A Study on the Long-Term Care System in New Zealand

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1. Introduction

In New Zealand, older people (aged 65 or over) accounted for about 17% of the total population in 2024. This proportion is projected to increase to 44% in 15 years. Currently, the majority of older people can live independently at home without any assistance and report that their overall health is good. Meanwhile, about half of those aged 85 or over receive in-home care services, and 28% receive institutional services. It is projected to be difficult to respond to the increasing demand for healthcare associated with the future growth of people aged 65 or over.

Regarding the basic structure of the long-term care system in New Zealand, Health New Zealand (a government agency under the Ministry of Health) manages and funds the long-term care system. The services had been provided through District Health Boards (DHBs)[1] until 2022, but the DHB system was discontinued and replaced by Health New Zealand. Although the new system was initially feared to take decision-making authority away from local municipalities, Health New Zealand has worked to enhance their decision-making authority for the last 12 months. The Ageing Well National Team and the Ageing Well Regional Leadership (leaders of local municipalities) have constantly maintained communication through a joint operational group and a jointly developed working program.

With the key priority of ensuring safe, proper, and respectful care to older people in the country, Health New Zealand plays a major role in linking national/regional plans and local care delivery in four regions (Northern, Te Manawa Taki, Central | Te Ikaroa, and Te Waipounamu). It strives to enhance the aged care system so that more people can enjoy healthy and independent living at home for longer periods of time. For those requiring institutional care services, it also works to address their needs by constantly providing quality care.

[1] Local organizations responsible for planning, providing, and funding public healthcare services (hospitals, community health services, etc.) in respective communities (districts)

Older people aged 65 or over, or those with specified disabilities are eligible for the care services. To receive public services, they take a comprehensive assessment on physical, cognitive, and social needs, conducted by Needs Assessment and Service Coordination (NASC), to determine the level of necessary services. The services are categorized into home support services and residential care, as summarized in Table 1.

Table 1: Types of Care Services in New Zealand

	Type	Description
Home support services	Personal care	Getting out of bed, showering, dressing, taking medicines, etc.
	Household support	Cleaning, meal preparation, etc.
	Carer support	● Help for those living with or looking after the person for four hours or more each day ● Equipment to help with safety at home
Residential care	Rest home	
	Private hospital	
	Dementia facility	

Regarding payments and subsidies, home support services are partially subsidized except for the following three conditions: (1) the person has been in a care facility for an extensive period, (2) the person is eligible for Disability Support Services (DSS) provided by the Ministry of Disabled People, or (3) the care is for the treatment of injury covered by Accident Compensation Corporation (ACC)[2]. For residential care, public funding partially covers the cost if it is used through Health

[2] An accident compensation scheme providing benefits to victims of all types of injury, including automobile and workplace accidents

New Zealand. Those who do not use it through Health New Zealand, or those who are not eligible to receive public funding, need to pay all the costs on their own. While the ratio of out-of-pocket payments for residential care is determined based on the person's asset, due to the availability of the national pension system, about 40% of facility residents currently pay all the costs on their own.

Based on the information mentioned above, Table 2 compares the long-term care systems in New Zealand and Japan.

Table 2: Long-Term Care Systems in New Zealand and Japan

	New Zealand	Japan
System management	National government	Local government
Funding	National government	National, prefectural, and local governments; insurance premium
Needs assessment coordination agency	NASC	Community general support center, in-home long-term care support provider
Assessor (care planner)	Registered health professionals (e.g., nurse, occupational therapist, physical therapist)	Care manager
Assessment tool	interRAI	Basic information, basic checklist, others determined by each local government
Eligibility criteria	Quantitative and qualitative decisions based on interRAI results	Qualitative decision based on individual needs
Out-of-pocket payment (criteria)	Partial or full (asset)	10 to 30% (income)

Eligible service users	Older people, those with specified disabilities	In principle, those aged 65 or over with certification of needed long-term care (or support)
Review of plans	At least once a year	After the completion of the period set in care planning

What is unique about New Zealand is that the government requires the use of interRAI in the assessment of everyone aged 65 or over who requires support associated with aging. interRAI, a collaborative network of nonprofit clinicians and researchers from over 35 countries, is adopted and available in at least 45 countries (see Figure 1).

