into community step-up/step-down supports that prevent crisis-driven entry. Importantly, the same sustained reduction does not apply in the same way for retirement village residents (where any reduction is more temporary). This supports targeting reinvestment to settings and service models that demonstrably substitute for acute demand and improve outcomes.

The Hikaka et al. study

The use of interRAI data also reinforces the need for balanced, culturally safe transition funding for Māori: while some indicators improve after entry (e.g., falls), others worsen (e.g., depressive symptoms), meaning transition and ongoing ARC funding should include specific wellbeing supports (whānau connection, mental health screening and response) alongside mobility and safety interventions.

Figure 1: Boyd et al. (2016) hospitalisations before and after long-term care entry (Auckland cohort).]^{xv}

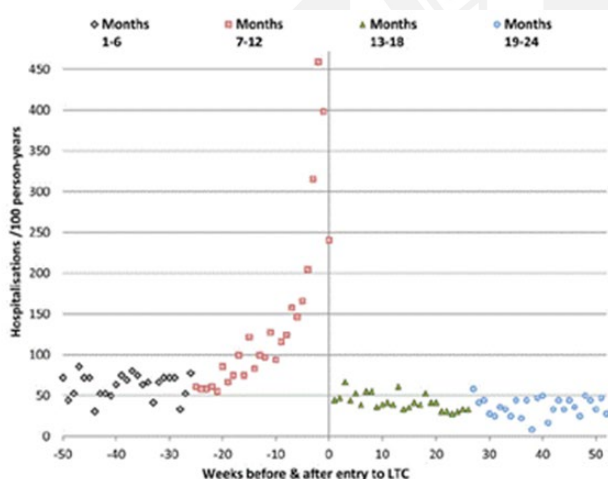


figure 1. Weekly hospitalisation rates (per 100 person-years) of residents 12 months before and 12 months after entry to LTC.

Question 7 - What changes are needed to the current aged care settings to support specific groups (e.g., Māori and Pacific communities, people with dementia, carers, rural communities, etc.)?

Aged care settings need to be reshaped to better support groups with higher need, including Māori and Pacific communities, people living with dementia, carers and rural communities. This includes explicitly honouring Te Tiriti o Waitangi through an equity lens and co-design with Māori communities, alongside building cultural safety capability across the workforce and within contracting and quality expectations. Dementia care should be strengthened through a rights-based, clinically competent approach (including advocacy and supported decision-making), carers and whānau should have clearer pathways and timely clinical advice and follow-up, and rural access should be improved through strengthened locality networks, outreach services and telehealth-enabled models of care.

Across all groups, the system should ensure timely access to the right level of support, recognising evidence that hospitalisations rise before long-term care entry^{xvi}, and should invest in community and transition supports that prevent deterioration and avoidable hospital use.

Key insights for NZ General Practice (65+ Focus)

✓ Immediate, practical implications for GPs

- **More structured frailty assessments** (e.g., FRAIL scale, gait speed).
- **Proactive care plans** for older adults, especially those in ARC.
- **Telehealth support** for facilities with limited GP access.
- **Routine medication reviews** to reduce polypharmacy.
- **Better integration with allied health** for falls, mobility, and nutrition.
- **Improved communication** with hospitals and ARC staff.

System-level changes that would support GPs ^{xvii}

Recommendation	NZ Status	Opportunity
Minimum staffing standards	Not mandated	Reduce GP workload and improve safety
Geriatric outreach teams	Patchy	Could reduce hospitalisations
Shared digital records	In progress	Still inconsistent across regions
Independent quality authority	Partial	Could improve transparency
Funded mental health access	Limited for 65+	Major gap for older adults

Final Summary and takeaway message for 65+ care

In Australia, the Royal Commission's reforms are fundamentally about restoring dignity, safety, and clinical quality for older adults.

Recommendation:

1. Specific opportunities to improve outcomes for older people

- Better integration with aged residential care
- Proactive frailty and preventive care
- Improved communication and digital systems
- Advocacy for rights and safety of older adults
- Workforce and funding reforms that reduce GP burnout

2. Immediate, practical implications for policy

- National workforce and staffing expectations, particularly for registered nurses in aged residential care.
- Accelerate integration initiatives under locality planning, including multidisciplinary teams and interoperable digital records.
- Expand mental health and cognitive support for older adults, particularly in aged residential care.
- Enhance quality and safety oversight, including transparent reporting of key indicators.
- Align funding with assessed need to support sustainable, high quality care for an ageing population.

New Zealand's demographic pressures make strengthening aged care an urgent and unavoidable priority. As you continue advising on the direction of system reform, we suggest the Australian Royal Commission's findings offer a coherent, evidence-based framework that can inform the development of a resilient, equitable, and fiscally sustainable aged-care system for Aotearoa.

Embedding principles such as rights, cultural safety, safety, integration, transparency, and sustainable funding within policy and service design would materially improve outcomes for older people. For New Zealand, these principles must be anchored in Te Tiriti o Waitangi. That requires genuine Māori partnership in governance and system design, culturally safe models of care, and transparent monitoring of equity in access, experience, and outcomes.

Incorporating these lessons into the ongoing reform agenda presents a significant opportunity. Doing so would not only enhance the wellbeing and independence of older people but also reduce pressure on acute services and contribute to a more sustainable, integrated, and equitable health system. The Advisory Group is well positioned

to champion these shifts and ensure that aged care evolves in a way that reflects the values and aspirations of all communities in Aotearoa.

Nāku noa, nā



Dr Prabani Wood
BA, BMBCh, MPH, FRNZCGP
Medical Director | Mātanga Hauora

Addendum

Insights and lessons are drawn from the Australian Royal Commission (the Commission) into Aged Care Quality and Safety.^{xviii} Although focused on the Australian system, is highly relevant to New Zealand given similar demographic trends, workforce pressures, and increasing acuity among people aged 65+ entering aged residential care. The review reported aged care quality, safety, governance, and funding. Outcomes of the review showed that older people deserve a safe, dignified, clinically competent system that actively supports ageing, not just reacting to decline.

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