Figure 1: Map of countries adopting interRAI

To support clinical decision making, interRAI can generate outputs providing evidence for measuring intervention success, extract statistical data backing policy recommendations, and combine core assessment criteria to eliminate the need for other nursing assessments. It is also interoperable with other interRAI devices in

different care settings (e.g., acute care, aged care). In New Zealand, the interRAI assessment is licensed to be used mainly in aged care, as well as for acute care assessments in ACC. Table 3 outlines main types of assessment used in New Zealand.

Table 3: Main Types of Assessment

	Target	Assessor
Contact Assessment	Those with non-complex conditions or symptoms	NASC
Home Care Assessment	Those who may require residential care, with slightly more complex or severe symptoms	NASC
Long Term Care Facilities Assessment	Those in residential care	・ Nurse in the facility ・ Qualified individual registered at the facility
Palliative Care Assessment	Those receiving residential or home care with a prognosis of less than six months	・ Nurse practitioner ・ Qualified individual at the facility

Every assessor is trained by interRAI Services (interRAI Team), which consists of clinical staff with professional qualifications. Despite the diversity of assessors' professional backgrounds, including nursing, occupational therapy, and physical therapy, they ensure consistent quality by receiving training, through annual tests and audit processes, to maintain the ability to use the assessment tools.

Before introducing interRAI, each region individually decided assessment items to be used, posing a risk of different interpretations by different assessors. Assessment was also conducted and managed with printed forms, which made it difficult to share data and information. To address these problems, discussion started in 2002 to introduce interRAI, aiming to develop a nationally uniform system. Contact Assessment and Home Care Assessment were introduced in 2006.

For residential homes, due to their large number, the pilot program started in 2012 and rolled out nationally in 2015. Although each residential home was supposed to implement interRAI, in the initial phase, these facilities were not sufficiently equipped with ICT infrastructure. To overcome this challenge, the homes were provided with laptop computers, one or two depending on their size, and DHBs helped them develop the infrastructure. Another challenge was transforming people's mindsets. Since everyone disliked change, efforts were made to convince them by highlighting the value of integration to interRAI.

Introduction of interRAI has already shown some positive outcomes. At the individual level, it allows users to check the effect of interventions as the result of each assessment is shown as a score. At the national level, interRAI data have been used for research. Last year, a paper was published on the effect (ROI) of conducting Home Care Assessment. The study has concluded that implementation will save about 0.5 million dollars per year while not implementing it will increase annual costs by up to about 1.7 million dollars.

Taking account of this institutional context, the present study aims to deepen an understanding of the long-term care system in New Zealand in order to help promote the reform of the long-term care system in Japan.

2. Methodology

To understand the long-term care system and initiatives that contribute to it in New Zealand, face-to-face interviews were conducted with government agencies and organizations engaged in aged care. The interviews took place between October 2 and October 8, 2025, with the following organizations shown in Table 4.

Table 4: Organizations That Participated in the Interviews

Organization	Description
Minister for Seniors	Casey Costello
Ministry of Health	Designing the system Responsible department: Family and Community Policy, Strategy and Policy Group

Health New Zealand	Managing and funding the system Responsible department: Ageing Well, Planning, Funding and Outcomes
Age Concern	A charity dedicated to people over 65, their friends, and whānau (families). They promote dignity, wellbeing, equity, and respect and provide expert information and support services in response to older people's needs.
Needs Assessment Service Co-ordination Association (NASCA)	A not-for-profit incorporated society serving as the national body for organizations that provide assessments, planning, funding, and/or service coordination for people living with disabilities and mental health.
Care Coordination	An organization that facilitates access to funded services for people aged over 65 years, to address identified health-related personal care and carer support needs, and support people to remain safely in their own homes in line with the national “Aging in Place” strategy.

3. Results

Based on the input obtained at each organization, this section summarizes the interview results, which have been categorized into the following themes: process of service use, process of needs assessment using interRAI, development of health promotion programs with local resources, best practice models in aged care, challenges in the current scheme, and improvement of the current scheme and future directions to address further population aging.

- Process of service use

A patient, their family, or their general practitioner (GP) contacts the local NASC when care services are needed. A registered health professional conducts the

patient's needs assessment, using a nationally uniform assessment tool interRAI. Based on the needs assessment results, the assessor selects necessary services (including informal services) for the patient and prepares a support plan. Information is shared with service providers via the interRAI assessment system (iAS), which also allows the accumulation of recorded regular assessment results after the services start.

Home and Community Support Services (HCSS) are currently provided through two different service and funding schemes. The conventional fee-for-service model (household support and personal care) has been provided without supervision by a registered health professional. In the last 10 years, however, this model has been gradually replaced with a restorative case-mix bulk-funding model, which is provided based on the rehabilitation philosophy to help achieve person-centered goals and promote independence under the supervision of a registered health professional. All the regions are expected to switch to this new service model within the next 24 months. This model is proven to significantly reduce the growth of service expenditures compared with the fee-for-service model by giving providers incentives to deliver efficient services and discharge patients once they no longer need services.

The services are reviewed regularly after being introduced, with potential adjustments if the patient's condition improves or worsens. The review must be conducted at least once a year but can be implemented more frequently if determined clinically appropriate. Reassessment using interRAI should be conducted at least once every three years. Although there has been an attempt to increase the frequency of reassessment to once a year, there is a concern about a significant cost burden.

- Process of needs assessment using interRAI

While the time between access to NASC and a needs assessment may differ in different districts, all NASCs implement the prioritization process to ensure those with urgent needs can use services without waiting. Home care can start in several days in urgent cases. But due to the limited number of assessors, it may take six to

12 weeks for non-urgent cases (their safety at home is ensured, but it will be better if services are available).

Medical information is collected as much as possible, including the history of medication and hospitalization, to determine the level of necessary assessment. Based on this information, the assessor gets an idea of the patient's complexity and conducts an assessment according to their condition. If the patient's condition is determined not complex, they are referred to a home care service provider, who will conduct an assessment. If the patient's condition is determined to be complex, an NASC assessor visits the patient's home and conducts an assessment using interRAI, based on the collected information. The results produce a clinical assessment protocol (predicting prognosis of condition/abilities) and an outcome scale (identifying risk), enabling the summarization of the patient's clinical and social conditions. Based on this information, the assessor prepares a support plan. Due to regional differences in available services and resources, assessors, not interRAI, select the services and local resources to be used.

- Development of health promotion programs with local resources

In addition to formal services, non-profit and other organizations in different regions provide various health promotion programs. This section introduces examples at Age Concern, an organization offering a variety of programs.

Some of the programs provided by Age Concern include falls prevention education, strength and balance classes, driver education, living without a car workshops, physical activity groups, and nutrition courses and workshops for older people. There are no required qualifications or criteria for participating in each program: People can join the activities if they are not hospitalized and can come to the program locations. The majority of participants are local residents aged 65 or over, but some start participating in the programs at younger ages, such as 55 or 60. To address the challenge of having fewer male participants, some Age Concern local branches organize male-only programs and cooking classes to facilitate male participation.

To recruit participants, they use the websites and social media of Age Concern local branches. They also collaborate with other social service providers to offer information. In distributing their newsletters, they also collaborate with local physicians, GPs, community centers, and governments (for pensioners).

Regarding associated costs, each program is implemented by volunteer peer leaders, which enables low-cost operations. The costs for using program sites are covered by participants' donations. A study on program ROI (return on investment) has found that each dollar invested in the program would return 2.40 dollars.

- Best practice models in aged care

The Waikato Supported Transfer and Accelerated Rehabilitation Team (START) program (started in 2010) and the Canterbury Community Rehabilitation Enablement & Support Team (CREST) service (started in 2011), both aiming to support earlier discharge from hospital, are best practice models developed in communities. In both programs, interdisciplinary teams and trained support workers visit patients' homes up to four times a day to provide personal care and exercise. They are proven to reduce not only the length of hospital stay but also older patients' readmission to hospital within 30 days and relocation to long-term care facilities.

In the CREST service, a team consisting of a nurse, an occupational therapist, a physical therapist, a support worker, and other relevant members provides home visits up to four times a day, seven days a week, for up to six weeks, aiming to help achieve the patient's goals and restore their independence after injury or illness. This team is fully integrated into the existing hospital, community health, and primary care services, and these services are mostly offered by community service providers (nonprofit organizations). A team based in a hospital and primary care, who identifies a potential participant based on a brief assessment, encourages the person to participate in the service and helps them select community service providers. This information is provided to the GP, CREST case manager, and if needed, psychogeriatric service. Information on medication change is shared with the primary care provider and the local pharmacy. Community service providers

offer transportation for the person to go home, if needed, and a CREST case manager conducts in-home assessment on the day of discharge.

➢ Challenges in the current scheme

The aged care scheme in New Zealand faces various and serious challenges and problems, including funding, human resources, equity, access, and infrastructure. Moreover, the composition of aged residential care (ARC) residents has been changing in recent years, with significant growth in those with more complex needs such as dementia, as well as those requiring hospital-level care. In 2024/25, about 33,000 people lived in ARC and additional 80,000 older people received home- or community-based support services. Recognizing this reality, in 2023, Health New Zealand launched the Aged Care Funding and Service Model Review to support more sustainable and equitable care. The following problems were identified through this review.

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

Independent studies conducted in 2010, 2019, and 2024 constantly showed a funding shortfall in ARC as well, pushing providers to introduce additional fees to cover costs. In New Zealand, ARC facilities are funded by means-tested user-pays, government subsidy, as well as additional fees paid by residents approved under the Age-Related Residential Care Agreement (ARRC). These additional fees are financial barriers for low-income people, creating further inequalities in access to healthcare especially for vulnerable people.

➢ Improvement of the current scheme and future directions to address further population aging

Since the review started, Health New Zealand has taken various measures to improve services, including the national rollout of a new HCSS model, facilitation of discussions on more equitable ARC funding methods, and investment in services to support hospital discharge and dementia care.

Age Concern has been developing services tailored to local characteristics, such as services for specific races (Māori and Pasifika people, immigrants) and groups (homosexual people), assistance in using online banking for communities without a bank, and digital literacy programs. Also, in the United Nations' Decade of Healthy Aging program, which started in 2021, Age Concern particularly focuses on agism as a key theme and has been cooperating with other organizations to develop campaigns to end agism. They constantly explore new activities that are linked with the United Nations' initiatives but adapted to address unique needs in New Zealand, including the development of integrated care and age-friendly communities. The challenges include funding, scalability, and validation of evidence: Under the current government administration, it is becoming considerably difficult to secure funding without ROI evidence.

4. Discussion

Based on these results, this section discusses what seem to be successful features of the long-term care system in New Zealand.

The first point is assessment; that is, unifying its method and ensuring its expertise. In New Zealand, assessors of aged care needs are required to use interRAI, the nationally uniform scale with the same assessment items, enabling consistent assessments by professionals. This mechanism not only helps understand cross-sectional needs including medical care, social care, and daily support, but also prevents differences in assessment criteria between regions or between assessors. It therefore clarifies service eligibility based on the assessment results.

The second point is a clear separation between service delivery and assessment. By separating assessing bodies from service providers, the system can prevent

biased assessment aiming to lead people to services; instead, it can organize support based on the person's condition.

The third point is the assessment process based on data utilization. interRAI allows users to easily accumulate and share assessment data, making it possible for them to understand changes in patients' condition over time, for the assessor and service providers to build shared understanding, and for the government to monitor the system. These functions serve as foundations to support the system operations. Meanwhile, due to serious challenges including the shortage of financial, human, and service resources, progress has been slow in incorporating preventive interventions in the system. Prevention tends to rely on locally developed health promotion programs.

5. Conclusion

Based on desk-top research and field interviews, this section summarizes the current long-term care system in New Zealand as follows.

- Older people's care needs are assessed by professionals with a uniform tool.
- Assessment and service delivery are separated under the system, ensuring the objectivity of assessment.
- Data are accumulated and shared at the practice level, using ICT.
- The focus of a service model is gradually shifted to home- and community-based care founded on the philosophy of rehabilitation.
- Meanwhile, structural challenges continue to exist, including shortages of financial and human resources as well as inequality in access. Systematic interventions in the prevention phase are limited.

The biggest learning from the system in New Zealand is the use of a uniform tool in needs assessment to understand the person's condition and predict prognosis, based on which services are provided. The practice in New Zealand suggests the need for Japan to take a similar step to build an assessment system: By using AI as a decision-making support tool, supplementing professional judgment in preparing care plans, we can conduct standardized assessments of functioning in

daily living and visualize changes in the person's condition based on longitudinal data, thereby linking the person to effective approaches.

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